KSDF 2024

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU KONGRESİ

17-21 NİSAN 2024
Rixos Sungate, Antalya

BİLİMSEL PROGRAM ve
BİLDİRİ ÖZETLERİ KİTABI

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KSDF 2024

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17-21 NİSAN 2024
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DAVET

Değerli Meslektaşlarım,

Ülkemizde daha önce kurulmuş olan Karadeniz, Ege, Akdeniz, Doğu Anadolu, Marmara ve İç Anadolu Kadın Sağlığı Derneklerinin bir araya gelerek oluşturduğu KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU hem Kadın Hastalıkları ve Doğum Uzmanı hekimlerimizin meslek örgütü olarak hem de Kadın Sağlığını ilgilendiren tüm konularla ilgilenmek üzere faaliyete başlamıştır.

Tüm Türkiye'de, Kuzey Kıbrıs Türk Cumhuriyeti ve Azerbaycan'da faaliyet gösteren Kadın Hastalıkları ve doğum hekimlerinin mesleki gelişimleri, bilimsel ve sosyal faaliyetlerine katkı sunmak için federasyon yönetimimiz bu yönde örgütlenerek Kadın Hastalıkları ve Doğum disiplini ile ilintili tüm diğer disiplinlere katkı sunmaktadır.

Öncelikli amacımız meslektaşlarımız arasında birlik ve dayanışma ruhu içinde mesleki bilgi, beceri ve eğitimlerimizi arttırmak olacaktır. Bununla birlikte toplumumuzda kadınlarımızın sağlığının korunması, geliştirilmesi ve sorunlarının çözülmesinde çaba harcamak da federasyonumuzun ana amaçları içindedir.

Federasyona üye her dernek yıllar içinde kurs - sempozyum - kongrelerini yapmış ve sıra Federasyonun genel kongresine gelmiştir. Planladığımız kongre Kadın Sağlığı alanında önemli bilgilerin paylaşıldığı, hepimizin bir araya geldiği ve gelecekteki çalışmaların şekillendirildiği önemli bir aktivite olacaktır.

"Sağlıklı Kadın, Güçlü Toplum, Güvenli Gelecek" mottomuz ile bu yılki kongremizde, Kadın Sağlığı konusundaki son gelişmeleri ve araştırmaları paylaşma fırsatını değerli katkılarınızla daha da özel hale getirmek istiyoruz. Bu amaçla sponsorluk toplantımızı düzenlemeyi ve bu toplantıda sizinle işbirliği fırsatlarımızı tartışmak istiyoruz.

Bilimsel program taslağını aşağıda bulacağınız kongrede sizlere sunulan sponsorluk seçenekleri hakkında düzenleyici firma tarafından bilgi verilecek ve işbirliği halinde ne tür kazanımlar elde edebileceği anlatılacaktır.

Sizden gelen katkıların, kadın sağlığına yönelik araştırmaları, eğitimi ve bilgi paylaşımını teşvik etme konusundaki misyonumuzu desteklememiz için kritik önem taşıdığını biliyoruz.

Sevgi ve Saygılarımızla

Gürkan Uncu
Kadın Sağlığı Dernekleri Federasyonu Başkanı

Bülent Urman
Kongre Başkanı

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU ONURSAL BAŞKANI

Victor Gomel

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU YÖNETİM KURULU

Kadın Sağlığı Dernekleri Federasyonu Başkanı
Gürkan Uncu

Karadeniz Kadın Sağlığı Derneği Başkanı
Davut Güven

Akdeniz Kadın Sağlığı Derneği Başkanı
Hüsnü Çelik

Marmara Kadın Sağlığı Derneği Başkanı
Işıl Kasapoğlu

Ege Kadın Sağlığı Derneği Başkanı
Erbil Doğan

Doğu Anadolu Kadın Sağlığı Derneği Başkanı
Yakup Kumtepe

İç Anadolu Kadın Sağlığı Derneği Başkanı
Salih Taşkın

KONGRE BAŞKANI

Bülent Urman

KONGRE SEKRETERLERİ

FEDERASYON
Kiper Aslan

FEDERASYON
Sinem Ertaş

KARADENİZ KSD
İbrahim Yalçın

AKDENİZ KSD
Pınar Çağlar Aytaç

DOĞU ANADOLU KSD
Onur Karaaslan

MARMARA KSD
Serenat Yalçın

İÇ ANADOLU KSD
Yavuz Emre Şükür

EGE KSD
Ahmet Demir

BİLİMSEL PROGRAM SORUMLULARI

MATERNAL FETAL TIP
Recep Has
Oluş Api
Bilge Çetinkaya Demir

ÜREME ENDOKRİNOLOJİSİ VE İNFERTİLİTE
Ahmet Zeki Işık
Başak Balaban
Aylin Pelin Çil

ONKOLOJİ
Mete Güngör
Doğan Vatansever
Yakup Yalçın

ÜROJİNEKOLOJİ
Serdar Aydın
Adnan Orhan
Ulaş Çoban

ENDOMETRİOZİS
Ercan Baştu
Onur Topçu
Üzeyir Kalkan

MENOPOZ
Fatih Durmuşoğlu
Levent Şentürk
Fatih Aktoz

KONTRASEPSİYON
Berna Dilbaz
Nefise Nazlı Yenigül
Yetkin Karasu

LAPAROSKOPİ
Kemal Özerkan
Erhan Şimşek
Nasuh Utku Doğan

GÖRÜNTÜLEME
Ayşe Seyhan
Murat Yassa
Pınar Birol İlter

ROBOTİK CERRAHİ
İlkkan Dünder
Ahmet Göçmen
Gürkan Kıran

FONKSİYONEL TIP
Yaprak Üstün
Pınar Bahat
Tülin Özdemir

KOZMETİK JİNEKOLOJİ
Süleyman Akhan
Ebru Alper
Orhan Orhan

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU DANIŞMA KURULU

Acar Koç
Ahmet Zeki Işık
Akın Sivaslıoğlu
Ali Ayhan
Ali Haberal
Atıl Yüksel
Barış Ata
Başak Balaban
Bülent Urman
Cemal Posacı
Cihat Ünlü
Çağatay Taşkıran
Esat Orhon
Faruk Köse
Fatih Durmuşoğlu
Fırat Ortaç
Fuat Demirci
Fuat Demirkıran
Gürkan Bozdağ
Hakan Seyisoğlu
Hakan Yaralı
İlkkan Dünder
Kemal Özerkan
Kunter Yüce
Kutay Biberoğlu
Macit Arvas
Mehmet Ali Vardar
Mete Güngör
Mustafa Bahçeci
Müfit Yenen
Namık Demir
Nejat Özgül
Recep Has
Rıza Madazlı
Semra Kahraman
Serdar Özşener
Tugan Beşe
Vedat Atay
Yaprak Üstün
Yücel Karaman

BİLİMSEL KURUL

Abdulkadir Turgut
Abdullah Karaer
Abdullah Tok
Ahmet Barış Güzel
Ahmet Demir
Ahmet Erdem
Alev Özer
Ali Sami Gürbüz
Arif Serhan Cevrioğlu
Aslıhan Yurtkal
Ateş Karateke
Aylin Pelin Çil
Ayşe Zehra Özdemir
Bahar Yüksel Özgör
Baki Şentürk
Belgin Devranoğlu
Berna Haliloğlu Peker
Berrin Avcı
Burak Karadağ
Burak Sezgin
Burcu Dinçgez Çakmak
Bülent Çakmak
Bülent Demir
Bülent Yılmaz
Cem Fıçıcıoğlu
Cem Somer Atabekoğlu
Cengiz Karakaya
Cenk Sayın
Cenk Yaşa
Cetin Çam
Cihan Çakır
Cihan Kaya
Çetin Çelik
Çetin Kılıççı
Deha Denizhan Keskin
Devrim Tok
Ebru Çelik
Emine Seda Güvendağ Güven
Emre Mat
Emsal Pınar Topdağı Yılmaz
Engin Türkgeldi
Engin Yurtçu
Erbil Kahraman
Ercan Mustafa Aygen
Erdal Kaya
Erdin İlter
Erdoğan Aslan
Eren Akbaba
Erkan Alataş
Erkan Kalafat
Eser Çolak
Esra Bulgan
Esra Çetinkaya
Esra Kuşcu
Ethem Serdar Yalvaç
Evrim Erdemoğlu
Ezgi Ceren Dallı
Faruk Abike
Fatma Ferda Verit
Fisun Vural
Funda Göde
Ganim Khatib
Gonca Çoban Şerbetçioğlu
Gökhan Yıldırım
Gülşah Aynaoğlu
Güvenç Karlıkaya
Hakan Aytan
Hale Göksever çelik
Hamdullah Sözen
Hasan Bahadır Saatli
Hüseyin Görkemli
Hüseyin Levent Keskin
Hüsnü Görgen
Işık Kaban
İbrahim Bildirici
İbrahim Kalelioğlu
İbrahim Veysel Fenkçi
İdris Koçak
İlhan Şanverdi
İlkbal Temel Yüksel
İnanç Mendilcioğlu
İrfan Kutlar
İsmail Bıyık
İsmail Çepni
İsmail Küçükerdoğan
İsmet Gün
Kadir Bakay
Kayhan Yakın
Kemal Güngördük
Kenan Serdar Dolapçıoğlu
Kübra Boynukalın
Levent Yaşar
Mahmut Öncül
Mehmet Bülbül
Mehmet Erdem
Mehmet Harma
Mehmet Yılmazer
Mehtap Polat
Melike Başpınar
Mert Küçük
Mert Tuğral
Mesut Öktem
Mesut Polat
Mete Çağlar
Murat Api
Murat Gültekin
Murat Muhçu
Murat Naki
Murat Öz
Murat Özekinci
Mutlu Meydanlı
Müge Harma
Müjde Canday
Nafiye Karakuş
Nefise Tanrıdan Okçu
Neşe Yücel
Nevin Sağsöz
Nida Bayık
Nilüfer Çetinkaya Kocadal
Nuray Bozkurt
Onur Karaaslan
Onur Karabacak
Orhan Orhan
Orhan Ünal
Osman Fadil Kara
Ömer Tarık Yalçın
Özcan Balat
Özgüç Takmaz
Özgür Akbayır
Özgür Öktem
Özgür Özyüncü
Özlem Dural
Paşa Uluğ
Petek Balkanlı
Pınar Özcan
Pınar Tokdemir Çalış
Pınar Yalçın Bahat
Rahmi Sinan Karadeniz
Ramazan Mercan
Rukset Attar
Sabahattin Altınyurt
Salih Burçin Kavak
Seda Keskin
Sefa Kurt
Selçuk Erkılınç
Selda Demircan Sezer
Selim Büyükkurt
Selin Özaltın
Serdar Açıkgöz
Serdar Dilbaz
Serkan Erkanlı
Sermet Sağol
Servet Özden Hacıvelioğlu
Sezcan Mümüşoğlu
Süleyman Engin Akhan
Süleyman Güven
Süleyman Salman
Şebnem Alanya Tosun
Şevki Çelen
Şevki Göksun Gökulu
Şule Yıldız
Tayyup Şimşek
Telce Ayşen Gürbüz Küçükceran
Temel Ceyhan
Tevfik Güvenal
Tuğba Saraç Sivrikoz
Ulaş Çoban
Ülkü Özmen
Ümit Özekici
Ümran Küçükgöz Güleç
Vehbi Yavuz Tokgöz
Veli Mihmanlı
Yakup Baykuş
Yasemin Taşçı
Yeşim Bayoğlu Tekin
Yusuf Üstün
Zeliha Cüylan

17 Nisan 2024, Çarşamba

FEDERASYON	AKDENİZ	KARADENİZ	BAKÜ/GENÇ ADIMLAR
13:30-18:00 BİRİNCİ TRİMESTER FETAL ULTRASONOGRAFİ ve DOPPLER	13:30-18:00 ENDOMETRİOZİS ULTRASONOGRAFİSİ	13:30-18:00 GENİTAL ESTETİK ve JİNEKOLOJİK LAZER KURSU	13:30-18:00 V-NOTES
15:30-16:00 KAHVE MOLASI			
DOĞU ANADOLU	**MARMARA**	**EGE**	**İÇ ANADOLU**
13:30-18:00 TRANSPERİNEAL PELVİK TABAN ULTRASONOGRAFİSİ	13:30-18:00 UZMANLARIN JİNEKOLOJİK ONKOLOJİDE SIK KARŞILAŞTIĞI SORUNLAR	13:30-18:00 AKADEMİK YAZI YAZMA	13:30-18:00 İNFERTİLİTE HEMŞİRELİĞİ

18 Nisan 2024, Perşembe

	FEDERASYON	AKDENİZ	KARADENİZ	BAKÜ/GENÇ ADIMLAR	DOĞU ANADOLU	MARMARA	EGE	İÇ ANADOLU
08:30-09:15	YARIŞACAK SÖZLÜ BİLDİRİLER 1	YARIŞACAK SÖZLÜ BİLDİRİLER 2	YARIŞACAK SÖZLÜ BİLDİRİLER 3	YARIŞACAK VİDEO BİLDİRİLER 1	SÖZLÜ BİLDİRİLER 1	SÖZLÜ BİLDİRİLER 2	SÖZLÜ BİLDİRİLER 3	VİDEO BİLDİRİLER 1
	09:15-09:30 ARA							
09:30-11:00	HPV VE KANSER	JİNEKOLOJİK GÖRÜNTÜLEME	HORMON TEDAVİSİNE GÜNCEL YAKLAŞIM	TÜRKİYE - AZERBAYCAN - KKTC ORTAK OTURUMU	SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ-MYOMEKTOMİ-KİST EKSİZYONU	MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ	HORMONAL KONTRASEPSİYONDA MAKET ÜZERİNDE İMPLANT EĞİTİMİ	POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM
	11:00-11:30 KAHVE ARASI							
	11:30-12:15 - FEDERASYON SALONU UYDU SEMPOZYUMU							
12:15-13:30	PANEL: ENDOMETRİOZİSTE NE ZAMAN CERRAHİ YAPALIM?	PANEL: EMBRİYOLOJİ	YARA TEDAVİSİ					
	13:30-14:30 ÖĞLE YEMEĞİ							
	13:45-14:30 ÖĞLE YEMEĞİNDE UZMANLA BULUŞUN Hale Göksever Çelik • Vehbi Yavuz Tokgöz • Yakup Kumtepe • Tugan Beşe • Serdar Günalp • Sefa Kurt • Işıl Kasapoğlu • Ahmet Erdem							
14:30-16:00	PANEL: OBSTETRİKTE TARTIŞMALI KONULAR	ÜROJİNEKOLOJİK CERRAHİ	FERTİLİTE PREZERVASYONU	FONKSİYONEL TIP	SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU	MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ	HORMONAL KONTRASEPSİYONDA MAKET ÜZERİNDE İMPLANT EĞİTİMİ	POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM
	16:00-16:30 KAHVE ARASI							
	16:30-17:15 - FEDERASYON SALONU UYDU SEMPOZYUMU							
	17:15-17:30 ARA							
17:30-19:00	PANEL: CANLI CERRAHİ LAPAROSKOPİK HİSTEREKTOMİ	PANEL: İNFERTİLİTEDE PROGESTERON	PANEL : GEBELİKTE AMPİRİK TEDAVİLER					

19 Nisan 2024, Cuma

	FEDERASYON	AKDENİZ	KARADENİZ	BAKÜ/GENÇ ADIMLAR	DOĞU ANADOLU	MARMARA	EGE	İÇ ANADOLU
08:30-09:15	YARIŞACAK SÖZLÜ BİLDİRİLER 4	YARIŞACAK SÖZLÜ BİLDİRİLER 5	YARIŞACAK SÖZLÜ BİLDİRİLER 6	YARIŞACAK VİDEO BİLDİRİLER 2	SÖZLÜ BİLDİRİLER 4	SÖZLÜ BİLDİRİLER 5	SÖZLÜ BİLDİRİLER 6	VİDEO BİLDİRİLER 2
09:15-09:30 ARA								
09:30-11:00	PRETERM DOĞUM VE KISA SERVİKS	IVF LABORATUVARINDA EN İYİ EMBRİYOYU YAPMAK VE SEÇMEK	İLERİ EVRE ENDOMETRİOZİS VE AĞRI	AVRUPA BİRLİĞİ PROJELERİ BAŞVURU PRENSİPLERİ	SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU	MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ	HORMONAL KONTRASEPSİYONDA MAKET ÜZERİNDE İMPLANT EĞİTİMİ	POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM
11:00-11:30 KAHVE ARASI								
11:30-12:15 - FEDERASYON SALONU UYDU SEMPOZYUMU								
12:15-13:30	PANEL: ADNEKSİYEL KİTLELERE YAKLAŞIM	IVF UYGULAMALARINDA EK TEDAVİLER	PANEL: OVER STİMÜLASYONU- BİREYSEL VS GENEL					
13:30-14:30 ÖĞLE YEMEĞİ								
13:45-14:30 ÖĞLE YEMEĞİNDE UZMANLA BULUŞUN • Özcan Balat • Orhan Ünal • Nevin Sağsöz • Melike Aslan • Mehtap Polat • Mehmet Yılmazer • Mehmet Harma • Cengiz Alataş • Davut Güven • Çetin Çelik								
14:30-16:00	İNKONTİNANSA YAKLAŞIM	BİRİNCİ TRİMESTER	POSTPARTUM ACİLLER	KSDF ADÖLESAN SAĞLIĞI PROJESİ	SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU	MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ	HORMONAL KONTRASEPSİYONDA MAKET ÜZERİNDE İMPLANT EĞİTİMİ	POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM
16:00-16:30 KAHVE ARASI								
16:30-17:15 - FEDERASYON SALONU UYDU SEMPOZYUMU								
17:15-17:30 ARA								
17:30-19:00	PANEL: CANLI CERRAHİ LAPAROSKOPİK MYOMEKTOMİ	PANEL: 40 YAŞINDAN SONRA FERTİLİTE	PANEL: DOĞUM İNDÜKSİYONU					

20 Nisan 2024, Cumartesi

	FEDERASYON	AKDENİZ	KARADENİZ	BAKÜ/GENÇ ADIMLAR	DOĞU ANADOLU	MARMARA	EGE	İÇ ANADOLU
08:30-09:15	YARIŞACAK SÖZLÜ BİLDİRİLER 7	YARIŞACAK SÖZLÜ BİLDİRİLER 8	YARIŞACAK SÖZLÜ BİLDİRİLER 9	YARIŞACAK VİDEO BİLDİRİLER 3	SÖZLÜ BİLDİRİLER 7	SÖZLÜ BİLDİRİLER 8	SÖZLÜ BİLDİRİLER 9	VİDEO BİLDİRİLER 3
	09:15-09:30 ARA							
09:30-11:00	HİSTEROSKOPİK CERRAHİ	KİŞİYE ÖZEL KONTRASEPSİYON	ROBOTİK CERRAHİ	KSDF GENÇ ADIMLAR OTURUMU 1	SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ-MYOMEKTOMİ-KİST EKSİZYONU	MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ	HORMONAL KONTRASEPSİYONDA MAKET ÜZERİNDE İMPLANT EĞİTİMİ	POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM
	11:00-11:30 KAHVE ARASI							
	11:30-12:15 - FEDERASYON SALONU UYDU SEMPOZYUMU							
12:15-13:30	PANEL: NEDENİ AÇIKLANAMAMIŞ İNFERTİLİTE	2. VE 3. TRİMESTER	ANORMAL UTERİN KANAMA					
	13:30-14:30 ÖĞLE YEMEĞİ							
	13:45-14:30 ÖĞLE YEMEĞİNDE UZMANLA BULUŞUN Işık Kaban • Burcu Kasap • Salih Taşkın • Cengiz Andan • Hüsnü Çelik • Mehmet Ali Narin • Erbil Doğan •Ercan Mustafa Aygen • Carlo Alviggi							
14:30-16:00	MENOPOZ VE MEME KANSERİ İLİŞKİSİ	JİNEKOLOJİK KANSERLERE GÜNCEL YAKLAŞIM	PANEL: KOZMETİK JİNEKOLOJİDE SINIRLARI ÇİZEBİLMEK	KSDF GENÇ ADIMLAR OTURUMU 2	SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU	MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ	HORMONAL KONTRASEPSİYONDA MAKET ÜZERİNDE İMPLANT EĞİTİMİ	POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM
	16:00-16:30 KAHVE ARASI							
	16:30-17:15 - FEDERASYON SALONU UYDU SEMPOZYUMU							
	17:15-17:30 ARA							
17:30-19:00	PANEL: CANLI CERRAHİ ENDOMETRİOZİS	PANEL: SERVİKAL PREMALİGN LEZYONLAR	KONJENİTAL ENFEKSİYONLAR					

21 Nisan 2024, Pazar

	FEDERASYON	AKDENİZ	KARADENİZ	BAKÜ/GENÇ ADIMLAR	DOĞU ANADOLU
08:30-09:15	OLGU SUNUMLARI 1	OLGU SUNUMLARI 2	OLGU SUNUMLARI 3	OLGU SUNUMLARI 4	OLGU SUNUMLARI 5
	09:15-09:30 ARA				
09:30-11:00	KOZMETİK JİNEKOLOJİK CERRAHİ	KONTRASEPSİYON	JİNEKOLOJİ VE OBSTETRİDE YAPAY ZEKA	OLGU SUNUMLARI 6	OLGU SUNUMLARI 7
	11:00-11:30 KAHVE ARASI				
	KAPANIŞ TÖRENİ				

17 Nisan 2024, Çarşamba

FEDERASYON SALONU

13:30-18:00 **BİRİNCİ TRİMESTER FETAL ULTRASONOGRAFİ ve DOPPLER**
Kurs Başkanı: Recep Has
Oturum Başkanları: Zeki Şahinoğlu, İnanç Mendilcioğlu

13:30-14:00 4 - 10 Hafta USG: GS, YS, Viabilite, CRL, Koryonisite: Normal ve Anormal Bulgular
Hakan Erenel

14:00-14:30 11 - 13+6 Hafta; CRL, NT, NK Ölçümleri: Normal ve Anormal Bulgular
Erzat Toprak

14:30-15:00 Doppler: DV, TR, Uterin Arterler: Normal ve Anormal Bulgular
Ebru Davutoğlu

15:00-15:30 Fetal MSS İncelemesi ve NTD Tanısı: Normal ve Anormal Bulgular
Tuğba Saraç Sivrikoz

Tartışma

15:30-16:00 **KAHVE ARASI**

16:00-18:00 **Oturum Başkanları: Halil Aslan, İbrahim Kalelioğlu**

16:00-16:30 Fetal Kalp İncelemesi: Normal ve Anormal Bulgular
Oya Demirci

16:30-17:00 Fetal Yüz, Nazal Üçgen, Maksiller Gap, Mandibular Gap: Normal ve Anormal Bulgular
Semir Köse

17:00-17:30 Fetal Toraks, Batın, Ekstremiteler: Normal ve Anormal Bulgular
Gülşah Aynaoğlu Yıldız

17:30-18:00 Birinci Trimesterde Fetal Ultrason ile CfDNA ile Entegrasyonu
Cihan İnan

Tartışma

AKDENİZ SALONU

13:30-18:00 **ENDOMETRİOZİS ULTRASONOGRAFİSİ**
Kurs Başkanı: Ayşe Seyhan
Oturum Başkanları: Ayşe Seyhan, Anna Štěpanovská

13:30-14:00 IDEA Konsensüsü Endometriozis Tanı ve Tanımlamasında Aynı Dili Konuşuyor muyuz?
Ayşe Seyhan

14:00-14:30 Pelvik Derin Endometriozisin Non-İnvaziv Teşhisi ve Sınıflandırılması için MR Görüntüleme Teknikleri
Metin Vural

14:30-15:00 Ultrason Görüntülerini Cerrahi Bulgularla İlişkilendirme
Bülent Urman

15:00-15:30 Endometriozisli Vaka Örnekleri ile Küçük Gruplar Halinde Tartışma
Ercan Baştu, Anna Štěpanovská, İsmail Bıyık, Mara Albanese

Tartışma

15:30-16:00 **KAHVE ARASI**

16:00-18:00 **Oturum Başkanları: Işıl Kasapoğlu, Sinem Ertaş**

16:00-16:30 Derin Endometriozis Nasıl Aranır? - Video Gösterimi
Sinem Ertaş

16:30-17:00 Adenomyozisin Ultrason ile Teşhisi ve MUSA Konsensüsü
Mara Albanese

17:00-17:30 Adenomyozisli Vaka Örnekleri ile Küçük Grup Tartışmaları
Ayşe Seyhan, Sinem Ertaş, Mesut Önal, Anna Štěpanovská

17:30-18:00 Ultrason ile Yüzeysel Endometriozis Tanısı
Stefano Guerriero

Tartışma

17 Nisan 2024, Çarşamba

KARADENİZ SALONU

13:30-18:00 **GENİTAL ESTETİK ve JİNEKOLOJİK LAZER KURSU**
Kurs Başkanları: Ebru Alper, Ozan Doğan
Oturum Başkanları: Ebru Alper, Ozan Doğan

13:30-14:00 Temel İlkeler
Ebru Alper
Komplikasyon Yönetimi
Ozan Doğan
14:00-14:30 Labioplasti-Teknikler, Hangi Hasta Hangi Teknik ?
Müjde Özer
14:30-15:00 Vajinoplasti
Songül Alemdaroğlu
15:00-15:30 Genital Bölge Hyalüronik Asit Uygulamaları
Sevtap Hamdemir Kılıç

15:30-16:00 **KAHVE ARASI**

16:00-18:00 **Oturum Başkanları: Sevtap Hamdemir Kılıç, Songül Alemdaroğlu**

16:00-16:30 - Lazer Enerji Modaliteleri Nelerdir?
- Lazerin Çalışma Prensipleri Nelerdir?
- Hangi Cihaz Tercih Edilmelidir, Neden?
Sevtap Hamdemir Kılıç
16:30-17:00 Genital Bölge Renk Açma, Vulvar Rejuvenasyon, Lazerin Klinik Ortamda Kullanım Alanları Nelerdir? Ofis Labioplastide Lazerin Kullanımı
Erhan Cömert
17:00-17:30 Kozmetik Jinekolojide Rejeneratif Tedaviler (Kök Hücre, PRP, Mezoterapi ve Ozon Uygulamaları)
Songül Alemdaroğlu
17:30-18:00 Liposuction ve Lipofilling
Ozan Doğan

Tartışma

BAKÜ/GENÇ ADIMLAR SALONU

13:30-18:00 **V-NOTES**
Kurs Başkanı: Üzeyir Kalkan
Oturum Başkanları: Ghanim Khatip, Özgüç Takmaz

13:30-14:00 V-NOTES Cerrahisine Giriş
- V-NOTES Cerrahisinin Sınırları
- Cerrahi Öncesi Hasta Hazırlığı
- İntraoperatif Hazırlık, Set-Up
- Postoperatif Takip ve Yönetim

Üzeyir Kalkan

14:00-14:30 V-NOTES
- VajinalFaz
- Kolpotomi Posterior
- Kolpotomi Anterior
- Kolpotomi Kapatılması

Özgüç Takmaz

14:30-15:00 V-NOTES
- Histerektomi
- Basit Histerektomi
- Lateral Pencere Tekniği ile Histerektomi

Murat Yassa

15:00-15:30 Tartışma

15:30-16:00 **KAHVE ARASI**

16:00-18:00 **Oturum Başkanları: Süleyman Salman, Bulut Varlı**

16:00-16:30 V-NOTES
- Adneksiyel Cerrahi
- Salpenjektomi, Adneksektomi
- Over Kist Eksizyonu

Behzat Can

16:30-17:00 V-NOTES
- Lateral Mesh Süspansiyonu
- Uterus Koruyucu V-NOTES Lateral Mesh Süspansiyonu
- Histerektomize Hastada V-NOTES Lateral Mesh Süspansiyonu

Süleyman Salman

17:00-17:30 V-NOTES
- Zor Cerrahiler
- Myomatö Uterus Histerektomi
- Adezyonlu Vakalarda V-NOTES
- Umblikal Herni Onarımı
- Adneksiyel Torsiyon
- Myomektomi

Cihan Kaya

17:30-18:00 Tartışma

17 Nisan 2024, Çarşamba

DOĞU ANADOLU SALONU

13:30-18:00 **TRANSPERİNEAL PELVİK TABAN ULTRASONOGRAFİSİ**
Kurs Başkanı: Murat Yassa
Oturum Başkanları: Serdar Aydın, Pınar Birol İlter

13:30-14:00 Pelvik Taban Ultrasonografisine (PTU) Giriş
- Uygulama Metodları; Transperineal, İntroital, Transvajinal
- Anatomik Tanımlamalar ve Nirengi Noktaları
- Resim, Video Kaydetme ve Data Biriktirme

Serdar Aydın

14:00-14:30 Pelvik Organ Prolapsusu Tanı ve Tedavisinde PTU
- Anatomik Tanımlamalar
- Ön Kompartman Prolapsusu, Green Tiplendirmesi
- Midüretral Sling ile Kime Kolporafi Posterior Yapalım, Kime Yapmayalım?
- Arka Kompartman Değerlendirilmesi

Pınar Birol İlter

14:30-15:00 Kadın Üriner İnkontinansı Tanı ve Tedavisinde PTU
- SUI, ISD, UUI Ayrımında PTU
- Mesane Hipermobilitesinin Tanınması
- Okült SUI Tanınması
- MUS için Doğru Anatomik Lokalizasyon Nedir?
- MUS Cerrahisinde Başarının Prediksiyonu
- MUS Komplikasyonları ve Örnekleri

Ozan Doğan

15:00-15:30 Tartışma

15:30-16:00 **KAHVE ARASI**

16:00-18:00 **Oturum Başkanları: Murat Yassa, Ecem Eren**

16:00-16:30
- Anal Sfinkter Değerlendirilmesinde PTU
- Anal Sfinkterin Sonografik Anatomisi
- Obstetrik Anal Sfinkter Hasarı (OASIS) Tanınması
- Okült OASIS Tanınması

Ecem Eren

16:30-17:00 İntrapartum Ultrasonografi (IP)
- Spontan Vajinal Doğumun Prediksiyonunda PTU
- Operatif Vajinal Doğum Başarılı Olacak mı?
- Sezeryan Kararı Nasıl Verilir?
- IP Ne Zaman Uygulayalım?
- Fetal Baş Duruş Anomalilerinin Tanınması

Pınar Birol İlter

17:00-17:30 Asinklitizm Tanısı
- Asinklitizm Nedir?
- Asinklitizm Tipleri ve PTU ile Tanınması
- Asinklitizmde FIGO Deneyimi ve Sonuçları
- Asinklitizmin Şiddetine Göre Yeni PTU Sınıflaması

Murat Yassa

17:30-18:00 Tartışma ve Canlı Hasta Hands-On Pelvik Taban Ultrasonu Uygulamaları

MARMARA SALONU

13:30-18:00 **UZMANLARIN JİNEKOLOJİK ONKOLOJİDE SIK KARŞILAŞTIĞI SORUNLAR**
Kurs Başkanı: Yakup Yalçın
Oturum Başkanları: Yakup Yalçın, Erbil Karaman

13:30-14:00 Servikal Sitoloji Anormallikleri ve Preinvaziv Lezyonların Yönetimi
Yakup Yalçın

14:00-14:30 Servikal Preinvaziv Lezyonların Tedavisinde Ablatif ve Eksizyonel Prosedürler
Şevki Göksun Gökulu

14:30-15:00 Endometrial Hiperplazilerin Yönetiminde Medikal Tedavi
Kemal Güngördük

15:00-15:30 Gestasyonel Trofoblastik Hastalıklar ve Neoplazilerinin Yönetimi
İbrahim Yalçın

15:30-16:00 **KAHVE ARASI**

16:00-18:00 **Oturum Başkanları: Selçuk Erkılınç, Recep Erin**

16:00-16:30 Adneksiyel Kitlelerde USG'nin Yeri ve Risk Skorlaması
Selçuk Erkılınç

16:30-17:00 Uterin Malignitelerde USG'nin Kullanımı
Hamdullah Sözen

17:00-17:30 Jinekolojik Malignitelerde BT ve MRG'nin Yorumlanması
Gökhan Öngen

17:30-18:00 Jinekolojik Malignitelerde Laparoskopinin Yeri
Doğan Vatansever

EGE SALONU

13:30-18:00 **AKADEMİK YAZI YAZMA**
Kurs Başkanı: Erkan Kalafat
Oturum Başkanları: Erkan Kalafat, Sibel Sakarya

13:30-14:00 İyi Bir Araştırma Makalesi Nasıl Yazılır?
Erkan Kalafat

14:00-14:30 Gözlemsel Araştırma Makalelerinde Dikkat Edilmesi Gerekenler
Sibel Sakarya

14:30-15:00 Tartışma

15:30-16:00 **KAHVE ARASI**

16:00-18:00 **Oturum Başkanları: Erkan Kalafat, Engin Türkgeldi**

16:00-16:30 Randomize Kontrollü Çalışmaların Raporlanması
Engin Türkgeldi

16:30-17:00 Sistematik Derleme ve Meta-Analizler: Bir Editör Makalenizi Nasıl Değerlendirir?
Barış Ata

17:00-17:30 Tartışma

İÇ ANADOLU SALONU

13:30-18:00 **İNFERTİLİTE HEMŞİRELİĞİ**
Kurs Başkanı: Funda Göde
Oturum Başkanları: Bülent Urman, Aslıhan Yurtkal

13:30-14:00 Over Stimülasyon Protokollerinin Doğru Şekilde Uygulanmasında Hemşirenin Rolü?
Seda Soyer

14:00-14:30 Yumurta Toplama İşleminde Karşılaşılabilecek Sorunlar ve Çözümler
Zeynep Güner

14:30-15:00 Aşırı Stimüle Edilmiş Hasta Nasıl Yönetilir?
Büşra Bulduk

15:00-15:30 Luteal Faz Desteği Nedir,Nasıl ve Ne Süre ile Uygulanır?
Funda Göde

Tartışma

15:30-16:00 **KAHVE ARASI**

16:00-18:00 **Oturum Başkanları: Gülşen Doğan Durdağ, Tülay Karataş**

16:00-16:30 Klivaj Embriyosu mu Blastokist Transferi Mi? Taze mi Donmuş mu?
Elif Korkmaz Ordu

16:30-17:00 Donmuş Embriyo Transferi için Endometrial Hazırlık Protokolleri
Gülşen Doğan Durdağ

17:00-17:30 Başarısız Sikluslarda Çift - Hemşire İlişkisi
İlkay Çorbacı Çınar

17:30-18:00 Tartışma

FEDERASYON SALONU

08:30-09:15 — **YARIŞACAK SÖZLÜ BİLDİRİLER 1**
Jüri: Bülent Urman, Mehmet Harma, Vedat Atay, Cansu Kaya
YS-01 / YS-02 / YS-03

09:15-09:30 — **ARA**

09:30-11:00 — **HPV VE KANSER**
Oturum Başkanları: Sinan Özalp, Tayyup Şimşek

09:30-09:50 HPV ve Servikal Kanser Epidemiyolojisi
Ali Ayhan
09:50-10:10 Türkiye Servikal Kanser Tarama Programı
Nejat Özgül
10:10-10:30 HPV'nin Medikal Tedavisi
Murat Gültekin
10:30-10:50 Konizasyon Endikasyonları ve Teknikleri
Seda Şimşek
10:50-11:00 Tartışma

11:00-11:30 — **KAHVE ARASI**

11:30-12:15 — **UYDU SEMPOZYUMU**
Uzun Etkili Kontrasepsiyonda Cilt Altı İmplantın Yeri
Oturum Başkanı: Gürkan Uncu
Konuşmacı: Nefise Nazlı Yenigül

ORGANON
Here for her health

12:15-13:30 — **PANEL: ENDOMETRİOZİSTE NE ZAMAN CERRAHİ YAPALIM?**
Panel Başkanı: Bülent Urman
Panelistler: Ertan Sarıdoğan, Gürkan Uncu, Stephano Angioni, Angelos Danilis

- Endometrioma
- Endometrioma ve Ağrı
- Derin İnfiltratif Endometriozis
- Derin Endometriozis, Barsak Tutulumu
- Derin Endometriozis, Adenomyozis, Barsak Tutulumu
- Derin Endometriozis, Barsak Tutulumu, Adenomyozis, Hidrosalpenks, Geçirilmiş Cerrahi
- Siyatik Sinir Tutulumu
- Tartışma

13:30-14:30 — **ÖĞLE YEMEĞİ**

FEDERASYON SALONU

13:45-14:30 **ÖĞLE YEMEĞİNDE UZMANLA BULUŞUN**

- **Hale Göksever Çelik** - Endometriozis ve İnfertilite
- **Vehbi Yavuz Tokgöz** - PCOS Olgularında Ovulasyon İndüksiyonu Nasıl Olmalıdır ?
- **Yakup Kumtepe** - Pelvik Prolapsus da Laparoskopik Yeni Cerrahi Yöntemler
- **Tugan Beşe** - Sentinel Lenf Nod Haritalaması
- **Serdar Günalp** - Erkek İnfertilitesi (Genel)
- **Sefa Kurt** - Over Kanseri
- **Işıl Kasapoğlu** - Optimal Histerosalpingografi Değerlendirilmesi Nasıl Olmalıdır?
- **Ahmet Erdem** - Açıklanamayan İnfertilite: Güncel Yönetim

14:30-16:00 **PANEL: OBSTETRİKTE TARTIŞMALI KONULAR**
Panel Başkanı: Recep Has
Panelistler: Tuğba Saraç Sivrikoz, Selim Büyükkurt, Serenat Yalçın, İnanç Mendilcioğlu

- Birinci Trimesterde SGA Tahmini ve Önlenmesi
- Çoğul Gebeliklerde Erken Doğum Profilaksisi
- Erken Doğum Tehdidinde İdame Tokolitik Tedaviler: Etkinlik ve Riskler
- Trombofili ve Gebelik Komplikasyonları Arasında Gerçekten Bir İlişki Var mı?
- Tartışma

16:00-16:30 **KAHVE ARASI**

16:30-17:15 **UYDU SEMPOZYUMU**
PİCO7, Tek Kullanımlık Negative Basınç Sistemleri ve İnsizyon Yönetimi
Oturum Başkanı: Gürkan Uncu
Konuşmacı: Hakan Uncu

Smith+Nephew

17:15-17:30 ARA

17:30-19:00 **PANEL: CANLI CERRAHİ LAPAROSKOPİK HİSTEREKTOMİ**
Panel Başkanı: Uğur Fırat Ortaç
Panelistler: Kemal Özerkan, Üzeyir Kalkan, Angelos Danilidis, Barış Güzel

LIVE

Cerrah: Nasuh Utku Doğan

AKDENİZ SALONU

08:30-09:15 — **YARIŞACAK SÖZLÜ BİLDİRİLER 2**
Jüri: Gürkan Uncu, Hüsnü Görgen, Güvenç Karlıkaya, Müfit Yenen, Batuhan Aslan
YS-04 / YS-05 / YS-06

09:15-09:30 — **ARA**

09:30-11:00 — **JİNEKOLOJİK GÖRÜNTÜLEME**
Oturum Başkanları: Ayşe Seyhan, Paşa Uluğ

09:30-09:50 Uterusun Optimal Görüntülemesi Nasıl Olmalı? - İntrakaviter ve İntramural Lezyonların Ayırıcı Tanısı
Anna Štěpanovská

09:50-10:10 Endometriozis Ultrasonografisi - Yüzeyelden Derine
Stephano Guerrerio

10:10-10:30 IOTA Adneks Modeli - Malignite Yönünden Şüpheli Adneksiyel Kitle Nedir?
Deha Denizhan Keskin

10:30-10:50 Adenomyozis Tanısında Ultrasonografinin Yeri
Sinem Ertaş

10:50-11:00 Tartışma

11:00-11:30 — **KAHVE ARASI**

12:15-13:30 — **PANEL: EMBRİYOLOJİ**
Gelecekte IVF Laboratuvarlarında Neler Değişecek, Yenilikler Neler Olacak?
Panel Başkanı: Başak Balaban
Panelistler: Alison Campbell, Sinan Özkavukcu, Kerem Dirican, İpek Keleş, Cihan Çakır

- IVF Laboratuvarına Otomasyon Nasıl Entegre Edilecek?
- IVF Laboratuvarlarında Kullandığımız Performans İndikatörleri Gelecekte Nasıl Değişikliğe Uğrayacak?
- IVF Laboratuvarda Tam Otomasyon Entegrasyonu Durumunda Gelecekte Embriyolog ve Laboratuvar Teknisyenlerinin Rolü Ne Olacak?
- Tartışma

13:30-14:30 — **ÖĞLE YEMEĞİ**

AKDENİZ SALONU

14:30-16:00 **ÜROJİNEKOLOJİK CERRAHİ**
Oturum Başkanları: Yakup Kumtepe, Ulaş Çoban

Apikal Prolapsusta Vajinal Operasyonlar mı Yoksa Abdominal Operasyonlar mı?
Fuat Demirci
Prolapsus Operasyonuna Histerektomi Ekleyelim mi? Uterusu Koruyalım mı?
Funda Güngör Uğurlucan
Prolapsusta En İyi Operasyonu Seçmek
Yakup Kumtepe
Prolapsus İnkontinans Birlikteliği Nasıl Yönetilmelidir?
Adnan Orhan
Tartışma

16:00-16:30 **KAHVE ARASI**

17:30-19:00 **PANEL: İNFERTİLİTEDE PROGESTERON**
Panel Başkanı: Hakan Yaralı
Panelistler: Filippo Ubaldi, Abha Maheswari, Kayhan Yakın, Gürkan Bozdağ, Murat Özekinci

- Foliküler Fazda Progesteron
- PPOS
- HCG Öncesi Progesteron Yüksekliği ve Önemi
- Luteal Fazda Progesteron
- Ne Zaman Başlansın?
- Nasıl Verilsin?
- Ne Zaman Kesilsin?
- Tartışma

KARADENİZ SALONU

08:30-09:15 **YARIŞACAK SÖZLÜ BİLDİRİLER 3**
Jüri: Davut Güven, Ömer Tarık Yalçın, Murat Api, Mustafa Bahçeci, Tuğba Akkök
YS-07 / YS-08 / YS-09

09:15-09:30 **ARA**

09:30-11:00 **HORMON TEDAVİSİNE GÜNCEL YAKLAŞIM**
Oturum Başkanları: Erdoğan Ertüngealp, Sezai Şahmay

09:30-09:50 Over Yaşlanması
Aylin Pelin Çil
09:50-10:10 Vazomotor Semptomlar ve Önemi
Hakan Seyisoğlu
10:10-10:30 Postmenopozal Dönemde Osteoporozun Yönetimi
Jale İrdesel
10:30-10:50 Hormon Replasman Tedavisi
Fatih Durmuşoğlu
10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

12:15-13:30 **YARA TEDAVİSİ**
Oturum Başkanları: Hakan Uncu, Tuğbay Tuğ

Yara İyileşmesinin Yönetimi ve Süreci Etkileyen Faktörler
Hakan Uncu
Yara Yatağının Hazırlanması ve Doğru Pansumanlar ile Örtülmesi
Tuğbay Tuğ
Yara Tedavisinde ve Cerrahi Alanda Negatif Basınçlı Uygulamalar
Tahir Özer
Tartışma

13:30-14:30 **ÖĞLE YEMEĞİ**

KARADENİZ SALONU

14:30-16:00 **FERTİLİTE PREZERVASYONU**
Oturum Başkanları: Temel Ceyhan, Remzi Atılgan

POF, POI ve Over Rezervini Azaltacak Cerrahiler Öncesinde Fertilite Prezervasyonu
Sezcan Mümüşoğlu
Çocukluk ve Adölesan Çağı Kanserlerinde Fertilite Prezervasyonu
Özgür Öktem
Meme Kanserli Hastalarda Fertilite Prezervasyonu:
BRCA Mutasyon Varlığı Yönetimi Değiştirir mi?
Volkan Turan
Kanser Hastalarında Over Stimülasyonu ve Endometrial Hazırlığın Püf Noktaları
Murat Sönmezer
Tartışma

16:00-16:30 **KAHVE ARASI**

17:30-19:00 **PANEL : GEBELİKTE AMPİRİK TEDAVİLER**
Panel Başkanı: Acar Koç
Panelistler: Bilge Çetinkaya Demir, Özgür Özyüncü, Cenk Sayın, Mert Turğal

- Progesteron
- Heparin ve Aspirin
- Kortizon ve Magnezyum
- Tartışma

BAKÜ/GENÇ ADIMLAR SALONU

08:30-09:15 **YARIŞACAK VİDEO BİLDİRİLER 1**
Jüri: Hüsnü Çelik, Murat Öz, Serdar Günalp, Recep Has, Emine Dinçer
YV-01 / YV-02 / YV-03 / YV-04

09:15-09:30 **ARA**

09:30-11:00 **TÜRKİYE - AZERBAYCAN - KKTC ORTAK OTURUMU**
Oturum Başkanları: Yegane Aliyeva, Müfit Yenen

09:30-09:50 Jinekolojik Cerrahide Komşu Organ İlişkileri
İslam Mahalov
09:50-10:10 Tekrarlayan IVF Başarısızlıklarında Co-Kültür
Yegane Aliyeva
10:10-10:30 Endometrium Kanserinde Laparoskopik Mapping
Müfit Yenen
10:30-10:50 Adölesanlarda Endometriozis ve Adenomyozis
İsmet Gün
10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

14:30-16:00 **FONKSİYONEL TIP**
Oturum Başkanları: Yaprak Üstün, Seda Keskin

Prematür Over Yetmezliği
Pınar Yalçın Bahat
PCOS
Yaprak Üstün
Gebelik ve Puerperyum
Rukset Attar
Menopoz
Tülin Dabakoğlu
Tartışma

DOĞU ANADOLU SALONU

08:30-09:15

SÖZLÜ BİLDİRİLER 1
Oturum Başkanları: Alper Başbuğ, Murat Işıkalan
SS-01 / SS-02 / SS-03 / SS-04 / SS-05 / SS-06

09:15-09:30 — **ARA**

09:30-11:00

İleri Düzey Laparoskopi Kursu
Sorumlular:
Yakup Kumtepe, Abdullah Karaer, Emsal Pınar Topdağı Yılmaz

SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU

· Histerektomi
· Salpingo-ooferektomi
· Over Kisti
· Ektopik Gebelik
· Endometriosis

Yakup Yalçın, Evrim Erdemoğlu

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 — **KAHVE ARASI**

13:30-14:30 — **ÖĞLE YEMEĞİ**

14:30-16:00

İleri Düzey Laparoskopi Kursu
Sorumlular:
Yakup Kumtepe, Abdullah Karaer, Emsal Pınar Topdağı Yılmaz

SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU

· Histerektomi
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· Over Kisti
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· Endometriosis

Ercan Baştu, Mehmet Ali Narin

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

MARMARA SALONU

08:30-09:15	**SÖZLÜ BİLDİRİLER 2** **Oturum Başkanları: Ramazan Erda Pay, Aysun Tekeli Taşkömür** **SS-09 / SS-10 / SS-11 / SS-12**
09:15-09:30	ARA
09:30-11:00	**Temel Laparoskopi Kursu** Sorumlular: **Işıl Kasapoğlu, Kiper Aslan, Orhan Orhan** MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ · Pegboard Uygulamaları · Makas Kullanımı · Sütür Kursu **Hüseyin Akıllı, Kiper Aslan, Serhan Can İşcan, Derman Başaran, Ghanim Khatip, Selçuk Yetkinel** Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi
11:00-11:30	KAHVE ARASI 
13:30-14:30	ÖĞLE YEMEĞİ 
14:30-16:00	**Temel Laparoskopi Kursu** Sorumlular: **Işıl Kasapoğlu, Kiper Aslan, Orhan Orhan** MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ · Pegboard Uygulamaları · Makas Kullanımı · Sütür Kursu **Deha Denizhan Keskin, Yavuz Emre Şükür, Seda Şimşek, Selen Doğan, Bülent Yılmaz, Adnan Orhan** Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

EGE SALONU

08:30-09:15

SÖZLÜ BİLDİRİLER 3
Oturum Başkanları: Yeliz Acar Sabır, Caner Çakır
SS-13 / SS-14 / SS-15 / SS-16 / SS-17 / SS-18

09:15-09:30 — **ARA**

09:30-11:00

Hormonal Kontrasepsiyonda Maket Üzerinde İmplant Eğitimi
Sorumlular:
Erbil Doğan, Ahmet Demir, Funda Göde

Yakup Baykuş

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 — **KAHVE ARASI**

13:30-14:30 — **ÖĞLE YEMEĞİ**

14:30-16:00

Hormonal Kontrasepsiyonda Maket Üzerinde İmplant Eğitimi
Sorumlular:
Erbil Doğan, Ahmet Demir, Funda Göde

Rulin Deniz

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

İÇ ANADOLU SALONU

08:30-09:15 **VİDEO BİLDİRİLER 1**
Oturum Başkanları: Hasan Ali İnal, Ayşenur Aksoy
VS-01 / VS-02 / VS-03 / VS-04 / VS-05

09:15-09:30 **ARA**

09:30-11:00 **POSTPARTUM KANAMA - 1. OTURUM**
Oturum Başkanları: Salih Taşkın, Şevki Çelen

09:30-09:45 Postpartum Kanama Risk Faktörleri, Tanısı, Anne Ölümlerindeki Yeri (Dünya'da ve Türkiye'de Güncel Durum)
Yaşam Kemal Akpak

09:45-10:05 Postpartum Kanama Profilaksisi ve Medikal Tedavisi
Gülşah Aynaoğlu Yıldız

10:05-10:20 Obstetrik Olgularda Sıvı ve Kan Ürünleri Replasmanı
Kadriye Yakut Yücel

10:20-10:35 Olgularla Risk Faktörlerinin Doğru Olarak Belirlenmesi
Yaprak Üstün

10:35-10:50 Olgularla Medikal Tedavi ve Sıvı - Kan Yönetimi
Yaprak Üstün

10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

12:15-13:45 **POSTPARTUM KANAMA - 2. OTURUM**
Oturum Başkanları: Yaprak Üstün, Levent Keskin

12:15-12:30 Postpartum Kanama Tedavisinde Balon Tamponad Uygulaması
Bulut Varlı

12:30-12:45 Postpartum Kanamada Kompresyon Sütür Teknikleri
Şevki Çelen

12:45-13:00 Postpartum Kanamada Arter Ligasyonları Kime Ne Zaman Uygulanmalı?
Çağatayhan Öztürk

13:00-13:15 Postpartum Kanamada Gözden Kaçanlar ve Dikkat Edilmesi Gereken Noktalar
Yusuf Üstün

13:15-13:30 Genital trakt yaralanmalarında tanı ve yaklaşım
H. Levent Keskin

13:30-13:45 Tartışma

İÇ ANADOLU SALONU

13:45-14:30 ÖĞLE YEMEĞİ

14:30-16:00

Sorumlular:
Salih Taşkın, Hüseyin Levent Keskin, Şevki Çelen

POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM

Hüseyin Levent Keskin, Gülşah Aynaoğlu Yıldız, Çağatayhan Öztürk

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

VICTOR GOMEL SÖYLEŞİ SALONU

12:15-13:30 **Ercüment Cengiz ile Yazarlık Söyleşileri** *(Federasyon standında kitap imza günü)*

16:00-16:30 **Bülent Urman ile Mentorluk Üzerine**

FEDERASYON SALONU

08:30-09:15 **YARIŞACAK SÖZLÜ BİLDİRİLER 4**
Jüri: Mete Güngör, Erbil Doğan, Ahmet Zeki Işık, Acar Koç, Ebru Yücel
YS-10 / YS-11 / YS-12

09:15-09:30 **KAHVE ARASI**

09:30-11:00 **PRETERM DOĞUM VE KISA SERVİKS**
Oturum Başkanları: Rıza Madazlı, Fatma Devran Bıldırcın

09:30-09:50 Birinci ve İkinci Trimesterde Kısa Serviksin Tanımı ve Yol Açtığı Riskler: Servikal Yetmezlik - Erken Doğum
Ebru Çelik

09:50-10:10 Asemptomatik Kısa Servikste Tedavi: Progesteron vs. Serklaj vs. Pesser
Metin İngeç

10:10-10:30 Transvajinal vs. Transabdominal Serklaj: Farkları, Kimlere, Ne Zaman?
Zehra Vural Yılmaz

10:30-10:50 Kortikosteroidin Kullanımı: Kılavuzların Karşılaştırılması
Oya Demirci

10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

11:30-12:15 **UYDU SEMPOZYUMU**
HPV, İlişkili Hastalıklar ve Kanserler, HPV Aşılarında Güncel Durum
Konuşmacı: M. Faruk Köse

MSD

12:15-13:30 **PANEL: ADNEKSİYEL KİTLELERE YAKLAŞIM**
Panel Başkanı: Mete Güngör
Panelistler: Evrim Erdemoğlu, Çağatay Taşkıran, Ayşe Seyhan, Müge Harma, Zeliha Fırat Cüylan

- Adneksiyel Kitlelerin Değerlendirilmesi
- Şüpheli Adneksiyel Kitlelere Yaklaşım
- Laparoskopi vs Laparotomi
- Gebelikte Adneksiyel Kitleler
- Tartışma

13:30-14:30 **ÖĞLE YEMEĞİ**

FEDERASYON SALONU

13:45-14:30 **ÖĞLE YEMEĞİNDE UZMANLA BULUŞUN**

- **Özcan Balat**- Adneksiyal Kitlelere Güncel Yaklaşım
- **Orhan Ünal** - Endometrium Kanseri ve Moleküler Patoloji: BRCA Taramasının Güncel Pratikte Yeri
- **Nevin Sağsöz** - Postpartum Kanamalar
- **Melike Aslan** - Laparoskopik Histerektomi
- **Mehtap Polat** - Polikisitik Over Sendromunda İnfertilite Varlığında Yaklaşım
- **Mehmet Yılmazer** - İstmosel, Histeroskopik Yaklaşım, Ne zaman? Nasıl?
- **Mehmet Harma** - HPV Aşıları
- **Cengiz Alataş** - İnfertil Hastaya Yaklaşım
- **Davut Güven** - HSG
- **Çetin Çelik** - Anormal Uterin Kanamalara Medikal Yaklaşım, Hangi Ajan ? Kime ? Nasıl ?

14:30-16:00 **İNKONTİNANSA YAKLAŞIM**
Oturum Başkanları: Fuat Demirci, Gamze Nur Cimili Şenocak

14:30-14:50 Aşırı Aktif Mesane İlk Adım Tedavisi - Dirençli Vakalarda Tedavi Seçenekleri
Petek Balkanlı

14:50-15:10 Adım Adım Mid-Üretral Sling Uygulaması ve Komplikasyonların Yönetimi
Cenk Yaşa

15:10-15:30 Mikst İnkontinans Tanı ve Tedavisi - Kişiselleştirilmiş Tedaviler
Gülin Feykan Yeğin

15:30-15:50 Kadın Üriner İnkontinansında Ürodinaminin Yeri - Pratik Ürodinami Değerlendirmesi
Esra Çetinkaya

15:50-16:00 Tartışma

16:00-16:30 **KAHVE ARASI**

16:30-17:15 **UYDU SEMPOZYUMU**
Kadın Sağlığında Yenilikçi Yaklaşımlar: Geleceğe Doğru Bir Bakış
Konuşmacı: Pınar Yalçın Bahat

ORZAX SAĞLIĞA HEDİYE

17:15-17:30 **ARA**

17:30-19:00 **PANEL: CANLI CERRAHİ LAPAROSKOPİK MYOMEKTOMİ**
Panel Başkanı: Onur Karabacak
Panelistler: Vedat Atay, Serkan Erkanlı, Servet Hacıvelioğlu, İsmail Bıyık, Onur Karaaslan

LIVE

Cerrah: Kemal Özerkan

AKDENİZ SALONU

08:30-09:15 **YARIŞACAK SÖZLÜ BİLDİRİLER 5**
Jüri: Salih Taşkın, Gülin Feykan Yeğin, Tugan Beşe, İpek Özçivit
YS-13 / YS-14 / YS-15

09:15-09:30 **KAHVE ARASI**

09:30-11:00 **IVF LABORATUVARINDA EN İYİ EMBRİYOYU YAPMAK VE SEÇMEK**
Oturum Başkanları: Berrin Avcı, Kerem Dirican

09:30-09:50 En İyi Embriyoyu Yapmak: Kültür Solüsyonlarında Neredeyiz? LIVE
David Gardner
09:50-10:10 En İyi Embriyoyu Seçmek; Morfolojinin Hala Değeri Var mı?
Elif Ergin
10:10-10:30 En İyi Embriyoyu Seçmek; AI/Deep Learning
Alison Campbell
10:30-10:50 En İyi Embriyoyu Seçmek - PGTa
Barış Ata
10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

12:15-13:30 **IVF UYGULAMALARINDA EK TEDAVİLER**
Oturum Başkanları: Mustafa Bahçeci, Cem Atabekoğlu

İntraendometrial Tedaviler - HCG, GSF, PRP ve Diğerleri
Ahmet Demir
Overi Gençleştirmek Mümkün mü?
Yeşim Bayoğlu Tekin
Histeroskopi ve Endometrial Travma
Abdullah Karaer
Vitaminler ve Beslenme Katkıları
Ayşe Zehra Özdemir
Tartışma

13:30-14:30 **ÖĞLE YEMEĞİ**

AKDENİZ SALONU

14:30-16:00 **BİRİNCİ TRİMESTER**
Oturum Başkanları: Oluş Api, Emine Seda Güvendağ Güven

14:30-14:50 Maternal Kardiyovaskuler Sağlık ve Preeklampsi İlişkisi LIVE
Basky Thilaganathan

14:50-15:30 Birinci Trimesterde Preeklampsi Taraması LIVE
Kypros Nicolaides

15:30-15:50 Preeklampsi Sınıflandırması ve Yönetiminde Yenilikler
Şevki Çelen

15:50-16:00 Tartışma

16:00-16:30 **KAHVE ARASI**

17:30-19:00 **PANEL: 40 YAŞINDAN SONRA FERTİLİTE**
Panel Başkanı: Gürkan Uncu
Panelistler: Filippo Ubaldi, Abha Maheswari, Kiper Aslan, Yunus Aydın

- Ne Zaman Dur Demek Lazım?
- İlk Defa Gelen vs Tekrar Gelen Hasta
- Over Stimülasyonu Nasıl Yapılmalı?
- 40 Yaşından Sonra PGT
- Adjuvanlar Yararlı mı?
- Tartışma

KARADENİZ SALONU

08:30-09:15 **YARIŞACAK SÖZLÜ BİLDİRİLER 6**
Jüri: Işıl Kasapoğlu, Başak Balaban, Nejat Özgül, Şerife Akbay
YS-16 / YS-17 / YS-18

09:15-09:30 **KAHVE ARASI**

09:30-11:00 **İLERİ EVRE ENDOMETRİOZİS VE AĞRI**
Oturum Başkanları: Davut Güven, Yücel Karaman

09:30-09:50 Ağrı Neden Oluşur? Pelvisin Nörofonksiyonel Anatomisi
Kiper Aslan

09:50-10:10 Kolorektal Endometrioziste Yönetim: Cerrahinin Zamanlaması ve Yöntemi
Bülent Urman

10:10-10:30 Cerrahinin Endikasyonları ve Zamanlaması
Stephano Angionni

10:30-10:50 Sakral Root Endometrioziste Tanısal Süreç - Ne Bilmeliyiz? LIVE
Gernot Hudelist

10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

12:15-13:30 **PANEL: OVER STİMÜLASYONU-BİREYSEL VS GENEL**
Panel Başkanı: Ahmet Zeki Işık
Panelistler: Flippo Ubaldi, Işıl Kasapoğlu, Kübra Boynukalın, Pınar Çağlar Aytaç, Yavuz Emre Şükür

- Gonadotropin Türü Fark Eder mi?
- Doz Seçimi ve Ayarlaması Önemli mi? Neye Göre, Nasıl?
- Prematür Luteinizasyon Tam Olarak Nedir, Ne Sıklıkla Görülür, Ne Anlamı Var?
- Trigger, Ne Zaman, Ne ile, Neden? Hastaya Göre Değişir mi?
- Trigger-OPU İntervali Önemli mi?
- Tartışma

13:30-14:30 **ÖĞLE YEMEĞİ**

KARADENİZ SALONU

14:30-16:00 **POSTPARTUM ACİLLER**
Oturum Başkanları: Mehmet Güney, İrfan Kutlar

14:30-14:50 Atoni Yönetimi
Wolfgang Henrich
14:50-15:10 Emboli Yönetimi
Yusuf Üstün
15:10-15:30 Hipertansif Aciller
Şebnem Alanya Tosun
15:30-15:50 Travma Yönetimi
Hüseyin Levent Keskin
15:50-16:00 Tartışma

16:00-16:30 **KAHVE ARASI**

17:30-19:00 **PANEL: DOĞUM İNDÜKSİYONU**
Panel Başkanı: Özgür Deren
Panelistler: Murat Işıkalan, İnanç Mendilcioğlu, Bilge Çetinkaya Demir

- Doğum İndüksiyonunda Doğru Zamanlama Nedir?
- Oligohidramnios, SGA Fetus, 40 Hafta ve Üzeri Gebelik, Kronik/Gestasyonel Hipertansiyon
- Doğum İndüksiyonunda Hangi Ajan En İyisi? Balon Kateter, Prostaglandinler?
- İkinci Trimester Gebelik Terminasyonunda Tedavi Seçenekleri ve İşlem Komplikasyonları
- Tartışma

BAKÜ/GENÇ ADIMLAR SALONU

08:30-09:15 **YARIŞACAK VİDEO BİLDİRİLER 2**
Jüri: Macit Arvas, Yakup Kumtepe, Çağatay Taşkıran, Zarnigar Gadirli
YV-05 / YV-06 / YV-07 / YV-08

09:15-09:30 KAHVE ARASI

09:30-11:00 **AVRUPA BİRLİĞİ PROJELERİ BAŞVURU PRENSİPLERİ**
Oturum Başkanları: Gürkan Uncu

Avrupa Birliği Mali Destekleri ve Sağlık Sektörü için Proje Fırsatları
Bülent Özcan

11:00-11:30 KAHVE ARASI

13:30-14:30 ÖĞLE YEMEĞİ

14:30-16:00 **KSDF ADÖLESAN SAĞLIĞI PROJESİ**
Oturum Başkanları: Süleyman Engin Akhan, Engin Yurtçu

14:30-14:50 Çocuk ve Ergenlerin Jinekolojik Değerlendirmesi
Özlem Dural
14:50-15:10 Çocuk ve Ergenlerde Vulvovajinal Problemler
Alev Özer
15:10-15:30 Ergenlerde Anormal Uterin Kanamaların Yönetimi
Emsal Pınar Topdağı Yılmaz
15:30-15:50 Çocuk ve Ergenlerde Müllerian Kanal Anomalilerinin Yönetimi
Süleyman Engin Akhan
15:50-16:00 Tartışma

16:00-16:30 KAHVE ARASI

DOĞU ANADOLU SALONU

08:30-09:15

SÖZLÜ BİLDİRİLER 4
Oturum Başkanları: Murat Gözüküçük, Anıl Ertürk
SS-19 / SS-20 / SS-21 / SS-22 / SS-23 / SS-24

09:15-09:30 KAHVE ARASI

09:30-11:00

İleri Düzey Laparoskopi Kursu
Sorumlular:
Yakup Kumtepe, Abdullah Karaer, Emsal Pınar Topdağı Yılmaz

SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU

· Histerektomi
· Salpingo-ooferektomi
· Over Kisti
· Ektopik Gebelik
· Endometriosis

Nasuh Utku Doğan, Fuat Demirci

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 KAHVE ARASI

13:30-14:30 ÖĞLE YEMEĞİ

14:30-16:00

İleri Düzey Laparoskopi Kursu
Sorumlular:
Yakup Kumtepe, Abdullah Karaer, Emsal Pınar Topdağı Yılmaz

SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU

· Histerektomi
· Salpingo-ooferektomi
· Over Kisti
· Ektopik Gebelik
· Endometriosis

Raziye Narin, Sevda Baş

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

MARMARA SALONU

08:30-09:15

SÖZLÜ BİLDİRİLER 5
Oturum Başkanları: Berrin Göktuğ Kadıoğlu, Nilüfer Cimşit Kemahlı
SS-25 / SS-26 / SS-27 / SS-28 / SS-29 / SS-30

09:15-09:30 — **KAHVE ARASI**

09:30-11:00

Temel Laparoskopi Kursu
Sorumlular:
Işıl Kasapoğlu, Kiper Aslan, Orhan Orhan

MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ

· Pegboard Uygulamaları
· Makas Kullanımı
· Sütür Kursu

İbrahim Yalçın, Özgüç Takmaz, Bulut Varlı, Utku Akgör, Çağatayhan Öztürk, Gonca Çoban

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 — **KAHVE ARASI**

13:30-14:30 — **ÖĞLE YEMEĞİ**

14:30-16:00

Temel Laparoskopi Kursu
Sorumlular:
Işıl Kasapoğlu, Kiper Aslan, Orhan Orhan

MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ

· Pegboard Uygulamaları
· Makas Kullanımı
· Sütür Kursu

Hamdullah Sözen, Serkan Erkanlı, Üzeyir Kalkan, Orhan Şahin, Barış Güzel

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

EGE SALONU

08:30-09:15

SÖZLÜ BİLDİRİLER 6
Oturum Başkanları: Kadriye Yakut Yücel, Orhan Şahin
SS-31 / SS-32 / SS-33 / SS-34 / SS-35 / SS-36

09:15-09:30 KAHVE ARASI

09:30-11:00

Hormonal Kontrasepsiyonda Maket Üzerinde İmplant Eğitimi
Sorumlular:
Erbil Doğan, Ahmet Demir, Funda Göde

Nefise Tanrıdan Okçu

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 KAHVE ARASI

13:30-14:30 ÖĞLE YEMEĞİ

14:30-16:00

Hormonal Kontrasepsiyonda Maket Üzerinde İmplant Eğitimi
Sorumlular:
Erbil Doğan, Ahmet Demir, Funda Göde

İsmail Küçükerdoğan

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

İÇ ANADOLU SALONU

08:30-09:15

VİDEO BİLDİRİLER 2
Oturum Başkanları: Ayşe Zehra Özdemir, Betül Keyif
VS-06 / VS-07 / VS-08 / VS-09 / VS-10 / VS-11

09:15-09:30 KAHVE ARASI

09:30-11:00

Sorumlular:
Salih Taşkın, Hüseyin Levent Keskin, Şevki Çelen

POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM

Yusuf Üstün, Gülin Feykan Yeğin, Kadriye Yakut Yücel

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 KAHVE ARASI

13:30-14:30 ÖĞLE YEMEĞİ

14:30-16:00

Sorumlular:
Salih Taşkın, Hüseyin Levent Keskin, Şevki Çelen

POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM

Caner Çakır, Yaşam Kemal Akpak, Murat Gözüküçük

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

VICTOR GOMEL SÖYLEŞİ SALONU

12:15-13:30 Üzeyir Kalkan Fotoğraf Sanatı Söyleşisi

16:00-16:30 Victor Gomel Gençlerle Söyleşi

FEDERASYON SALONU

08:30-09:15 **YARIŞACAK SÖZLÜ BİLDİRİLER 7**
Jüri: Esat Orhon, M. Faruk Köse, Fatih Durmuşoğlu, Mehmet Ali Vardar, Esat Temiz
YS-19 / YS-20 / YS-21

09:15-09:30 **ARA**

09:30-11:00 **HİSTEROSKOPİK CERRAHİ**
Oturum Başkanları: İdris Koçak, Kahraman Ülker

09:30-09:50 Histeroskopik Cerrahiyi Kolaylaştırmak için Doğru Set-Up Nasıl Olmalı?
Elif Aylin Taşkın
09:50-10:10 Submüköz Myom ve İnfertilite - Eski Bir Soruna Yeni Yaklaşım
Salvatore Vitale
10:10-10:30 İntrauterin Sineşilerin Prognostik Sınıflandırılması ve Cerrahisi
Erhan Şimşek
10:30-10:50 İsthmosel ve İnfertilite - Ne Zaman Cerrahi Yapalım?
Orhan Orhan
10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

11:30-12:15 **UYDU SEMPOZYUMU**
Gebelik Öncesi Dönemden Gebeliğe Optimal Mikrobesin Desteği
Oturum Başkanı: Salih Taşkın
Konuşmacı: Yusuf Üstün

12:15-13:30 **PANEL: NEDENİ AÇIKLANAMAYAN İNFERTİLİTE**
Panel Başkanı: Bülent Urman
Panelistler: Abha Maheswari, Sezcan Mümüşoğlu, Carlo Alviggi, Pınar Çağlar Aytaç

- Nedeni Açıklamak İçin Hangi Testleri Yapalım?
- Ovulasyon, Erkek Faktörü, Uterus ve Tüpler
- Çiftin Prognozunu Nasıl Belirleyelim?
- Tedavi: Beklemek, Aktif Tedavi, Mekanik ve Cerrahi Tedaviler, Destekleyici Tedaviler
- Tartışma

13:30-14:30 **ÖĞLE YEMEĞİ**

FEDERASYON SALONU

13:45-14:30 **ÖĞLE YEMEĞİNDE UZMANLA BULUŞUN**

- **Işık Kaban** - Laparoskopik ve Histereskopik Myomektomide Tips and Tricks
- **Burcu Kasap** - Pelvik Organ Prolapsusunda Güncel Yönetim
- **Salih Taşkın** - Minimal İnvaziv Jinekolojik Cerrahi
- **Cengiz Andan** - Endometriozis
- **Hüsnü Çelik** - Zor Histerektomi
- **Mehmet Ali Narin** - V- NOTES Yapmalımıyız? Teknik Nasıl Olmalı ?
- **Erbil Doğan** - Konjenital Uterin Anomalilere Yaklaşım
- **Ercan Mustafa Aygen** - Olgular Eşliğinde Her Yönüyle Polikistik Over Sendromu
- **Carlo Aliviggi** - Kötü Ovaryan Yanıt Nasıl Öngörülür, Sınıflandırma Sistemleri Nasıl Oluşturulur, İyi Bir Makale ve Çok Merkezli Çalışmalar Nasıl Tasarlanır?

14:30-16:00 **MENOPOZ VE MEME KANSERİ İLİŞKİSİ**
Oturum Başkanları: Fatih Durmuşoğlu, Kutay Biberoğlu

14:30-14:50	Menopozda HRT Alternatifleri **Serdar Dilbaz**
14:50-15:10	Menopoz ve Meme Kanseri İlişkisi **Levent Şentürk**
15:10-15:30	Menopozun Genitoüriner Sendromu **Linden Hirchberg**
15:30-15:50	Postmenopozal Dönemde Testosteron LIVE **Rossella Nappi**
15:50-16:00	Tartışma

16:00-16:30 **KAHVE ARASI**

16:30-17:15 **UYDU SEMPOZYUMU**
İleri Cerrahi Teknolojisi ile Frozen Pelvis ve Histerektomi: LigasureXP'nin Rolü
Oturum Başkanı: Uğur Fırat Ortaç
Konuşmacı: Çağatay Taşkıran
Medtronic

17:15-17:30 ARA

17:30-19:00 **PANEL: CANLI CERRAHİ ENDOMETRİOZİS** LIVE
Panel Başkanı: Cihat Ünlü
Panelistler: Ercan Baştu, Kiper Aslan, Mohamed Achour, Süleyman Güven, Onur Topçu, Mara Albanese

Cerrah: Bülent Urman, Burak Giray

AKDENİZ SALONU

08:30-09:15 **YARIŞACAK SÖZLÜ BİLDİRİLER 8**
Jüri: Rıfat Gürsoy, Uğur Fırat Ortaç, Fuat Demirci, Yaprak Üstün, Arif Can Özsipahi
YS-22 / YS-24

09:15-09:30 **ARA**

09:30-11:00 **KİŞİYE ÖZEL KONTRASEPSİYON**
Oturum Başkanları: Ruşen Aytaç, Selin Özaltın

09:30-09:50 Kime, Hangi Oral Kontraseptif?
Raziye Narin
09:50-10:10 Adölesan Dönemde Uzun Süreli Oral Kontraseptif Kullanımı: Endikasyonları ve Sakıncaları
Yetkin Karasu
10:10-10:30 40 Yaşından Menopoza Kadar Olan Dönemde Oral Kontraseptif Kullanımı
Sinan Karadeniz
10:30-10:50 Tek Başına Progestinler
Mehmet Bülbül
10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

12:15-13:30 **2. VE 3. TRİMESTER**
Oturum Başkanları: Şevki Çelen, Serenat Yalçın

2. Trimesterde Anomali Taraması
İbrahim Kalelioğlu
Fetal Gelişim Kısıtlılığı
Hüseyin Ekici
Plasenta ve Kordon Anomalileri
Gökhan Yıldırım
Çoğul Gebelik Muayenesi LIVE
Asma Khalil
Tartışma

13:30-14:30 **ÖĞLE YEMEĞİ**

AKDENİZ SALONU

14:30-16:00 **JİNEKOLOJİK KANSERLERE GÜNCEL YAKLAŞIM**
Oturum Başkanları: Kunter Yüce, Fuat Demirkıran

14:30-14:50 Over Kanseri
Ali Ayhan
14:50-15:10 Endometrium Kanseri
Mutlu Meydanlı
15:10-15:30 Serviks Kanseri
Hüsnü Çelik
15:30-16:00 Tartışma

16:00-16:30 **KAHVE ARASI**

17:30-19:00 **PANEL: SERVİKAL PREMALİGN LEZYONLAR**
Panel Başkanı: Uğur Fırat Ortaç
Panelistler: Macit Arvas, Mehmet Ali Vardar, Mehmet Coşkun Salman, Esra Kuşçu

- Vakalarla Servikal Premalign Lezyonlarda Anormal Sitolojiye Yaklaşım
- Vakalarla Servikal Premalign Lezyonlarda Anormal Histolojiye Yaklaşım
- Tartışma

KARADENİZ SALONU

08:30-09:15 **YARIŞACAK SÖZLÜ BİLDİRİLER 9**
Jüri: Cemal Posacı, Hüsnü Çelik, Hakan Seyisoğlu, Yücel Karaman, Merih Oğur
YS-25 / YS-26 / YS-27

09:15-09:30 **ARA**

09:30-11:00 **ROBOTİK CERRAHİ**
Oturum Başkanları: İlkkan Dünder, Salih Taşkın

09:30-09:50 Robotik Myomektomi
M. Faruk Köse
09:50-10:10 Robotik Histerektomi
Derman Başaran
10:10-10:30 Robotik Pelvik Paraaortik Lenf Nodu Diseksiyonu
M. Murat Naki
10:30-10:50 Robotik Sakrokolpopeksi
Ahmet Göçmen
10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

12:15-13:30 **ANORMAL UTERİN KANAMA**
Oturum Başkanları: İbrahim Veysel Fenkçi, Kenan Dolapcıoğlu

Anormal Uterin Kanama ve Endometrial Hiperplazi
Tolgay Tuyan İlhan
Anormal Uterin Kanamaların Sınıflandırması (PALM-COEIN) ve Yönetimi Nasıl Yapılır?
Selen Doğan
Endometrial Intraepitelyal Neoplazilerin (EIN) Yönetimi Nasıl Yapılır?
Sevda Baş
EIN Dışında Endometrial Hiperplazilere Güncel Yaklaşım
Seda Şahin Aker
Tartışma

13:30-14:30 **ÖĞLE YEMEĞİ**

KARADENİZ SALONU

14:30-16:00

PANEL: KOZMETİK JİNEKOLOJİDE SINIRLARI ÇİZEBİLMEK
Panel Başkanı: Ebru Alper
Panelistler: Müjde Özer, Ozan Doğan, Süleyman Engin Akhan

- Myth?
- Mani?
- Tıbbi Gereklilik?
- Etik Sınırlar?
- Jinekolog mu, Plastik Cerrah mı?
- Sosyokültürel Faktörler, Motivatörler
- Tartışma

16:00-16:30 **KAHVE ARASI**

17:30-19:00

KONJENİTAL ENFEKSİYONLAR
Oturum Başkanları: Acar Koç, Zeki Şahinoğlu

Gebelikte Hangi Enfeksiyöz Ajanlar Taranmalı?
Neşe Yücel
Konjenital CMV Enfeksiyonunun Yönetimi
Murat Işıkalan
Toxoplazma Enfeksiyonunun Tanı ve Yönetimi
Sabahattin Altunyurt
Konjenital Enfeksiyonların Kranyal Görüntüleme Bulguları
Tuğba Saraç Sivrikoz
Tartışma

BAKÜ/GENÇ ADIMLAR SALONU

08:30-09:15 **YARIŞACAK VİDEO BİLDİRİLER 3**
Jüri: Faruk Buyru, İlkkan Dünder, Kunter Yüce, Kemal Özerkan, Esra Nazlı Döktür
YV-09 / YV-10 / YV-11 / YV-12

09:15-09:30 **ARA**

09:30-11:00 **KSDF GENÇ ADIMLAR OTURUMU 1**
Oturum Başkanları: Tansu Bahar Gürbüz, Bahadır Koşan

09:30-09:50 Yurtiçi Doktora Programı
Can Benlioğlu
09:50-10:10 Klinik Araştırma Master ve Sertifika Programları
Melis Cantürk
10:10-10:30 Yurtdışında Kadın Doğum Uzmanlığı Prosedürleri
Cengiz Karakaya
10:30-10:50 Asistanlık Süresince Eğitim İmkanları ve Programlar
Koray Saçıntı
10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

13:30-14:30 **ÖĞLE YEMEĞİ**

14:30-16:00 **KSDF GENÇ ADIMLAR OTURUMU 2**
Oturum Başkanları: Ramazan Erda Pay, Zeynep Kübra Usta

14:30-14:50 Malpraktisten Korkmalı mıyız? Kendimizi Nasıl Korumalıyız?
Murat Civaner
14:50-15:10 İlgi Alanlarına Göre KSDF- Genç Adımların Alt Gruplarının Oluşturulması
Bekir Savcı Telek
15:10-15:30 Asistanlar ve Genç Uzmanlar için ENTOG (Avrupa Kadın Hastalıkları ve Doğum Asistanları Derneği) Kapsamında burs ve Çalışma İmkanları
Sofia Tsiapakidou
15:30-15:50 Asistanlık Eğitiminde Mentörlük ve İlgi Gruplarının İletişimi
Ece İrem Özcan
15:50-16:00 Tartışma

DOĞU ANADOLU SALONU

08:30-09:15

SÖZLÜ BİLDİRİLER 7
Oturum Başkanları: Didem Alkaş, Çağanay Soysal
SS-08 / SS-37 / SS-38 / SS-39 / SS-40 / SS-42

09:15-09:30 — **ARA**

09:30-11:00

İleri Düzey Laparoskopi Kursu
Sorumlular:
Yakup Kumtepe, Abdullah Karaer, Emsal Pınar Topdağı Yılmaz

SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU

· Histerektomi
· Salpingo-ooferektomi
· Over Kisti
· Ektopik Gebelik
· Endometriosis

M. Murat Naki, Doğan Vatansever

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 — **KAHVE ARASI**

13:30-14:30 — **ÖĞLE YEMEĞİ**

14:30-16:00

İleri Düzey Laparoskopi Kursu
Sorumlular:
Yakup Kumtepe, Abdullah Karaer, Emsal Pınar Topdağı Yılmaz

SİMÜLASYON İLE LAPAROSKOPİK HİSTEREKTOMİ - MYOMEKTOMİ - KİST EKSİZYONU

· Histerektomi
· Salpingo-ooferektomi
· Over Kisti
· Ektopik Gebelik
· Endometriosis

Onur Karabacak, Ahmet Göçmen

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

MARMARA SALONU

08:30-09:15

SÖZLÜ BİLDİRİLER 8
Oturum Başkanları: Ümit Arslan Naykı, Sadettin Oğuzhan Tutar
SS-43 / SS-44 / SS-45 / SS-46 / SS-47 / SS-48

09:15-09:30 — **ARA**

09:30-11:00

Temel Laparoskopi Kursu
Sorumlular:
Işıl Kasapoğlu, Kiper Aslan, Orhan Orhan

MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ

· Pegboard Uygulamaları
· Makas Kullanımı
· Sütür Kursu

Şevki Göksun Gökulu, Kemal Güngördük, Orhan Orhan, Servet Hacıvelioğlu, Kadir Bakay, Şirin Aydın Deniz

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 — **KAHVE ARASI**

13:30-14:30 — **ÖĞLE YEMEĞİ**

14:30-16:00

Temel Laparoskopi Kursu
Sorumlular:
Işıl Kasapoğlu, Kiper Aslan, Orhan Orhan

MAKET ÜZERİNDE LAPAROSKOPİK SÜTÜR EĞİTİMİ

· Pegboard Uygulamaları
· Makas Kullanımı
· Sütür Kursu

Alev Esercan, Koray Aslan, İlker Selçuk, Burak Sezgin

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

EGE SALONU

08:30-09:15

SÖZLÜ BİLDİRİLER 9
Oturum Başkanları: Fadıl Kara, Ceren Ünal
SS-49 / SS-50 / SS-51 / SS-52 / SS-53

09:15-09:30 — **ARA**

09:30-11:00

Hormonal Kontrasepsiyonda Maket Üzerinde İmplant Eğitimi
Sorumlular:
Erbil Doğan, Ahmet Demir, Funda Göde

Nefise Nazlı Yenigül

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 — **KAHVE ARASI**

13:30-14:30 — **ÖĞLE YEMEĞİ**

14:30-16:00

Hormonal Kontrasepsiyonda Maket Üzerinde İmplant Eğitimi
Sorumlular:
Erbil Doğan, Ahmet Demir, Funda Göde

Burcu Dinçgez

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

İÇ ANADOLU SALONU

08:30-09:15

VİDEO BİLDİRİLER 3
Oturum Başkanları: Abdullah Tok, Selma Ermin
VS-12 / VS-13 / VS-14 / VS-15 / VS-16 / VS-17

09:15-09:30 **ARA**

09:30-11:00

Sorumlular:
Salih Taşkın, Hüseyin Levent Keskin, Şevki Çelen

POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM

Hüseyin Levent Keskin, Çağatayhan Öztürk, Gülin Feykan Yeğin

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

11:00-11:30 **KAHVE ARASI**

13:30-14:30 **ÖĞLE YEMEĞİ**

14:30-16:00

Sorumlular:
Salih Taşkın, Hüseyin Levent Keskin, Şevki Çelen

POSTPARTUM KANAMA YÖNETİMİ - MAKET ÜZERİNDE EĞİTİM

Yusuf Üstün, Seda Şahin Aker, Kadriye Yakut Yücel

Belirlenen Küçük Gruplara Sürekli Olarak Uygulama Eğitimi

GİRNE SALONU

09:30-11:00 **İNFERTİLİTE HEMŞİRELİĞİ**
Kurs Başkanı: Funda Göde
Oturum Başkanları: Gülşen Doğan Durdağ, Tülay Karataş

09:30-09:50 Klivaj Embriyosu mu Blastokist Transferi Mi? Taze mi Donmuş mu?
Elif Korkmaz Ordu

09:50-10:10 Donmuş Embriyo Transferi için Endometrial Hazırlık Protokolleri
Gülşen Doğan Durdağ

10:10-10:30 Başarısız Sikluslarda Çift - Hemşire İlişkisi
İlkay Çorbacı Çınar

10:30-10:50 Tartışma

VICTOR GOMEL SÖYLEŞİ SALONU

12:15-13:30 **Aytun Aktan Bahçeci ile Tiyatro Söyleşisi**

16:00-16:30 **Gürkan Uncu ile Mentorluk Üzerine**

FEDERASYON SALONU

08:30-09:15 **OLGU SUNUMLARI 1**
Oturum Başkanları: Sema Baki, Göksel Kanmaz
OS-01 / OS-02 / OS-03 / OS-04 / OS-05 / OS-06 / OS-07

09:15-09:30 **ARA**

09:30-11:00 **KOZMETİK JİNEKOLOJİK CERRAHİ**
Oturum Başkanları: S. Engin Akhan, Müjde Özer

09:30-09:50 Labioplasti Teknikleri, Preop Hazırlık, Postoperatif Bakım, Komplikasyon Yönetimi
Müjde Özer

09:50-10:10 Vajinal Relaksasyon Tedavisinde Cerrahinin Yeri: Vajinoplasti, İdeal Yaklaşım Nedir?
Ozan Doğan

10:10-10:30 Genital Bölge Hyalüronik Asit ve PRP Uygulamaları
Sevtap Handemir Kılıç

10:30-10:50 Vulvovajinal Lazer, Radyofrekans ve HIFU Uygulamaları
Aşkı Ellibeş Kaya

10:50-11:00 Tartışma

11:00-11:30 **KAHVE ARASI**

KAPANIŞ TÖRENİ

AKDENİZ SALONU

08:30-09:15 — **OLGU SUNUMLARI 2**
Oturum Başkanları: Bülent Ayas, İlknur Merve Ayazoğlu
OS-08 / OS-09 / OS-10 / OS-11 / OS-12 / OS-13 / OS-14

09:15-09:30 — **ARA**

09:30-11:00 — **KONTRASEPSİYON**
Oturum Başkanları: Berna Dilbaz, Müjde Canday

09:30-09:50 Hormonal Kontraseptifler ve Kanser
Berna Dilbaz
09:50-10:10 Hormonal Kontraseptilfer ve Tromboemboli
Nefise Nazlı Yenigül
10:10-10:30 Oral Kontraspetiflerin Endometrial Etkileri
Sefa Arlıer
10:30-10:50 Her Yönüyle Acil Kontrasepsiyon
Koray Görkem Saçıntı
10:50-11:00 Tartışma

11:00-11:30 — **KAHVE ARASI**

KAPANIŞ TÖRENİ

KARADENİZ SALONU

08:30-09:15 — **OLGU SUNUMLARI 3**
Oturum Başkanları: Nergis Ertürk, Sevtap Seyfettinoğlu
OS-15 / OS-16 / OS-17 / OS-18 / OS-19 / OS-20 / OS-21

09:15-09:30 — **ARA**

09:30-11:00 — **JİNEKOLOJİ VE OBSTETRİDE YAPAY ZEKA**
Oturum Başkanları: Sedat Kadanalı, Cengiz Andan

09:30-09:50 Yapay Zeka ve Ultrasonografi ile Anomali Taraması
Nilüfer Cimşit Kemahlı
09:50-10:10 İnfertil Çifte Yaklaşımda Yapay Zeka Algoritmaları
Şeyma Hasköylü
10:10-10:30 IVF Laboratuvarında Yapay Zekanın Kullanımı
Cihan Çakır
10:30-10:50 Adneksiyel Kitlelerin Değerlendirilmesinde Yapay Zeka
Kadir Bakay
10:50-11:00 Tartışma

11:00-11:30 — **KAHVE ARASI**

KAPANIŞ TÖRENİ

BAKÜ/GENÇ ADIMLAR SALONU

08:30-09:15	OLGU SUNUMLARI 4 Oturum Başkanları: Orhan Orhan, İzel Selin Özsoy OS-22 / OS-23 / OS-24 / OS-25 / OS-26 / OS-27 / OS-28
09:15-09:30	ARA
09:30-11:00	OLGU SUNUMLARI 6 Oturum Başkanları: İsmail Küçükerdoğan, Arif Caner Erdoğan OS-36 / OS-37 / OS-38 / OS-39 / OS-40 / OS-41 / OS-42 / OS-43 / OS-44 / OS-45 / OS-46 / OS-47 / OS-48 / OS-49 / OS-50 / OS-51 / OS-52 / OS-53 / OS-54 / OS-55 / OS-56 / OS-57 / OS-58 / OS-59

DOĞU ANADOLU SALONU

08:30-09:15	OLGU SUNUMLARI 5 Oturum Başkanları: Mehmet Bülbül, Muhammed Ahsen Öğrenci OS-29 / OS-30 / OS-31 / OS-32 / OS-33 / OS-34 / OS-35 / OS-63
09:15-09:30	ARA
09:30-11:00	OLGU SUNUMLARI 7 Oturum Başkanları: Ayşe Zehra Özdemir, Merve Dizdar OS-60 / OS-61 / OS-62 / OS-64 / OS-65 / OS-66 / OS-67 / OS-68 / OS-69 / OS-70 / OS-71 / OS-73 / OS-74 / OS-75 / OS-76 / OS-77 / OS-78 / OS-79 / OS-80 / OS-81 / OS-82 / OS-83
11:00-11:30	KAHVE ARASI 

KAPANIŞ TÖRENİ

YARIŞACAK SÖZLÜ BİLDİRİLER

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

YS-01

Exploring the influence of various factors on oocyte maturation rates and clinical outcomes in ART cycles

Zehra Selen Mutlu, Cihan Çakır
Bursa Uludağ Üniversitesi Histoloji ve Embriyoloji AbD

Aim

The primary objective of our study is to identify factors that have a detrimental effect on oocyte maturation rates in in vitro fertilization cycles, while also evaluating the impact of oocyte maturation rates on clinical outcomes.

Material and Method

Within the scope of our study, we conducted a retrospective analysis of fresh assisted reproductive technology (ART) cycles performed at Bursa Uludağ University ART Center between 2011 and 2024. Oocyte maturation rates of all cycles were evaluated. Four separate groups were determined according to oocyte maturation rates: Group 1 (n=1306) (oocyte maturation rate >75%), Group 2 (n=1038) (oocyte maturation rate 50%-75%), Group 3 (n= 241) (oocyte maturation rate 25%-49%) and Group 4 (n=96) (oocyte maturation rate <25%). We compared patients' baseline characteristics, baseline hormonal parameters, and ovarian stimulation profiles between these groups to identify potential factors affecting oocyte maturation. We also examined embryological parameters and clinical outcomes in these groups to determine the impact of oocyte maturation on overall ART cycle performance.

RESULTS: A comparative analysis was performed to evaluate baseline characteristics and ovarian stimulation profiles between different groups. The analysis revealed that factors such as female age (p=0.021), infertility etiology (p=0.019), AMH level (p=0.010) and trigger type (p<0.043) had a statistically significant effect on oocyte maturation. In particular, Group 1 exhibited the highest statistically significant fertilization (p=0.420), blastulation (p<0.001) and implantation (p<0.001) rates per transfer. In contrast, comparable embryological parameters and clinical outcomes were observed across Groups 2, 3, and 4.

CONCLUSION: In conclusion, our study identified several significant factors that influence oocyte maturation rates in in vitro fertilization cycles, encompassing patient characteristics, hormonal parameters, stimulation protocols, and trigger types. Moreover, higher oocyte maturation rates, notably observed in Group 1, were associated with enhanced fertilization, blastulation, and implantation rates per transfer, underscoring the pivotal role of oocyte maturation in optimizing clinical outcomes within ART cycles.

Keywords: ART, maturation, oocyte

YS-02

Evaluation of Genetic and Perinatal Results of Amniocentesis Performed Over the Viability Threshold with Abnormal Ultrasound Findings

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OBJECTIVE: The aim of this study is to evaluate the correlation between karyotype disorders and perinatal prognosis in pregnant women with abnormal ultrasonographic findings who underwent amniocentesis for karyotype analysis.

MATERIALS-METHODS: İn our study, we retrospectively evaluated the data of pregnant women who applied to XXXX University Hospital Gynecology and Obstetrics Clinic between March 2022 and March 2023 and had abnormal ultrasonographic findings. Patients' data including age, gravidity, parity, number of abortions, gestational age when amniocentesis performed, screening test result, if any were abnormal ultrasonographic findings, family history, consanguineous marriage, number of insertions, QF-PCR applied on fetal chromosomes and micro-array performed to detect submicroscopic deletions and duplications were collected electronically. Ultrasonographic findings were evaluated in two separate groups: cardiovascular anomaly and central nervous system/neural tube defect anomaly. And each group was divided into two subgroups as good and poor perinatal prognosis. For each group; QF-PCR, chromosomal analysis, micro-array anomaly rate, fetocide procedure rate, delivery date, type of birth, preterm birth rate, stillbirth rate, 1st and 5th minute Apgar scores, newborn hospitalization rate and duration, postnatal infection, operation, and neonatal death rate, family history, consanguineous marriage rate, advanced maternal age rate, and accompanying ultrasound anomaly rate differences were examined. It was planned to evaluate the correlation between karyotype disorders and perinatal prognosis by comparing perinatal prognosis criteria according to system anomalies.

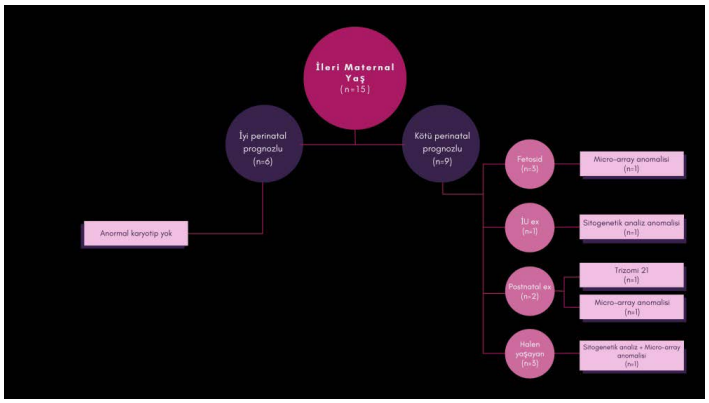
RESULTS: In our study, no complications, amniotic fluid leakage, fetal loss or culture failure occurred due to amniocentesis. The chromosomal anomaly rate was found to be 23.43% (n=15). It was observed that 71.42% of the cases with poor perinatal prognosis and high fetal morbidity were accompanied by at least one other system anomaly, especially skeletal system anomalies. A significant difference was found between the good and poor fetal prognosis groups of those with cardiovascular anomaly and central nervous system anomaly/neural tube defect in terms of average delivery date, 1'st and 5'th minute Apgar score, low birth weight and neonatal death rate (p<0.05). It was determined that there was a significant difference between the good and poor fetal prognosis groups of those with cardiovascular anomalies in terms of the anomaly rate in micro-array and the rate of other accompanying system anomalies (p <0.05).

CONCLUSION: Since genetic disorders accompanying abnormal ultrasonographic findings can predict poor perinatal prognosis and high fetal morbidity, patient may be offered the option of pregnancy termination after the ethics committee

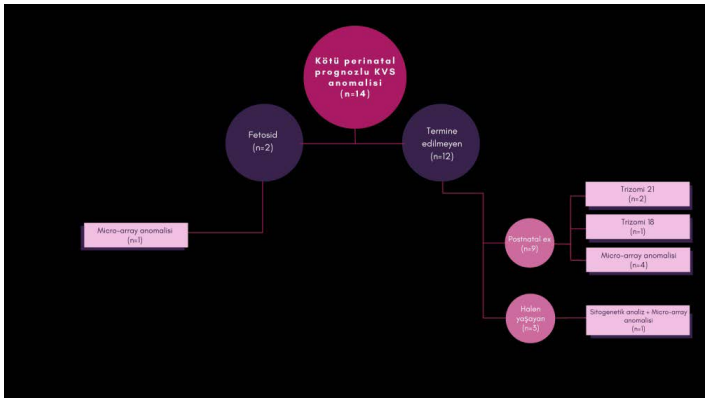
meeting. Patients who do not accept pregnancy termination option should be informed about possible antenatal and postnatal risks, and close fetal follow-up should be recommended. Micro-array, which will be routinely added to conventional karyotype analysis, will be beneficial in terms of patient management when considering anomalies due to possible submicroscopic changes below the band resolution limit of chromosome analysis.

Keywords: Late amniocentesis, Fetal Abnormalities, Viability Threshold, Chromosomal abnormality, Micro-array

Results of Genetic Analysis



The Relationship between Abnormal Cardiovasculer Ultrasonographic Findings and abnormal karyotype



YS-03

Assesment Of Usp17 And Tpt1 Expressions On Primary Tumor Tissue And Metastatic Tissue Of Patients With High Grade Serous Ovarian Cancer And The Relation To Distant Metastasis

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OBJECTIVES: Ubiquitination; It is the main regulatory process involved in the repair of DNA destruction and regulation of the cell cycle. Ubiquitin specific protease 17 (USP17) plays a regulatory role in cell proliferation and migration by sending signals through the RAS pathway. In addition, translationally controlled tumor protein 1 (Tpt1) is a protein that is associated with cancer progression and is expressed in high amounts in many tumors. The aim of this study is to compare the expression rates of these proteins in primary and metastatic tissue.,

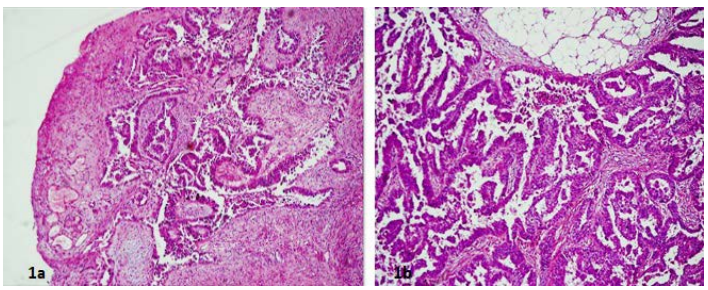
METHODS: The study was conducted between June 2013 and June 2017, with tests performed with USP17 and Tpt1 receptor kits on the pathology blocks of patients whose definitive pathology results were found to be high-grade serous ovarian cancer. Receptor positivity rate in primary tissue and metastatic tissue samples of these patients was investigated.

RESULTS: Ovarian cancer pathologic slides belonging to 33 patients were included in the study. A statistically significant difference was obtained between the expressions of USP17 in primary and metastatic tissue (p=0.04, correlation coefficient=0.349). USP 17 expression was higher in metastatic tissue. On the other hand, there was no significant difference between metastatic tissue and primary tissue in terms of Tpt 1 expressions.

CONCLUSIONS: Unlike Tpt1, measurement of USP17 in serum can provide us with preliminary information about the presence of metastases in patients.

Keywords: High-grade serous ovarian cancer, metastasis, ubiquitin-proteasome pathway, ubiquitin specific proteaz 17, translationally-controlled tumor protein 1

Figure 1: H&E stain

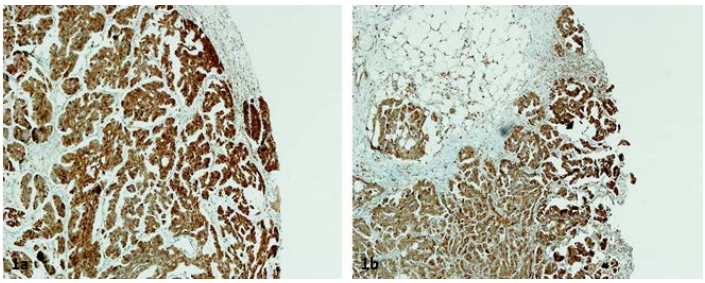


Primary and metastatic tissue of ovarian cancer. (a) Primary tissue of ovarian cancer. (b) Metastatic tissue of ovarian cancer. (H&E stain, magnification power: 100x)

Table 1: Correlation of USP17 and Tpt1 expressions between primary ovarian tissue and metastatic tissue

Variables	Correlation Coefficient	p value
USP 17	0,349	0,04
Tpt 1	0,285	0,10

Figure 2: USP17 Expression

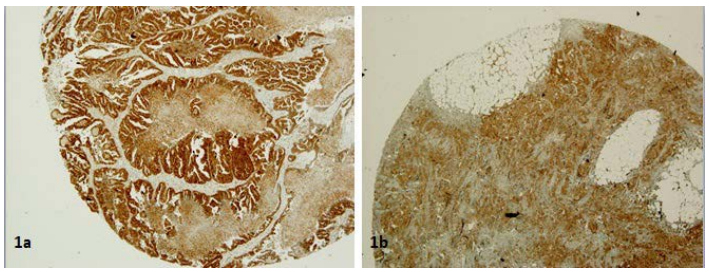


USP 17 expression in primary and metastatic tissue of ovarian cancer. (a) Primary tissue of ovarian cancer. (b) Metastatic tissue of ovarian cancer. (Magnification power: 100x)

Table 2: Comparison of USP 17 and Tpt 1 Expressions by Stage

	3B	3C	4	p value
Usp 17 expression in primary tissue	4,28 ± 1,25	4,38 ± 1,32	4,8 ± 1,64	0,68
Usp 17 expression in metastatic tissue	4,42 ± 1,61	4,04 ± 1,74	4,8 ± 1,3	0,62
Tpt 1 expression in primary tissue	7,42 ± 4,42	8,09 ± 3,76	8,00 ± 3,08	0,96
Tpt 1 expression in metastatic tissue	6,28 ± 4,34	6,38 ± 3,61	9,60 ± 1,67	0,21

Figure 3: Tpt1 Expression



Tpt 1expression in primary and metastatic tissue of ovarian cancer. (a) Primary tissue of ovarian cancer. (b) Metastatic tissue of ovarian cancer. (Magnification power: 40x)

Table 3: Comparison of USP 17 and Tpt 1 expressions of patients who received neoadjuvant chemotherapy (n = 8) and those who did not (n = 25)

	Neoadjvuvant chemotherapy +	Neoadjuvant chemotherapy -	p value
Usp 17 expression in primary tissue	4,64 ± 1,35	3,75 ± 1,03	0,062
Usp 17 expression in metastatic tissue	4,40 ± 1,60	3,75 ± 1,75	0,293
Tpt 1 expression in primary tissue	8,56 ± 3,47	6,00 ± 4,00	0,117
Tpt 1 expression in metastatic tissue	7,44 ± 3,62	5,00 ± 3,33	0,071

Table 4: Categorization of Tpt 1 Expressions

Categories for Tpt 1	Tpt 1 in primary tissue	Tpt 1 in metastatic tissue	p value
0 (No expression)	%3 (n=1)	%9,1 (n=3)	0.61
1 (1-4 low expression)	%24,2 (n=8)	%30,3 (n=10)	
2 (5-8 intermediate expression)	%24,2 (n=8)	%24,2 (n=8)	
3 (9-12 high expression)	%48.4 (n=16)	%36,4 (n=12)	

Table 5: Categorization for USP 17 Expressions

Categories for USP 17	USP 17 in primary tissue	USP 17 in metastatic tissue	p value
Negative (0-2)	%9 (n=3)	%21,2 (n=7)	0.15
Positive (3-6)	%90,9 (n=30)	%78,8(n=26)	

YS-04

Impact of growth hormone co-treatment in patients with diminished ovarian reserve on IVF outcomes

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OBJECTIVE: Human oocytes and cumulus cells have GH receptors (GHRs) and can be directly influenced by GH, and GH can promote nuclear maturation of denuded human oocytes. Since GH is involved in the regulation of female and male infertility, it has consequently been applied in the management of infertility for many years, especially in patients with poor ovarian response or poor prognosis. During ovarian stimulation, GH administration can improve the success rate of in vitro fertilization (IVF) probably through the beneficial effects of GH on oocyte quality as indicated by a higher number of mature oocytes and embryos arriving at the transfer stage and a higher fertility rate in GH-treated patients. Poor ovarian response to gonadotropin stimulation for IVF is common and is a predictor for low pregnancy rates. There are numerous strategies that have been suggested to improve the outcome in the poor responder women despite their limited successes. One other option is administration of growth hormone (GH) to potentiate the effect of exogenous gonadotropins. Results from the published studies were conflicting regarding the effect of GH during controlled ovarian stimulation for IVF. In this study, we assessed the efficacy of growth hormone co-treatment during controlled ovarian stimulation in poor responders for IVF.

METHODS: This study was carried out at the Health Sciences University, Ankara Etlik Zübeyde HanımWomen's Health Teaching and Research Hospital IVF Clinic. A total of one hundred and ninty one women with DOR who underwent IVF cycles were included in the study. In our study, DOR was defined as having a basal FSH value of >10 IU/L and E2 of >80 pg/mL measured within 1–3 months of the IVF cycle, and AFC of <7 or AMH levels of <1.1 ng/mL. Eighty nine patients with DOR who received GH during the study period were designated as the study group (Group A), while and the 102 patients with DOR who did not received GH as co-treatment were chosen as the control group (Group B). GH was given by subcutaneous injection of 2 mg (equivalent to 6 IU GH) every other day from the day of gonadotropin initiation in combination with gonadotropin treatment.

RESULTS: Days of stimulation and the total dose of gonadotropin used were significantly higher in the GH group. Basal estradiol and FSH levels were significantly lower in study group than the control group. No significant correlation was found between the groups in terms of number of metaphase 2 oocytes recovered, 2PNs (pronuclear), number of retrieved oocyte and the peak value of serum estradiol achieved at hCG day.The clinical pregnancy rate of the group A patients was higher than those in the control group, although this did not reach to statistical significance (Table1).

CONCLUSION: This present study has shown that poor responder women undergoing repeated IVF treatment and co-stimulated with GH achieve more oocytes, higher fertilization rate if growth hormone started, as compared with women of the same status but the clinical pregnancy rate did not increase significantly in GH group.

Keywords: Poor responder, Controlled ovarian hyperstimulation, Growth hormone, IVF

Table1. Demographic and stimulation characteristics of the patients

characteristics	Group A (n=89) mean±sd	Group B (n=102) mean±sd	p
age,years	33.15 ± 5.45	33.11 ± 4.54	0.850
body mass index, kg/m2	26.22 ± 4.63	25.6 ± 4.12	0.614
basal FSH,IU/l	8.62 ± 7.47	10.16 ± 5.34	0.008
basal estradiol, pg/ml	46.39 ± 35.36	57.32 ± 42.99	0.015
duration of stimulation, (days)	10.79 ± 2.23	9.72 ± 1.69	0.016
total gonadotropin dose,IU	3326.83 ± 1290.11	2748.04± 704.39	0.001
estradiol on day of hCG day,pg/ml	1399.14 ± 1185.00	1120.04 ± 719.02	0.514
progesterone on day of hCG day,pg/ml	0.55 ± 0.53	1.03 ± 4.05	0.683
number of oocyte retrieved	7.24 ± 6.52	4.89 ± 4.00	0.074
mature(M2) oocyte number	4.69 ± 4.61	3.78 ± 3.23	0.720
2PN(pronuclear)	2.32 ± 2.39	2.25 ± 2.51	0.403
implantation rate n(%)	23 (44.2)	16(34.2)	0.300
clinical pregnancy rate(%)	19 (39.4)	13 (37.7)	0.417

YS-05

Evaluation of serum and amnion fluid fractalkine levels in preterm labor: a case-control study

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AIM: According to the World Health Organization, preterm labor is defined as resulting in live birth before completing the 37th week of pregnancy. Premature birth is a serious obstetric problem that maintains its place today due to the high perinatal mortality and morbidity rates it causes. Preterm birth is the main cause of neonatal mortality and one of the important reasons for hospitalizations in the prenatal period. Many biochemical markers that may increase in maternal blood and amniotic fluid have been investigated in relation to the factor in the etiology of preterm birth. A test alone may not be sufficient to diagnose premature birth. CX3CL1 is the best known representative of the δ-chemokine family and is now called as fractalkine. It is known that proinflammatory chemokines have important roles in implantation, placental angiogenesis, invasion of trophoblasts into spiral arteries, and fetomaternal immune response. Studies on patients with premature rupture of membranes and intrauterine growth retardation have shown that fractalkine is high in the amniotic fluid. In this study, we investigated the levels of fractalkine, a pro-inflammatory chemokine, in the serum and amniotic fluid of pregnant women who gave birth due to premature labor. METHOD: After obtaining approval from the Fırat University ethics committee, 40 healthy patients between 37-41 weeks of gestation who applied to the Fırat University obstetrics clinic and had an elective cesarean delivery were included in the control group (Group1, G(1)), 40 patients between 24-37 weeks of gestation who gave birth by cesarean section with preterm labor were included as a case group (Group2, G(2)). Age, gravida, parity, number of living children, number of abortions, gestational weeks, fetal birth weight, 1st and 5th minute Apgar scores of the groups were evaluated. Fractalkine levels were measured in maternal serum and amniotic fluid obtained during cesarean section (table). The Shapiro−Wilk test and Mann–Whitney U tests were used in statistical analysis. $p < 0.05$ was considered to be statistically significant.

RESULTS: When G1 and G2 were compared statistically in terms of maternal age, gravida, parity, number of living children, number of abortions, respectively, no statistically significant difference was observed between G1 and G2 ($p = 0.52$, $p = 0.07$, $p = 0.32$, $p = 0.46$, $p = 0.14$). When G1 and G2 were compared statistically in terms of, weeks of gestation, fetal birth weight, 1st and 5th Minute Apgar scores respectively, gestational week, fetal birth weight, 1st and 5th Minute Apgar scores were statistically higher in G1 than in G2 ($p=0.00$, $p=0.00$, $p=0.00$, $p=0.00$). When G1 and G2 were compared in terms of amnion fluid fractalkine levels, G2 was found to be statistically significantly higher than G1 ($p=0.00$), while no statistical difference was found between maternal serum fractalkine levels ($p=0.07$) (table).

CONCLUSION: High amniotic fluid fractalkine levels may contribute to the inflammatory state in the amniotic fluid, leading to adverse fetal outcomes in the threat of preterm labor. Acknowledgement: Thanks to Prof. Dr. Nevin İlhan for biochemical measurements.

Keywords: prematür birth, amnion mai, fractalkine

Demographic parameters and fractalkine, levels in maternal serum of G1 and G2

Parameters	G1 (n=40)	G2 (n=40)	P values
Maternal age (years)	31.5 (24- 41)	32 (19- 45)	0.52
Gravida	4 (1- 8)	3 (1- 6)	0.07
Parity	2 (0- 6)	2 (0- 5)	0.32
Number of living children	2 (0- 6)	2 (0- 5)	0.46
Number of abortions	0 (0- 5)	0 (0- 3)	0.14
Gestational week	38 (37- 40.5)	34 (26- 36.9)	0.00
Fetal birth weight (gram)	3025 (2450-3960)	2075 (800- 3500)	0.00
1th minute apgar score	7 (4- 9)	5 (0- 8)	0.00
5th minute apgar score	9 (7- 10)	7,5 (0- 10)	0.00
Serum flactalkine levels, ng/ml	0.31 (0.24- 40.01)	4.15 (0.25- 102)	0.71
Amnion mai fractalkine levels, ng/ml	0.25 (0.20- 3.11)	5.20 (0.25- 9.4)	0.00

values are presented as median (minimum−maximum), $p < 0.05$ was considered to be statistically significant.

YS-06

In vitro inhibition of uterine contractions using electrospun nanofibers loaded with nifedipine and ML7

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OBJECTIVE: To formulate a nanofiber-based controlled drug delivery system that could be effective in preventing uterine contractions and can be used for the treatment of preterm labor.

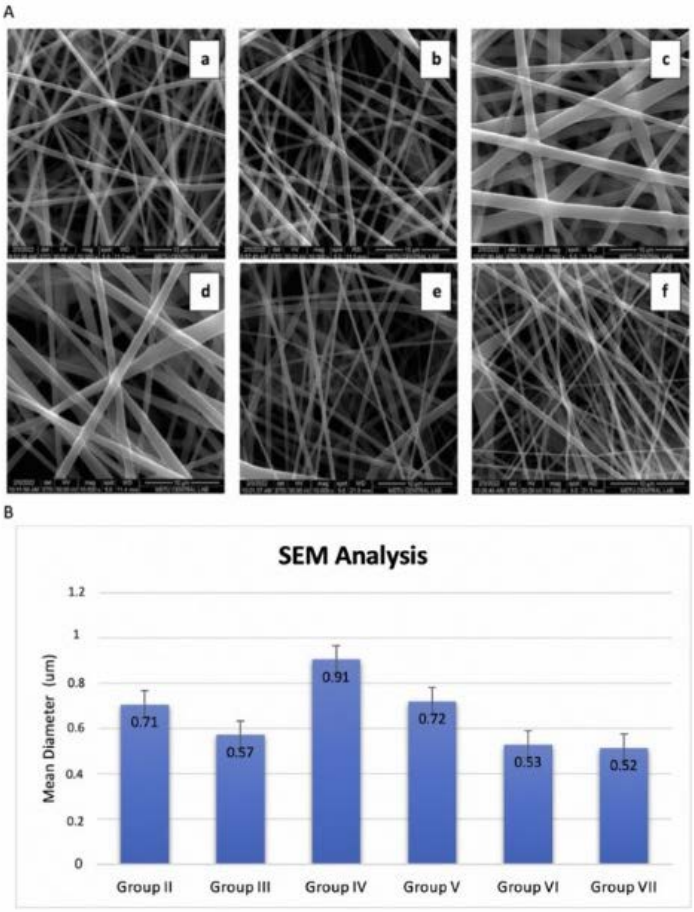
PATIENTS AND METHODS: We utilized uterine tissue samples obtained from ten pregnant women who underwent cesarean section at term to investigate the impact of nanofibers on spontaneous and induced myometrial contractions. We prepared nifedipine and ML7-loaded nanofibers using the electrospinning method with Poly(D,L-lactide-co-glycolide (PLGA) polymer, resulting in seven groups of nanofibers, including a control group. Group I served as the control, Group II was non-drug loaded nanofiber, Group III was nifedipine (10-5 M) loaded nanofiber, Group IV was ML7 (3x10-5 M) loaded nanofiber, Group V was ML7 (3x10-5 M) and nifedipine (10-5 M) nanofiber, Group VI was ML7 (3x10-5 M) and nifedipine (3x10-5 M) nanofiber, and Group VII was ML7 (3x10-5 M) and nifedipine (10-4 M) nanofiber. To evaluate the contractile response, the nanofibers loaded with different doses of ML7 and nifedipine were applied to the tissue strips, and in vitro organ bath experiments were performed. Full-thickness uterine samples were cleared of the serosa and surrounding tissues, and eight strips (3x10 mm) were prepared from each sample. The seven different nanofiber formulations were gently placed and sutured on the strips, with one strip always kept as the time control. We recorded spontaneous, KCl-induced, and stimulated cumulative oxytocin-induced contractions from all samples in all groups. After completing all experiments, the viability of the strips was checked, and weight measurement was recorded.

RESULTS: The administration of drug-loaded polymers resulted in a significant decrease in both the frequency and intensity of spontaneous and induced contractions in all groups ($p<0.01$). No significant difference was observed between the control group and the non-drug-loaded nanofiber group in post hoc analysis ($p=0.704$). In terms of amplitude and frequency of contractions, the most significant decrease was observed in group VII at cumulative oxytocin doses compared to the control and non-drug-loaded nanofiber groups ($p<0.05$). Additionally, group VI also showed a significant decrease in contraction intensity and frequency compared to the control and non-drug-loaded nanofiber groups ($p<0.05$). While the use of nifedipine and/or ML7 loaded nanofibers decreased both intensity and frequency of contraction, this attenuation was not significant compared to the control and empty polymer groups. However, a more significant inhibition was observed when ML7 was used with nifedipine at doses of 3x10-5 M and 10-4 M.

CONCLUSIONS: The results indicate that human uterine contractions can be inhibited using calcium channel blocker (nifedipine) and myosin light chain kinase inhibitor (ML7) loaded nanofibers in uterine tissue strips. These results strongly suggested the potential for the development of locally effective and safe controlled drug release systems to prevent premature birth.

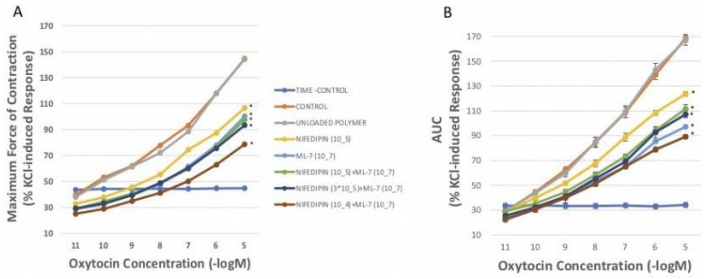
Keywords: Preterm Birth, Ca+2 channel blocker, Myosin light chain kinase inhibitor, Polymeric nanofiber formulation.

A, Scanning electron microscopic appearance of the nanofibers (magnification ratio: X10.000; voltage 30 kv), (a) Group II; (b) Group III; (c) Group IV; (d) Group V; (e) Group VI; (f) Group VII and (B), fiber diameters (Mean±SEM) of the nanofibers.



Group II: Non-drug loaded nanofiber; Group III: Nifedipine (10-5 M) loaded nanofiber; Group IV: ML7 (3x10-5 M) loaded nanofiber; Group V: ML7 (3x10-5 M) and Nifedipine (10-5 M) nanofiber; Group VI: ML7 (3x10-5 M) and Nifedipine (3x10-5 M) nanofiber; Group VII: ML7 (3x10-5 M) and Nifedipine (10-4M) nanofiber.

Oxytocin dose-response curves of the myometrial strips. A, The maximum force of contraction at each dose is used. B, Area under the curve (AUC) recorded between the application of two consecutive doses. The values are given as percent of the KCl-indu



Group I and II. Group I: Control; Group II: Non-drug loaded; Group III: Nifedipine (10-5 M) loaded; Group IV: ML7 (3x10-5 M) loaded; Group V: ML7 (3x10-5 M) and Nifedipine (10-5 M) loaded; Group VI: ML7 (3x10-5 M) and Nifedipine (3x10-5 M) loaded; Group VII: ML7 (3x10-5 M) and Nifedipine (10-4 M) loaded nanofibers.

Schema of contraction and relaxation cycle in smooth muscle cell

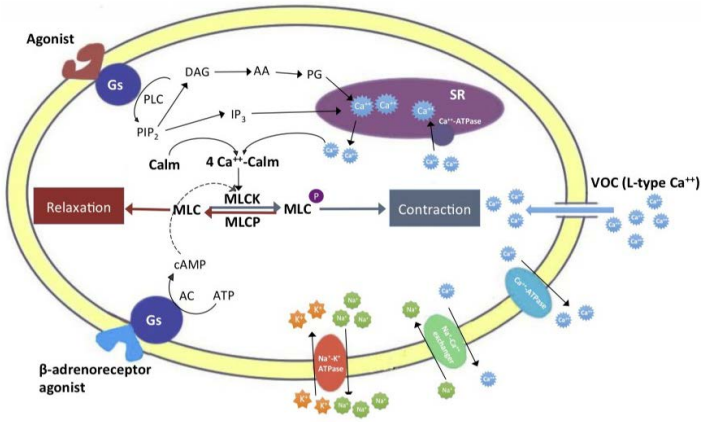
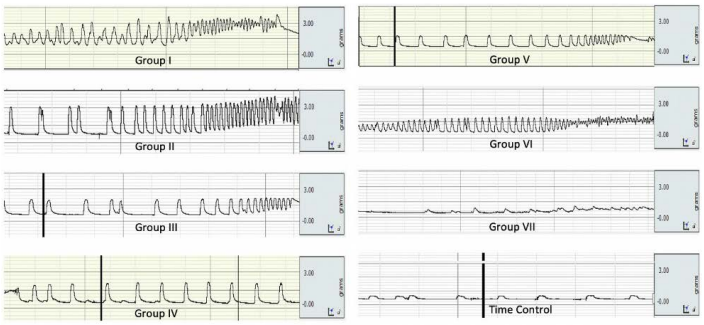


Figure is adopted with permission from Pehlivanoğlu et al.

The real-time recording of oxytocin dose-contraction responses of the myometrial strips in experimental groups.



Group I: Control; Group II: Non-drug loaded; Group III: Nifedipine (10-5 M) loaded; Group IV: ML7 (3x10-5 M) loaded; Group V: ML7 (3x10-5 M) and Nifedipine (10-5 M) loaded; Group VI: ML7 (3x10-5 M) and Nifedipine (3x10-5 M) loaded; Group VII: ML7 (3x10-5 M) and Nifedipine (10-4 M) loaded nanofibers.

The experimental groups and the doses of nifedipine and ML7 loaded to the nanofibers.

Group	Name	Concentration
I	Control (No nanofiber)	N/A
II	Non-drug loaded empty nanofiber	No drug
III	Nifedipine loaded nanofiber	10-5 M
IV	ML7 loaded nanofiber	3x10-5 M
V	ML7 and Nifedipine loaded nanofiber	3x10-5 M/10-5 M
VI	ML7 and Nifedipine loaded nanofiber	3x10-5 M/3x10-5 M
VII	ML7 and Nifedipine loaded nanofiber	3x10-5 M/10-4M

Demographic and clinical findings of the patients.

	n=10
Age (Years)	29.5 (25-34)
Gravida (number)	2 (2-3)
Para (number)	1 (1-2)
BMI (kg/m2)	28.3 (26.3-33.1)

he frequency and maximum force of contraction of spontaneous activity and KCl-induced response of myometrial strips in experimental groups.

		Time control	Group I	Group II	Group III	Group IV	Group V	Group VI	Group VII
Spontaneous contraction	Frequency (contraction number/5 min)	1.23±0.02	1.31±0.01	1.25±0.01	1.10±0.02	1.03±0.02*	1.0±0.03*	0.92±0.03*	0.88±0.02*
Spontaneous contraction	Force of contraction (% of KCl-induced contraction)	21.33±1.89	20.86±3.01	22.16±2.96	16.90±2.38	17.04±2.45	13.18±0.99*	11.36±1.69*,**	9.08±1.35*,**
KCL-Induced	Maximum Force of Contraction (% of KCl-induced con- traction)	100.0	103.28±4.80	85.85±1.92	68.45±1.68*	54.90±6.03*, ***	64.01±4.85*,	56.83±2.95*,***	52.49±4.20*,***

Frequency (contraction number/5 min).

	Time control	Group I	Group II	Group III	Group IV	Group V	Group VI	Group VII
10-11	1.2±0.01	1.4±0.01	1.4±0.02	1.1±0.02	1.1±0.02	1.1±0.03	1.1±0.02	0.9±0.02*
10-10	1.2±0.02	1.7±0.2	1.5±0.04	1.1±0.02	1.1±0.03	1.1±0.03	1.0±0.03	0.9±0.02*
10-9	1.2±0.02	2.0±0.1	1.9±0.1	1.1±0.02	1.2±0.03	1.2±0.03	1.1±0.03	1.0±0.02*
10-8	1.2±0.01	2.5±0.2	2.4±0.2	1.3±0.03*	1.3±0.03*	1.3±0.03*	1.1±0.03	1.0±0.02*
10-7	1.2±0.02	3.3±0.2	3.2±0.2	1.4±0.03*	1.4±0.03*	1.4±0.03*	1.2±0.04*	1.0±0.02*
10-6	1.2±0.01	4.1±0.2	3.8±0.2	1.6±0.05*	1.4±0.03*	1.4±0.03*	1.3±0.05*	1.1±0.03*
10-5	1.2±0.02	4.7±0.2	4.5±0.2	1.8±0.06*	1.6±0.05*	1.6±0.05*	1.4±0.05*	1.1±0.04**

YS-07

Evaluation of the relationship between fetal biacromial diameter and macrosomia in term pregnancies

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OBJECTIVE: The aim of our study is to assess the ultrasonographic measurement of fetal biacromial diameter for the prediction of macrosomia

METHODS: A total of 169 pregnant women in consecutive term (37-42 weeks of gestation) who applied to Marmara University Pendik Training and Research Hospital for delivery were included in this prospective study. Participants were divided into two groups according to their birth weight as those who gave birth 4000 gr and above as the macrosomic group and those who gave birth below 4000 gr as the non- macrosomic group. Demographic characteristics, ultrasonographic biometric measurements, biacromial diameter measurements, birth and postnatal data were compared between the groups. ROC curve analysis was performed to evaluate the best cut-off value of biacromial diameter in predicting macrosomia.

RESULTS: Macrosomic delivery occurred in 46 (27.2%) of 169 patients. The mean age in the study group was 28.71±6.00, the mean body mass index was 31.09±5.20, and the mean week of gestation calculated according to the last menstrual period was 39.22±0.98. Age and BMI values between the groups were found to be similar. The mean birth weight was found to be 3616.41±457.58 grams. Similar cesarean rates were found in both groups. Biacromial diameter was found to be significantly higher in the macrosomia group with a mean of 146.19±9.38 mm. ROC analysis of the biacromial diameter in predicting macrosomia had 67% sensitivity and 76% specificity at the 140.50 mm cut-off value, and 87% sensitivity and 69% specificity at the 139.50 mm cut-off value. CONCLUSION: The sonographic measurement of fetal biacromial diameter appears to be a new, simple, and useful method for predicting fetal macrosomia.

Keywords: biacromial diameter, macrosomia, ultrasound, sensitivity, specificity

YS-08

The role of levator hiatal area measured by intrapartum transperineal 3D ultrasonography in predicting labor duration and mode of delivery

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AIM: Intrapartum 3D transperineal ultrasonography, being a non-invasive method, is a tool that can help predict labor follow-up and mode of delivery by considering patient comfort. By evaluating the levator hiatal area, we aimed to predict indications for a cesarean section such as non-progressive labor and head-pelvis incompatibility at the first admission of the pregnant woman to the delivery unit, and to prevent maternal and fetal complications caused by prolonged labor.

METHOD: In our prospective and single-center study, 194 pregnant women between the ages of 18-45, between 37 and 42 weeks of gestation, who were admitted to Kanuni Training and Research Hospital for labor between 01/07/2023 and 25/12/23 were included. Intrapartum transperineal 3D ultrasonography measurements of levator hiatal area (LHarea), levator hiatal anteroposterior diameter (LHap), and levator hiatal transverse diameter (LHrl) were recorded in 3 different states: rest (R), contraction (C), and Valsalva (V). An independent sample t-test, chi-square test, Pearson correlation test, repeated measures analysis of variance, logistic regression analysis, and ROC analysis were used in the statistics of the findings.

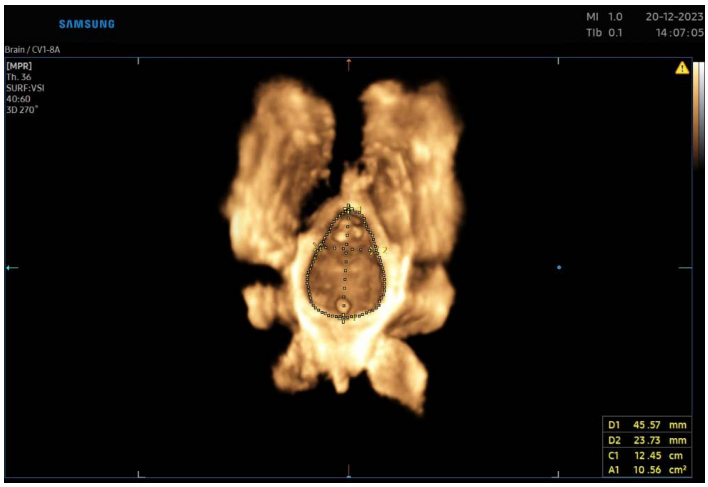
RESULT: In pregnant women with levator ani coactivation, the duration of the second stage of labor was found to be longer, but no correlation was found with the mode of delivery. As LHareaR, LHareaC, LHareaV, LHrlR, LHrlC, and LHapV measurements increased, the duration of the second stage of labor decreased. It was found that the mean LHarea measurements of nulliparous pregnant women who delivered by cesarean section were smaller in all 3 cases compared to the pregnant women who delivered normally (14.82 cm2 vs. 21.54 cm2 for LHareaR, 12.12 cm2 vs. 16.52 cm2 for LHareaC, and 19.6 cm2 vs. 25.56 cm2 for LHareaV). To predict normal delivery in nulliparous pregnant women, ROC analysis was performed and cut-off values were determined. The cut-off value for LHareaR was 17.60 cm2 (AUC=0.974, 93.2% sensitivity, 92.5% specificity, p<0.000), the cut-off value for LHareaC was 13.89 cm2 (AUC=0.869, 78%, 4% sensitivity, 79.1% specificity, p<0.000), and the cut-off value for LHareaV was 22.21 cm2 (AUC=0.857, 78.4% sensitivity, 80.6% specificity, p<0.000). According to the logistic regression model in nulliparous pregnant women, a 1 unit increase in LHareaV decreased the probability of a cesarean section by 91.3%.

CONCLUSION: Smaller levator hiatal measurements prolong labor and increase the likelihood of a cesarean section. Levator ani coactivation does not predict the mode of delivery but prolongs the duration of the second stage of labor. Previous studies in the literature by Lanzarone, Dietz, Siafarikas, Van Veelen, Brunelli, et al. with 3D TPU were performed before the onset of labor. Although the findings in our study overlap with the literature, it is the

first and only study performed intrapartum with 3D TPU.

Keywords: coactivation, labor, levator hiatal area, transperineal 3D ultrasound

Levator hiatus ölçümleri



3D transperineal usg ile levator hiatus anteroposterior çap, transvers çap ve levator hiatal alan ölçümleri

YS-09

Thyroid autoantibodies in early pregnancy are associated with an increased risk of gestational diabetes

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OBJECTIVE: Thyroid hormone is an essential hormone for normal pregnancy and fetal development. Placental and fetal development in the first half of pregnancy depends on maternal thyroid hormone levels. Therefore, maternal thyroid dysfunction may lead to adverse pregnancy outcomes such as miscarriage, intrauterine growth restriction, hypertensive disorders, and preterm delivery. Furthermore, 2-17% of all pregnant women are positive for thyroid peroxidase antibody (AntiTPO) or anti-thyroglobulin antibody (AntiTG). Anti-TPO positivity adversely affects maternal thyroid status, pregnancy, and the developing fetus. Thyroid antibody positivity also increases the risk of postpartum thyroid dysfunction. This study aimed to investigate the relationship between maternal thyroid autoantibodies measured in the early weeks of pregnancy and gestational diabetes.

MATERIALS-METHODS: Between January 2018 and March 2023, 180 patients who underwent routine follow-up and had maternal thyroid autoimmune antibodies (thyroid peroxidase antibody, anti-thyroglobulin antibody) checked for any indication during the first-trimester pregnancy examinations were included in the study. Patients who underwent a 50 g oral glucose tolerance test (OGTT) between 24-28 weeks of gestation and had normal results were compared with pregnant women who had test results >140 mg/dL and therefore underwent 100 g OGTT. In 100 g OGTT, gestational diabetes was diagnosed if two values were above baseline, and impaired glucose tolerance was diagnosed if one value was above baseline. Antibody positivity was diagnosed if the antiTPO value was >35 IU/mL and antiTG was >50 IU/mL.

RESULTS: A total of 180 patients were included in the study. Autoimmune thyroid antibody positivity was detected in 50 (27.7%) patients in the study group. In 140 patients (77.7%) in the study group, 50 g OGTT was within normal limits, and in 40 patients (22.3%), 100 g OGTT was additionally performed. 5 patients (2.7%) were diagnosed with gestational diabetes mellitus (GDM) and 25 patients (13.8%) had impaired glucose tolerance. In the group of patients who underwent 100 g OGTT, autoimmune antibody positivity was significantly higher than in the group who underwent only 50 g OGTT (p=0.034). However, autoimmune antibody levels were higher in patients diagnosed with GDM than in patients with impaired glucose tolerance, but no significant difference was found.

CONCLUSION: Autoimmune diseases may increase the risk of developing gestational diabetes. Impaired glucose tolerance is more common in patients with autoimmune thyroid antibody positivity in the first trimester of pregnancy.

Keywords: Anti-TG, Anti-TPO, Gestational diabetes mellitus, Glucose intolerance, Pregnancy, Thyroid autoimmunity

YS-10

Vaginal microbiota composition in pregnant women with short cervix before and after Progesterone Treatment: a longitudinal study

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OBJECTIVES: To examine the differences in vaginal microbiota between women with short and normal cervical length during the second trimester of pregnancy, and evaluate the impact of vaginal progesterone treatment on the vaginal microbiota.

METHODS: The prospective longitudinal study involved women with a cervical length ≤25 mm at 20-24 weeks of gestation was conducted at Koc University Hospital. The cervicovaginal swabs were collected during the 11+0-13+6, 20+0-24+6, and 28+0-34+6 weeks of gestation. After the collection of samples, cervical length was measured using transvaginal ultrasonography. The women with a cervical length ≤25 mm (n=32) and women with a cervical length > 25 mm (n=27) as a control group were included. The 16S rRNA bacterial gene was sequenced using the QIAseq 16S/ITS Panel Kit and Illumina MiSeq platform. Bioinformatic analysis included demultiplexing FASTQ files, aligning high-quality sequences with the SILVA database, and removing chimeric sequences. Taxonomic annotation was performed using Mothur with SILVA as the reference.

RESULTS: Women with a short cervix had dysbiotic vaginal microbiota with significantly increased alpha diversity (P=0.018). The short cervix group have shown vaginal microbiota dysbiosis with an increasing alpha diversity index compared to controls (p=0.018) and higher relative abundance of G. vaginalis (p=0.520), A.vaginae (p=0.599) and L.iners (p=0.553). There was a significant decrease in L. gasseri ratio (p=0.023) in the second trimester of pregnancy. The ratios of L. crispatus and L. iners were not different between groups (%36.5 vs. 32.2%; P=0.55 and 39.7% vs. 41.2%; P=0.574, respectively). Longitudinal analysis revealed a decline in L. crispatus and increases in L. iners, L. jensenii and A. vaginae in women with a short cervix in the second trimester. Progesterone treatment did not significantly affect bacterial diversity in both groups (P=0.28). Additionally, the relative abundance of L. crispatus (44.4% vs 41.2%; P=0.14) and L. iners (33.9% vs 37.3%; P=0.17) remained consistent following treatment.

CONCLUSION: This study highlights dysbiotic changes in the vaginal microbiota of women with short cervix, particularly in the abundance of specific bacterial taxa. The findings demonstrate that vaginal progesterone treatment does not exert significant alterations on the vaginal microenvironment. This suggests that its efficacy in preventing preterm birth in women with a short cervix may be mediated through alternative biological pathways rather than through modifications of the vaginal microbiota.

Keywords: Cervical length, Vaginal microbiota, Progesterone treatment

YS-11

Comparison of different progesterone applications in luteal phase support in artificially prepared frozen embryo transfer (fet) cycles

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Introduction and AIM: In vitro fertilization (IVF) is one of the assisted reproductive technologies available for infertile couples. In IVF, fertilization occurs in a laboratory setting, where sperm and eggs are brought together to form an embryo, which is then transferred to the uterus in an attempt to establish a pregnancy. However, there is still debate regarding the appropriate use of progesterone support for this process. Specifically, in cycles where frozen embryos are being transferred, luteal phase support must be provided through the use of progesterone. Choosing between different methods of progesterone administration to provide luteal phase support can affect treatment success and pregnancy rates. Therefore, comparing the effectiveness of different progesterone administration methods in frozen embryo transfer cycles is an important research topic. The objective of this study is to compare different progesterone administration methods used in artificially prepared frozen embryo transfer cycles.

MATERIALS-METHODS: A randomized prospective study including 237 infertile women was performed between June 2022 and December 2022 in the IVF center of a tertiary university hospital. Patients who underwent HRT-FET (single – blastocyst) were randomized into three groups depending on the luteal phase progesterone regimen; Group 1 (incrementally increased vaginal progesterone doses; 400mg-600mg-800 mg), Group 2 (600 mg vaginal) and Group 3 (on the day of ET subcutaneous progesterone 25 mg added to 600 mg vaginal). Serum progesterone levels were measured on the day of starting progesterone administration, on the day of embryo transfer and on the day of pregnancy testing.

RESULTS: A total of 237 patients were included (67 in Group1, 95 in Group2, 75 in Group3). The median serum progesterone levels on the day of ET in Group 1 were significantly higher than the other groups [Respectively; 12.9 ng/ml (6.6-24.5), 10.5 ng/ml (0.20-25.9), 9.8 ng/ml (3-25.5), p<0.01]. Live birth rates (LBR) were similar between the groups (Respectively; 37%, 34.8%, 28.3%, p=0.345). The ROC analysis showed a significant correlation between progesterone level on ET day and LBRs (Area under curve: 0.65, p= 0.004) and a threshold of progesterone to predict the LB was found at 10.65 ng/ml (71% sensitivity and 51% specificity).

CONCLUSION: Lower serum progesterone levels (<10 ng/ml) were associated with reduced live birth rates and higher miscarriage in FET cycles LPS with vaginal progesterone. However, there is uncertainty about the association between serum progesterone levels and different routes of progesterone administration luteal phase support protocols in HRT-FET cycles. A serum progesterone level on the day of embryo transfer greater than 10.65 ng/ml is related to higher live birth rates, regardless of the progesterone regimen.

Keywords: Assisted reproductive technology, frozen embryo transfer, progesterone, vitrification

YS-12

Evaluation of the effects of COVID-19 infection and COVID-19 mRNA vaccine on ovarian reserve

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AIM: To reveal possible negative effects by comparing the ovarian reserves and ovarian functions of women of reproductive age who had COVID-19 infection or were vaccinated with 2 doses of COVID-19 mRNA vaccine with those before infection or vaccination.

METHOD: Between the ages of 16-44, who applied to Istanbul University-Cerrahpasa, Cerrahpasa Medical Faculty Hospital between January 2021 and September 2023, and who had a COVID-19 PCR (+) positive test result or who did not have an infection within the same date range and received 2 doses of COVID-19 mRNA vaccine were identified. Among these patients, those with known basal ovarian reserve parameters (Anti-Müllerian Hormone(AMH), Follicle Stimulating Hormone(FSH), Luteinizing Hormone(LH), Estradiol(E2)) were selected. The patients were followed up. Ovarian reserve parameters were repeated 6 months after infection or vaccination.

FINDINGS: 71 patients in the infection arm and 97 patients in the vaccine arm were evaluated in the study. Basal hormone values and ovarian reserve parameters before vaccination and infection were compared with those after. In the results in the infection group; Delta AMH: 0.40±0.86, Delta FSH: 0.16±2.91, Delta LH: 0.08±2.94, Delta E2: 1.46±29.95, Delta PRL: 0.31 ±13.97, Delta TSH: 0.20±1.38; In the vaccine group, Delta AMH: 0.22±0.69, Delta FSH: 0.23±1.82, Delta LH: 0.04±2.97, Delta E2: 4.50±37.45, Delta PRL: -0.04±11.45, Delta TSH: 0.10±1.02 were found. It was concluded that there was no statistically significant change (p>0.05). The analysis was repeated according to age groups and in the patient group with polycystic ovary syndrome. The results were similar to the general population. Apart from this, compared to previous studies, a higher rate of menstrual irregularity was observed in both arms in our patient group: in infection group, 38,03%; in vaccination group, 18,55%. All menstrual irregularities were seen temporarily within 6 months.

CONCLUSION: No negative effects of COVID-19 infection and mRNA vaccines on ovarian reserve were observed in the short-term. COVID will continue to be in our lives with new variants. Long COVID is a new research topic being emphasized today. For long-term results, new studies with larger patient populations need to be conducted in the future

Keywords: Anti-Müllerian Hormone, COVID-19, mRNA vaccine, ovarian reserve, SARS-CoV-2

Table 1: Comparison of hormonal parameters before and after infection in people with COVID-19

	Before COVID-19	After COVID-19	p
AMH (ng/ml)	3,70±2,71	3,30±2,71	0,380
FSH (mIU/ml)	6,44±2,53	6,60±2,65	0,721
LH (mIU/ml)	8,25±4,20	8,33±4,40	0,918
E2 (pg/ml)	54,05±32,92	52,58±25,27	0,773
PRL (ng/ml)	20,50±11,16	20,80±8,70	0,858
TSH (µIU/ml)	2,27±1,44	2,07±1,18	0,357
Total Testosteron (ng/dl)	42,76±17,01	41,05±15,06	0,691
Free Testosteron (pg/ml)	2,30±1,23	2,08±0,92	0,712

Table 2: Comparison of hormonal parameters before and after COVID-19 mRNA vaccine

	Before vaccine	After vaccine	p
AMH (ng/ml)	3,68±2,60	3,47±2,47	0,540
FSH (mIU/ml)	6,11±2,21	6,36±2,44	0,454
LH (mIU/ml)	7,03±3,54	7,07±3,26	0,951
E2 (pg/ml)	52,22±37,82	49,54±27,69	0,579
PRL (ng/ml)	22,12±11,07	21,98±8,82	0,925
TSH (µIU/ml)	2,19±0,98	2,09±0,91	0,471
Total Testosteron (ng/dl)	38,06±12,55	36,97±13,56	0,681
Free Testosteron (pg/ml)	1,80±0,66	1,81±0,72	0,977

Table 3: Comparison of changes in hormonal parameters between groups

	Infection group (n:71)	Vaccine group (n:97)	p
Delta AMH	0,40±0,86	0,22±0,69	0,143
Delta FSH	0,16±2,91	0,23±1,82	0,852
Delta LH	0,08±2,94	0,04±2,97	0,930
Delta E2	1,46±29,95	4,50±37,45	0,584
Delta PRL	0,31±13,97	-0,04±11,45	0,862
Delta TSH	0,20±1,38	0,10±1,02	0,569

Table 4: Rates of menstrual irregularity development after infection and vaccination

	Infection group (n:71)	Infection group (n:71)	Vaccine group (n:97)	Vaccine group (n:97)
	n	%	n	%
Menstrual irregularity	27	38,03	18	18,55
Amenorrhea	6	8,45	1	1,03
Oligomenorrhea	5	7,04	5	5,15
Hypomenorrhea	6	8,45	2	2,06
Oligomenorrhea +hypomenorrhea	6	8,45	7	7,22
Menometrorrhagia	4	5,64	3	3,09

YS-13

Investigation of the role of Relaxin, Matrix Metalloproteinase-2 and Interleukin-6 in body fluids for diagnosing deep infiltrative endometriosis in women with chronic pelvic pain

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AIM: Endometriosis is the most frequent gynecological cause of chronic pelvic pain. Several serum marker studies have been conducted to aid in the differential diagnosis of deep infiltrative endometriosis, but clear results have yet to be obtained. Among these markers, IL-6 is the most significant. There has been a recent increase in publications regarding the expression of Matrix Metalloproteinase 2 (MMP-2) and relaxin in endometriotic foci. MMP-2 is involved in cytoskeleton regulation, while relaxin levels increase during pregnancy. Our study aimed to evaluate the predictive success of relaxin, MMP-2, and IL-6 in body fluids in deep infiltrative endometriosis compared to healthy controls. Additionally, we aimed to investigate the role of these molecules in the pathophysiology of deep infiltrative endometriosis and compare their effectiveness by measuring the levels of vaginal fluid, peritoneal fluid, and serum.

METOD: This case-control study was conducted at Bursa Yüksek İhtisas Training and Research Hospital between June 2022 and June 2023. The study included women over 35 years of age with complete fertility who presented to the outpatient clinic with chronic pelvic pain and were diagnosed with endometriosis. The study group consisted of patients diagnosed with deep infiltrative endometriosis and/or adenomyosis after examination, laboratory, and imaging tests, while the control group consisted of patients who underwent tubal ligation without pelvic pain. Prior to the operation, all patients had 10 cc of vaginal wash fluid and serum samples collected. During laparoscopy, 20 cc of pelvic washing fluid was collected. ELISA was used to measure levels of Relaxin, Matrix Metalloproteinase-2 (MMP-2), and IL-6. The study was financially supported by the University of Health Sciences as a scientific research project.

RESULT: The study included 60 patients, with 30 (50%) in the deep infiltrative endometriosis group and 30 (50%) in the control group. Significant differences were observed between the two groups in terms of IL-6 ($p<0.001$) and MMP-2 ($p<0.001$) levels in vaginal, peritoneal and serum samples, with higher levels in the deep infiltrative endometriosis group and lower levels of relaxin ($p<0.001$). Although there was a statistically significant difference between the predictive role of vaginal and peritoneal relaxin ($p=0.03$), there was no statistically significant difference between the predictive role of peritoneal and serum relaxin ($p=0.45$). Additionally, there was no statistically significant difference between the predictive role of vaginal, peritoneal and serum IL-6. Furthermore, there was no statistically significant difference in the predictive roles of vaginal and peritoneal IL-6, MMP-2, and relaxin in deep infiltrative endometriosis. The results for serum relaxin and IL-6 were also similar. In the correlation analysis, the predictive success of vaginal fluid, peritoneal fluid, and serum values of all markers, except serum MMP-2, were found to be correlated with each other.

CONCLUSION: The diagnosis of deep infiltrative endometriosis in patients can be predicted by measuring Relaxin, MMP-2 or IL-6 levels in vaginal fluids. This supports the role of Relaxin, MMP-2, and IL-6 in the pathophysiology of deep infiltrative endometriosis.The elevation of MMP-2 may be due to low levels of Relaxin.

Keywords: Deep infiltrative endometriosis, chronic pelvic pain, Relaxin, Matrix Metalloproteinase-2, Interleukin-6,

YS-14

Prospective evaluation of cervicovaginal laminin and fetal fibronectin levels for predicting timing of birth and impact on maternal-fetal outcomes in preterm risk pregnancies

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OBJECTIVE: The aim of the study is to investigate the predictive success of cervicovaginal laminin levels measured in women at risk of Preterm Birth (PTB), compared to fetal fibronectin (fFN) levels and cervical length (CL) measurement, and to elucidate the relationship between these findings and maternal-neonatal outcomes.

MATERIALS-METHODS: This prospective cohort study was conducted at Bursa Yüksek Ihtisas Training and Research Hospital between 1/08/2022 and 1/07/2023. A total of 91 pregnant women, presenting to our hospital's obstetrics or emergency clinics with groin pain and/or contractions and diagnosed with threatened PTB between 24-32 weeks of gestation, were included in the study. Sociodemographic characteristics, medical and obstetric histories, and detailed pregnancy histories of patients were recorded. Cervicovaginal swabs were obtained for fFN and alpha-laminin levels. Data on pelvic examinations, cervical dilation, softening, ultrasonography findings were recorded. Clinical follow-ups of patients, gestational weeks at delivery, pregnancy complications, delivery methods, neonatal outcomes and maternal outcomes were recorded. Patients were grouped as those delivering <37 weeks (preterm group) and those delivering ≥37 weeks (term group) and compared in terms of clinical parameters. Subgroup analysis was also performed within the preterm group for deliveries below and above 34 weeks. Cut-off values for laminin, fFN and CL for predicting PTB were calculated using ROC analysis. Logistic regression analysis was used to determine the role of independent variables in predicting PTB.

RESULTS: Among the 91 included patients, 34(37.4%) experienced PTB, while 57(62.6%) had term deliveries. The sociodemographic characteristics, medical histories, and previous pregnancy details were similar across groups. As expected, the preterm group had significantly lower gestational weeks and birth weights compared to the term group, with a significantly higher requirement for neonatal intensive care. In the preterm group, CL was shorter compared to the term group (25(10-43)mm vs. 35(20-42) mm, p<0.001), and levels of fFN and alpha-laminin were significantly higher (11.57(5.64-111.2)ng/mL vs. 8.49(5-25.8)ng/mL, p=0.008 and 288.1(123.9-2586.1)ng/mL vs. 173.02(55-865.1)ng/mL, p=0.002, respectively). Statistically significant cut-off values for predicting PTB were recorded as CL <30 mm, fFN <10.73 ng/mL, and alpha-laminin <235.06 ng/mL. The sensitivity and specificity for alpha-laminin at the specified cut-off were calculated as 64.7% and 71.9%, respectively (AUC=0.699,p=0.005). A positive correlation was observed between fFN and alpha-laminin levels in Spearman correlation analysis (r=0.496,p=0.003). There were no statistically significant differences in CL, fFN, and alpha-laminin levels between early and late preterm groups. Logistic regression analysis revealed a significant association between a short cervix and PTB, while fFN and alpha-laminin were not identified as significant variables for predicting PTB.

CONCLUSION: In patients diagnosed with threatened PTB between 24-32 weeks of gestation, CL measurements, along with fFN and alpha-laminin levels in cervicovaginal fluid, may predict deliveries before 37 weeks of gestation. Alpha-laminin, a newly evaluated protein in cervicovaginal fluid, can be utilized for real preterm labor screening in high-risk patients. Further multicenter and large-scale studies with high levels of evidence are needed to better elucidate the predictive success of cervical laminin levels in predicting preterm delivery.

Keywords: preterm birth, alpha-laminin, fibronectin, cervical length

YS-15

The Impact of Uterine Manipulator on Laparoscopic Hysterectomy Outcomes

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INTRODUCTION: Laparoscopic hysterectomy, a minimally invasive surgical approach for uterine removal, has gained prominence in gynecological practice. The common belief in the utility of uterine manipulator during these procedures to aid in uterine manipulation and potentially enhance outcomes, such as reducing complications like ureteric injury and shortening operation time, is widely acknowledged. However, a comparative analysis of perioperative parameters in patients with and without manipulator use in laparoscopic hysterectomies is lacking. In this retrospective analysis, we aim to investigate whether the utilization of uterine manipulator contributes to improved perioperative outcomes in laparoscopic hysterectomy. By examining data from 702 cases, we aim to provide insights into the efficacy and necessity of uterine manipulator in enhancing surgical outcomes.

Materials: A total of 702 laparoscopic hysterectomies performed for benign pathologies were retrospectively included in the study. The procedures were conducted between January 2014 and June 2021. Various parameters were assessed, including operation time, blood loss, intraoperative and postoperative complications, conversion rates to laparotomy, uterine weight, and hospital stay.

RESULTS: There were no statistically significant differences in age between the two groups (p=0.269), and although the length of hospital stay showed a trend towards significance, it did not reach statistical significance (p=0.063). The difference in uterine weight between the two groups was statistically significant, with patients using uterine manipulators having a lower mean uterine weight (180.1 gr ± 143.4) compared to those without manipulator use (207.5 gr ± 184.7) (p=0.042). Among the observed complications, six ureter injuries were identified, all of which occurred within the manipulator group (p=0.134). Additionally, eleven cases necessitated conversion to laparotomy within the manipulator group, whereas only two patients required laparotomy in the no-manipulator group (p=0.32). A higher incidence of bladder injury was observed in the group without uterine manipulator usage (p=0.021). However, there was no significant impact of uterine manipulator use on intraoperative complications overall (p=0.341). Regarding the need for transfusion, there was a notable increase in the group with uterine manipulator usage (p=0.043).

CONCLUSION: In conclusion, while the use of uterine manipulator shortens operation time, it does not confer superiority in terms of ureter injury and intraoperative complications.

Keywords: Complications, Laparoscopic hysterectomy, Ureter injury, Uterine manipulator

YS-16

The Effect of Pelvic Floor Training Program in Prevention of Perineal Trauma During Birth: A Quasi-Randomised Controlled Trial”

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BACKGROUND: The use of the pelvic floor muscle training for urinary incontinence treatment is well established but little is known about its effects in labor and newborn outcomes. OBJECTIVES: To evaluate the effects of antenatal pelvic floor muscle training and strength in labor and newborn outcomes in low-income pregnant women. METHODS: This is a randomized controlled trial that recruited forty-two nulliparous healthy pregnant women aged between 18-36 years old and able to contract the pelvic floor muscles. The participants were included in the study with 20 weeks of gestational age and had their pelvic floor muscles measured by vaginal squeeze pressure. They were randomly allocated into two groups: training group and a non-intervention control group. Then, all participants had their labor and newborn outcomes evaluated through consultation of medical records by a blinded researcher. RESULTS: There were no statistically significant differences between the groups regarding gestational age at birth, type of labor, duration of the second stage of labor, total time of labor, prevalence of laceration, weight and size of the baby, and Apgar score. No correlation was observed between pelvic floor muscle strength and the second stage or the total length of labor. CONCLUSIONS: This randomized controlled trial did not find any effect of pelvic floor muscle training or pelvic floor muscle strength on labor and newborn outcomes.

Keywords: Labor, muscle training, newborn, pelvic floor, physical therapy.

YS-17

Assessment of artificial shrinkage and assisted hatching techniques in frozen-thawed embryo transfer cycles: impact on blastocyst survival and clinical outcomes

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Aim

The primary objective of this study is to assess the impact of artificial shrinkage procedure implemented prior to blastocyst vitrification, as well as the application of assisted hatching technique before blastocyst transfer subsequent to thawing, within the first frozen-thawed embryo transfers cycles. The study aims to elucidate the effects of these interventions on both blastocyst survival rates and clinical outcomes.

Material and Method

A retrospective comparative study was undertaken to analyze frozen embryo transfer cycles conducted at Bursa Uludag University assisted reproductive technology (ART) Center from 2011 to 2024. Cycles in which first single frozen embryo transfers were performed were included in the study. Embryo quality evaluations were determined by the Gardner blastocyst score. The investigation focused on comparing the blastocyst survival rates and clinical outcomes across three groups: Group 1 (n=902) involved the implementation of both artificial shrinkage and assisted hatching; Group 2 (n=133) entailed the application of artificial shrinkage without assisted hatching; and Group 3 (n=189) comprised cycles in which neither artificial shrinkage nor assisted hatching were employed.

RESULTS: Baseline characteristics of patients across the three groups were found to be statistically similar, indicating no significant differences. Similarly, there were no statistically significant variations in basal hormonal parameters and ovarian stimulation characteristics among the patient groups. Upon assessing the quality of transferred embryos, it was observed that the blastocyst quality scores were comparable across all three groups (p=0.631). Additionally, statistical analysis indicated that the post-thaw cryosurvival rates of the blastocysts did not show significant differences (p=0.273). Moreover, the implantation rates of the transferred embryos were determined to be statistically indistinguishable among the three groups, with rates of 38.6%, 40.6%, and 39.2%, respectively (p=0.902), indicating no significant difference.

CONCLUSION: In summary, our present investigation demonstrates that pre-blastocyst vitrification artificial shrinkage and post-thaw assisted hatching procedures do not significantly affect cryosurvival and implantation rates. To enhance the robustness of these findings and establish a higher level of evidential support, further studies are imperative.

Keywords: artificial shrinkage, assisted hatching, vitrification

YS-18

Scar endometriosis: Retrospective analysis of 25 cases

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INTRODUCTION

Endometriosis is defined as the presence of endometrial tissue functioning outside the uterus. Scar endometriosis is a rare form of endometriosis typically observed following cesarean section or gynecological surgeries. The frequency of scar endometriosis has been increasing recently due to the rising rate of cesarean deliveries.

OBJECTIVE

In this study, we aimed to contribute to the literature by evaluating the clinical characteristics and surgical outcomes of patients operated for scar endometriosis and to raise awareness of this condition.

METHODS

We retrospectively reviewed the data of 25 patients who underwent surgery for scar endometriosis between 2016 and 2023. Demographic characteristics, clinical features, imaging methods used for diagnosis, and surgical details were recorded from the patients' files. The obtained data was analyzed using SPSS Statistics 26 software.

RESULTS

The mean age of the patients was 34.1 ± 6.4 years (range: 25-48). The most common reason for referral among patients was cyclic abdominal pain (64%). The second most common reason was palpable mass (28%). While 23 patients had a history of cesarean delivery, 2 patients who had vaginal deliveries had a history of myomectomy. Magnetic Resonance Imaging was used in the preoperative diagnosis of 9 out of 25 patients. There was a statistically significant relationship between lesion volume and anatomical location of the lesion ($p<0.005$) and parity number ($p<0.05$). Histopathologically, scar endometriosis was confirmed in 24 patients, while 1 patient's pathology was reported as fibrolipomatous tissue. After surgery, patients were followed up for an average of 7 months (range: 3-12), and recurrence of endometriotic focus in another area was observed in 1 patient.

CONCLUSION

Scar endometriosis should be considered in all reproductive-age women with a history of obstetric or gynecological surgeries presenting with cyclic pain and palpable swelling that negatively affect women's health and daily life. A detailed history and physical examination are often sufficient for diagnosis. Imaging methods can be used for diagnosis when necessary. Surgical excision forms the basis of treatment. The number of surgeries undergone and the anatomical location of the lesion provide information about the size of the lesion. Further recommendations can be provided with advanced studies involving a larger patient population.

Keywords: cesarean section, painful scar, scar endometriosis

YS-19

The Relationship Between Pathology Results And Adenomyosis In Endometrioid Type Endometrial Cancer

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OBJECTIVE: Endometrium cancer (EC) is the most common cancer among gynecological cancers in Turkey. The most crucial symptom is postmenopausal bleeding, and most of the patients can be diagnosed at an early stage. Endometroid carcinoma is the most common type of EC (80%). Adenomyosis is characterized by the migration of endometrial glands and stroma from the basal layer of the endometrium to the myometrium. A meta-analysis showed that overall survival was significantly increased in endometrial cancer patients with adenomyosis. In this study, we aimed to evaluate the association of adenomyosis with pathology results in patients diagnosed with endometrioid type endometrial cancer and operated for this reason in our clinic.

MATERIALS-METHODS: The study included patients operated on in the gynecological oncology clinic of a tertiary care hospital with pathology results of endometrioid adenocarcinoma. Demographic and clinical characteristics were obtained from medical records. Systemic diseases, smoking or alcohol use, and chronic diseases were excluded from our study.

RESULTS: The study included 167 cases. In 136 cases, no adenomyosis was detected on pathological examination, while 31 cases were found to have adenomyosis. The mean age of the cases was 59.85 ± 9.27 years, median gravida: 2.00, median parity: 2.00. In our study, it was found statistically significant that the presence of adenomyosis was associated with less cervical stromal involvement (p: 0,015). No significant correlation was found with other parameters.

CONCLUSION: In a study conducted, it was found that patients with concurrent endometrial cancer and adenomyosis were diagnosed earlier, and pathology results were lower grade. Accordingly, better prognosis and higher survival rates were observed. This is compatible with the current view that endometrial cancer associated with adenomyosis has a more favorable prognosis and may be a result of early diagnosis due to the prominent symptoms of the two diseases (4). Other studies have found that endometrial cancer and adenomyosis are associated with a better prognosis and lower risk of nodal metastases (5, 6). In our study, it was found to be statistically significant that the presence of adenomyosis was associated with less cervical stromal involvement (p: 0.015). In addition, although not statistically significant, we found that myometrial adenomyosis was associated with less myometrial invasion.

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Keywords: Adenomyosis, endometrioid adenocarcinoma, prognosis

Tablo 1: Demographic Characteristics of Patients

Tablo 1: Demographic Characteristics of Patients

	Without adenomyosis (n = 136)	With adenomyosis (n = 31)	p
Age	59,33 ± 9,27	62,13 ± 9,11	0,130
Gravida	2,53 ± 2,12	3,31 ± 2,16	0,083
Parite	2,22 ± 1,95	3,07 ± 2,10	0,058
Size (cm)	3,56 ± 1,94	2,81 ± 1,59	0,052
DM			
No	91	22	0,663
Yes	45	9	
HT			
No	82	14	0,124
Yes	54	17	

Tablo 2: Pathological findings of patients

Tablo 2: Pathological findings of patients

		Without adenomyosis (n = 136)	With adenomyosis (n = 31)	p
Grade	1	98	24	0,802
	2	25	5	
	3	13	2	
Myometrial İnvasion	<%50	91	26	0,063
	>%50	45	5	
Lymphovascular space invasion	No	118	30	0,205
	Yes	18	1	
Cervical stromal invasion	No	115	31	0,015*
	Yes	21	0	
Size	<2 cm	27	7	0,734
	>2 cm	109	24	
Pelvic Lymph Node Involvement	No	124	30	0,466
	Yes	12	1	
Paraaortic Lymph Node Involvement	No	133	30	0,564
	Yes	3	1	
Serosa or Adnexal Involvement	No	132	31	1,000
	Yes	4	0	
Vaginal or Parametrium Involvement	No	134	31	1,000
	Yes	2	0	
Distant Metastasis	No	129	31	0,351
	Yes	7	0	

YS-20

Management of Preterm Cases Using Clinical Decision Analysis

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AIM: The management of preterm patients, particularly in cases of very early preterm birth, is a subject of controversy regarding which treatment should be applied to which patient. Therefore, it is crucial for clinicians to develop a successful decision-making process based on evidence-based medicine principles. Data on the use of clinical decision analysis, which simplifies complex decision-making, in preterm labour are limited. Therefore, our aim in this study was to investigate the effect of seven different treatment strategies on neonatal mortality and morbidity in preterm labour using clinical decision analysis. The objective of this study is to evaluate maternal and foetal outcomes based on treatment and outcome arms, and determine the most effective treatment strategies using decision trees. Furthermore, the preterm cases were classified as either early or late preterm, and the treatment strategies outlined in accepted guidelines were compared.

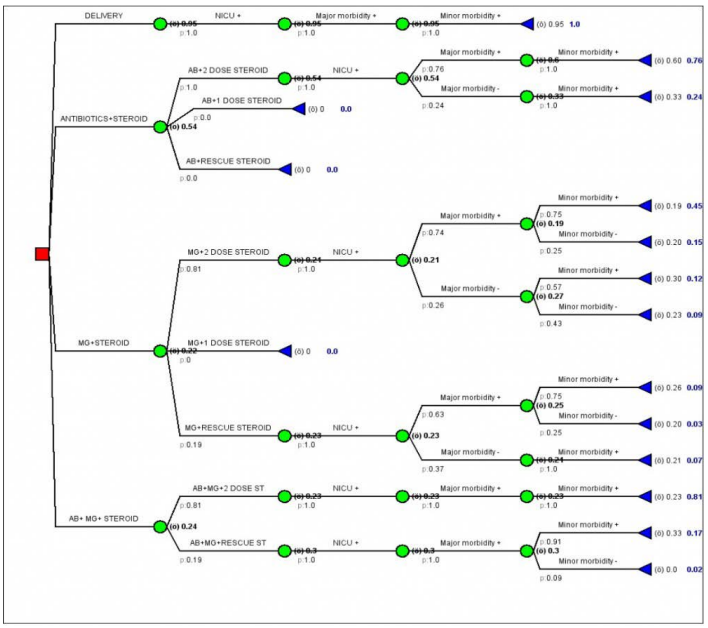
METOD: This study analysed data from 4577 patients aged 18-45 years who experienced preterm birth between January 2015 and December 2021 at Bursa Yuksek Ihtisas Training and Research Hospital. The decision nodes for managing cases born alive between 24-37 weeks were determined based on treatments decided by the physician. These treatments were categorised as delivery, antibiotics, steroid administration, magnesium use, and their associations. The data were analysed using clinical decision analysis. After determining the chance and decision nodes in line with the clinical decision analysis strategy, the database findings were incorporated into the decision tree and calculations were performed.

RESULT: The study group consisted of 4577 patients, with 50.7% experiencing early preterm labour and 49.3% experiencing late preterm labour. Additionally, 24.7% of patients gave birth between 24-28 weeks, while 75.3% gave birth between 28-34 weeks. The decision tree demonstrated that patients who delivered between 24-28 weeks without any treatment had a 0.95 probability of death. Patients who received only antibiotics had a 0.04 probability of death. Patients who received neuroprotective magnesium and steroids had a 0.22 probability of death, while patients who received antibiotics, neuroprotective magnesium and steroids had a 0.24 probability of death. The decision tree shows that the probability of death in cases between 28-34 weeks of gestation without any treatment was 0.61, 0.36, 0.23, 0.19 and 0.19 in cases who received only antibiotics, only steroids, tocolytics and steroids, respectively. Patients treated with antibiotic and steroid had a probability of 0.14, while patients treated with neuroprotective magnesium and steroid had a probability of 0.13. The lowest probability of death was observed in patients treated with antibiotic, neuroprotective magnesium and steroid, with a probability of 0.03.

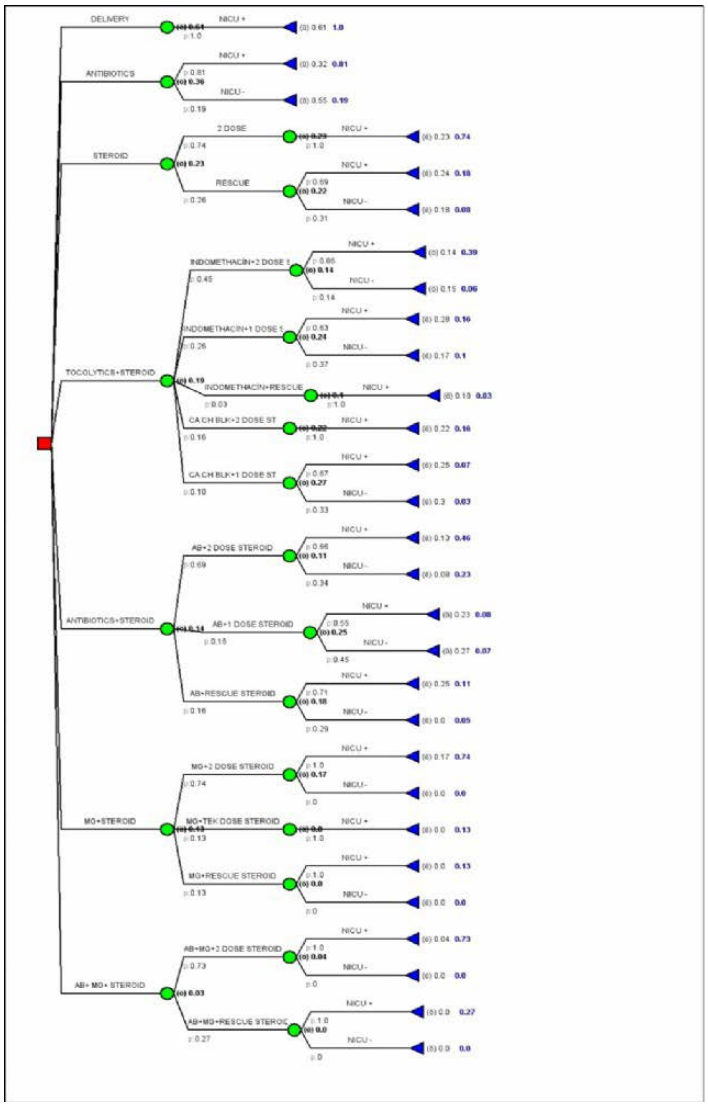
CONCLUSION: Clinical decision analysis is crucial for clinicians when making decisions about preterm case management, especially when evidence-based data is limited. As neonatal mortality rates are an indicator of a country's development, reducing this rate is of utmost importance. Steroid and magnesium treatments have been shown to improve outcomes in early preterm births, which are the most common patients in neonatal unit hospitalisations. This study demonstrates the usefulness of clinical decision analysis in managing preterm cases.

Keywords: Clinical decision analysis, preterm labour, preterm rupture of membranes, early preterm labour, late preterm labour

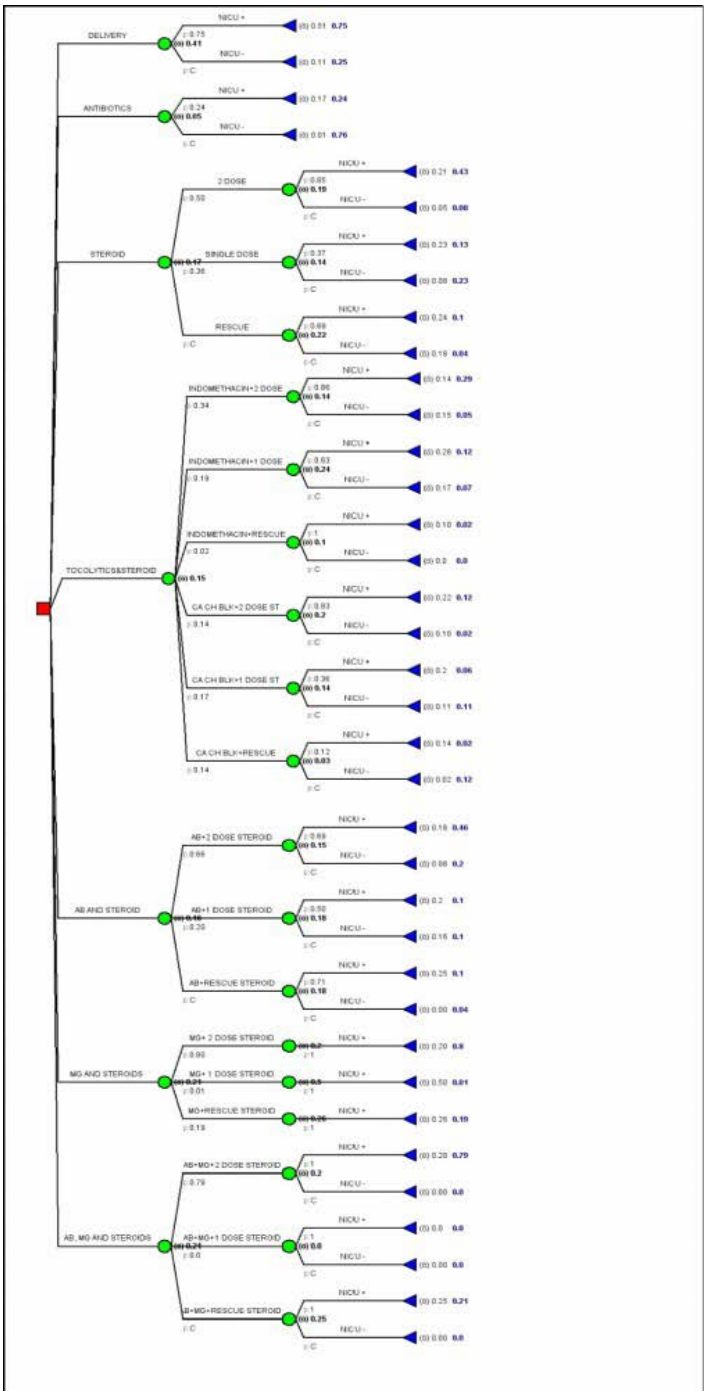
Decision tree 24-28 weeks



Decision tree 28-34 weeks



Decision tree all cases



YS-21

Factors influencing the decision-making for transfer day in fresh embryo transfers: a comparative analysis of cleavage and blastocyst stages

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Aim

The objective of our investigation is to identify the factors that influence the decision-making process in the selection of the fresh embryo transfer day within our center. Furthermore, we assess and compare the clinical outcomes associated with cleavage-stage and blastocyst-stage embryo transfers. This research was designed to clarify the determinants that guide the strategic decisions made regarding the selection of transfer days at our center.

Material and Method

This study presents a retrospective analysis of single fresh embryo transfer cycles conducted at the Bursa Uludag University assisted reproductive technology (ART) center from 2011 to 2024. Intracytoplasmic sperm injection was uniformly administered to all oocytes. Subsequent to fertilization, fresh embryo transfers were conducted either on day 3 (Cleavage Group (n=575)) or day 5 (Blastocyst Group(n=1461)). Comparative assessments were made between the two groups with regards to patients' baseline characteristics, basal hormonal parameters, and ovarian stimulation profiles. Furthermore, an analysis was conducted to compare embryonic development parameters and clinical outcomes across both groups.

RESULTS: We conducted a comparative analysis of baseline characteristics among patients in the two groups, revealing statistically significant differences. The Cleavage Group exhibited higher female age ($p<0.001$), male age ($p<0.008$), and infertility duration ($p<0.013$) compared to the Blastocyst Group. Furthermore, statistically lower values of hCG day antral follicle count ($p=0.001$) and estradiol levels ($p<0.001$) were identified in the Cleavage Group relative to the Blastocyst Group. Additionally, the Cleavage Group demonstrated statistically lower total oocyte count ($p<0.001$), oocyte maturation rate ($p<0.001$), fertilization rate ($p<0.001$), and cleavage rate ($p<0.001$). Collectively, a diminished implantation rate was observed in the Cleavage Group (27%) compared to the Blastocyst Group (38%) ($p<0.001$).

CONCLUSION: In conclusion, our study indicates that patient characteristics and cycle features, particularly embryological parameters, play a crucial role in the decision-making process for selecting the day of embryo transfer. Notably, patients with poorer prognoses tend to have a higher inclination toward cleavage-stage embryo transfer, associated with lower clinical success rates. These findings underscore the significance of considering individualized factors in the strategic determination of embryo transfer days, with potential implications for optimizing clinical outcomes in assisted reproductive technologies. Further investigations and interventions may be warranted to refine this decision-making process and enhance overall success rates in single fresh embryo transfer cycles.

Keywords: blastocyst, cleavage, fresh embryo transfer

YS-22

Effect of shock index, modified shock index, and age-adjusted shock index on adverse outcome of postpartum hemorrhage

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PURPOSE: The aim of this study is to evaluate the predictive role of shock index (SI), modified shock index (MSI), and delta shock index (ΔSI) in predicting postpartum hemorrhage (PPH) and adverse maternal outcomes.

MATERIAL-METHODS: In this cross-sectional cohort study, a study group consisting of 416 pregnant women who delivered at our hospital had postpartum hemorrhage was compared with 467 control patients with normal follow-up. SI (Pulse/systolic blood pressure), MSI (pulse/mean arterial pressure), ΔSI (input SI – 2nd or 6th hour SI) values were calculated.

RESULTS: A total of 883 postpartum women were included in the study. The study group had higher peripartum, 2-hour, and 6-hour values SI ($p=0.011$, $p=0.001$, $p < 0.001$, respectively). Peripartum MSI values ($p=0.004$), 2-hour MSI values ($p < 0.001$) and 6-hour MSI values ($p < 0.001$) were significantly lower in the control group than in the PPH group. When the groups were evaluated, the cut-off value of the 2-hour parameter SI > was 0.8909 (sensitivity 30%, specificity 84%) and the 6-hour parameter SI > was 0.8909 (sensitivity 40%, specificity 80%) for predicting postpartum hemorrhage requiring blood transfusion and surgical intervention. The cut-off value of the 2nd hour MSI parameter was > 1.2 (sensitivity 34%, specificity 82%) and the cut-off value of the 6th hour MSI parameter was > 1.2652 (sensitivity 32%, specificity 90%).

CONCLUSION: The 2nd and 6th hour SI and 2nd and 6th hour MSI values were significantly higher in patients with postpartum hemorrhage. Values greater than 0.89 for SI and 1.2 for MSI were considered significant for predicting postpartum hemorrhage with maternal impairment.

Keywords: Diastolic blood pressure, heart rate, maternal morbidity, mortality, obstetric hemorrhage.

Table 1.

Table 1. Demographic characteristics of the study.

	Control group (n=467)	Study group (n=416)	P
Age[c] (years)	28.49 ± 5.75	27.48 ± 6.15	.004
Parity[c]	2.32 ± 1.17	2.33 ± 1.38	.402
Body Mass Index at birth[c] (kg/m²)	28.85 ± 4.62	28.13 ± 4.52	.015
Pregestational BMI[c] (kg/m²)	25.99 ± 4.30	25.46 ± 4.17	.046
Gestational age[c] (weeks)	38.19 ± 2.21	37.75 ± 2.89	.112
Smoking[a]			.001
No	416 (89.1%)	395 (95.0%)	
Yes	51 (10.9%)	21 (5.0%)	
Multiple pregnancy[a]			.001
No	462 (98.9%)	397 (95.4%)	
Yes	5 (1.1%)	19 (4.6%)	
Type of delivery[a]			.180
Cesarean section	300 (64.2%)	285 (68.5%)	
Primary CS	75 (%25)	74(%25)	
Recurrent CS	225 (%75)	211 (%75)	
NVD	167 (35.8%)	131 (31.5%)	

[a] Chi-square analysis, [b]Fisher's Exact Test, [c]Mann Whitney test
BMI: Body Mass Index, CS: Ceserean Section, NVD: Normal Vaginal Delivery

Table 2.

Table 2. Prevalence of maternal adverse effects due to postpartum bleeding.

Maternal Adverse effects	Prevelance n(%)	P
Transfusion[a]	396 (%95.2)	<.001
Balloon Tamponade[a]	23 (%5.5)	<.001
Compression Suture[a]	14 (%3.4)	<.001
Laceration repair in the operating room [a]	21 (%5.0)	<.001
Relaparotomy[a]	13 (%3.1)	<.001
Artery Ligation[a]	39 (%9.4)	<.001
Hysterectomy[b]	7 (%1.7)	.005
Therapeutic Curettage[b]	7 (%1.7)	.005
Need for referral / intensive care[b]	3 (%0.7)	.104
MODS[b]	3 (%0.7)	.104

[a] Chi-square analysis, [b]Fisher's Exact Test, [c]Mann Whitney test
MODS: Multiple organ dysfunction syndrome

Table 3.

Table 3. Comparison of shock indexes and parameters in study groups.

	Control group (n=467)	Study group (n=416)	p
Heart rate (beats per minute)			
At delivery[c]	83.36 ± 5.51	85.12 ± 7.07	.011
2 hour later delivery[c]	86.86 ± 10.95	91.96 ± 14.12	<.001
6 hour later delivery[c]	87.19 ± 9.67	94.68 ± 14.59	<.001
Systolic blood pressure (mm Hg)			
At delivery[c]	113.61 ± 8.35	113.56 ± 10.77	.325
2 hour later delivery[c]	110.84 ± 8.52	111.82 ± 10.40	.135
6 hour later delivery[c]	110.76 ± 7.84	110.75 ± 11.01	.580
Diastolic blood pressure (mm Hg)			
At delivery[c]	71.16 ± 7.44	70.52 ± 8.70	.095
2 hour later delivery[c]	67.64 ± 7.16	67.49 ± 7.85	.775
6 hour later delivery[c]	67.46 ± 7.01	67.75 ± 8.28	.812
MAP			
At delivery[c]	85.31 ± 6.95	84.87 ± 8.70	.107
2 hour later delivery[c]	81.98 ± 6.67	82.27 ± 7.88	.889
6 hour later delivery[c]	81.89 ± 6.21	82.08 ± 8.43	.777
SI			
At delivery[c]	.74 ± .07	.75 ± .08	.011
2 hour later delivery[c]	.79 ± .12	.83 ± .16	.001
6 hour later delivery[c]	.79 ± .11	.87 ± .17	<.001
Δ SI 2 hour later delivery[c]	-.05 ± .14	-.08 ± .18	.135
Δ SI 6 hour later deliveryt[c]	-.05 ± .14	-.11 ± .18	<.001
MSI			
At delivery[c]	.98 ± .10	1.01 ± .12	.004
2 hour later delivery[c]	1.07 ± .16	1.13 ± .22	<.001
6 hour later delivery[c]	1.07 ± .15	1.17 ± .22	<.001
Age-adjusted shock Index			
At delivery[c]	21.01 ± 4.71	20.73 ± 5.14	.132
2 hour later delivery[c]	22.39 ± 5.47	22.65 ± 5.95	.691
6 hour later delivery[c]	22.42 ± 5.14	23.54 ± 6.18	.029

[a] Chi-square analysis, [b]Fisher's Exact Test, [c]Mann Whitney test
MAP: Mean Arterial Pressure, SI: Shock Index, Δ SI: Delta Shock Index, MSI: Modified Shock Index

Table 4. Multivariate logistic regression analysis of factors affecting postpartum bleeding.

	OR	Lower	Upper	P
Smoking	0.455	0.226	0.914	0.027
Multiple pregnancy	2.485	0.646	9.557	0.185
Age (>35)	1.091	0.949	1.254	0.220
Gestational BMI (>30)	0.946	0.846	1.059	0.338
Pregestational BMI (>30)	1.047	0.932	1.176	0.436
Heart Rate (>100)				
At delivery	1.052	1.011	1.094	0.013
2 hour later delivery	1.014	0.980	1.050	0.416
6 hour later delivery	1.038	1.003	1.075	0.035
SI (>0.89)				
At delivery	0.502	0.002	156.507	0.814
2 hour later delivery	0.009	0.000	1.119	0.056
6 hour later delivery	17.540	0.020	15743.767	0.409
MSI (>1.2)				
At delivery	2.229	0.048	103.454	0.682
2 hour later delivery	6.582	0.201	215.123	0.289
6 hour later delivery	0.781	0.028	22.097	0.885
Age-adjusted Shock Index- 6 hour later delivery	0.909	0.768	1.076	0.268
Hb <10				
At delivery	0.697	0.347	1.400	0.311
2 hour later delivery	0.436	0.186	1.022	0.056
6 hour later delivery	0.803	0.398	1.618	0.539
Hct <30				
At delivery	1.215	0.957	1.543	0.111
2 hour later delivery	0.995	0.755	1.313	0.973
6 hour later delivery	0.910	0.724	1.144	0.422

BMI: Body Mass Index, SI: Shock Index, MSI: Modified Shock Index, Hb: Hemoglobin, Hct: Hematocrit.

Table 5.

Table 5. ROC analysis results of SI, MSI, and age-adjusted shock index parameters in predicting postpartum hemorrhage.

Parameters	AUC	Cut off value	Sensitivity(%95 CI)	Specifity (%95CI)	+ LR (%95 CI)	- LR (%95 CI)	+ PV (%95 CI)	- PV (%95 CI)
At delivery SI	0,554	>0,7273	16,11 (12,7 - 20,0)	93,58 (91,0 - 95,6)	2,51 (1,7 - 3,8)	0,90 (0,9 - 0,9)	69,1 (58,9 - 78,1)	55,6 (52,0 - 59,1)
2 hour later delivery SI	0,566	>0,8909	30,05 (25,7 - 34,7)	84,15 (80,5 - 87,3)	1,90 (1,5 - 2,4)	0,83 (0,8 - 0,9)	62,8 (55,7 - 69,6)	57,5 (53,7 - 61,2)
6 hour later delivery SI	0,628	>0,8909	40,14 (35,4 - 45,0)	80,73 (76,9 - 84,2)	2,08 (1,7 - 2,6)	0,74 (0,7 - 0,8)	65,0 (58,8 - 70,8)	60,2 (56,3 - 64,1)
At delivery MSI	0,559	>1,0696	27,40 (23,2 - 32,0)	83,51 (79,8 - 86,8)	1,66 (1,3 - 2,1)	0,87 (0,8 - 0,9)	59,7 (52,4 - 66,7)	56,4 (52,6 - 60,1)
2 hour later delivery MSI	0,576	>1,2	34,13 (29,6 - 38,9)	82,66 (78,9 - 86,0)	1,97 (1,5 - 2,5)	0,80 (0,7 - 0,9)	63,7 (57,0 - 70,0)	58,5 (54,6 - 62,3)
6 hour later delivery MSI	0,628	>1,2652	32,93 (28,4 - 37,7)	90,58 (87,6 - 93,1)	3,50 (2,6 - 4,8)	0,74 (0,7 - 0,8)	75,7 (68,8 - 81,7)	60,3 (56,5 - 63,9)
At delivery Age-adjusted SI	0,529	≤17,22	30,05 (25,7 - 34,7)	79,01 (75,0 - 82,6)	1,43 (1,1 - 1,8)	0,89 (0,8 - 1,0)	56,1 (49,3 - 62,7)	55,9 (52,0 - 59,7)
2 hour later delivery Age-adjusted SI	0,508	>24,324	36,78 (32,1 - 41,6)	70,45 (66,1 - 74,6)	1,24 (1,0 - 1,5)	0,90 (0,8 - 1,0)	52,6 (46,7 - 58,4)	55,6 (51,5 - 59,6)
6 hour later delivery Age-adjusted SI	0,543	>32,967	9,38 (6,8 - 12,6)	97,64 (95,8 - 98,8)	3,98 (2,1 - 7,7)	0,93 (0,9 - 1,0)	78,0 (63,9 - 88,6)	54,7 (51,3 - 58,2)

YS-23

Correlation of HPV Positivity and Type with Colposcopy Results in Patients with Atypical Squamous Cells of Undetermined Significance (ASC-US)

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INTRODUCTION: In our study, we aimed to investigate patients with ASC-US smear results by considering their previous smear, previous HPV and current HPV results and evaluating the effects of these parameters on colposcopy and ECC results.

Materials and METHODS: This is a retrospective descriptive cross-sectional study conducted between January 2022 and June 2022. 217 patients who met the criteria were included in the study. Patients' age, gravida, parity, previous smear, previous HPV, current HPV and colposcopy results were recorded. HPV results were classified as negative, HPV 16/18 positive, and HPV other high-risk positive. Colposcopy and ECC results were classified as negative, LSIL, and HSIL. Colposcopy and ECC results of the patients were compared with previous smear, previous HPV and current HPV results.

RESULTS: Considering the results of 217 ASC-US patients with a mean age of 41.8 ± 8.75 years, a statistically significant correlation was found between previous smear, previous HPV and current HPV results with colposcopy ($p=0.003$, $p<0.001$, $p<0.001$, respectively). When the previous smear and previous HPV results of the patients were examined, considering that the previous smear result is negative, patients who are ASC-US or LSIL negative based on their previous HPV results, HPV type 16/18 positive and HPV other high-risk positive, a statistically significant correlation was found between them and colposcopy results ($p=0.001$, $p<0.001$, $p=0.007$). Considering the previous and current HPV positivity of the patients, previously HPV negative patients had a lower risk of HSIL compared to patients previously with HPV type 16/18 positive and other high-risk positive results. In patients with a previous HPV negative result, when the current HPV negative, HPV 16/18 positive and HPV other high-risk positivity were evaluated, a statistically significant correlation was found between colposcopy results ($p=0.001$). When the ECC results of the patients were compared according to the previous smear, previous HPV and current HPV status, a correlation was found between ECC results and previous HPV results ($p=0.023$). In the group of patients whose previous HPV result was positive for type 16/18, the risk of HSIL was found to be highest in ECC.

CONCLUSION: While there is sufficient evidence for the management of many subgroups in terms of cervical pathologies, the optimal approach is still unclear for the management of ASCUS. Follow-up and treatment with the right indication both helps patients undergo less invasive procedures and minimizes both costs and labor. In the case of HPV positivity in patients whose smear results are ASC-US, we often referred to colposcopy. At the beginning of our study, we started by looking for an answer to the question, "Should we evaluate every patient with equal risk?". In our study, we evaluated the patient with the combination of current and recent cytology results and have drawn to the conclusion that every patient with the same current results should not be evaluated with equal risk, and the decision of colposcopy and ECC should be made considering the previous smear and HPV status of the patients.

Keywords: ASC-US, ECC, HPV, Colposcopy, Smear

YS-24

The Value of Cervical Length Change for Prediction of Preterm Birth

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OBJECTIVE: To study the value of the cervical length alteration from the first trimester to the second trimester in predicting preterm birth.

METHODS: A longitudinal prospective study starting from 2016 was conducted. Cervical length was measured by transvaginal sonography at 11- 14 weeks and 20-24 weeks. Patients' delivery information was recorded every 3-4 months. The statistics were evaluated with R program.

RESULTS: 1042 patients with first and second-trimester cervical length measurements were included in the study. The overall preterm birth rate (<37 weeks) in the study cohort was 9.5% (100/1042). 12 patients delivered below 34 weeks and 5 patients delivered below 28 weeks' gestation. The change in cervical length was modelled with multilevel regression using random slope and intercept. Patients with positive slope (increasing cervical length from first to second trimester), had longer pregnancy duration compared to the neutral or negative slope (median: 39.0 vs 38.7 weeks, $P<0.001$). Preterm birth below 37 weeks was also more common in neutral or decreasing cervical length changes compared to positive changes (11.9% vs 7.1%, $P=0.008$). Those with increasing cervical length measurements had lower hazard (HR: 0.75, 95% CI: 0.66 to 0.85) of early delivery compared to neutral or decreasing cervical length measurements. Slope of cervical change was significantly associated with preterm birth below 37 weeks (positive slope, RR: 0.59, 95% CI: 0.39 - 0.89, $P=0.013$) but not with preterm birth below 34 weeks (RR: 0.78, 95% CI: 0.23 - 2.47, $P=0.686$). However, the overall predictive accuracy of cervical change was low (AUC: 0.58, 95% CI: 0.51 - 0.64).

CONCLUSION: The shortening of cervical length could may have a diagnostic accuracy in the prediction of preterm birth.

Keywords: cervical length measurement, first trimester screening, preterm birth, second trimester screening

YS-25

Endocervical Length Measurement Between 11-14 Weeks, Evaluation Of The Prediction Power of the Second Trimester Cervical Shortness

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OBJECTIVE: The aim of our study is to evaluate the predictive capability of endocervical length measurement between 11-14 weeks of gestation for second trimester cervical shortness.

MATERIALS-METHODS: Pregnant women between 11-14 weeks of gestation who applied to Bursa Uludağ University Faculty of Medicine, Department of Obstetrics and Gynecology, Perinatology and Pregnancy Follow-up outpatient clinics were included in our prospective study. Demographic data and pregnancy anamnesis of all patients were recorded. Endocervical length measurements were made by transvaginal ultrasonography at 11-14 weeks, 16-20 weeks and 20-24 weeks and recorded. Patterns of endocervical length change and the power of measurements to predict endocervical shortness at week 24 were analyzed. Patients with short cervix and needing medication were recorded.

RESULTS: 113 patients were included in our study. Following the measurements between 11-14 weeks,the remeasurements made between 20-24 weeks were evaluated, the rate of patients with lengthening in the cervix measurement was 69% (n=78) and the rate of patients with a shortening in the cervix measurement was 31% (n=35). B, BC and posterior lip measurements were found to increase statistically significantly with gestational age. No correlation was found with C and anterior lip measurement. Short cervix at 20-24 weeks was detected in only 2 patients.

DISCUSSION: Studies with larger sample sizes are needed to evaluate the capability of cervical length measurement at 11-14 weeks to predict cervical shortening at 20-24 weeks. Our study is the first in the literature to evaluate anterior and posterior lip measurements.

Keywords: Cervical Length, Cervical Measurement, Cervix, Prediction, Preterm Birth, Transvaginal Ultrasound

YS-26

Correlation Between HPV 16 and 18 Positivity and Preneoplastic Lesions of the Cervix: A Colposcopic Study at Akdeniz University Hospital

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INTRODUCTION: HPV (Human Papillomavirus) 16 and 18 positivity represent significant global health concerns, being recognized as major contributors to cervical cancer. Among the approximately 200 types of HPV, HPV 16 stands out for its notable oncogenic potential and its link to various malignancies, including cervical cancer, anogenital cancers, and head and neck cancers. This study focuses on individuals with HPV 16 or 18 positivity in their HPV test results, or those with both HPV 16 and 18 positivity, investigating their correlation with preneoplastic and neoplastic lesions of the cervix.

METHODS: A total of 97 women admitted to Akdeniz University Hospital in 2023 were included in the study. These women had either HPV 16 or 18 positivity in their HPV test results, or both HPV 16 and 18 positivity.All patients underwent colposcopy, during which biopsies were taken from suspicious areas. Endocervical samples were collected from all patients showing no staining with acetic acid.

RESULTS: Among the 75 (77.3%)patients who tested positive for HPV 16, 10 (10.3%)patients tested positive for HPV 18, and 12 (12.4%) patients tested positive for both HPV 16 and 18, all underwent colposcopy procedures. In the HPV 18 positive group, one patient was found to have CIN 2 lesions. 29.5% of participants reported a history of smoking. While 61.9% of participants showed no abnormal histopathology, 38.1% exhibited varying degrees of abnormal histopathology. Additionally, 24.7% of participants had signs consistent with CIN3plus, suggesting a significant presence of high-grade cervical lesions. However, lesions of CIN 3 and above were not observed in any of the HPV 18 positive patients. In the HPV 16/18 positive patient group, three patients were found to have CIN 3 lesions.

CONCLUSION: HPV types 16 and 18 remain pivotal in cervical cancer screening, warranting thorough colposcopic evaluation. In our study, the number of patients admitted with HPV 16 was significantly higher than HPV 18 and HPV 16/18. Interestingly, no cases of CIN 3 or higher lesions were found among HPV 18 positive patients. HPV 16/18 cases exhibited a higher prevalence of CIN 3 lesions compared to single HPV 18 infections. However, the limited sample size and the absence of long-term follow-up in our study are notable limitations. Future research is crucial to delve deeper into the implications for cervical cancer prevention and management strategies.

Keywords: Cervical Intraepithelial Neoplasia, Colposcopy, HPV infection, HPV 16, HPV 18

YS-27

Is spotting bleeding a predictor of IVF outcome?

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INTRODUCTION: Implantation bleeding, which refers to light spotting or bleeding in early pregnancy, is a common symptom. It can cause concern for the mother about the pregnancy status or prompt visits to the emergency department. However, its predictive value and relationship with pregnancy outcomes are still unclear. This study aims to investigate whether there are significant differences in pregnancy outcomes between women who experience implantation bleeding after embryo transfer and those who do not.

METHODS: A retrospective cohort study was carried out, involving 110 women who had undergone embryo transfer from January 2021 to January 2024. Patients were instructed to inform nursing staff in the event of bleeding before pregnancy tests. The data was derived from medical records kept by the nurses. These participants were categorized into two groups depending on whether they experienced implantation bleeding or not: Group A consisted of 46 women reporting implantation bleeding, and Group B comprising 64 women without such bleeding. Relevant demographic characteristics, obstetric history, and pregnancy outcomes were extracted from medical records and compared between the two groups. Statistical analysis was performed using chi-square tests and the Mann- Whitney U test to evaluate the association between implantation bleeding and pregnancy outcomes.

RESULTS: Among the 110 women included in the study, 46 (41.8%) reported experiencing implantation bleeding, while 64 (58.2%) did not. There were no significant differences in age (p=0.11), previous obstetric history, or first b-hcg value(=0.59) between the two groups. Clinical pregnancy rates (=p=0.86), pregnancy outcomes including miscarriage rates, and presence of adenomyosis(p=0.45) were also similar between two groups.

DISCUSSION: For patients, the period between embryo transfer and b-hcg result can be quite stressful. Experiencing vaginal bleeding during this time can intensify anxiety about the process. Although there are RCTs suggest the occurrence of bleeding before a positive b-hcg test is associated with lower pregnancy rates (1),(2); our data showed no significant differences in pregnancy outcomes between two groups. Although the results did not show a difference in the rate of live births, they should be confirmed by further trials with larger sample sizes.

CONCLUSION: In conclusion, our study indicates that the presence of implantation bleeding does not indicate the risk of miscarriage or does not alter the pregnancy outcomes. Further research is necessary to understand the reasons behind implantation bleeding during pregnancy and its clinical significance. These findings are crucial for guiding counseling and management strategies for women experiencing implantation bleeding after an embryo transfer.

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Keywords: implantation bleeding, luteal phase bleeding, pregnancy outcome

YARIŞACAK VİDEO BİLDİRİLER

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

YV-01

Obturator nerve repair in a patient with endometrial cancer

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Introduction/BACKGROUND: Laparoscopic surgery is a worldwide used technique for endometrial cancer surgery. Complications associated with the surgery include bleeding and conversion to laparotomy. Obturator nerve injury is a complication of pelvic lymphadenectomy. Herein, we aim to report the repair of obturator nerve injury in an endometrial cancer patient. A 35-year-old woman, gravida: 4, parity: 4, was admitted to our hospital with abnormal uterine bleeding. Endometrial biopsy revealed endometrioid adenocarcinoma grade 2. Ultrasonographic imaging showed a 3 cm endometrial tumor. No distant metastasis was seen on CT and MRI images. Laparoscopic hysterectomy and pelvic lymphadenectomy were planned.

METHODOLOGY: The surgery was initiated with pelvic lymphadenectomy. During left pelvic lymphadenectomy, obturator vein injury occurred. A suction catheter was used to remove bleeding; however, due to impaired vision, obturator nerve injury occurred during hemostasis in the avascular space between the external iliac artery and the psoas muscle. The cut ends of obturator nerves were found. The tension was high when the cut ends were brought together. The nerve was freed from neighboring tissues. 3-0 Vicryl suture was used for suturing, and 4 interrupted sutures were applied.

RESULTS: The patient complained of left thigh pain after surgery. Analgesia was given to reduce the pain. Physical therapy was prescribed for the patient. The patient was able to perform adduction with limited restriction.

CONCLUSION: Obturator nerve injury is one of the complications of endometrial cancer surgery. Conversion to laparotomy is not needed for the repair. Laparoscopic obturator nerve injury repair has favorable outcomes even in the early postoperative period.

Disclosures: In the current video, we present the repair of obturator nerve injury in an endometrial cancer patient.

Keywords: Endometrial cancer, Laparoscopy, Obturator nerve

YV-02

Laparoscopik approach to cervical myom

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A uterine myoma is a significant contributor to pelvic pain in women and can result in abnormal uterine bleeding, tenesmus, urinary retention, constipation, and sexual dysfunction, depending on its location and size. Here, we present a case of a 37-year-old Virgo patient with a cervical uterine myoma and the corresponding surgical procedure performed.

The patient complained of groin and back pain, with a history of regular menstrual cycles and normal bleeding. No accompanying symptoms of dysuria or vaginal discharge were reported. The patient had no known illnesses but had a history of laparoscopic cystectomy.

During the examination, transabdominal ultrasound (TAUSG) revealed an 81x52 mm FIGO 8-class myoma originating from the posterior cervix. An externally conducted MRI confirmed an 80x50mm myoma unrelated to the cervical canal.

The decision was made to perform a laparoscopic myomectomy (L/S myomectomy).

After setting up the laparoscopic system, graspers were inserted through bilateral hypogastric trocars, and a Thunderbeat device was introduced through the left palmer trocar. The peritoneum was elevated and dissected from the left paracolic space, entering the retroperitoneum. After identifying the ureter, the left pararectal space was cleared. Subsequently, the peritoneum was dissected from the right paracolic area to the promontory level, reaching the myoma near the cervix.

Using a laparoscopic needle, 30 cc of 0.3 units/ml diluted vasopressin was injected into the myoma. A vertical incision was made on the peritoneum over the myoma, and after exposing the myoma cleavage, it was held with a laparoscopic tenaculum, followed by sharp dissection and enucleation. The myoma was placed in an endobag, morcellated, and two spongostans were inserted into the myoma bed. A complete layer closure with Quill Barbed 1.0 was performed after achieving hemostasis. The procedure concluded without complications following adequate bleeding control.

Keywords: Cervical myom, FIGO 8 class myoma, Laparoscopic Myomectomy

YV-03

The Advantage of 3D Ultrasonography in Myoma Imaging-Case Report

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INTRODUCTION: Three-dimensional (3D) pelvic sonography is a fast developing field for the evaluation of various gynecologic disorders such as uterine anomalies, endometrial disorders, fibroids, intrauterine device (IUD) localization, adnexal masses and tubal disorders. The most useful plane that can be obtained with 3D transvaginal sonography is the coronal view of the uterus and adnexa. This plane cannot be routinely obtained with standard 2D ultrasonography. Evaluation of the endometrium and myometrium in leiomyomas is important for clinical management. With 2D ultrasonography, it can be difficult to distinguish a submucosal leiomyoma from an intramural one or to determine its relationship to the endometrial cavity. This relationship is particularly important in patients with infertility problems, recurrent pregnancy failures and abnormal uterine bleeding. On 2D imaging, it can be difficult to assess the location of individual masses and their proximity to each other, especially when multiple leiomyomas are present. 3D imaging allows us to more clearly assess the uterine cavity to better evaluate the location of leiomyomas, their submucosal or intramural components, and their position compared to other leiomyomas. This information is invaluable when making clinical decisions.

Case Report

A 41-year-old patient (G1P1) presented with abnormal uterine bleeding for the last 1 year. Laparotomic myomectomy was planned as a result of 2d ultrasonography. The 2d ultrasonography performed in our clinic showed a 29x23mm type 3 myoma. The patient was then evaluated with 3d ultrasonography. 3d view was evaluated as figo 1 myoma and the treatment plan was changed. The patient underwent hysteroscopic myomectomy. With the use of 3D ultrasonography, the patient was treated with a minimally invasive method instead of laparotomy.

Keywords: hysteroscopi, leiomyom, myomectomy, 3D-USG

YV-04

Hysterectomy with V–NOTES technique in an obese patient who underwent conization due to HGSIL

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ENTRANCE

Hysterectomy is one of the most frequently performed gynecological surgeries. Many different techniques have been defined, and the technique to be chosen is determined by the surgical indication, patient characteristics, skills and preference of the surgeon. Vaginal natural orifice transluminal endoscopic surgery (V-NOTES) is a minimally invasive approach that aims to reduce tissue injury, reduce postoperative morbidity and mortality, and improve the patient's quality of life.

CASE REPORT

The patient, a 52-year-old female patient who had 2 vaginal births, previously underwent conization in our clinic due to HGSIL, had been in menopause for 5 years and had hypertension. Transvaginal ultrasonography of the patient, whose body mass index was 32, was compatible with menopause. In the pelvic examination, grade 2-3 desensus was observed, cystocele and rectocele were not observed. The patient was followed up in the gynecological oncology clinic and her follow-up results showed HPV (-) and smear and colposcopy results were normal. There was no abnormality in the endometrial biopsy. V-NOTES hysterectomy was planned for the patient with Grade 2-3 vaginal prolapse and bleeding complaints. The beginning of hysterectomy with V-NOTES technique and vaginal hysterectomy is the same. Following anterior and posterior colpotomy, the sacrouterine ligaments are clamped, sutured and tied, then the V-NOTES port is placed and inflated. Usually 10mmHg pressure is sufficient. Starting from the left of the patient, the cervix is pushed forward and medially, and the cardinal ligaments, uterine artery, board and round ligament are clamped, cut and tied respectively. After the same procedures are repeated on the right side, bilateral salpingectomy is performed. Salpingectomy and adnexetomy are easily performed because the ureters are usually easily visualized on the pelvic side wall. After the hysterectomy is completed, the port is removed and the specimen is taken out.

CONCLUSION

V-NOTES is a comfortable technique for both the patient and the physician when applied to appropriate patients and experienced surgeons. Although adnexial surgery is possible in the hands of skilled vaginal surgeons, studies examining surgical intervention during vaginal hysterectomy have shown that the feasibility of salpingectomy or adnexectomy cannot be completed in 25% of the time. V-NOTES allows the surgeon to perform uterine or adnexal surgery under direct vision without the need for abdominal intervention, so we recommend that it be applied as an alternative to conventional laparoscopy, not as a replacement.

Keywords: V-NOTES, Hysterectomy, POP, VAH, HPV, CIN

YV-05

Laparoscopic Surgery for Deep Infiltrating Endometriosis and Adenomyosis

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BACKGROUND: Laparoscopic surgery for deep infiltrating endometriosis (DIE) and adenomyosis represents a significant advancement in the field of reproductive surgery. Minimal invasive approach offers numerous advantages over traditional surgery, including reduced postoperative pain, shorter hospital stays, and faster recovery times. DIE is a complex condition characterized by the abnormal growth of endometrial tissue outside the uterus, often infiltrating surrounding organs. Adenomyosis, on the other hand, involves the presence of endometrial tissue within the muscular wall of the uterus. Both conditions can lead to symptoms such as severe pelvic pain and infertility, making effective surgical intervention crucial for improving patients' quality of life.

Case Presentation: In presented case, the patient was a 36 years nullipar woman, who applied to gynecology outpatient clinic because of severe pain. She experienced the pain every day and it was at the lower abdominal region bilaterally and augments during menses. She has used pain killers almost every day. When questioned further, she mentioned she recently got married, had been trying to conceive for 3 months and hasn't been pregnant before. Also, she said that she had a mild pain and disturbance during coitus. She had a surgical history of laparoscopy twice (2015- laparoscopic bilateral endometrioma, 2018 laparoscopic cholecystectomy. AMH level was 0.7 ng/mL. In pelvic examination, perinea-vulva-vagina and cervix looked normal. At the bimanual examination she defined pain at a single region (right posterior fornix). TVU was performed, the uterus was retrovert with a 28x41mm adenomyoma at the posterior uterine wall, bilateral hydrosalpinx, nodule on bowel, 5 endometriomas at the right ovary (the largest was 41mm) and 1 9mm endometrioma at the left ovary. HSG also revealed the bilateral hydrosalpinx.

AIM: In order to alleviate symptoms and restore normal anatomical structures, laparoscopic surgery option followed by ART treatment was presented to the patient.

METHOD: Laparoscopic surgery with ipsilateral trocar placement (2 10mm and 2 5mm) was preferred. Bilateral salpingectomy, endometrioma excision, bowel shaving, resection of focal adenomyotic regions, myomectomy and adenomyomectomy were performed. All the material excised were collected in the endobag via colpotomy. The colpotomy incision were sutured with 3/0 v-lock suture. After the abdomen was cleaned and checked for any bleeding, the procedure was completed.

CONCLUSION: Minimal invasive surgery for deep infiltrating endometriosis and adenomyosis stands at the forefront of gynecological advancements, offering patients a less invasive and more effective treatment option. The continuous refinement of surgical techniques and technologies further contributes to improved outcomes and enhanced patient satisfaction in the management of reproductive health.

Keywords: adenomyosis, endometriosis, laparoscopy, minimal invasive, reproductive surgery

YV-06

Laparoscopic hysterectomy for giant uteri

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Purpose

The first laparoscopic hysterectomy (LH) was performed by Harry Reich in Kingston, Pennsylvania in 1988 (1). Traditionally it is a less invasive method compared to open surgery. LH offers advantages such as faster recovery times, less blood loss and less postoperative pain and hospitalisation (2). Anatomical changes, previous surgical interventions, excessive adhesions may cause performing LH more difficult, but it is not impossible. Myoma uteri is one of the most common causes of benign hysterectomy (2). LH is generally not preferred in patients with large fibroids because of impaired anatomical view and increased risk of bleeding. Although LH is not recommended in patients with uterine weight >500 grams or uterine size >15 weeks in some studies in the literature, there is no guideline on this subject (3). In recent studies, LH has been accepted to be safely performed by experienced surgeons regardless of the size of the uterus, the number or localisation of fibroids (4). In our clinic, we often perform LH safely on many cases with giant myomas or large uterus. We will present one of these cases in this presentation.

Findings

45 years old premenopausal patient, who was previously followed up for fibroids, to our clinic with abdominal swelling, excessive vaginal bleeding and chronic pelvic pain. She had a history of previous caesarean section. On ultasonography, the uterus was 20 weeks in size.

Materials and methods

Verres was inserted into the abdomen through a transverse incision, two cm above the umbilicus. The other three entries were made approximately two cm above the normal symphysis entries. The retroperitoneum was entered and the ureter was dissected in both sides. Both branches of the internal iliac arteries were revealed and clipped. Routine LH steps were continued untill reaching vaginal cuff. The myoma was exposed with the help of a harmonic scalpel and the horizontal uterine diameter was reduced. The peritoneum of the rectum was lowered with the help of a harmonic scalpel and the posterior cuff was cut vertically. The uterus and the giant myoma were removed from the cuff as a whole. The patient tolerated the operation well. The operation lasted two hours.

RESULTS: In the presence of fibroids enlarging the uterus densely, localising the ureter by entering the retroperitoneal space and ligation of the hypogastric artery are very effective on intraoper-

ative injuries and bleeding. Reducing the volume of the uterus by performing myomectomy during the procedure both facilitates LH stages and prevents vagina-cuff and surrounding organ injuries.

CONCLUSION: In surgical centres with laparsocopy experience, uterine size is not a discriminating criterion for LH. Removal of the uterus from the vagina or removal using a morcellator is an important step after LH. If the use of a morcellator is deemed appropriate, using morcellator in an endobag or tissue bag is important for preventing a seperation of an underlying sarcoma. Also, unwanted organ and tissue damage may be caused during removal from the vagina. Therefore using different techniques for removing the uterus can be useful.

Keywords: Giant uteri, Laparoscopic hysterectomy, Myoma uteri

YV-07

Huge Adnexal Mass Managed Minimally Invasive Surgery Using Fluoroscopy C-Arm Cover Bag

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INTRODUCTİON: Minimally invasive surgery is widely used to manage adnexal masses. However, the main concern of minimally invasive surgery is dissemination of the abdomen and contamination to port sites. Sterile endobags are used in order to prevent dissemination. There are commercial endobags which can be as much as 15 cm in diameter.

AIM: Huge adnexal masses can be removed from the abdomen in a sterile and minimally invasive approach.

METHOD: We present the management of a huge adnexal mass using a fluoroscopy C-Arm cover bag.

The patient was admitted to our department with the diagnosis of an adnexal mass. Ultrasonography revealed a mass of 17 cm in diameter. No ascites or distant metastasis was detected. Ca 125 level was 47. Laparoscopic exploration and salpingooferectomy were performed. Posterior colpotomy was performed for the removal of the mass. A fluoroscopy C- Arm bag was put into the abdomen through a colpotomy incision using straightened needle and threads. After taken into the abdomen the needles were passed through the abdominal wall and the threads were pulled for insertion of the bag through the colpotomy incision.

The mass was put into the bag and the needles were passed through the abdominal wall and the thread was brought outside the vagina for pulling back the bag. When the opening of the bag was taken outside the vagina the cyst was aspirated and the mass was removed without any contamination. Frozen section revealed borderline tumor and staging was performed laparoscopically.

RESULTS: The removal of huge masses may be problematic since the mass may not fit into bags. Controlled rupture of the masses which are strongly supposed to be benign was shown not to have adverse outcomes. However, a mass must be removed in sterile bags which has suspicion of malignancy. Huge adnexal masses may be managed using a Fluoroscopy C-Arm cover bag successfully without any contamination.

CONCLUSIONS: Huge adnexal masses may be managed using a Fluoroscopy C-Arm cover bag successfully without any contamination.

Keywords: Adnexal Mass, Minimally Invasive Surgery, Fluoroscopy C-Arm Cover Bag

YV-08

A Rare Case: Postcoital retroperitoneal bleeding

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Ankara Etlik Şehir Hastanesi

INTRODUCTION: Retroperitoneal hematomas are the result of blood loss due to injury to the parenchymal tissue or vascular structures in the retroperitoneal space. It often refers to bleeding in the retroperitoneal area due to trauma, vascular lesions, tumors, surgical intervention and anticoagulant therapy. In our case report, we aimed to summarize the clinical course of our patient who applied to our clinic with the complaint of postcoital abdominal pain.

METHOD: A 28-year-old, nulligravid patient was referred from the external center to our hospital with the preliminary diagnosis of abdominal pain and ovarian cyst rupture. It was learned that the last menstrual date of the patient's gynecological history was 3 weeks ago and had a laparotomic myomectomy 2 years ago. There is no history of additional disease and the medication he used. The patient said that the complaint of abdominal pain started after sexual intercourse.

RESULTS: All abdomen tomography performed in the outer center was interpreted as diffuse foreground ovary cyst rupture in all quadrants in the abdomen. The first hemogram looked by us of the patient with excentral hemoglobin: 10.1 hematocrit: 30 wbc:10.3 plt: 390 b-hcg negative: 8.6 hematocrit: 25.7 wbc: 11.31 plt:390. On ultrasound, 110x 80 mm free yeast was observed in the natural appearance of the endometrium 8mm uterus, the ovaries were observed in the natural abdomen. Collum movements were natural, no active bleeding was observed during the speculum examination. In the examination of the abdress, defense +, rebound + was detected. Pulse:117 Blood pressure:96/58 detected the patient's operation was decided by considering the foreground of ovarian cyst rupture.

Following proper field cleaning and covering, 10mm trocar entered west from umblikus level, pneumoperitoneum was created. 2 5 mm trocars were placed from the right and left side wall of the abdomen. Approximately 10 cm of mine was monitored in the west and cleaned with the help of an aspirator. In laparoscopy, the right and left ovary was natural, no bleeding focus was seen. It was seen as a 2 cm hematoma and laceration area at the intersection of the western and left sacrouterin region. The laseration was dissected with the help of ligasure, the hematoma area in it was emptied. Retroperitone was entered to determine the focal point of the laseration area. Active bleeding was not observed. Ureter peristaltism was monitored.

CONCLUSION: Retroperitoneal hematoma may not always appear due to abdostrinal blunt injury. As in our case, blunt traumas to the vagina and cervix cause retroperitoneal hematoma and may appear with severe bleeding and abdominal pain in the patient.

Keywords: Bleeding, postcoital, retroperitoneum,

YV-09

Extraperitoneal Laparoscopic Burch Colposuspension

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Introduction/BACKGROUND: Burch colposuspension is a widely accepted technique for the treatment of stress urinary incontinence. Laparoscopic Burch colposuspension offers advantages over the open Burch colposuspension (i.e., reduced bleeding, shorter postoperative recovery time), and it is more minimally invasive. However, the surgery duration is longer. This video presents the case of a 42-year-old female patient with a history of difficult birth, gravida 2, parity 2, and Vaginal Birth 2. She had no surgery or any significant medical history. After urodynamic tests, she was diagnosed with stress urinary incontinence (SUI), and it was decided to perform an extraperitoneal laparoscopic Burch colposuspension.

METHODOLOGY: The patient was placed in a low lithotomy position. The bladder catheter was inflated with 30mL of fluid. A 10mm bladeless trocar was inserted into the umbilicus. After that dissectionn was started by creating a space between the peritoneum with pressure by using camera. Since there was sufficient space, two 5mm trocars were placed on each side. The bladder tissues were dissected until the pubocervical fascia was reached. The white line-shaped arcus tendinous fascia pelvis, which remained medially to the obturator internus muscle, was observed. The urinary catheter balloon was held with fingers. The urinary catheter balloon was held with fingers. Fingers were also used dissection in the paraurethral region was checked. The pubocervical fascia and pubourethral ligaments were visualized. Cooper's ligaments extend along the pectineal line and join the lacunar ligament at the base. Non-absorbable sutures were used for both the pubocervical fascia and Cooper's ligaments. At that stage, the key point is not to pass through the periosteum since it may cause postoperative pain. Cooper's ligaments extend along the pectineal line and join the lacunar ligament at the base. Non-absorbable sutures were used for both the pubocervical fascia and Cooper's ligaments. The seams must be tension-free. At that stage, the key point is not to pass through the periosteum since it may cause postoperative pain. During the procedure, the vagina was assessed using fingers. After performing sufficient dissection and obtaining strong tissues in the defined anatomical structures, the procedure was completed.

RESULTS: Operating time was 24 minutes, and there was no blood loss. The patient was discharged on postoperative day 1. At the 1-month follow-up, a significant symptomatic improvement was observed in the patient.

CONCLUSION: In our patient, we performed the extraperitoneal Burch colposuspension technique, and total surgical time was 37 minutes. Skipping the steps of opening and closing the peritoneum and directly entering the space of Retzius allow to save significant time. An appropriate dissection strategy allows to visualization of anatomical landmarks.

Keywords: Burch colposuspension, Extraperitoneal space, Laparoscopy

YV-10

Gross adnexal mass: Sertoli-Leydig cell tumor

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Introduction/BACKGROUND: A 27-year-old female patient with cerebral palsy and epilepsy was admitted due to abdominal swelling that had increased in the last six months. On CT, an ovarian mass extending from the pelvis to the left upper quadrant, 234 mm in diameter, multiseptated, multiloculated, with cystic and solid components, was observed. The AFP level in the blood was 1210 ng/ml and the CA125 level was 132 units/mL.

METHODOLOGY: Under general anesthesia, the abdomen was entered through an incision made in the middle. No tumor was found in the liver, spleen, small intestine, colon, mesentery and omentum. The dilated gonadal vein, surrounded by multiple bulky lymph nodes, was excised to the origin of the inferior vena cava. At this point, it was clamped and cut. A multicystic mass originating from the right ovary, measuring 33*30 cm, weighing 7600 grams, and containing solid areas was removed from the abdomen with the capsule intact. Pelvic and para-aortic lymphadenectomy and omentectomy were added to the procedure. Due to the patient's desire for fertility, a normal-looking left ovary and uterus were left.

RESULTS: The patient was discharged on the 4th postoperative day without any complications. Final pathology revealed a moderately differentiated Sertoli-Leydig cell tumor containing heterologous elements. Heterologous elements containing gastrointestinal-type epithelium and areas showing focal neuroendocrine differentiation were observed in the tumor. Lymph node involvement and lymphovascular invasion were not observed.

CONCLUSION: Sertoli-Leydig cell tumor is a differentiated sex cord-stromal tumor of the ovary. It is seen at a young age and is rare. Most patients are diagnosed at an early stage. Histology is usually low grade and lymph node metastasis is rare. The definitive diagnosis is made by a final pathological examination.

Disclosures: In the current video, we present a fertility-sparing operation for a gross Sertoli-Leydig cell tumor.

Keywords: Adnexal mass, Fertility-sparing operation, Sertoli-Leydig cell tumor

YV-11

Minimally invasive management of large ovarian cyst by laparoscopic approach

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Laparoscopy is a well-established approach in adnexal surgery for small benign masses. However, its use for large adnexal masses has been less common, with laparotomy typically considered the gold standard. This is due to various technical challenges associated with laparoscopy, including a restricted surgical field, the risk of unintended cyst rupture during Veress needle or trocar insertion, and concerns about malignancy.

Our case is a 19-year-old female patient who had not been pregnant applied to the outpatient clinic with complaints of frequent urination and abdominal distension. Ultrasound revealed a multiloculated cystic mass filling the pelvis, measuring approximately 18 cm and having a septa thickness of 3 mm. The ovarian mass was thought to be benign on magnetic resonance imaging. Ca125, Ca19-9, alpha feto protein and human chorionic gonadotropin were within normal laboratory values.

We successfully performed ovarian cyst surgery with a laparoscopic extracorporeal approach on a large ovarian cyst. This technique involved accessing the cyst through a single incision in the suprapubic region, outside the abdominal cavity. This approach helped minimize the risk of cyst contents leaking into the peritoneal cavity. In our video, we showed that making a single incision in the suprapubic region is a safe approach in large adnexal benign cystic masses. This technique not only reduced costs by eliminating the need for traditional laparoscopic instruments, but also provided a cosmetically attractive result. Our young patient, whose pathology report confirmed the expected diagnosis of benign serous cystadenoma, was discharged from the hospital on the first day after the surgery, being extremely satisfied with the minimal scar, especially in the abdominal area.

In conclusion, while laparotomy has traditionally been the preferred approach for managing large adnexal masses, recent advancements in laparoscopic techniques have expanded its application in selected cases. With careful patient selection and the use of advanced imaging and instrumentation, laparoscopy can be a safe and effective alternative to laparotomy for patients with very large adnexal cysts.

Keywords: Ovarian cystectomy, young patient, minimally invasive surgery

YV-12

Ovarian Torsion – Hotdog in Bun Technique –

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INTRODUCTION: Ovarian torsion is a medical emergency commonly presenting %2.7 and %7,4 in all gynaecological emergencies of reproductive age. (1). Misdiagnosing can cause infertility problems and ovarian atrophy. İt is important to diagnose timely in combination with ultrasound and other imaging technique. The most common cause of ovarian torsion is ovarian cyst more than 5 cm and usually more common in right side (2). Elongated pedicles of infundibulopelvic ligament is another cause of ovarian torsion (3). In adolesant girls torsion commonly seen in the absence of adnexal pathology (4).

Method

The case is presented of a nulliparous 28 year-old woman who presented on with symptoms of acute pain and vomiting. On ultrasonography, enlargerd left ovarian mass was shown in with doppler findings suggestive of a possibility of ovarian torsion. Therefore, the patient was taken to diagnostic laparoscopy. The left ovary was observed to rotate around itself three times and detorsion was done. Oophoropexy was performed by 'hotdog in bun' technique. Ethibond 1.0 suture was used to bun round ligament followed by under mesosalpinx trough to utero ovarian ligament and got back in opposite side and tied.

Conclusion

Detorsion and oophoropexy is more popular way than oophorectomy and new surgical techniques that are increasing in popularity. There is no evidence that which oophoropexy prevents recurrence of ovarian torsion. New surgical approach to ovarian torsion is 'hotdog in bun' technique thats leads to fix together round and uteroovarian ligament with mesosalpinx (5).This method can prevent recurrent ovarian torsion but further research is needed to obtain evidence for clinical approach.

Keywords: ovarian torsion, oophoropexy, hotdog in bun,

OLGU SUNUMLARI

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

OS-01

The Missing Intra Uterine Device and Hysteroscopic Approach

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39-year-old female patient, no active gynecological complaints. She applied to us for a routine control examination. She has been protected with a IUD for 2 years. No IUD thread was observed in the speculum examination. Since the IUD was not clearly observed in the cavity in TVUSG, the patient underwent a full abdominal tomography. CT comment: "Metallic density of the IUD placed in the uterine endometrium is observed, the tip of the IUD passes the myometrium and extends into the abdomen, and even one end of the IUD is observed in the lumen of the adjacent sigmoid colon." General surgery planned a colonoscopy for the patient. During the colonoscopy, one end of the IUD perforated the intestine and was observed inside the lumen. Three options were discussed to remove this missing IUD.

1)hysteroscopy

2)laparoscopy

3)colonscopy

An attempt was made to make a choice among the three methods according to the patient's profit and loss ratio in terms of comorbidity and complications of the procedure planned to be performed. These options were explained to the patient in detail and the patient was included in the decision phase and a joint decision was made within the framework of medical principles, taking into account the patient's ideas and preferences. With the hysteroscopic method. The operation was planned to be performed.

The cavity was entered with the help of a hysteroscope. It was observed that the IUD perforated the right cornual area and extended to the extra endometrial area. The IUD was removed with the help of a grasper. No active bleeding was observed from the perforated uterine area. Then, it was observed that the fluid we used during hysteroscopy came from the anus. General surgery opinion was obtained due to in utero colonic fistula formation.

The general surgeon recommended that the patient's regimen be followed in a closed manner during follow-ups and suggested monitoring her symptoms in terms of vital general status and acute abdomen symptoms. At the same time, due to uterine rupture, the patient was monitored for vaginal bleeding and hemogram. After 48 hours, the patient's regimen was changed to regimen 1 and follow-up continued. Gradually, the patient's regimen was changed to regimen 2. During the follow-ups, the patient's general condition was good, her vital signs were stable, she did not develop an acute abdomen, she did not have any vaginal bleeding, and the patient was discharged after receiving a general surgeon's opinion and recommending an outpatient clinic check-up.

In the outpatient clinic control examination performed 1 week later, since the patient had no complaints, symptoms or any detectable pathology that could be associated with the situation in the table in question, the patient's regimen was changed to regimen 3 and an outpatient clinic check-up was recommended 1 month later.

No pathology was detected in the patient at the outpatient clinic check 1 month later.

Keywords: colonoscopy, hysteroscopy, IUD

figure 2

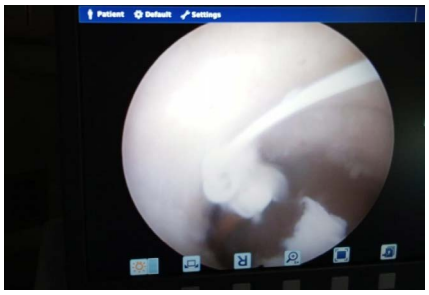


figure 3

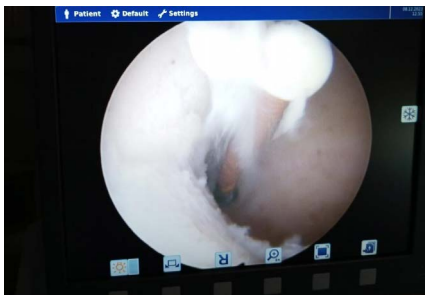


figure 4

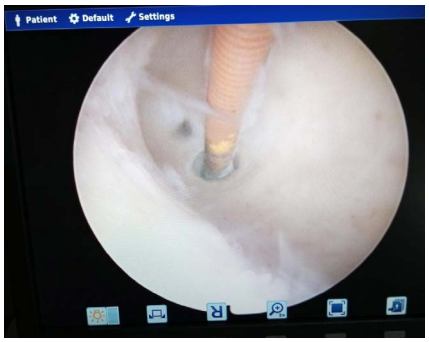
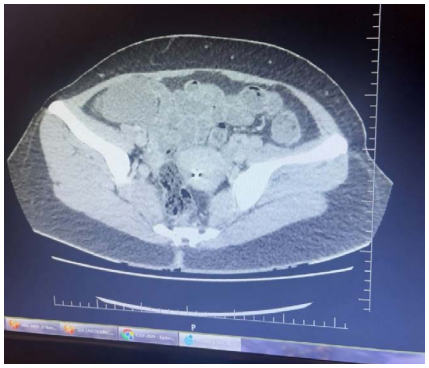


figure 5



OS-02

A Rare Case: Fetal Intraabdominal Umbilical Vein Varix

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Fetal intraabdominal umbilical vein varix (FIUVV) is a rare finding with an incidence ranging from 0.4-1.1/1000. Normally, the diameter of the intra-abdominal umbilical vein increases linearly from 2 mm at 15 weeks gestation to 7-8 mm at term. FIUVV can be defined as a portion of the intra-abdominal umbilical vein at least 50% wider than the non-dilated portion; a dilatation of ≥9 mm; or a dilatation ≥2 SD above the mean value for gestational age. FIUVV usually appears as a cystic intra-abdominal mass (dilated gallbladder, mesenteric,urachal or hepatic cysts, or digestive duplication). Demonstration of the continuity of the lesion with the umbilical vein and flow with color Doppler imaging facilitates the differential diagnosis.

The incidence of chromosomal abnormalities is approximately 2.8% in fetuses with FIUVV, and the most common chromosomal anomaly is trisomy 21. Other abnormalities associated with FIUVV are cardiovascular abnormalities, fetalhydrops, fetal anemia-related complications, umbilical vessel abnormalities, intrauterine growth restriction and even intrauterine fetal death. Isolated FIUVV has a reasonably good outcome; however, when it is associated with other structural anomalies, the outcome rates are variable. A 15-fold increase in the incidence of chromosomal abnormalities and an eightfold increase in the risk of intrauterine fetal death in cases accompanied by ultrasound abnormalities have been demonstrated in the literature. Furthermore, a review of the literature shows that the incidence of fetal death or potential obstetric complications is much higher when FIUVV is diagnosed before 26 weeks of gestation. This finding is consistent with previous case reports of good fetal outcomes when FIUVV is detected late in pregnancy.

CASE

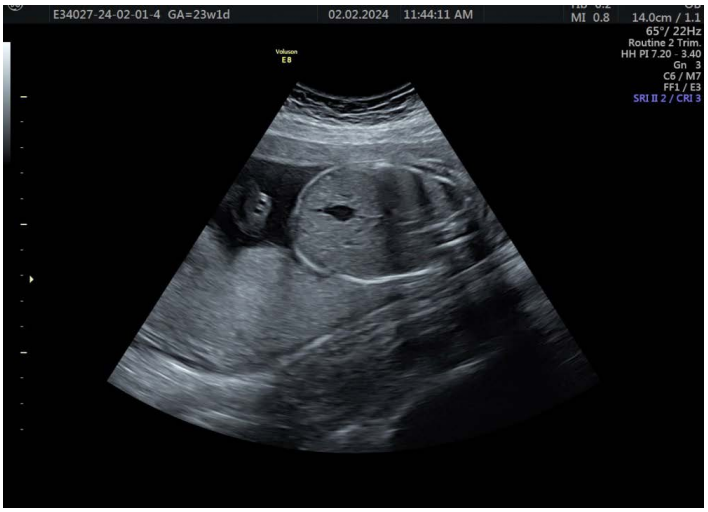
A 28-year-old patient (gravida 1 and parity 1) was first admitted to us at 13 weeks. The 1st trimester combined test was reported as normal and detailed ultrasonography was performed at 23rd gestational week. Focal stenosis (2.2 mm) and focal dilatation (7 mm) were observed in the intraabdominal umbilical vein. A diagnosis of fetal intraabdominal umbilical vein varices was made by differential diagnosis from other abdominal cystic lesions by color Doppler ultrasonography. When the varix was examined in detail, no thrombus or turbulent flow was observed. Screening of other systems, including cardiac anomalies most commonly associated with FIUVV, revealed no abnormalities. Amniocentesis was recommended but could not be performed due to patient's reluctance. The patient was evaluated as isolated FIUVV. She was followed up with ultrasonography and tococardiography at 2-week intervals. There was no progression in umbilical vein dilatation during follow-up. No growth retardation was detected and the patient reached the 28th gestational week of pregnancy and her follow-up continues.

CONCLUSION

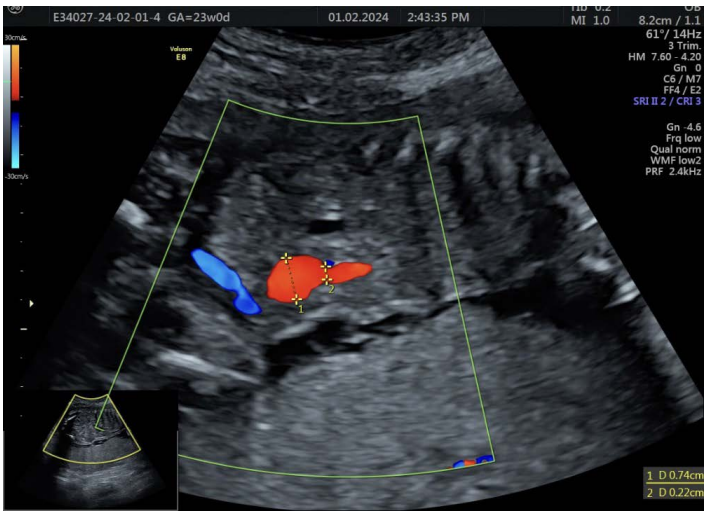
FIUVV is a rare finding but has good postnatal outcomes when isolated. When FIUVV is detected on antenatal ultrasound examination, targeted ultrasound to rule out the possibility of other associated anomalies is recommended.If there are additional sonographic abnormalities, fetal karyotyping should be performed. Serial ultrasound scans should be performed to assess fetal cardiac function, using color Doppler to exclude thrombosis of the umbilical vein, and cardiotocography to ensure normal fetal wellbeing until the delivery.

Keywords: dilatation, ultrasonography, umbilical vein, varix,

FIUVV 2D usg görüntüsü



FIUVV doppler görüntüsü



OS-03

Coexistence of endometrial stromal sarcoma and endometrial adenocarcinoma in a patient with bicornuate uterus and postoperative adjuvant therapy management

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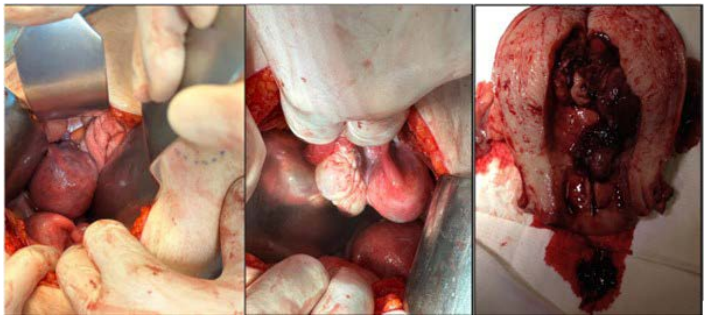
INTRODUCTION: Bicornuate uterus with abnormal fundal external indentation due to bicornuate uterus paramesonephric duct fusion defect is the most common congenital uterine anomaly. The type without cervical duplication is called 'bicornuate, unicollis'.The most common gynecological malignancy in developed countries is endometrial adenocarcinoma.The most common histological type is "Endometrioid adenocarcinoma" and it accounts for 80% of endometrial cancers.Endometrial stromal tumors(EST) are uterine mesenchymal tumors that resemble the endometrial stroma of the endometrium,which functions histologically.In general, ESTs are rare malignancies with an annual incidence of approximately 0.30 per 100,000 women and occur in the perimenopausal period.

CASE: A 69-year-old patient who was admitted to our gynecologic oncology outpatient clinic due to postmenopausal bleeding and abdominal swelling was admitted to our clinic for surgical exploration with findings of adnexal mass and endometrial thickness increase as a result of imaging methods.It was learned that the patient had 4 normal births in her history.Intraligamentary fibroids, hormone-secreting ovarian malignancy and endometrial malignancies were considered as preoperative preliminary diagnoses in terms of adnexal mass.During the operation, it was observed that the patient had a bicornuate uterine anomaly.Bilateral ovaries were normal.Two uterine horns of approximately 10*12cm, which were larger than the size consistent with age, were observed(Figure 1).The patient underwent total abdominal hysterectomy and bilateral salpingoophorectomy and was sent for frozen section. The result of frozen was reported as endometrioid adenocarcinoma for the right uterine horn, grade 2, malignancy invasive to the outer 1/2 of the myometrium, and hypercellular mitotic active leiomyoma in the left uterine horn.Pelvic lymph node dissection and surgical exploration were performed in accordance with the surgical staging.The patient was evaluated at the gynecologic oncology council with the final pathology.Bicornus uteri left cornus stage 1B high grade endometrial stromal sarcoma, right cornus endometrioid carcinoma, grade 2, LVSI positive, external 1/2 myometrial invasion(14/24mm), Stage 3C1ii endometrioid type endometrial cancer with one metastatic pelvic lymph node.Considering NCCN 2023 version 1 as adjuvant therapy, follow-up according to high grade ESS in the left corn was deemed appropriate.However, surgically staged endometriod type Stage 3C endometrial cancer in the right corn was deemed appropriate to receive systemic CT+/-EBRT+/-Brachytherapy.

DISCUSSION: The association of Müllerian anomalies with endometrial carcinoma is very rare. In fact, as in our case, no other case has been identified in the literature in terms of endometrial stromal sarcoma and endometrial adenocarcinoma with uterine anomaly.Total hysterectomy without morcellation and bilateral salpingo-oophorectomy(BSO) as EST treatment are first-line treatment of early-stage LG-ESS.In advanced or recurrent LG-ESS, surgical cytoreduction followed by hormonal therapy or vice versa are acceptable treatments.Surgical cytoreduction and neoadjuvant or adjuvant chemotherapy may be considered in advanced or recurrent HG-ESS.Typical staging surgery as a treatment for adenocarcinoma of the endometrium consists of bilateral salpingo-oophorectomy and hysterectomy with pelvic/paraaortic lymph node dissection.Treatment is organized according to the stage and the risk of recurrence.Radiotherapy is primarily used in the early stages, and chemotherapy may be added if there is high-grade histology or advanced disease.In our case with concomitant malignancies, it should be evaluated in multidisciplinary oncology councils in terms of adjuvant treatment.

Keywords: Bicornuat uterus, Endometrial stromal sarcoma, Endometrial adenocarcinoma, Uterine anomaly

Figure 1: Image of bicornuate uterus and endometrial malignancy



OS-04

17 Weeks and 4 Days Non-Ruptured Tubal Ectopic Pregnancy

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Ectopic pregnancy refers to a condition in which a fertilized egg settles outside the uterine endometrial cavity and continues to mature. According to their site, classified as tubal, ovarian, intraligamentary, cervical, scar or abdominal. An ectopic pregnancy occurs in the fallopian tube and is known as a tubal pregnancy. Ectopic pregnancy affects about 1.5% to 2.0% of all pregnancies and accounts for 5% of maternal fatalities. 70% of ectopic pregnancies occur between weeks 5 and 8, while 20% occur between weeks 9 and 10, 10% of cases are detected a after 10 weeks of pregnancy.

Because almost all ectopic pregnancies are detected early, an advanced second trimester tubal pregnancy is uncommon. Transvaginal sonography is straightforward and useful for diagnosing ectopic pregnancy, however abdominal sonography is commonly utilized in the second trimester (growing pregnancies). There are few published cases on this issue. The example we shall present is an ectopic pregnancy with no regular follow-up and no rupture in the second trimester.

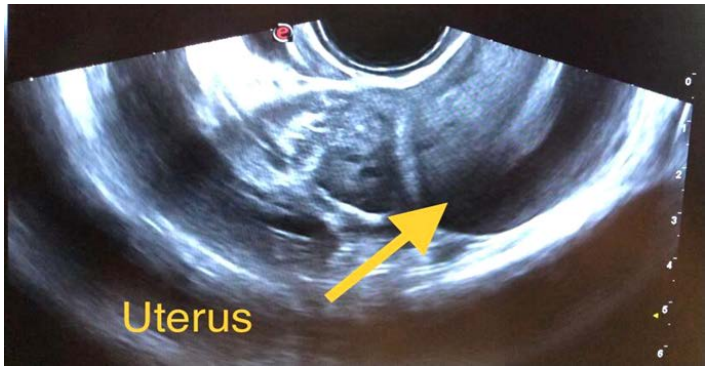
The present case is a 27-year-old female patient with gravida 3 parity 2. The patient presents to our emergency department only with the complaint of vaginal spotting. LMP was 18/06/21 (18 weeks 2 days). The patient did not attend regular follow-ups. The patient's vital signs were stable. In the abdominal ultrasonography, BPD: 17w1d HC: 17w3d AC: 17w4d FL:17w2d, AFI: normal, EFW: 222gr fhr (-) fetus which was evaluated to be in the intrauterine cavity, was observed. The patient was diagnosed with missed abortion. The termination protocol was applied to the patient with a total of 2 misoprostols within 12 hours. Since the desired cervical dilatation did not occur, it was decided to insert a foley catheter for mechanical dilatation. Before the foley catheter was inserted, it was re-evaluated with transvaginal ultrasound, and it was observed that there was not a pregnancy in the uterine cavity and endometrium was 10 mm. The gestational sac was extrauterine, and a fetus compatible with 17 weeks 4day was observed in the left adnexal area. (Picture-1,2).

The patient was operated with the preliminary diagnosis of ruptured abdominal scar from the old cesarean section or left tubal ectopic pregnancy. The abdomen was entered with a Pfannenstiel incision. In exploration; The uterus was seen as normal size in the midline, and the old scar line was seen as intact (Picture-3). A non-ruptured ectopic focus, approximately 16 cm in diameter, was observed in the left tube. Left salpingectomy was performed. After removal of the mass, the mass was opened by making an incision. Fetus and placenta were observed (Picture-4,5,6).

When we look at ectopic pregnancy cases around the world, not only in our case, but also in other cases it appears to be difficult to diagnose ectopic pregnancy in 2nd trimester. The diagnosis of ectopic pregnancy site is more difficult. After this case, in which transvaginal ultrasound is not indicated due to patient satisfaction and late gestational week, we suggest that vaginal USG should be considered in addition to abdominal USG to differentiate intra-uterine or extra-uterine pregnancy.

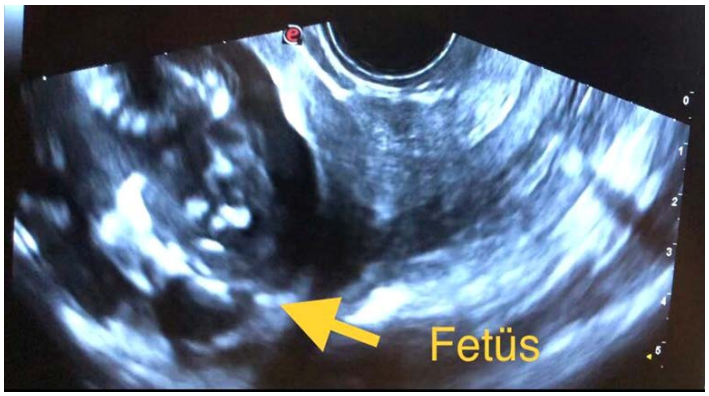
Keywords: ectopic pregnancy, non-ruptured, transvaginal ultrasound, uterus

Picture 1



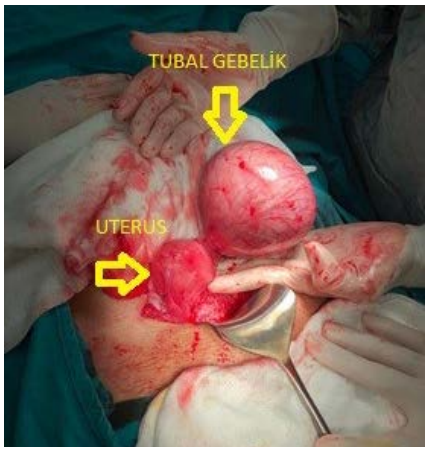
Ultrasound (uterus)

Picture 2



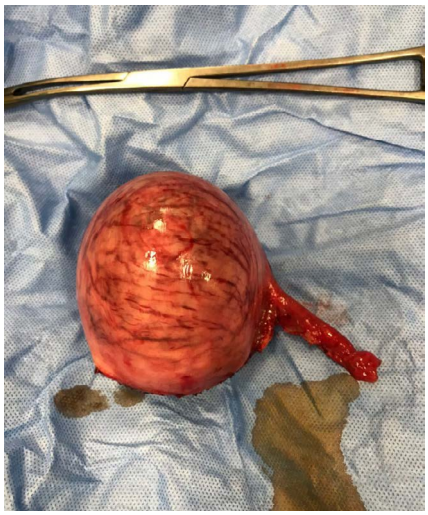
Ultrasound (The gestational sac was extrauterine, and a fetus compatible with 17 weeks 4day was observed in the left adnexal area)

Picture 3



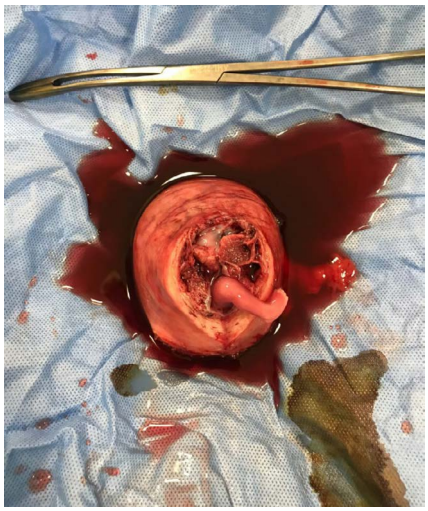
Non Ruptured Tubal Pregnancy and uterus (in the operation)

Picture 4



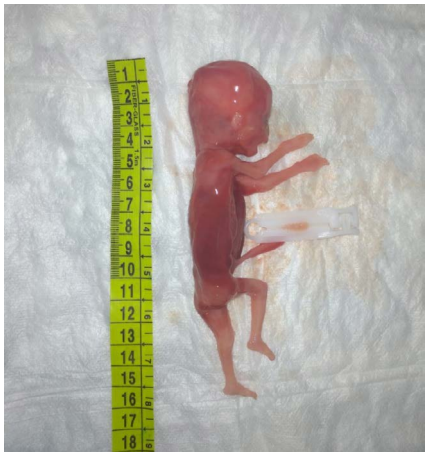
Non Ruptured Tubal Pregnancy (in the operation)

Picture 5



Non Ruptured Tubal Pregnancy (17w4d fetus, in the operation)

Picture 6



17w4d FHR (-) fetus (in the operation)

OS-05

A huge lipoma of left labia majora in 28-year-old woman

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[2]Department of Obstetrics and Gynaecology, Medikalpark VM Hospital, Samsun, Turkey

A 28-year-old virgin woman presented with a large left labial swelling that had been enlarging for the last five years. İn examination we found aproximately 12 Centimeters labial swelling. She had not any illness or another health problem.

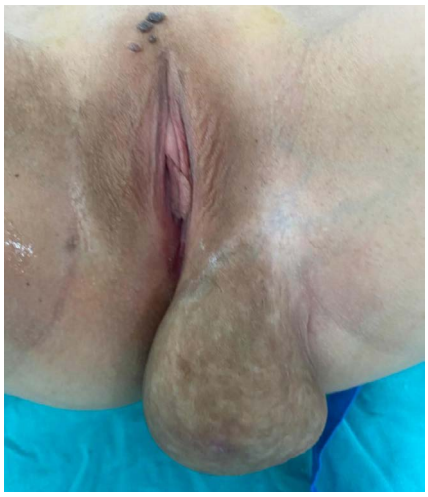
The presentation of a large labial swelling that has been enlarging over several years may initially raise concerns for other diagnoses such as Bartholin's abscess or cysts, inguinal hernia or neoplastic conditions. Therefore, thorough evaluation and differential diagnosis are essential in such cases. Frequently, patients may have more than one lipoma. Malignant transformation of a lipoma into a liposarcoma is rare. İf enlarging occurred for example in few months, must be thinking about biopsy from mass. İn this patient we did not think about canser as first possible diagnosis.

Preoperative superficial ultrasonography was used to identify diagnoses. With superficial ultrasound has been seen that fatty, lobular tissue under vulvar skin. Doppler imaging showing minimal vascularity further supports the diagnosis of a benign lipomatous lesion. We decided with this findings in this case diagnosis of vulvar lipoma and planned surgery. İn surgery the mass was excised, and histopathology report resulted as benign lipoma of vulva. The patient was discharged 1 day after surgery. No complications developed

Lipoma is a benign tumor form that is often seen in older ages. This benign tumors composed of mature fat cells that can occur in various parts of the body, including the vulva. However, their occurrence in the vulvar region, especially of significant size as described in the case, is indeed uncommon in younger individuals. This case underscores the importance of considering lipomas in the differential diagnosis of vulvar swellings, even in younger individuals, and highlights the role of imaging modalities such as ultrasound in guiding diagnosis and management decisions.

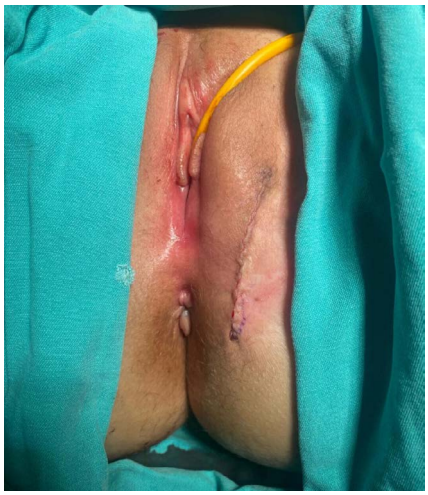
Keywords: lipoma, vulva, tumour, labia majora's neoplasms

Figure 1.



Preoperative vulvar view

Figure 2.



Postoperative view of vulva

OS-06

Isolated tubal torsion mimicking an ovarian cyst: a case report

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BACKGROUND: Isolated fallopian tube torsion (IFTT) is one of the most common surgical emergency in adolescents and reproductive age group. Congenital anomalies, presence of intrauterine devices, hydrosalpinx, pelvic inflammatory disease (PID), tubal ligation or adhesions, adnexal venous congestion, ovarian or paraovarian cysts, and trauma are risk factors associated with IFTT. In this report, we presented a case of IFTT, which developed asymptomatically and was incidentally detected.

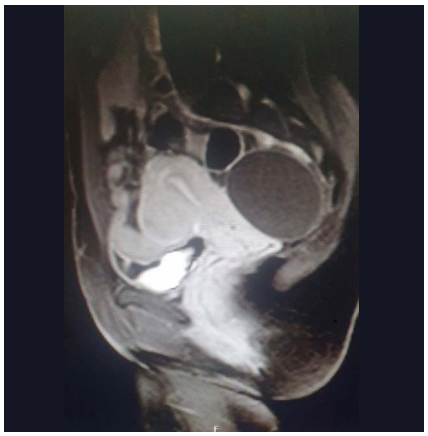
CASE: The patient, a 36-year-old, nulliparous woman with a diagnosis of uterine leiomyoma and a right ovarian cyst measuring 5 cm in size, was referred to our hospital due to abnormal uterine bleeding. Her history revealed no previous surgery and no comorbidities. Serum hemoglobin concentration was recorded at 12.6 g/dL, and tumor markers were within the normal reference range. Magnetic resonance imaging (MRI) and transvaginal ultrasonography (TVS) revealed a 2 cm type-7 fibroid located at the uterine fundus, a 5 cm type-3 fibroid, and a 2 cm type-6 fibroid in the anterior region of the uterine corpus Additionally, a 5 cm anechoic cyst originating from the right ovary was reported (Figure 1). Laparotomy was performed. The aforementioned fibroids were excised. The left adnexa and right ovary were normal. It was observed that the proximal region of the right fallopian tube was completely twisted, leading to necrosis (Figure 2). Right salpingectomy was performed (Figure 3). The diagnosis was confirmed by final pathology. She was admitted to the ward after surgery and discharged the following day. The post-operative follow-up was uncomplicated.

DISCUSSION: Isolated fallopian tube torsion (IFTT) is described as a rare cause of lower abdominal pain in women. According to current literature, its approximate incidence is 1 in 500,000. Non-specific clinical signs and symptoms often complicate the diagnosis. Distinguishing IFTT from other conditions such as adnexal mass, ovarian torsion, PID, ectopic pregnancy, appendicitis, degenerating myoma, or urinary diseases poses a diagnostic challenge for clinicians. The definitive diagnosis of tubal torsion is still made retrospectively, usually after surgery. Currently, detorsion of the tube is the preferred treatment option unless there is suspicion of tubal necrosis or malignancy. In the presence of ultrasonographic features suggestive of torsion and a normal ovary on observation, the possibility of tubal torsion should be considered. In this case, no evidence of torsion was observed on the ultrasonography. Moreover, the patient did not describe typical clinical findings of torsion, was asymptomatic, and presented with abnormal uterine bleeding that had been ongoing for 6 months.

CONCLUSION: IFTTT is a rare clinical entity; despite advanced imaging techniques, the diagnosis can often be missed, and it should be noted that it may present asymptomatically.

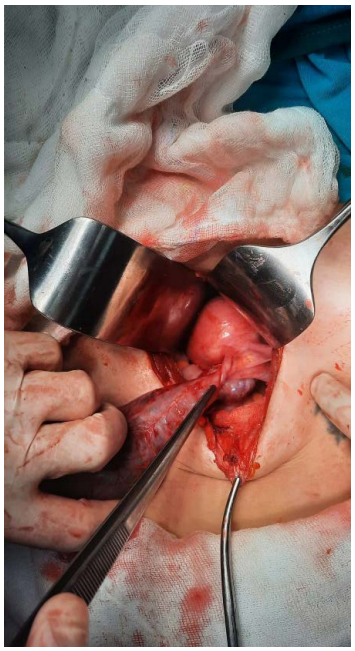
Keywords: adnexal torsion, isolated fallopian tube torsion, ovarian cyst

Figure 1



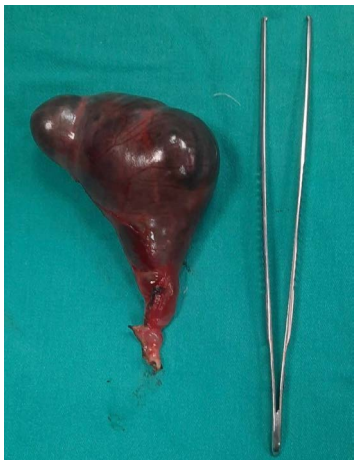
The right isolated tubal torsion mimicking a right ovarian cyst (MRI)

Figure 2



The proximal region of the right fallopian tube was completely twisted.

Figure 3



The fallopian tube was enlarged and necrosed.

OS-07

A rare case of interstitial ectopic pregnancy

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Ectopic pregnancy (EP) is a potentially life-threatening condition in which a fertilized ovum implants outside the endometrial cavity, occurring in approximately 1.5% to 2.0% of all pregnancies. Quantitative measurements of human chorionic gonodotropin hormone (ß-hCG) and transvaginal ultrasound imaging (TV-USG) have an important role in early and accurate diagnosis of EP. EP is most commonly tubally located with 96%. Interstitial ectopic pregnancy (IEP) is a rare condition defined as a pregnancy that develops lateral to the round ligament in the uterine part of the fallopian tube. The incidence of IEP is 2-4% of EP and 1.4% of all pregnancies are classified as ectopic. There are many risk factors that cause EP. The most important causes of EP are previous infections, surgeries and congenital anomalies. The highest risk was associated with a history of previous EP or tubal surgery. Recurrent pelvic infections increase the risk of EP.

IEP may be misdiagnosed as intrauterine because they are partially implanted in the endometrium. In IEP, a rupture can occur at any time during early pregnancy, but in 20% of cases it occurs beyond 12 weeks of amenorrhea. If rupture occurs, bleeding can be severe enough to be life-threatening. The maternal mortality rate in IEP is between 2% and 2.5%. Early diagnosis and appropriate treatment are important in reducing maternal mortality.

Case

A 29-year-old woman was admitted to the gynecology clinic because of menstrual delay. TV-USG examination revealed that the endometrial cavity was empty and there was a 6 weeks and 2 days old fetus with fetal heartbeat inside the gestational sac in the right tubal interstitial part of the uterus (Figure 1). In the obstetric history of the patient, it was learned that she was nulliparous, had no history of gynecologic surgery that could cause IEP and no assisted reproductive technique was used during pregnancy. Minimal vaginal bleeding was positive and abdominal pain, defiance/rebound were negative.

During hospitalization, β-Hcg value was 12091.97 mIU/mL and hemoglobulin (Hgb) value was 13.6 g/dL. It was decided to administer a single dose of systemic Methotrexate (MTX) treatment (50 mg/m2) and the patient was followed up.

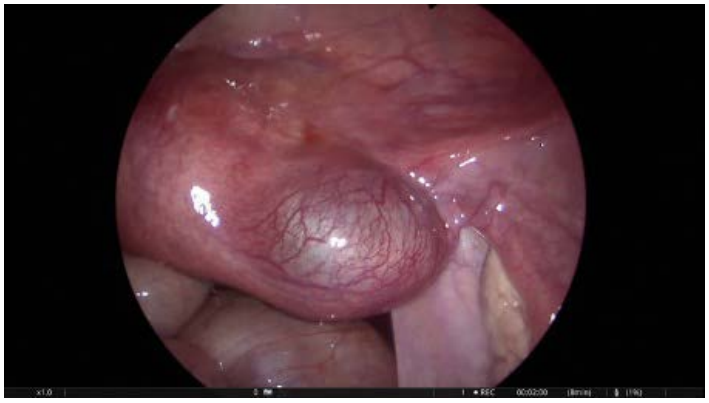
On the 7th day of MTX administration, the patient's β-hCG value was 14999.71 mIU/mL and Hgb value was 12.2 g/dL fetal heartbeat was negative.. Due to the failure of medical treatment, laparoscopic right cornual wedge resection was decided. When the abdomen was entered laparoscopically, minimal coagulum was observed in the Douglas cavity and uterine EP material was seen in the right side of the uterus (Figure 2). Right cornual wedge

resection was performed and sutured laparoscopically. No complication developed during the procedure. After the 1st day of surgery β-hCG value was 3518.78 mIU/mL, Hgb was 11.1 g/dL. The patient was discharged on the 3rd day of the surgery.

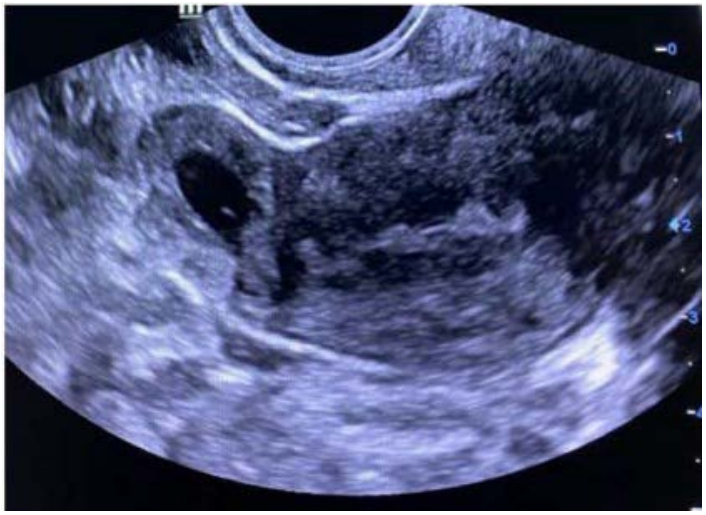
CONCLUSION: In conclusion, IEP are rare diseases that require early diagnosis and can be treated with systemic MTX in hemodynamically stable patients in the absence of contraindications or surgical excision of the pregnancy material in cases where medical treatment is considered unsuccessful or inadequate.

Keywords: Ectopic pregnancy, interstitial ectopic pregnancy, maternal death

Interstitial pregnancy image in laparoscopy



Right interstitial pregnancy image on transvaginal USG



OS-08

A Rare Case Seen After Preeclampsia: Spontaneous Liver Rupture

Ayse Yigit, Edanur Yilmaz, Fahri Burcin Fıratlıgil
Ankara Etlik City Hospital Gynecology and Obstetrics Perinatology Clinic

A Rare Case Seen After Preeclampsia: Spontaneous Liver Rupture

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Ankara Etlik City Hospital, Gynecology and Obstetrics Perinatology Clinic

OBJECTIVE: Spontaneous liver rupture (SLR) is a rare complication that may be associated with pre-eclampsia. Although it is associated with nonspecific clinical findings, it may have a highly fatal clinical outcome for both the mother and the fetus. The incidence is approximately 1/45000 - 1/225000 and although most cases occur in the late second and third trimester, a third of cases occur in the postpartum period, particularly in the first 48 hours. Clinical manifestations include non-specific symptoms such as back pain and right upper quadrant pain, nausea and vomiting, and hemodynamic instability, which may lead to delays in diagnosis. The diagnosis is made by ultrasound and especially computed tomography (CT).

Although surgery is the primary approach in the treatment of SLR, transcatheter arterial embolization has taken the lead with the developments of the last 10 years.

Our case summarizes the clinical course of a patient who underwent an emergency cesarean section (C/S) due to severe pre-eclampsia and developed SLR in the 24th postoperative hour.

Method

A 33-year-old pregnant woman, multiparous (1C/S), was admitted to our clinic in the 34+4/7th week of pregnancy due to hypertension. After stabilization of the mother, she was delivered by emergent C/S due to blood pressure values of 190/110 mmHg and the occurrence of headaches and visual disturbances. Postoperative follow-up revealed back pain and elevated liver enzymes. Abdominal ultrasonography revealed a 115*60 mm hematoma (Figure-1) at the subcapsular level of the liver, whereupon the patient was referred to the Department of General Surgery with a provisional diagnosis of SLR.

Findings

Subsequent CT scan revealed perihepatic free fluid of about 5 cm and hypodense areas in the right upper lobe of the liver and emergency laparotomy (LT) was performed with a diagnosis of SLR. LT showed an approximately 10 cm hematoma under the Glisson's capsule (Figure-2) and hemorrhagic free fluid. After draining the hematoma and controlling the bleeding, the surgery was completed without complications. The patient was discharged on the 10th postoperative day in good general condition.

CONCLUSION: Our case emphasizes that the diagnosis of SCR with nonspecific findings after severe preeclampsia should always be considered, even if it is rare. Clinical findings are often inadequate and imaging techniques are used for diagnosis. Ultrasonography is the first choice for diagnosis, but CT is the mainstay. Our case

is important because it is a rare example of SLR following severe pre-eclampsia and leads to rapid diagnosis and treatment.

Keywords: Liver, Preeclampsia, Rupture

Figure 1. Ultrasonographic image of the hematoma observed in the liver

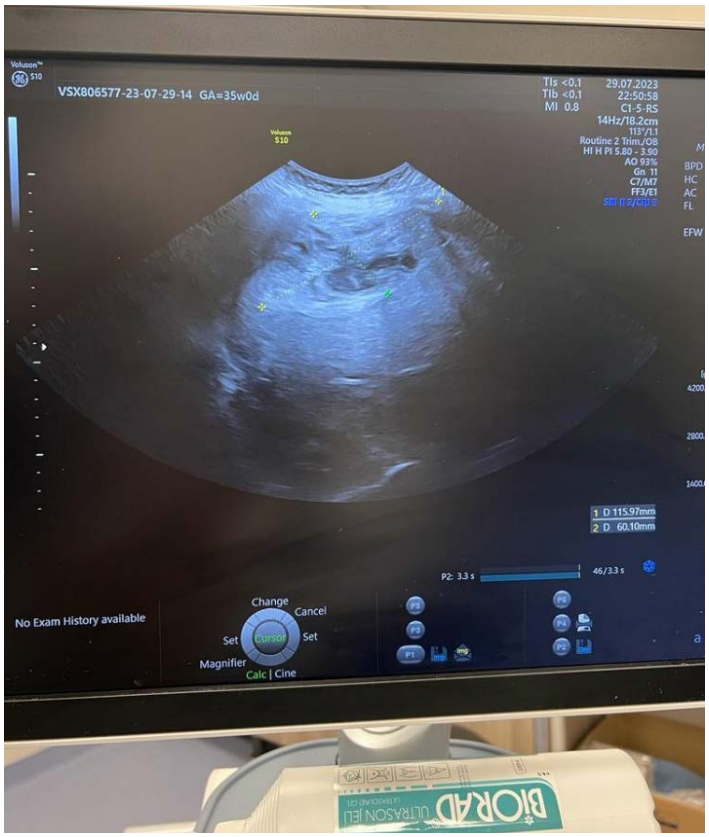
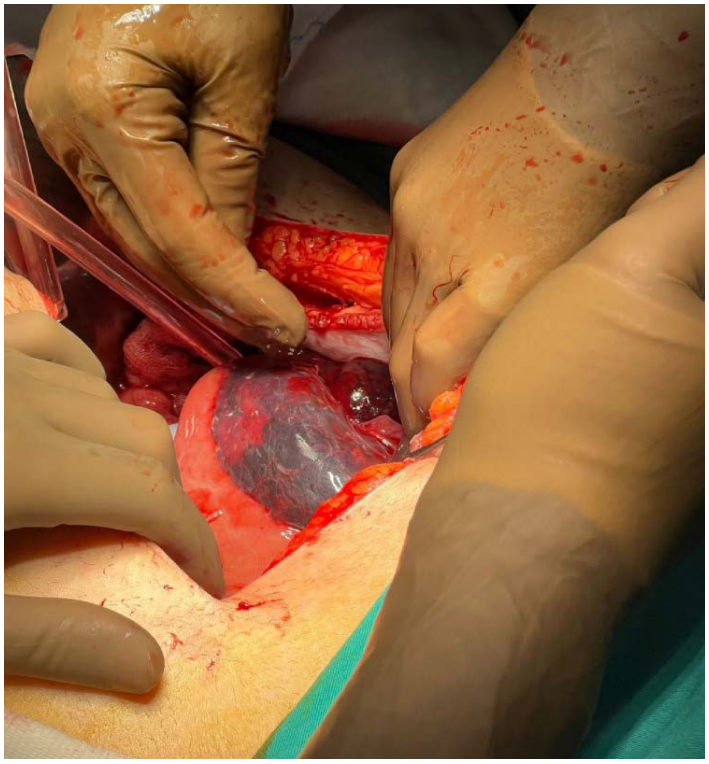


Figure 2. Intraoperative appearance of ruptured liver



OS-09

OHVIRA syndrome presenting with chronic vaginal discharge and infertility

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Department of Obstetrics and Gynecology, Faculty of Medicine, Recep Tayyip Erdogan University, Rize, Turkiye

Introduction

Obstructed hemivagina and ipsilateral renal anomaly (OHVIRA) is a rare congenital developmental syndrome manifested by uterine duplication, lower genital tract obstruction, and unilateral renal anomaly. The exact incidence is not known but is estimated to occur in 0.1 to 3.8% of the general population. Clinical symptoms include dysmenorrhea, pelvic pain and sometimes infertility.

In this case we are presenting a patient with OHVIRA syndrome. Despite receiving treatment for pelvic inflammatory disease, the patient could not get pregnant. However with the right diagnosis and treatment she had a spontaneous pregnancy.

Case Report

A 26-year-old, nulliparous patient applied to the clinic with complaints dysmenorrhea, foul-smelling vaginal discharge and pelvic pain. It was learned that the patient got married 8 months ago, she has received antibiotic treatment many times, and recently she was hospitalized for pelvic inflammatory disease, but her complaints continued. Additionally, the patient wanted to become pregnant. It was learned that she had only one kidney congenitally.

In speculum examination; brown, foul-smelling discharge was observed from the left side of the vagina. In ultrasonography; there was a double uterus image and a cystic mass between the cervix and vagina. (Figure-1) The patient underwent an MRI because there were concerns about OHVIRA syndrome. In the MRI double endometrial cavity and double cervical canal were observed but left kidney was not observed.(Figure-2) A cystic mass with dense content in the left cervical canal was also discovered.(Figure-3) Surgical operation was planned for the patient. A blind ending hydrosalpinx on the left tube was observed during laparoscopic inspection.

(Figure-4) Vaginoplasty was performed. When the pinpoint orifice on the left side of the vagina, where the smelly discharge was coming from, was enlarged, dense and foul smelling fluid started to drain out.

Chromotubation was performed. While methylene blue passed from the right tube to the abdomen, it did not pass from the left tube.

The patient was stable and her foul smelling vaginal discharge resolved during postoperative follow-up. Spontaneous pregnancy was detected in the 2nd month after the operation

Discussion

OHVIRA syndrome was first reported in 1922, and this syndrome started to be known as Herlyn-Werner-Wunderlich syndrome beginning in the 1970s.

Patients with this anomaly had dysmenorrhea (73%), a pelvic or paravaginal mass (71%), and an impacted right uterus and vagina (63.5%) as the most common symptoms. Similarly, our patient also had dysmenorrhea. In our case the blind side was on the left side, and there was a constantly foul-smelling discharge coming from a small area where the blocked left cervix drained. We think that this inflammatory process prevented possible pregnancies in this patient. The fact that pregnancy occurred in the first month after the treatment ban was lifted supports our idea.

Conclusion

In conclusion, it is essential to emphasize the significance of early diagnosis in OHVIRA syndrome, a condition that remains poorly known. It is one of the conditions that should be considered in infertile patients with treatment-resistant discharge and a history of renal anomalies.

Keywords: Infertility, OHVIRA, Syndrome

Figure-1

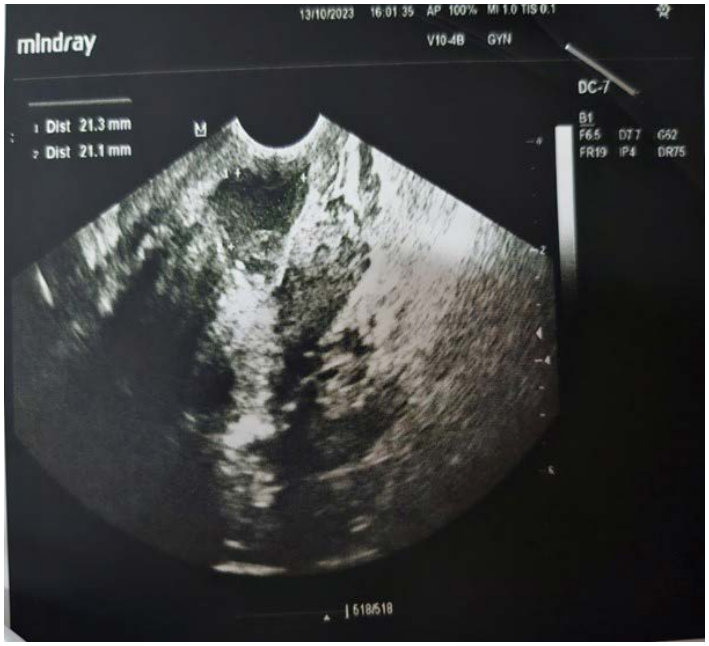


Figure-2

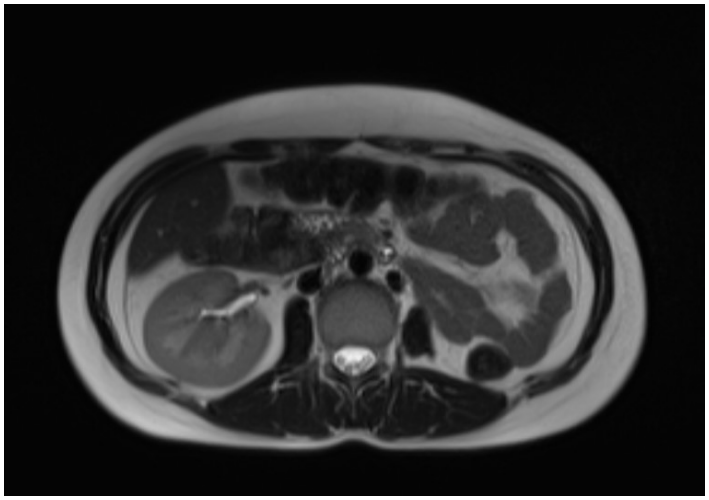


Figure-3

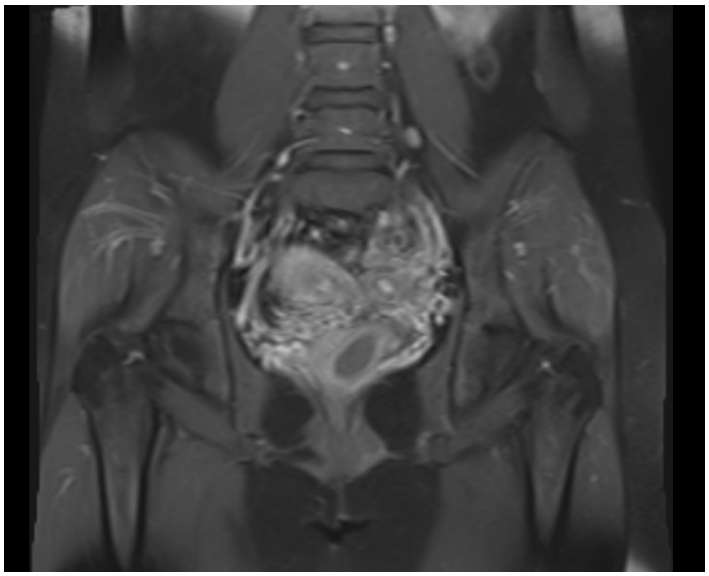
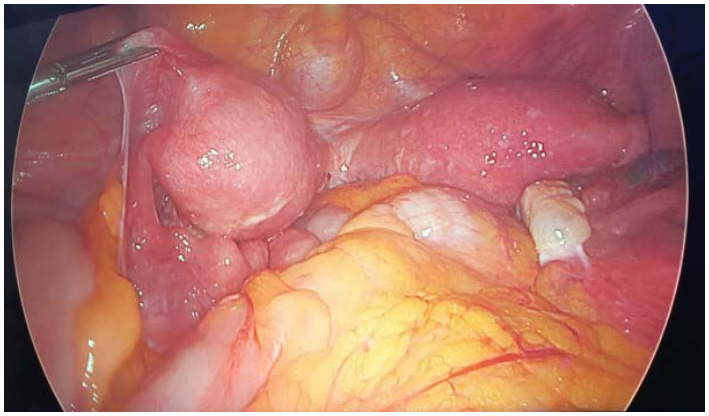


Figure-4



OS-10

Post-treatment ventriculomegaly in a hydropic supraventricular tachycardia (SVT) case which cured with antiarrhythmic treatment

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[2]Department of Obstetrics and Gynecology, Health Sciences University, Cam and Sakura City Hospital, Istanbul, Turkey

INTRODUCTION: Fetal tachycardia is a serious condition which cause fetal heart failure and hydrops and eventually fetal neurologic sequels may occur. Treatment and follow-up are vital to prevent long term fetal morbidities. The aim of this study is presenting a case of post-treatment ventriculomegaly in a hydropic supraventricular tachycardia (SVT).

METHODS: Thirty-eight years old pregnant women who had no chronic illness, no surgical history other than laparoscopic appendectomy and no medication use, had applied to our clinic at 21w+5d of gestational age with fetal tachycardia, and hydrops was diagnosed in another center. She was hospitalized due to hydrops fetalis and fetal SVT. After she evaluated by pediatric cardiologists, flecainide 3x100 mg and digoxin 2x0.5 mg had started with diagnosis of atrioventricular reentrant tachycardia. At the examination two weeks later, there was no arrhythmia and fetal hydrops symptoms were improved. Medication was decided to be discontinued if SVT would not occur with follow-up. Fetal ventriculomegaly was diagnosed at 24w+2d of gestational age and bilateral ventricular diameters get larger with weekly examinations. Fetal MRI was requested at 26w+2d of gestational age and it reported as bilateral ventriculomegaly with hemorrhage sequel at the level of basal ganglion-insula of right periventricular area. Diffusion MRI was planned at the 32. week of gestation.

RESULTS: The relationship between fetal tachycardia and intracranial hemorrhage is not a well enlightened area and there are few cases reported in the literature focuses on this topic. Schade et al. had a case series of three fetuses developed neurologic deficits after SVT diagnosis [1]. Two fetuses had hypoxic ischemic, and one had hemorrhagic lesions and they were treated for SVT. Oudijk et al. evaluated 11 neonates in terms of neurologic function who had experienced SVT with hydrops [2]. Three infants showed periventricular echogenicity and one had parenchymal hemorrhage on the neonatal cranial imaging.

CONCLUSION: Fetal tachycardia may cause circulatory problems and disrupts the cerebral perfusion. Hydrops might be the evidence of circulatory disorder. Finally yet importantly, since fetal cerebrovascular autoregulation is not fully functioning, fetuses with circulatory problems such as SVT with hydrops are more prone to neurologic morbidities.

References

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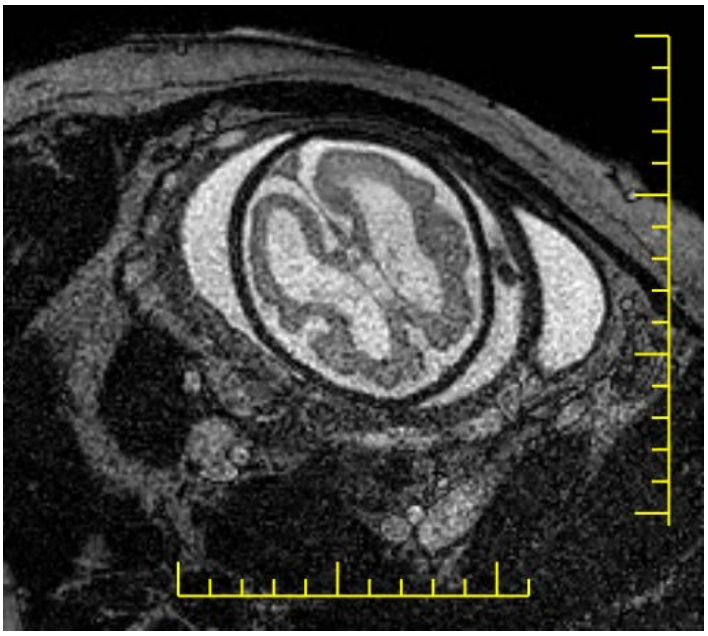
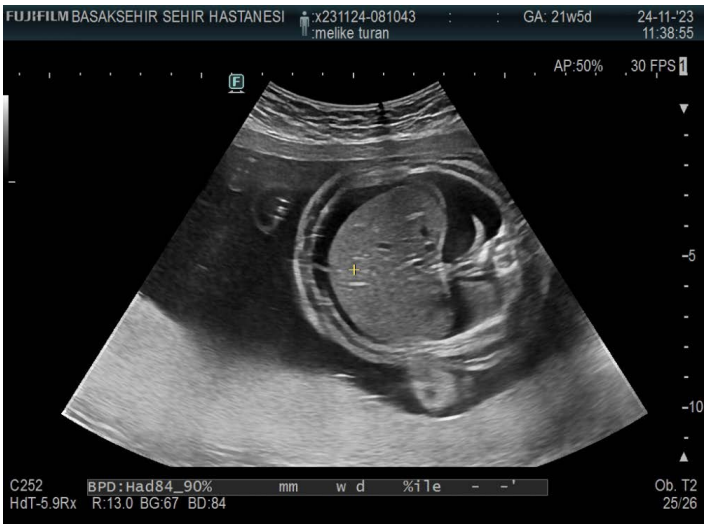
2. Oudijk MA, Gooskens RH, Stoutenbeek P, De Vries LS, Visser GH, Meijboom EJ. Neurological outcome of children who were treated for fetal tachycardia complicated by hydrops. Ultrasound Obstet Gynecol. 2004 Aug;24(2):154-8. doi: 10.1002/uog.1106. PMID: 15287052.

Keywords: hydrops fetalis, supraventricular tachycardia, ventriculomegaly

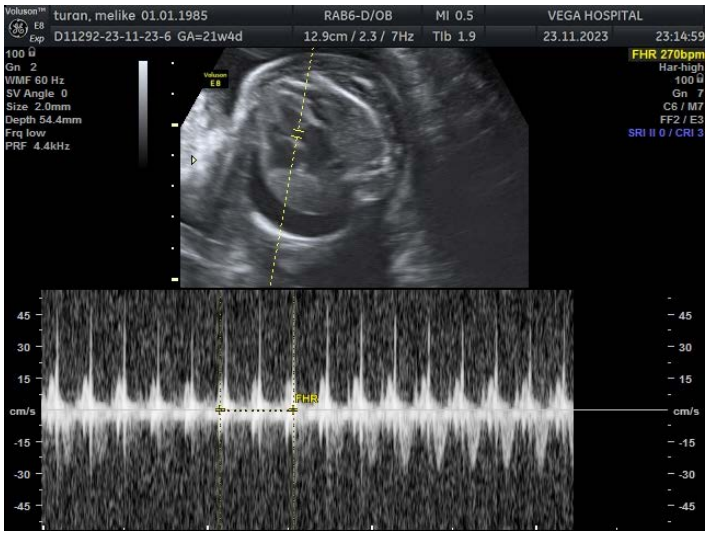
fetal cranial MRI



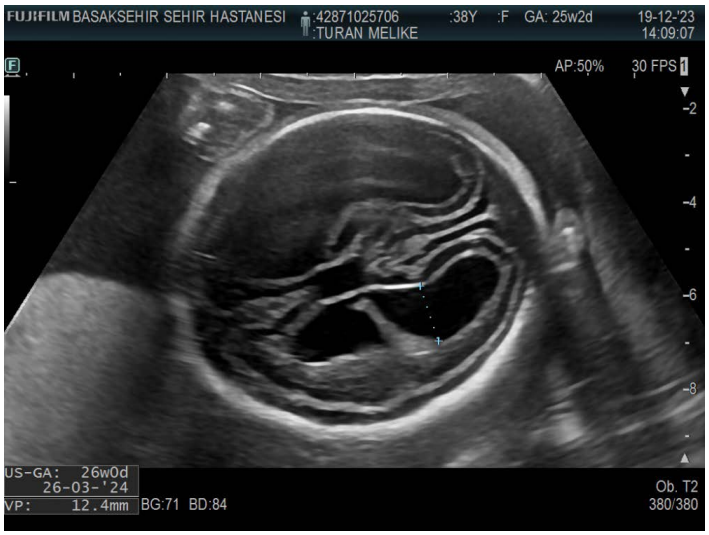
fetal hydrops



fetal tachycardia at the first admission



ventriculomegaly after antiarrhythmic treatment



OS-11

Right para tubal cyst mimicking malignancy on magnetic resonance imaging: A case report

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[2]Department of Obstetrics and Gynecology,University of Health Sciences, Faculty of Medicine, City Hospital, Erzurum, Turkey
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PURPOSE: A correct diagnosis of the nature of a pelvic mass is important to decide on the procedure of surgery. So, a detailed preoperative imaging evaluation is mandatory to detect the nature and its relationship with surrounding organs. Here we presented a young woman with a pelvic mass for which preoperative pelvic computed tomography suggested ovarian malignancy.

CASE: A 32-year-old woman presented to the emergency department with lower abdominal and pelvic pain for the last few months. Transvaginal ultrasonography revealed a hypoechoic mass of 60 x 70 mm in size with cystic components in the right ovary. Laboratory tests were unremarkable and a Contrast-enhanced Magnetic Resonance Imaging (MRI) scan showed a multi-septate cystic right adnexal mass with 8 x 9 cm, and a small amount of ascites, with no further alterations. The patient was hospitalized with the presumptive diagnosis of an ovarian tumor suspicious of malignancy. Laparoscopic exploration of the pelvic cavity showed a large cystic mass consisting of multiple vesicles resembling a bunch of grapes with a total size of 6 x7 cm, located in the para tubal area in the right adnexal region and extending to the left adnexal region. The uterus and left adnexa were unremarkable. (Fig. 2). Excision of the mass was performed with bipolar diathermy and the specimen was removed in an endo-bag. A piece was sent to the pathology department for a frozen section. It was reported that no distinction could be made between malignant and benign, but there were atypical cells. Therefore, appendectomy, omentum biopsy, and right salpingectomy were performed. The final pathology was reported as serous cystadenoma, tubal segments containing chronic salpingitis, stromal fragments containing hemorrhage-myxoid changes, and foci of endometriosis (consistent with torsion) paratubal cyst structures (Fig 3, Fig 4). The patient was discharged three days after the operation.

CONCLUSION: The findings of our case suggested that although MRI may provide a useful preoperative evaluation in terms of the size and nature of mass as well as the accompanying changes, a high level of clinical suspicion was important for the correct diagnosis. Pathological evaluation is important for the extent of surgery to avoid unnecessary exploration.

Keywords: paratubal cyst, malignancy, laparoscopy

Fig 1: Preoperatif MR view,

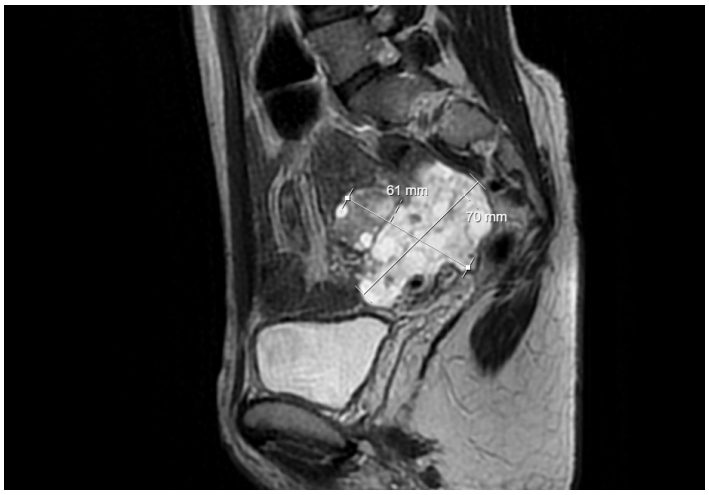


Fig 2: Laparoscopic view

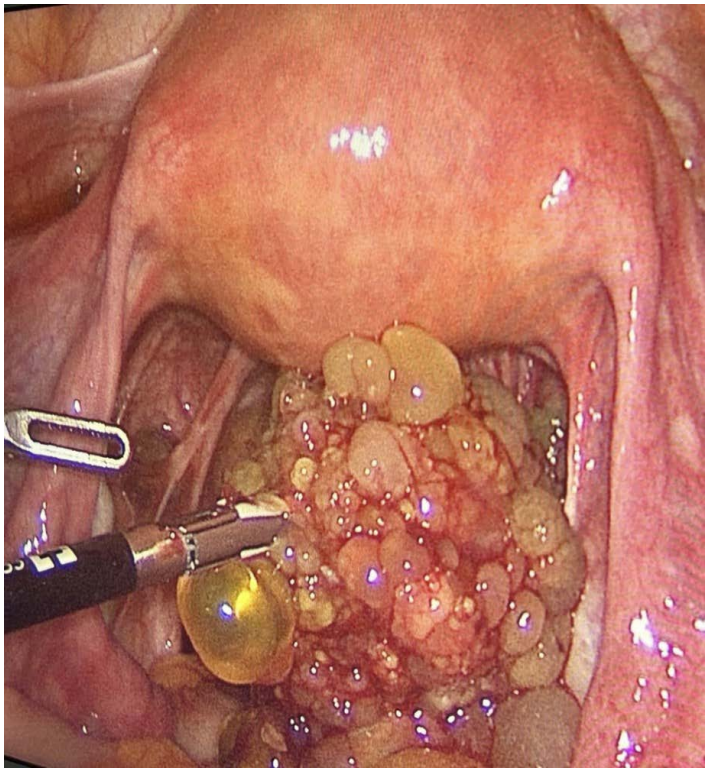


Fig. 3: Areas of necrosis and bleeding in cystadenoma

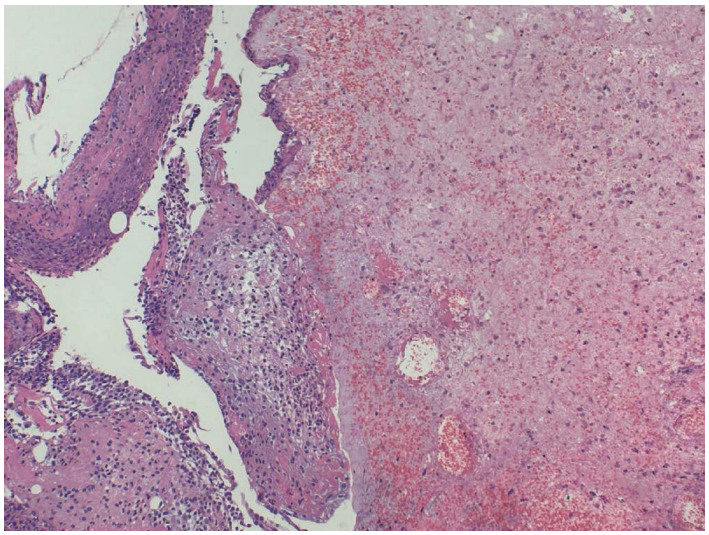
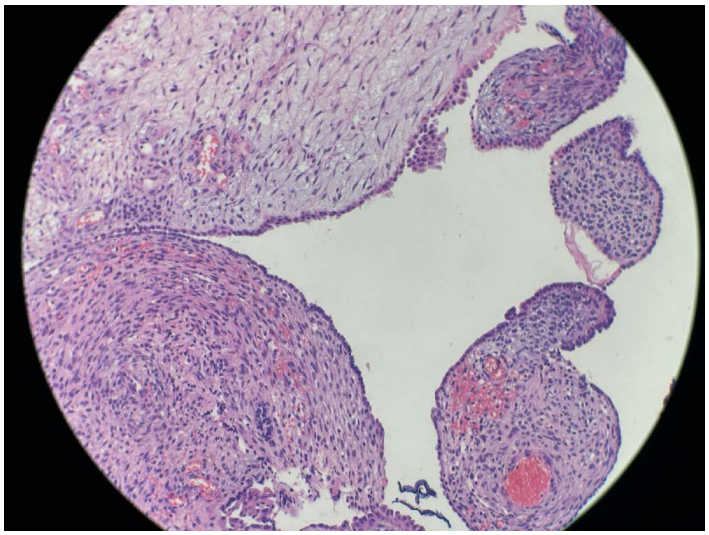


Fig4: Serous cystadenoma epithelium



OS-12

Acute abdomen presenting with adnexal torsion and sigmoid volvulus

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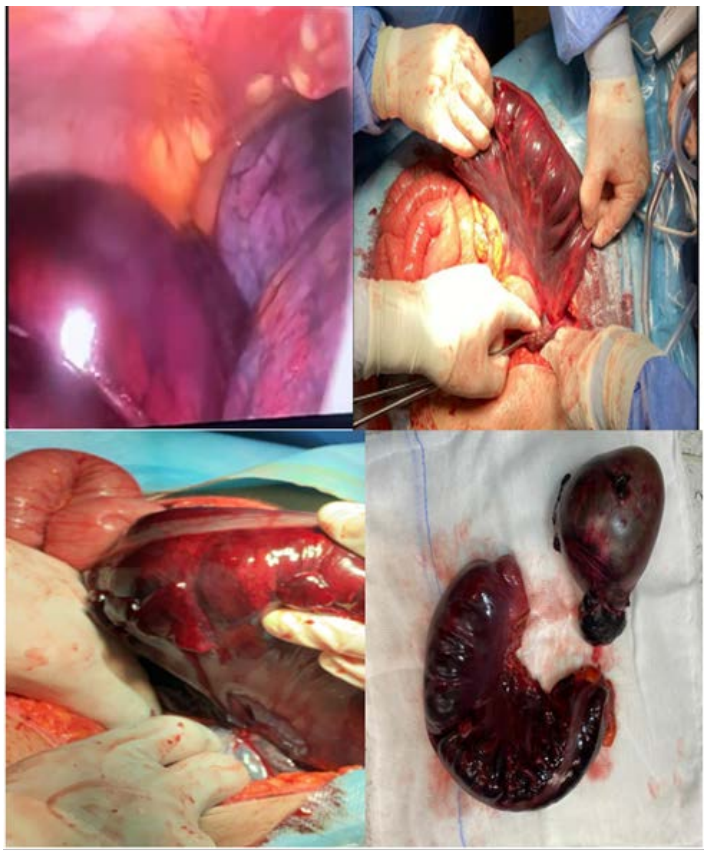
INTRODUCTION: Adnexal torsion occurs as a result of the rotation of the ovary around its supporting ligaments, the infundibulopelvic and utero-ovarian ligaments. It often leads to impaired blood flow. This condition is gynecologic surgery emergency. Volvulus is the bending of the intestine around the axis of blood flow. In the case of sigmoid volvulus, the twist occurs at the base of the sigmoid mesentery. Sigmoid volvulus is the most common type of volvulus of the colon. Sigmoid volvulus is an emergency for general surgery.

CASE: The 17-year-old patient was admitted to the emergency department with severe abdominal pain, nausea, vomiting and profound anemia that lasted for about six hours. Later, abdominal ultrasound revealed an adnexal mass in her right ovary. The patient who requested gynecologic consultation was evaluated. Doppler ultrasound showed that there was no blood flow in the ovary and ovarian torsion. An emergency operation was decided. When the abdomen of the patient was explored with laparoscopy, it was observed that the size of the right ovary increased, and it was observed that it rotated around the infindibulopelvic ligament three times. In addition, the sigmoid colon was thought to be torsioned and increased in size. The pelvis could not be visualized clearly due to the colon with a discarded. Uterus and left ovary could not be clearly evaluated. It was decided to explore the patient by laparotomy. The abdomen was entered through a vertical incision. The right ovary was detorsioned, but since its color and blood supply did not improve, right salpingooophorectomy was performed. General surgeon perop was involved in the case. Resection was performed on the torsioned part of the sigmoid colon. Then end-to-end anastomosis was performed. The patient did not develop complications in postoperative follow-up 5. He was discharged with healing on the day. (Figure 1)

DISCUSSION: Adnexal torsion is a gynecologic surgical emergency, which can be difficult to diagnose. If alternative diagnoses have been ruled out and clinical suspicion remains, diagnostic laparoscopy is the next best step. This can cause a number of symptoms, including severe pain when blood flow is disturbed. This is a true surgical emergency that, if not diagnosed promptly, can lead to necrosis, ovarian loss, and infertility. Sigmoid volvulus is a condition that needs to be managed urgently in terms of general surgery. Patients can present with a wide range of clinical conditions: from asymptomatic to open peritonitis secondary to colon perforation. These patients usually need immediate treatment, such as endoscopic decompression of the colon or anterior colectomy. Open or laparoscopic surgery is the mainstay of the treatment of sigmoid volvulus, except in some cases where conservative treatment is prioritized (e.g., patients who are not suitable for surgery). In our case, these two emergencies were followed together. Therefore, a multidisciplinary approach should be taken to acute abdominal conditions. The pelvis should not be considered isolated. Upper abdominal and other general surgery emergencies should be considered.

Keywords: Adnexal torsion, Sigmoid vulvulus, Acute abdominal pain

Figure 1: Laparoscopy and abdominal surgery images of adnexal torsion and sigmoid volvulus.



OS-13

Lateral sinus vein thrombosis after cesarean section

Hatun Çolak, Erdal Şeker
Osmaniye State Hospital, Osmaniye

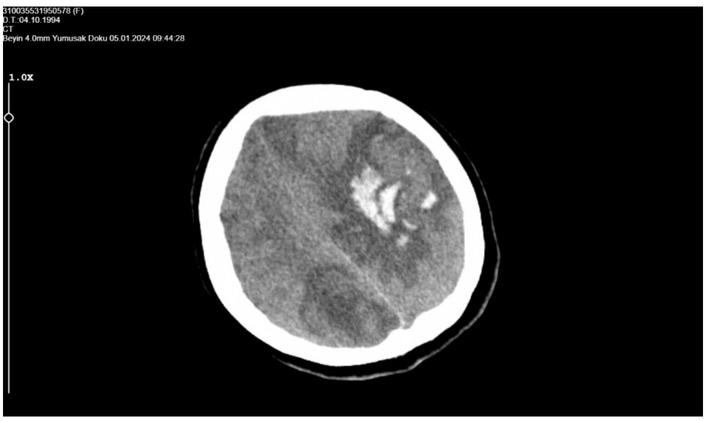
29 years old G3P1Y1A1 (C/S) 38w4d pregnant, elective caesarean section was planned. A live female baby weighing 3100 grams with an Apgar score of 8/9 was delivered by cesarean section under spinal anesthesia. The patient, whose follow-up was stable, left the hospital by signing voluntarily at the 30th postoperative hour. antibiotics, enoxaparin iron and analgesic medications were given. Preop hb/htc:9.3/29 plt:262.000 tit: negative alt/sub: 6/14 TA:110/60, postop hb/htc:9.3/30 plt:194.000. On the 4th postoperative day, she applied to the emergency room with complaints of fainting and seizures.

CT taken in the emergency room; The third and lateral ventricles are slightly prominent.

Intraparenchymal hemorrhages and white matter edema were observed in an area of approximately 83x45 mm at the vertex level on the left. Minimal midline shift was observed from left to right at the vertex level. In the CT scan taken on the 12th day of hospitalization, there was regression in the hyperdense areas observed in the evaluation performed with the previous CT scan. A line suggesting an asymmetric fracture was observed at the posterior level of the mastoid cell in the right temporal bone (Fracture? Separation in the suture line?). In the CT scan taken on the 20th day, possible parenchymal hematoma areas containing large-sized heterogeneous diffusion restriction areas were observed in the right parietal and left frontoparietal. Focal diffusion restriction areas were also observed at the level of the temporal horn of the left lateral ventricle. Mr venography; Both transverse sinuses in the lateral section and the sigmoid sinus are partially excluded from the examination. In the included sections; The right transverse sinus is hypoplastic. It could not be followed exactly in a focal area, it may be secondary to hypoplasia. According to the venous thromboprophylaxis risk criteria, we gave our patient enoxaparin for prophylaxis. We wanted to emphasize the importance of venous thrombophrophylaxis risk assessment in this case.

Keywords: Lateral sinus vein thrombosis, pregnancy, venous thrombus

control CT



control CT on the 2nd day of hospitalization

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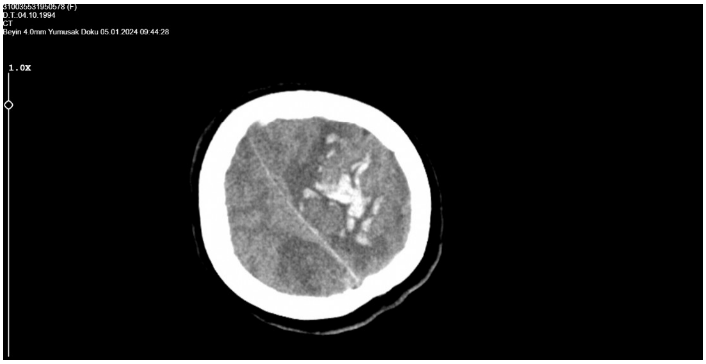

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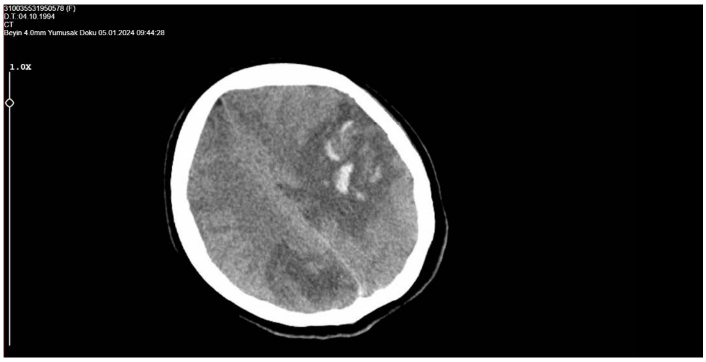

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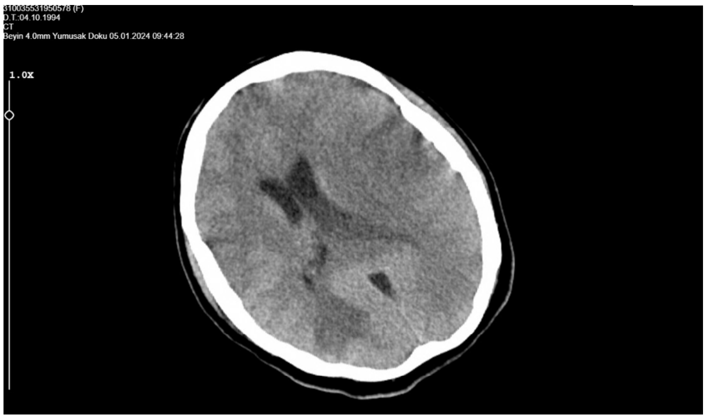
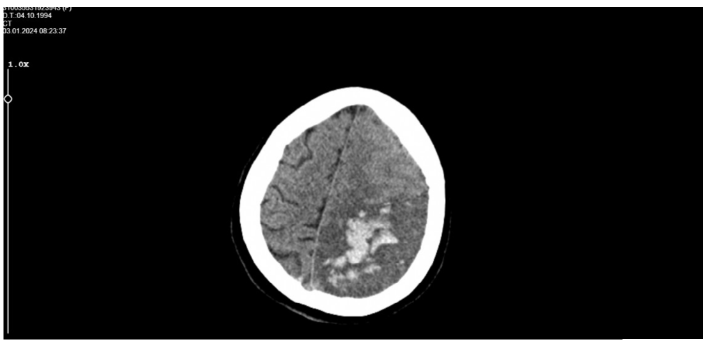


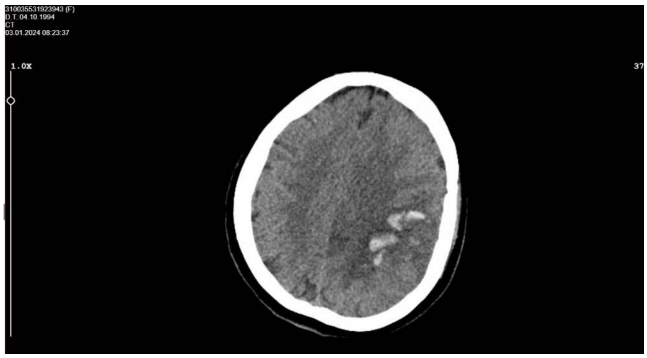
control CT on the 2nd day of hospitalization

CT in emergency application



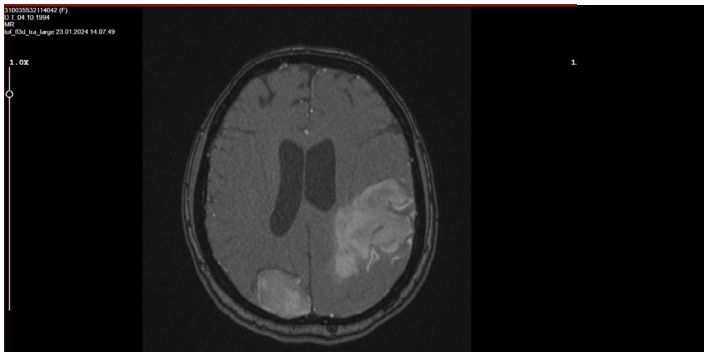
CT in emergency application

CT in emergency application



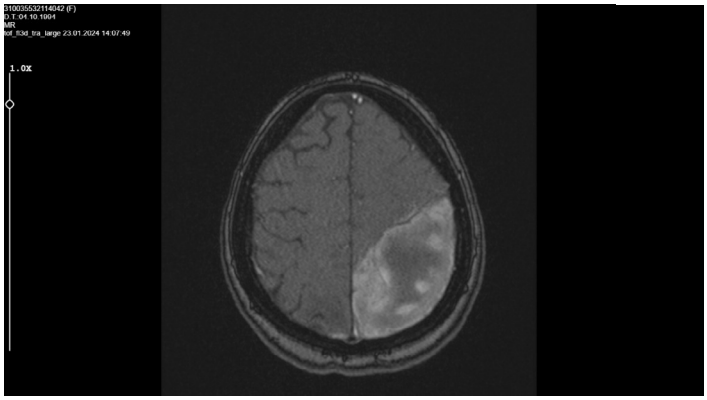
CT in emergency application

Diffusion MRI



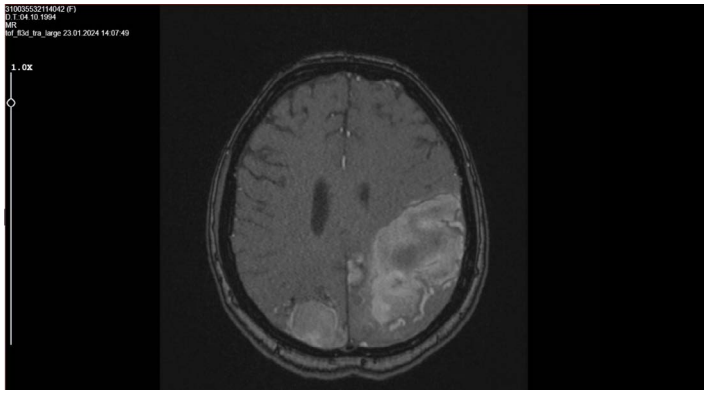
Diffusion MRI image on day 20

Diffusion MRI



Diffusion MRI image on day 20

Diffusion MRI



Diffusion MRI image on day 20

OS-14

Rudimentary horn excision with minimally invasive surgery, case report

Elif Ayaz, Erbil Karaman, Onur Karaaslan, Çağrı Ateş, Latif Hacıoğlu
YYÜ DURSUN ODABAŞ TIP MERKEZİ

Congenital uterine anomalies(CUA) are a wide-spectrum condition that presents with symptoms such as pelvic pain, prolonged and abnormal menstrual bleeding, recurrent pregnancy losses or preterm birth. It is caused by congenital developmental disorder of the Müllerian duct. It is considered polygenic and multifactorial(1). While its prevalence in society is accepted to be around 3-5%, the anomaly rate is higher in groups with a history of infertility, recurrent pregnancy losses and preterm birth.(2) Since there is no universal classification, uncertainties continue regarding diagnosis, treatment and evaluation of response to treatment. The three main mechanisms for abnormal uterine development are agenesis/hypoplasia, defective lateral fusion and defective vertical fusion.

The obstructed hemiuterus may be completely separate from the nonobstructed unicornuate uterus or it can be fused to it.(3) Intraoperative canalization of the single cervix and injection of blue dye will confirm which uterus communicates with the cervixUltrasound imaging will help to determine whether a hemiuterus with endometrium is present on the side opposite the unicornuate uterus. If sonographic findings are uncertain, we have found magnetic resonance imaging to be helpful.Patients with a noncommunicating uterine horn, functional endometrium on imaging studies, and pelvic pain In addition to symptomatic relief, excision of an obstructed rudimentary blind horn will eliminate reflux, which has been associated with remission of endometriosis, and will eliminate the risk of pregnancy implantation in the obstructed uterine horn (4). Our aim in this case report is to emphasize the importance of minimally invasive surgery in uterine horn excision.

Keywords: Congenital müllerian anomalies, Müllerian duct, pelvic pain

Case

An 18-year-old patient applied to the outpatient clinic with the complaint of cyclic abdominal pain and dysmenorrhea. The patient's pain started 2 days before menstruation and went away when menstruation ended. An unicornuate uterus was observed in the ultrasonography. Bilateral ovaries were evaluated as normal. Non-communicating rudimentary horn was observed in the MRI taken to explain the cyclic pain. Laparoscopic rudimentary horn excision was planned for the patient. The non-communicating rudimentary horn was excised by hemihysterectomy. The left rudimentary horn and left tuba uterina were excised and sent to pathology. The retroperitoneum was opened and the ureter was observed to be normal. Surgery was terminated without complications developed.

Keywords: cyclic abdominal pain, laparoscopic, ureter

Discussion

Anatomic correction can be effective in some CUA's, but in others uterine vascularization and myometrial and cervical function may remain abnormal and prevent the desired functional outcome. Surgery can be effective in patient with septate uterus or bicornuate uterus with recurrent pregnancy loss and unicornuate uterus with cyclic or noncyclic pain. In patients with unicornuate uterus and pelvic pain. Laparoscopy should be accepted as the gold standard in the diagnosis and excision of rudimentary horn. In these cases(5), laparoscopic excision should be the first choice to reduce the complication rate and accelerate recovery.

Keywords: cyclic abdominal pain, laparoscopic, ureter,Congenital müllerian anomalies, Müllerian duct, pelvic pain

OS-15

Prenatal diagnosis of fetal lymphangioma; A RARE CASE

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Prenatal diagnosis of fetal lymphangioma; A RARE CASE

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Department of Obstetrics and Gynecology, Ondokuz Mayıs University School of Medicine, Samsun/ Turkey

INTRODUCTION: Fetal lymphangiomas are benign hamartomatous tumours and characterized by the appearance of a uni-or multi-septate cystic mass.They are considered a rare congenital malformation, occurring in 0,8-18in every 6000 live births.It is associated with a 2% rate of additional structural or karyotype abnormalities.These lesions can develop in any part of the body where lymphatic vessels are present;However,they are frequently seen in the neck region (75%) On ultrasonography,they appear as thin-walled,multi-septated,multicystic and hypoechoic masses.

CASE: A 22-year-old pregnant woman,gravida1,underwent an ultrasound examination at 37 weeks' gestation.The patient was referred to our center at approximately 36 gestational weeks with the preliminary diagnosis of a mass in the fetal neck.It was verbally learned that first trimester screening test was low risk for aneuploidy,no gross pathology was observed on the second trimester anatomical scan.The examination revealed a78*43*47 mm multi-septated cyst at the left side of fetal neck extending to left shoulder as presented in Figure 1A.Color Doppler showed that there was no flow in the cystic mass.No additional anomalies other than polyhydramnios were observed in third trimester ultrasonography.Abnormal fetal Doppler findings and hydrops were not observed.Weekly follow-up was performed with the preliminary diagnosis of fetal lymphangioma.The woman underwent planned cesarean delivery at 39 weeks of gestation and a 3440 gr sized male infant was delivered with APGAR score of 8 and 9,at 1st and 5th minutes,respectively.There was no need for an ex utero intrapartum treatment (EXIT) procedure.Postnatal view of the newborn, a63*58*36 mm lesion with septations located under the trapezius muscle on the left side of the neck was observed,which was thought to be lymphangioma in the foreground without contrast enhancement (Figure B-C).

Figure(A) Sagittal scan at the left nuccal cystic lymphangioma of a fetus at 37 gestational Figure(B) Corresponding neonatal appearance.

Figure C Appearance of nuccal cystic lymphangioma at MRİ In case,no numerical or structural anomaly was detected in the postnatal genetic evaluation by G-banded standard karyotyping,awaiting results of microarray evaluation.The current condition of the patient is evaluated in a multidisciplinary council by Pediatric Surgery-Interventional Radiology-Pediatric Oncology.In its current state (no compression symptoms, no difficulty in swallowing, no difficulty in breathing), a conservative follow-up decision taken.

DISCUSSION: Here,we report a rare case of septated fetal lymphangioma on the left side neck.About 70-80% of cystic hygromas occur in the neck while the remaining 20–30% of the tumors occurs in the axillary region and other rare locations. It is known that accurate prenatal diagnosis and regular monitoring of foetuses with lymphangioma can improve the prognosis and help prevent

serious complications.Prognosis is favourable,unless there is associated cardiac failure, hydrops or high airway compression.In our case, cardiac failure and hydrops fetalis did not occur during prenatal follow-up. In conclusion,prenatal diagnosis and regular monitoring of fetuses with lymphangiomas can help prevent serious complications.Prenatal findings can help doctors choose the best mode and timing of delivery-,as well as the appropriate treatment for fetuses and newborns.

Keywords: Fetal malformation,tumors,prenatal diagnosis

figure B

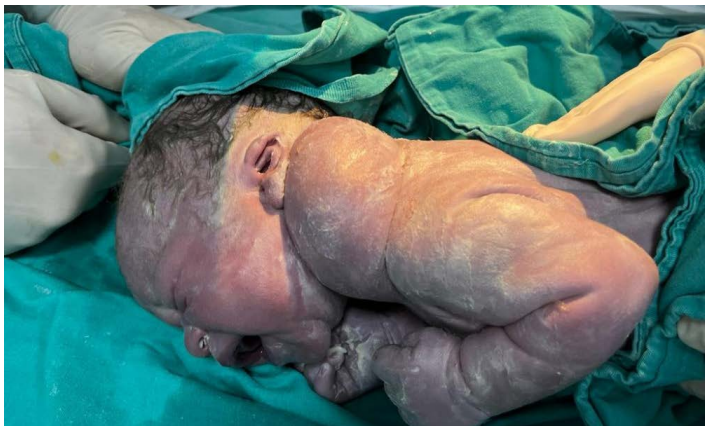


figure C

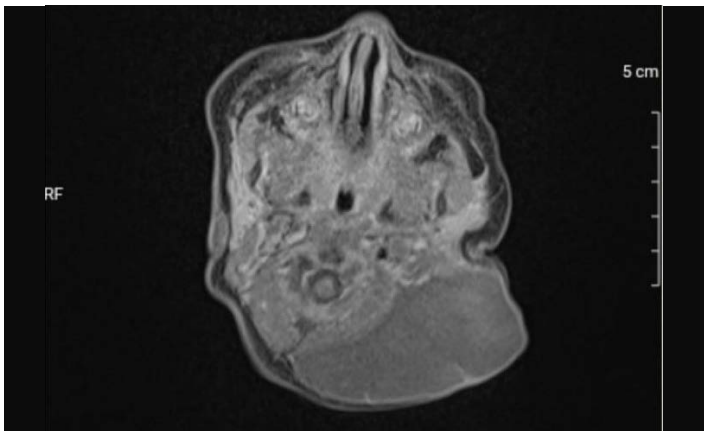
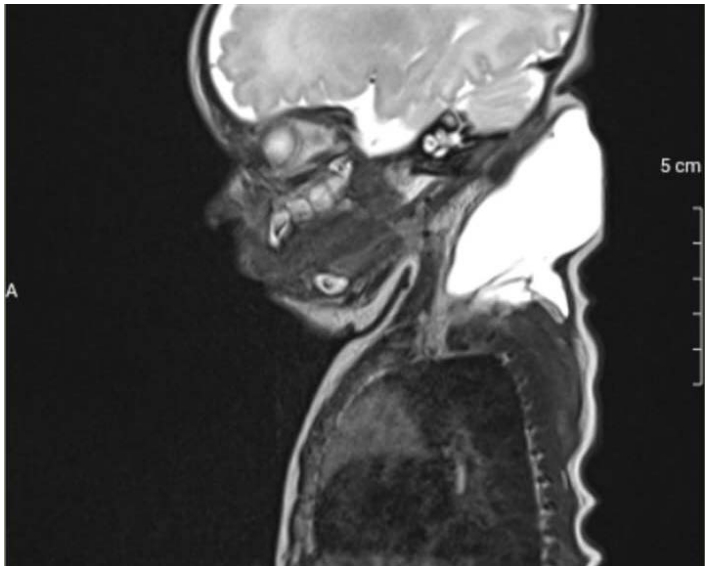


FİGURE C



OS-16

Fetal sacrococcygeal teratoma: A case report

Şule Ütü, Ayşe Zehra Özdemir, Hüseyin Ekici
Depertment of gynecology and obstetrıcs, Ondokuz Mayıs University Samsun,Turkey

Indroductıon: Teratomas are the most commonly encountered germ cell tumors. They consist of one or more embryonic layers and contain tissues that do not conform to their anatomical location. In fetuses and newborns, the most commonly observed region for teratomas is the sacrococcygeal area.Sacrococcygeal teratomas occur in one out of every 35,000-40,000 live births.Fetuses with sacrococcygeal teratomas carry a high risk for perinatal morbidity and mortality.Prenatal ultrasonography, as in prenatal diagnosis, is also important for monitoring tumor size, early detection of complications, and determining the appropriate time and method for delivery.

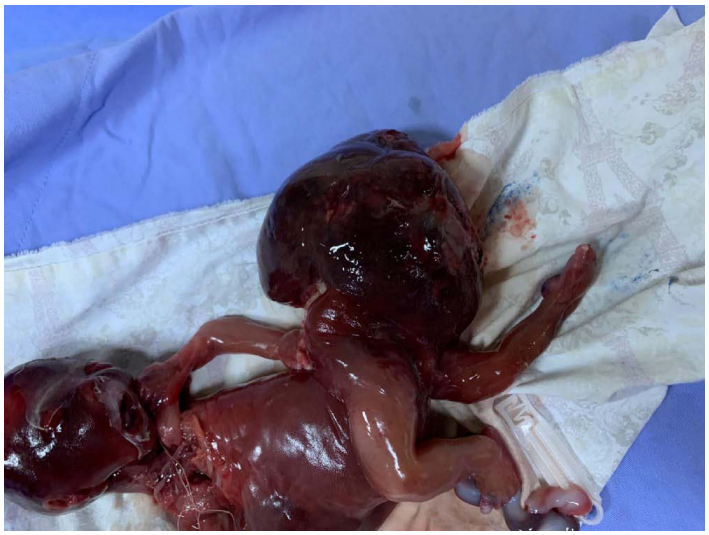
We aimed to present a case of sacrococcygeal teratoma diagnosed during the prenatal period, with termination decided due to the unfavorable prognosis.

CASE: A 29-year-old, G2P1 pregnant woman at 19 weeks gestation was referred to our clinic due to a mass detected in the sacrum on an external ultrasound examination. The patient has no known additional medical conditions.On obstetric ultrasound, a solid appearance consistent with an increased vascularization teratoma, extending into the fetal pelvis, with cystic areas measuring 76*71*52 mm in the fetal sacrococcygeal region, was observed. Evaluation of the lower extremities revealed pes equinovarus deformity in the right lower extremity.Fetal echocardiography was within normal limits, and no evidence of hydrops or polyhydramnios was observed.On MR evaluation, a space-occupying lesion with smooth lobulated contours, measuring approximately 87x88x71 mm in the sacrococcygeal region, extending intrapelvically towards the right lateral aspect of the bladder, and containing solid and cystic components, was observed.Amniocentesis was performed, and a normal karyotype was observed.Due to the unfavorable prognosis, termination of pregnancy was recommended, and a male fetus weighing 645 grams was aborted Dıscussion:Sacrococcygeal teratoma (SCT) is of germ cell origin and is the most commonly encountered fetal tumor.In patients with sacrococcygeal teratoma, other anomalies may accompany at a rate of 15%. These include imperforate anus, sacral bone defect, duplication of the uterus or vagina, spina bifida, and meningomyelocele.In our case, an additional anomaly of pes equinovarus deformity was observed in the right lower extremity.The diagnosis of SCT can be made during the prenatal period with ultrasound. The main criteria to be observed on ultrasound during tumor monitoring include tumor size, growth rate, tumor structure, presence of polyhydramnios, placental enlargement, and signs of heart failure.In some cases, MRI imaging is recommended. Compared to sonography, MRI more accurately characterizes the intrapelvic and abdominal dimensions of the tumor and compression of adjacent organs, aiding in preoperative planning for prenatal counseling and surgical resection.Prenatal diagnosis and close monitoring have improved outcomes for fetal SCT, but overall perinatal mortality remains high.Predictions of perinatal mortality for prena-

tal diagnosed SCT range from 25% to 50%, including cases of pregnancy termination, intrauterine death, and neonatal death.Potential perinatal complications include preterm birth, spontaneous tumor hemorrhage or rupture, and maternal Mirror syndrome.SCT continues to be a rare event. Accurate prenatal diagnosis is crucial for both prenatal and postnatal management as well as subsequent pregnancies. Additionally, identifying prognostic factors is necessary to optimize the management of prenatally diagnosed SCTs.

Keywords: sacrokoksigeal teratoms,neural tube defect,case report, fetal mrı

sakrococsigeal teratoms ultrasonografi



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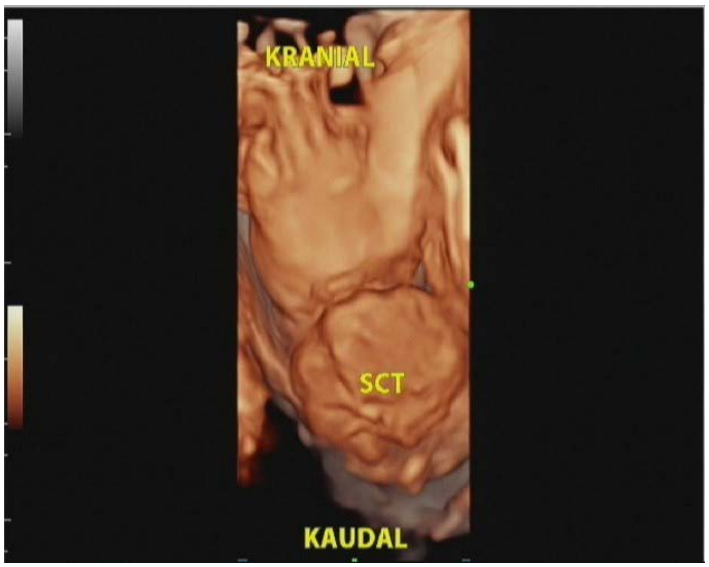

OS-17

Removal of large scar endometriosis: a case report

Ülfet Sena Metin, Cemre Alan, Ali Acar
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Introduction

Endometriosis is a condition in which the endometrial gland and stroma exhibit ectopic function outside the uterine cavity. Surgical scar endometriosis is a subtype of extrapelvic endometriosis. In patients who have previously undergone surgery, endometrial tissue has formed close to the incision area. Symptoms are nonspecific and variable for each patient. Scar endometriosis patients classically present to the hospital with cyclic pain and maybe bleeding at the scar site that manifests itself during the menstrual period.

Method

In this case report, consent was obtained or waived from our patient. We present a 45-year-old woman who presented to our center with abdominal pain and a palpable mass at the old incision The patient reported cyclic abdominal pain and bleeding at the incision site. After the examination, the history and the tests, it was thought that the mass was a scar endometriosis. During surgery, a 9X5 cm scar endometriosis lesion with skin, subcutaneous, fascia and rectus muscle invasion was observed. The surgical scar endometriosis lesion was dissected and excised from the surrounding tissue. A hemovac drain was placed in the rectus muscle. The patient was discharged on postoperative day 1 without complications. The final pathology result was interpreted as endometriosis externa.

RESULTS: Bleeding and pain at the incision site are not always present. In some cases, such as our patient's, they can occur with every menstrual period. Healthcare professionals should be cautious when diagnosing due to the wide range of symptoms. A review of the literature indicates that the average size of surgically removed endometriosis tissue is 4.5 x 3.5 cm. In contrast, the endometriosis lesion removed from our patient measured 8.5 cm. This case is noteworthy due to the larger size of the lesion compared to what is typically reported in the literature.

CONCLUSION: Our aim in presenting this case is to draw attention to the awareness of large scar endometriosis, specifically extrapelvic endometriosis, which presented in the form of giant scar endometriosis.

Keywords: cyclic pain, large scar endometriosis, scar endometriosis

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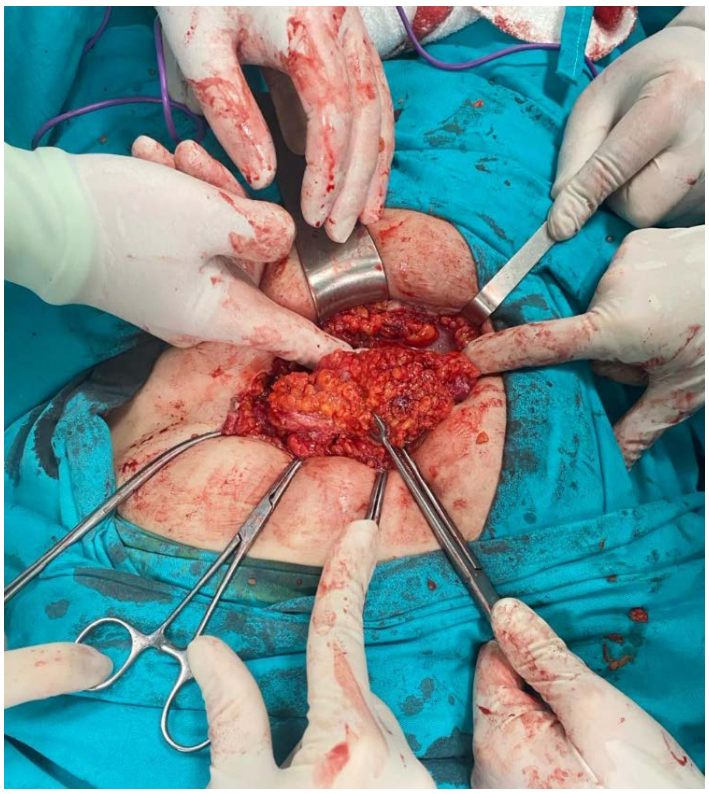

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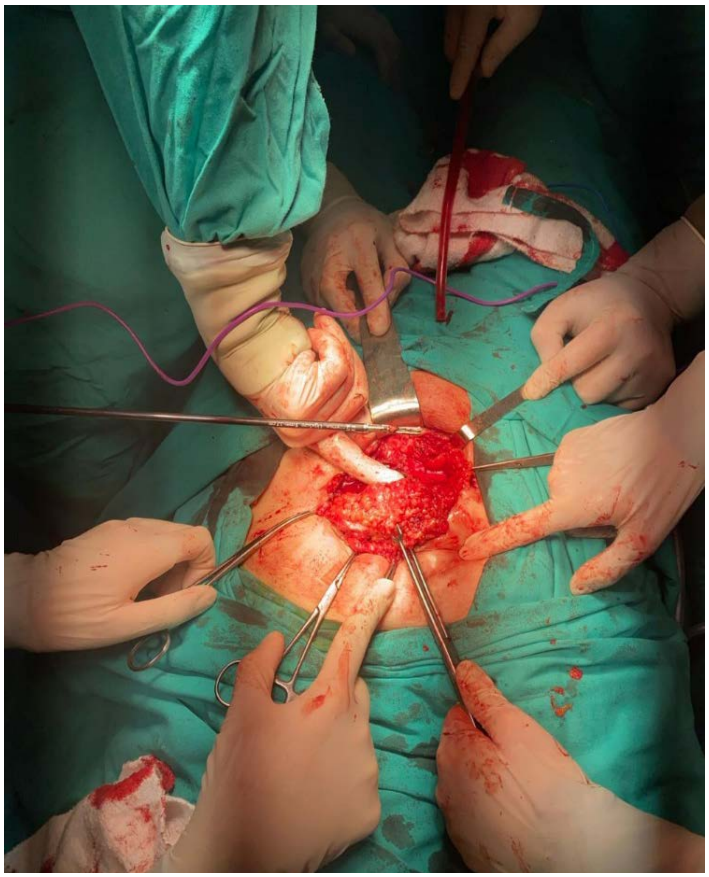

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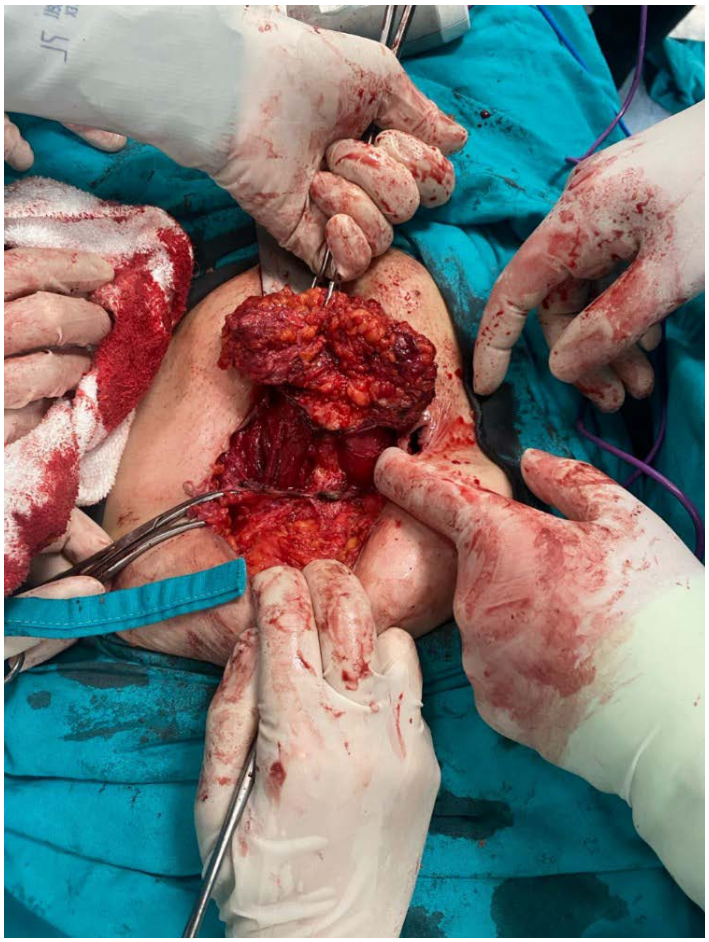

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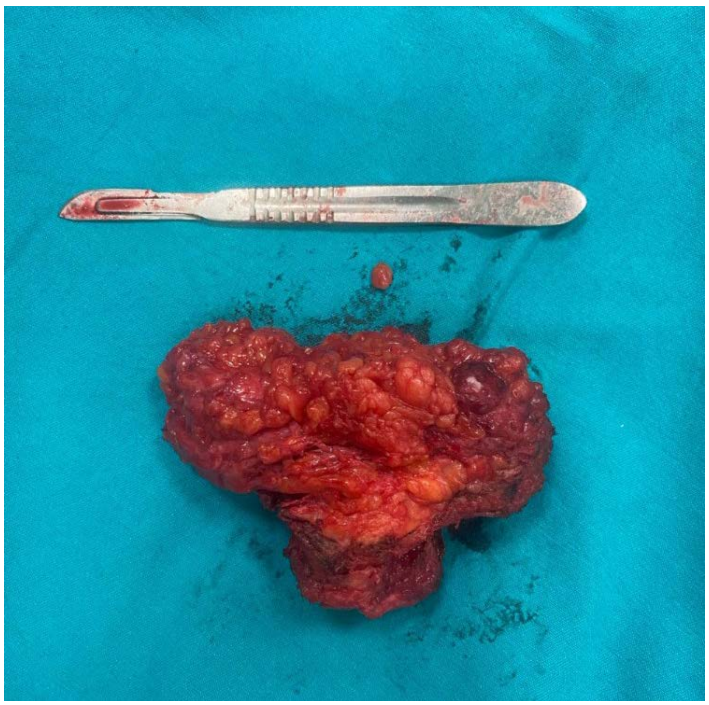

çıkarılan kitlenin final görüntüsü

OS-18

Management of thyroid papillary cancer in in-vitro fertilization pregnancy: the uncertainty

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OBJECTIVE: Thyroid cancer is the most common endocrine cancer and accounts for 1-4% of all cancers. On average, 5% of thyroid nodules develop cancer. It is approximately four times more common in women than in men. In Turkey, thyroid cancer is the second most common cancer in women after breast cancer. The most common type of thyroid cancer among young women is papillary, and in 10% of these cancers, patients are pregnant or postpartum at the time of diagnosis. Although the prevalence of thyroid papillary cancer is high among pregnant women, the first diagnosis is usually made in the postpartum period. The management of the diagnosis and treatment of thyroid cancer during pregnancy represents serious risks for both the patient and the fetus. The fact that the thyroid gland usually secretes more hormones in early pregnancy may be responsible for the increased rate of differentiated thyroid cancer during pregnancy. Treatment of thyroid cancer during this period includes surgical or medical therapy and follow-up until delivery.

METHODS: Decisions about surgical and medical treatment of thyroid cancer in pregnant women with viable fetuses are ethically problematic. Publications have often reported a conflict between optimal maternal treatment and fetal health. Thyroidectomy is frequently performed in this patient group during the second trimester. Since the data on non-operated patients are limited, we aimed to present this case from this point of view. RESULTS: A 38-year-old patient, who was married for 16 years and had a diagnosis of habitual abortion, was followed up for pregnancy after in-vitro fertilization(IVF). A thyroid biopsy performed in the prenatal period with complaints of hoarseness, difficulty in swallowing, and shortness of breath revealed thyroid papillary carcinoma. Thyroidectomy was postponed due to IVF pregnancy, early-stage carcinoma, and upon the request of the patient with the opinion of the relevant branch. Antenatal follow-up revealed polyhydramnios, skin striae, and diffuse pigmentation after 32 weeks. At 37 weeks of gestation, she was hospitalized for induction of labor due to rupture of membranes. The patient was then taken to a cesarean section with the indication of fetal distress. A 3350 g, 8/10 Apgar female baby was born. No fetomaternal complications were observed. Thyroidectomy was performed at the 6th month postpartum after the baby was started on supplementary food. Radioactive iodine treatment was administered after the lactation period.

CONCLUSION: Due to the increasing incidence of infertility and late marriages, the likelihood of cancer in the prenatal period is increasing in pregnancies at advanced maternal age. In a case of unoperated thyroid papillary carcinoma in pregnancy, late-onset severe polyhydramnios with accompanying skin pigmentation and striae were remarkable. Similar case series may be instructive for the collection of data that can be evaluated as predictive markers.

Keywords: In vitro fertilization, Papillary thyroid carcinoma, Pregnancy, Prognosis, Thyroid cancer

OS-19

Prenatal diagnosis of Milroy's Disease

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INTRODUCTION: Nonne-Milroy disease, referred as Primary Congenital (Familial) Lymphedema type 1 (PCL), presents with lower extremity lymphedema starting usually at infancy. It commonly affects the dorsum of the foot and may present as pedal edema limited to the toes and foot or may involve the entire lower extremity. It is inherited in OD manner and is a lifelong condition. Mutations in the FLT4 gene, which encodes VEGFR3 (vascular endothelial growth factor receptor 3) results in dysgenesis of microlymphatic vessels. It has an incidence of 1 in 33,000 individuals.

We present a prenatal diagnosis of a 27 weeker fetus who presented with bilateral pedal lymphedema extending below the knee, with no other major malformations. Prenatal genetic diagnosis was confirmed.

Case Presentation

A 35-year-old multigravid woman, at 27+1 weeks of gestation, underwent ultrasound evaluation due to fetal extremity abnormalities. Biometric measurements were consistent with gestational age, and amniotic fluid index measured 15cm. Bilateral fetal lymphedema, approximately 4.8mm thick, was observed on the dorsal surface of the feet extending to the knees. Detailed obstetric examination found no other malformations or amniotic band. The umbilical cord contained 3 vessels, with no signs of hydrops.

The mother has insignificant medical history. TORCH infection screening yielded negative results. First-trimester aneuploidy screening indicated low risk. The couple had no consanguinity. The father reported congenital lymphedema limited to the dorsal aspect of his right foot. There was no known family history of lymphedema or hydrops. The first child in the family had no lymphedema or other pathology.

Genetic analysis via cordocentesis at 27+1 weeks of gestation revealed a normal karyotype in the fetus. Microarray analysis showed an arrhg19x2 result. WES analysis identified the FLT4 (NM_182925.5) c.2828G>C(p.Arg943Pro) variant as homozygous in the fetus, classified as "Damaging–Deleterious". There is no ClinVar database entry for this variant. Literature and database studies suggested it to be "likely pathogenic". Given the father's unilateral congenital lymphedema, a preliminary diagnosis of fetal Milroy disease was made via prenatal diagnosis. The FLT4 gene is linked to autosomal dominant inheritance in disorders like "Lymphatic malformation 1" and "Congenital heart defects, multiple types, 7". Affected individuals may exhibit lymphedema (particularly in the lower limbs), nail and skin alterations, hemangiomas, and cardiac abnormalities. Severity varies, and non-hydropic fetalis is rare.

At term, the baby weighed 3300 grams. At birth, 5 mm pedal lymphedema and a left lumbar hemangioma were detected. At

the 15-month follow-up, minimal lymphedema with underlying lipomatous tissue was observed, along with slight enlargement below the knees, particularly affecting the dorsal aspect of the feet. The patient's shoe size was 2 sizes larger than peers, with no other complaints or findings. The hemangioma had reduced in size and was millimetric.

CONCLUSION: The diagnosis of congenital anomalies can be made prenatally through ultrasound examination. When such a situation is encountered, it is essential to thoroughly inquire about the family history and, if necessary, examine the parents as well. Many congenital genetic anomalies can be diagnosed prenatally using Whole Exome Sequencing (WES).

Keywords: Nonne-Milroy disease, Pedal Lymphedema, Prenatal diagnosis, Primary Congenital Lymphedema type 1, Whole Exome Sequencing

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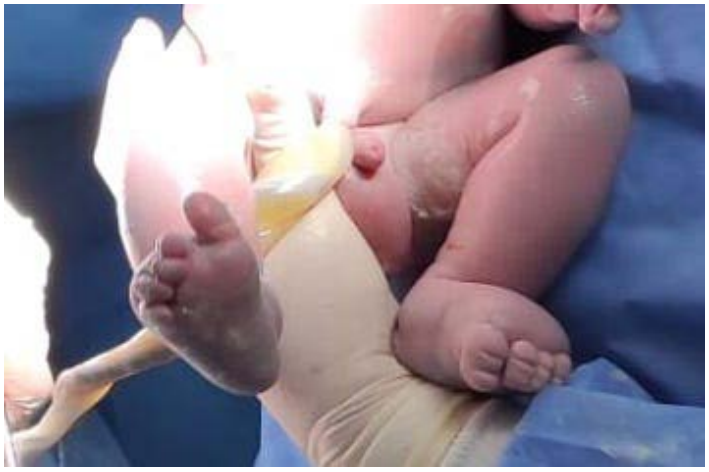

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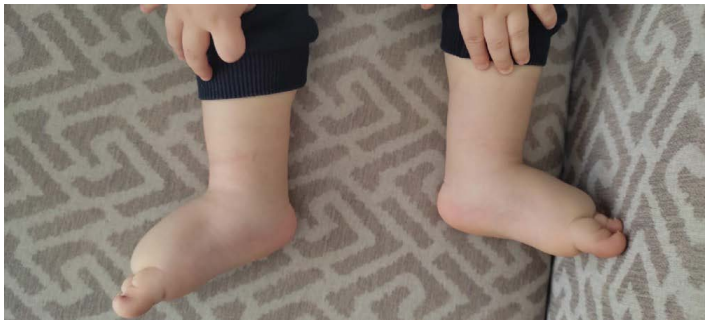

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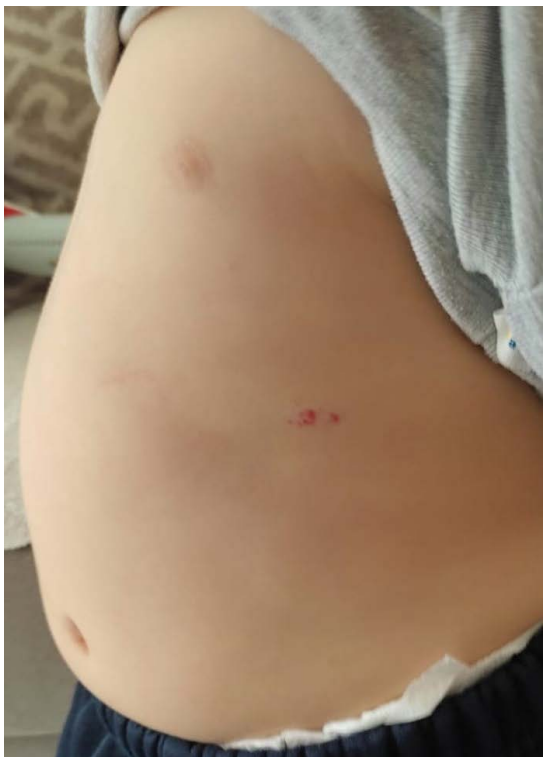

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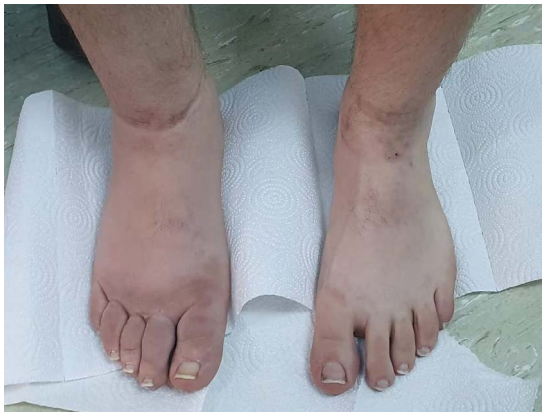

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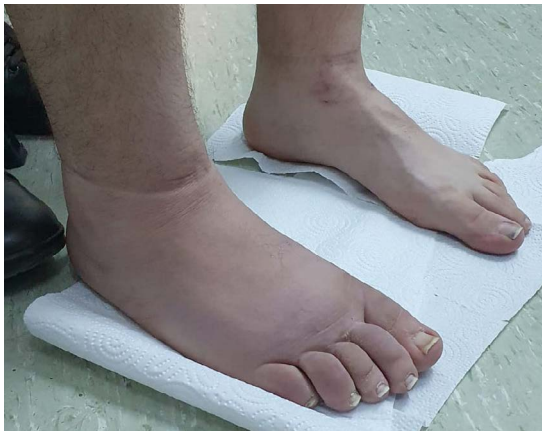

Baba, ayak ve bacaklar, yan

OS-20

Gliomatozis peritonei in 17 years old girl with immature ovarian teratoma: A case report

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A 17-year-old patient was operated with the indication of adnexal mass. Omentum was attached to the side wall of the abdomen, therefore partial omentectomy was performed. Omental biopsy result was reported as gliomatosis peritonei. The pathology result of the right oophorectomy material was reported as grade 1 immature teratoma. Since the treatment of gliomatosis peritonei was performed according to the degree of immature teratoma, the patient was followed up without additional treatment.

This case report aims to describe the process of diagnosis and treatment of gliomatosis peritonei with immature teratoma. Gliomatosis peritonei refers to the implantation of glial tissue on the visceral and parietal peritoneal surface, often associated with immature teratoma. Immature teratoma clinically presents as a large pelvic mass, primarily turning up in the first three decades. Immature teratomas show an increase in many serum tumor markers; for example, there may be an increase in Ca125 and alpha-fetoprotein (AFP)

A 17-year-old patient presented with complaints of abdominal distension, nausea, vomiting and abdominal pain. On physical examination, all the vitals were stable. On pelvic ultrasound, a mass of approximately 30 cm with cystic, calcific and solid components extending from the pelvic region to the epigastric region was observed. Although it is not known from which ovary the mass originated, the uterus was normal. The patient underwent pelvic magnetic resonance imaging (MRI). In pelvic MRI, a 28x18x11 cm mass with cystic, calcific and solid components, thought to originate from the right ovary extending from the pelvic region to the epigastric region, was observed and was evaluated in favor of a malignant lesion. Ca125 value was 572 U/ml (normal range < 35 U/mL) and ca19-9 value was 2048 U/ml (normal range < 30 U/mL) were detected from serum tumor markers. The other tumor marker levels were in the normal range.

According to the comprehensive preoperative evaluation, malignancy was suspected and the patient was operated with the indication of adnexal mass. During exploration, approximately 30 cm solid mass originating from the right adnexa and extending over the umbilicus to the xiphoid was observed. No acid fluid was detected in the abdomen. The patient underwent laparotomy and right salpingoopherectomy was performed with the indication of right adnexal mass. There was no abnormality on the left ovary and fallopian tube. The right ovarian cyst was removed and the intraoperative frozen section result was reported as a germ cell tumor compatible with teratoma in the foreground. Since the omentum was adhered to the right adnexa and anterior abdominal wall, approximately 10 cm of omental tissue was excised. As a result of the final pathology, the mass in the right ovary was reported as grade 1 immature teratoma. The pathology result of the partial omentectomy material performed completely incidentally was reported as gliomatosis peritonei.

Keywords: immature teratoma,gliomatosis peritonei, grade

OS-21

A case of cardiomyopathy following caesarean section mimicking respiratory tract infection

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INTRODUCTION: Peripartum cardiomyopathy (PPCM) is a form of dilated cardiomyopathy that can lead to high maternal and infant mortality. Peripartum cardiomyopathy is seen between the last 4 weeks of pregnancy and the 5th postpartum month. In this case, we aimed to present a patient who presented with respiratory tract infection signs and was diagnosed with peripartum cardiomyopathy.

CASE: A 24-year-old primigravida patient, 41 weeks pregnant according to her last menstrual period, was admitted to our hospital with a complaint of shortness of breath. In the ultrasonographic examination, a single, alive fetus compatible with its gestational age was observed. Vaginal examination revealed 3 cm dilatation and 60% dilatation. The patient stated that she had been using antibiotics as treatment for an upper respiratory tract infection and shortness of breath for the past week.

In the second hour of hospitalization, she underwent emergency cesarean section due to fetal distress. A 3700g female infant was delivered with APGAR of 8-9. The patient's heart rate was 150-170 bpm and oxygen saturation was 70-75% at the 0th hour after surgery, so the patient was consulted to the pulmonology. The patient underwent thorax CT with contrast because of pulmonary embolism suspicion. In the thorax CT interpretation, no embolism was observed, but infective patches and ground glass densities were observed in the lower lobes of both lungs (imaging results compatible with COVID-19) (Picture 1). Her ECG showed normal sinus rhythm with troponin: 103 and d-dimer: 1.6 microgram/mL. Antimucolytic agents, steroids, anti-influenza treatment was added to the patient, who remained in the SO2: 75-80% band despite O2 treatment at the 4th postoperative hour. The Respiratory PCR panel result of the patient, who was transferred to the surgical intensive care unit, was negative. Her echocardiography result was as the following: SR 100/ MIN, EF 35%, global hypokinesia of left ventricle,moderate to severe mitral insufficiency,moderate to severe tricuspid insufficiency. With these results, the patient was transferred to coronary intensive care unit following the diagnosis of postpartum cardiomyopathy. In order to keep patient's prolactin level to low, milk inhibition was started with cabergoline 0.5 mg. After the follow up in the cardiology service for 5 days, care for cardiac insufficiency treatment was arranged and she was discharged.Patient's cardiology follow-up continues.

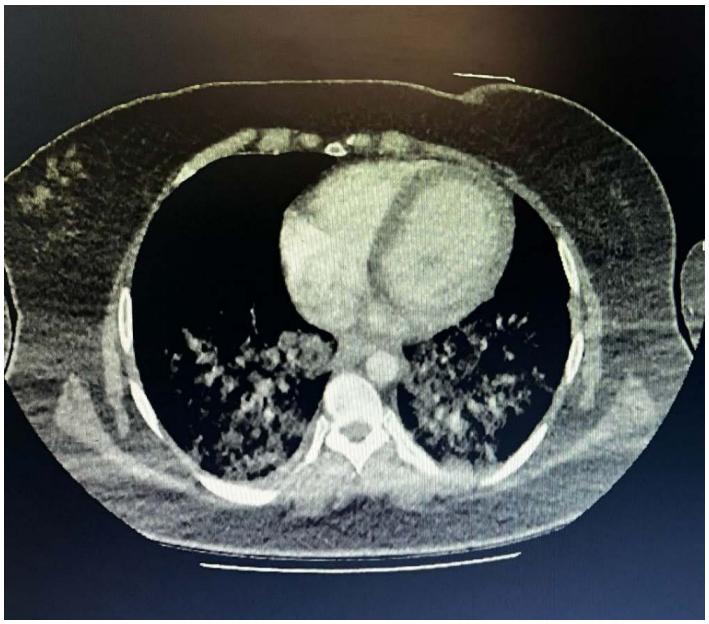
DISCUSSION: In patients with PPCM, the most common presenting complaints are shortness of breath (90%), weakness, palpitations (62%) and edema (60%). This patient also had the complaints of shortness of breath and cough, with this findings and results of imaging methods suggested Covid-19 infection, causing confusion for the right diagnosis.

Although the exact underlying cause is not clear many factors such as infections, myocarditis, immunological factors, oxida-

tive stress caused by prolactin are blamed. Reducing prolactin in milk inhibition with cabergoline is intended for treatment. CONCLUSION: Although peripartum cardiomyopathy is rare in pregnant women, it is a condition that should be kept in mind in symptomatic patients, considering that the risk of mortality is high for both mother and baby and early initiation of treatment improves the prognosis.

Keywords: Covid-19, peripartum cardiomyopathy,shortness of breath,

Figure-1



OS-22

Preconceptional laparoscopic cervicoisthmic cerclage: A Case Report

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Objectives

Transvaginal cervical cerclage (TVC) is a procedure where a tape is placed on the cervix to create a mechanical effect to prevent the cervix from opening too early during pregnancy. When TVC fails, laparoscopic transabdominal isthmo-cervical cerclage (TAC) may be recommended. In this study, our aim was to report the effect of preconceptional laparoscopic TAC in a case of failed TVCs due to cervical insufficiency.

METHODS: A 36-year-old patient, gravida 8, parity 0, abortion 8, was admitted to our clinic with a history of cervical insufficiency. In her first pregnancy, a missed abortion occurred at 8 weeks. Other miscarriages occurred in the second trimester. The patient had one failed conceptional prophylactic and two failed emergency TVCs. The patient's two pregnancies were terminated by hysterotomy. She had a myomectomy via laparotomy 10 years ago. The patient's gynecological examination and ultrasound evaluation were normal. Preconceptional laparoscopic TAC operation was performed. Under general anesthesia, the patient was placed in the lithotomy position. Operative set-up included 15 mmHg pneumoperitoneum, created using the closed Veress technique and three trocars: a 10-mm trocar in the umbilicus for the zero-degree laparoscope; 5 mm trocars in the right and left iliac fossa. The uterus was manipulated with a sponge on ring forceps placed in the posterior fornix. The anterior peritoneum was dissected over the uterovesicalis. The bladder was pushed down through the isthmus area. A 5 mm Mersilen suture with a straight needle is inserted into the abdominal cavity through the trocar. The needle was passed from posterior to anterior (lateral to the uterosacral ligament and medial to the ureter and uterine artery). This process was also done on the contralateral side. The tape was knotted with adequate blocking intracorporeal suturing sequence at the anterior part of cervico-isthmic junction, and Monocryl 2-0 stitch was made to fix the knot. The procedure was ended with the anterior reperitonization. The surgery was completed without any intraoperative complications and within 60 minutes. The patient was discharged in the first day postoperatively and became pregnant two months after surgery. The cesarean section was performed due to severe preeclampsia at the 36th week of pregnancy. A live and healthy male baby weighing 2830 g was born. During the caesarean section, tape was left for subsequent pregnancies.

Discussion

The laparoscopic TAC can be performed before or after conception. Performing TAC preconceptionally mitigates the concerns of difficult exposure due to an enlarged pregnant uterus, increased risk of bleeding and the possible risks to the pregnancy. The laparoscopic approach has advantages such as short hospital stay, reduced postoperative pain and rapid recovery. However, there is no

cohort study dealing with the difference between the preconceptional and postconceptional laparoscopic cervical cerclage.

CONCLUSIONS: Laparoscopic TAC in non-pregnant women diagnosed with cervical insufficiency is safe and feasible in experienced clinics. Also it has all the advantages of minimally invasive surgery.

Keywords: cervical insufficiency, laparoscopic cervicoisthmic cerclage, recurrent miscarriage

OS-23

First trimester diagnosis of sirenomelia: A case report

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INTRODUCTION: Sirenomelia, also known as mermaid syndrome, was first described by Rocheus et al., in 1542 and is a rare and potentially lethal congenital anomaly characterized by partial or complete fusion of the lower extremities. The genetic transmission has not been fully proven, and the two most significant hypotheses in its pathogenesis are the vitelline artery stealing hypothesis and defective blastogenesis. The incidence of sirenomelia syndrome, which is also considered the most severe form of caudal regression, is 1 in 60,000 to 1 in 100,000, and gastrointestinal abnormalities, genitourinary disorders, cardiovascular anomalies, single umbilical artery, indeterminate genitalia, and neural tube defects may accompany this syndrome. We aimed to present the ultrasound findings and management of a case of sirenomelia diagnosed in the first trimester.

CASE: A 26-year-old G2P1Y1 mother with a gestational age of 11 weeks and 5 days, based on the last menstrual period, presented to the perinatology clinic from an external center due to an increase in nuchal translucency. In the transvaginal ultrasonographic evaluation of a patient with no medical history or genetic traits in the family, a single living fetus with normal amniotic fluid was observed with a crown-rump length (CRL) consistent with 12 weeks and 3 days, nuchal translucency of 3mm, lower extremity show fusion, bladder is not visualized, bilateral fused cystic dysplastic kidneys, and a single umbilical artery. Based on these ultrasonographic findings, the diagnosis of sirenomelia was made, the family was informed of the decision of the council, and the pregnancy termination was performed with the approval of the parents. Since the family did not accept autopsy and chromosomal analysis, further investigation and examination could not be performed.

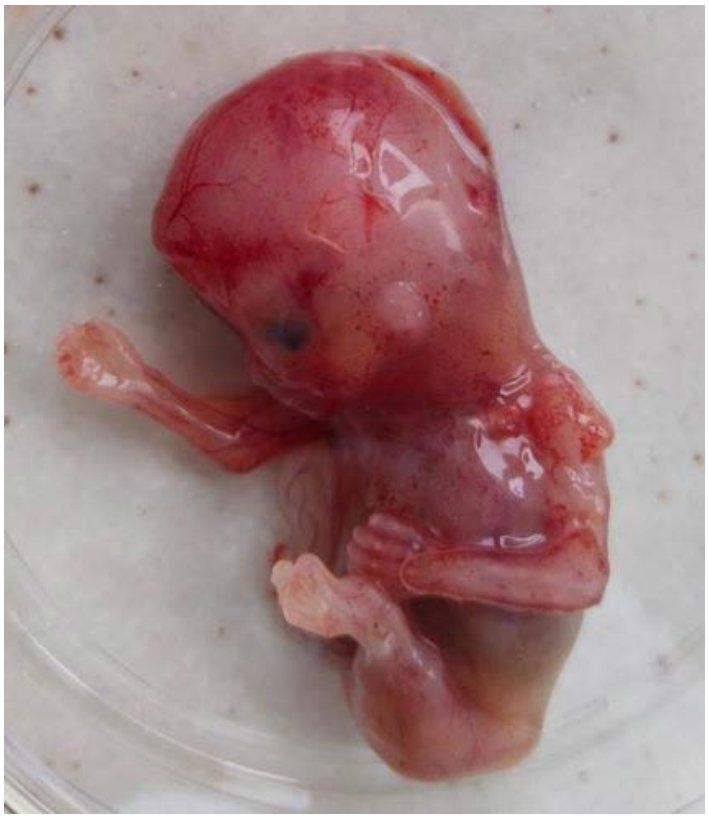
DISCUSSION: Sirenomelia is a very rare, lethal, and multisystemic congenital anomaly. Sirenomelia is classified based on the number of lower extremity bones. Sirenomelia apus refers to the absence of both feet, sirenomelia unipus indicates the presence of a single foot, and sirenomelia dipus describes the condition where both feet are present. The prognosis varies only depending on the presence and severity of other systemic anomalies. Researchers believe that both environmental and genetic factors may play a role in the development of this disorder. Poorly controlled maternal diabetes is a maternal disease known to be associated with sirenomelia. However, only 0.5%-3.7% of sirenomelia cases have been reported in diabetic mothers. Exposure to extrinsic elements such as teratogenic agents may lead to sirenomelia. In our case, there was no teratogen exposure, and glycemic control was good.

The diagnosis of sirenomelia is more feasible in the first trimester compared to later stages of pregnancy because there is still an adequate amount of amniotic fluid present, which is less affected by fetal urine production. Therefore, early fetal anatomical screening

in the first trimester seems to be the most appropriate time as it can facilitate earlier detection of fused extremity malformations and minimize the physical and psychological trauma associated with the termination of pregnancy in later stages.

Keywords: first trimester, sirenomelia, prenatal diagnosis

Figure 1



Examination of the fetus

OS-24

Incidental intravenous leiomyomatosis in the right gonadal vein without intracardiac extension: A case report

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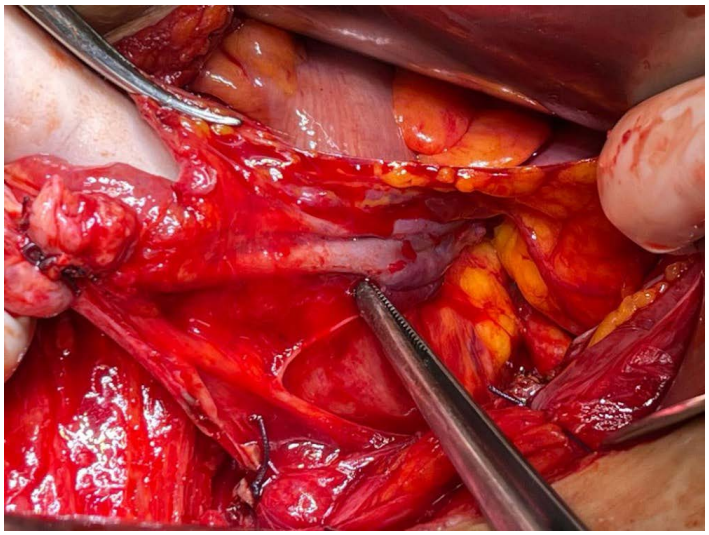
Intravenous leiomyomatosis, initially identified in 1986 and reported in fewer than 300 cases until 2018, is an exceedingly rare condition. Although histologically benign, it poses a risk of mortality due to its potential to extend to the right heart through the inferior vena cava. Gonadal vein involvement was observed in one-third of reported cases, with the right gonadal vein being the most common site (44.4%). Owing to its rarity and the fact that patients are typically asymptomatic until the tumor extends into the heart, early diagnosis is infrequent.

We present a case of intravenous leiomyomatosis without cardiac extension in the right gonadal vein, incidentally detected intraoperatively in a 41-year-old woman who presented to the outpatient clinic due to heavy menstrual bleeding. Her preoperative examinations, including pelvic MRI, revealed no additional findings other than uterine leiomyoma and anemia. After this unexpected intraoperative diagnosis, it was confirmed that there was no mass extending to the right heart by cardiac echocardiography and CT angiography in the postoperative period. The case will be discussed in conjunction with current literature data.

Keywords: Leiomyoma, intravenous leiomyomatosis, right gonadal vein

picture



Intraoperative image showing the right gonadal vein

OS-25

Antenatal diagnosis of subdiaphragmatic bronchopulmonary sequestration: A case report

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INTRODUCTION: Subdiaphragmatic extralobar pulmonary sequestration is a rare type of pulmonary sequestration that is often discovered incidentally during routine ultrasound scans. Its prevalence has increased as equipment resolution has improved, awareness of perinatologists, and radiologists has increased. In intralobar sequestration(ILS), the sequestration shares the common pleura with the normal lung; in extralobar sequestration (ELS), the sequestration has its own visceral pleura. Most ELS drains into the systemic circulation through the azygous or hemiazygous vein or vena cava. Appropriate prenatal diagnosis of ELS is important to optimize the management strategy for affected neonates. This study reported on a fetus diagnosed with supradiaphragmatic and subdiaphragmatic pulmonary sequestration via prenatal ultrasound.

Case

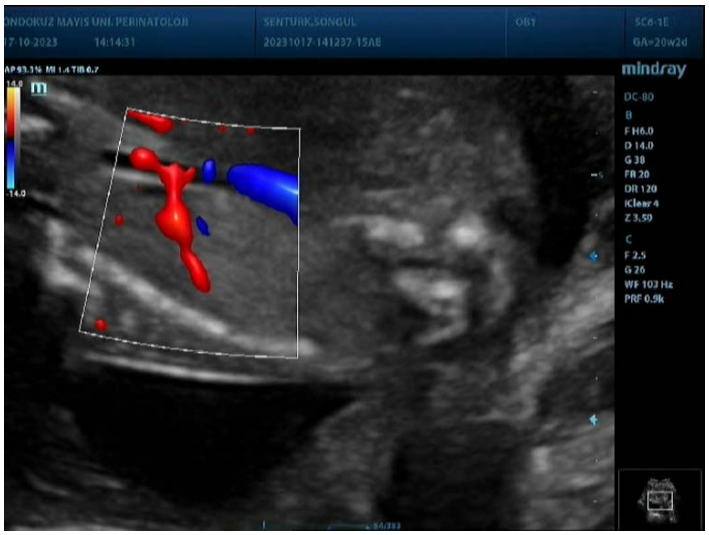
A 25-year-old G1 mother with a gestational age of 16 weeks and 6 days, presented to the perinatology clinic from an external center due to an increase in nuchal translucency. The patient had no significant medical history or genetic predisposition within the family. In the ultrasound evaluation, there was a lesion at the base of the left lung, measuring 20*22*16 mm, with a supradiaphragmatic wedge-shaped hyperechoic appearance. It is receiving circulation from the descending aorta on Doppler examination. Adjacent to the mass, an extrathoracic subdiaphragmatic mass measuring 10*8*9 mm was observed. The lesions were consistent with bronchopulmonary sequestration. Amniocentesis was performed and microarray result was normal. Serial prenatal follow-up ultrasound examinations were performed to evaluate the change in the size of the lung mass and the development of hydrops. Hydrops did not develop and the size of the mass regressed during follow-up.

Discussion

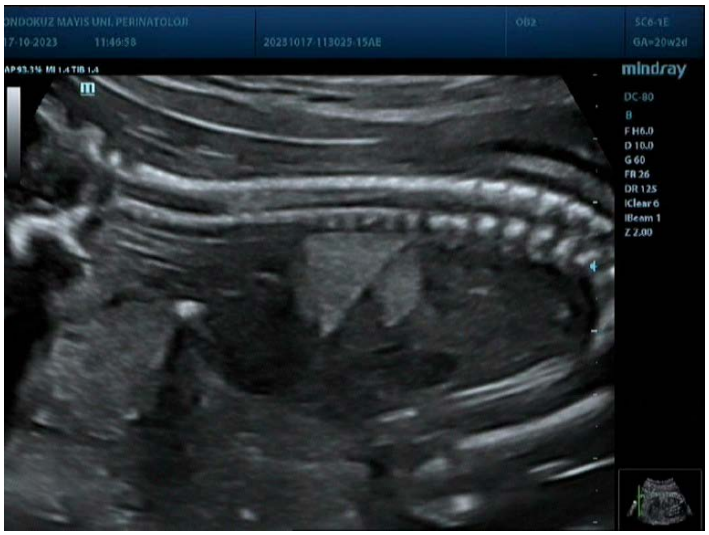
Bronchopulmonary sequestration is classified as intralobar and extralobar according to its structure and venous drainage. Extralobar sequestration (ELS) lack connection with the tracheobronchial system and can be supradiaphragmatic, subdiaphragmatic, or transdiaphragmatic. ELS is predominantly supradiaphragmatic (85-90%) and typically located on the left. It is important to differentiate subdiaphragmatic cases of ELS from adrenal gland pathologies. Only 2.5% of all pulmonary sequestrations are detected subdiaphragmatic. Differential diagnosis includes cystic adenomatoid malformation (CPAM), neuroblastoma, teratoma, bronchial atresia, and adrenal hemorrhage. The diagnosis is established by demonstrating hyperechoic solid lung tissue on ultrasound, which receives blood supply from one or multiple vessels originating from the aorta and drains through the azygos or inferior vena cava. After the diagnosis is established, a thorough anatomical scan should be performed to assess for concomitant pathologies. Close monitoring is necessary to observe the development of hydrops or pleural effusion. Spontaneous resolution is possible. Typically, no treatment is administered during the prenatal period, but in the presence of hydrops, options include laser coagulation, steroids, and either birth or thoracoamniotic shunt. In the postnatal period, after CT/MRI, embolization or resection may be considered.

Keywords: Bronchopulmonary sequestration, case report, congenital lung malformation, doppler, subdiaphragmatic

Doppler examination



Subdiyafragmatik ELS



OS-26

Aggressive Angiomyxoma in the labium majus

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INTRODUCTION: Aggressive angiomyxoma is a very rare, slow-growing benign tumor of mesenchymal origin. It is seen mostly in women in the reproductive period and in the 3rd - 4th decades. It can occur superficially or deeply as a mass in the vulva, vagina, perineum and pelvis. Aggressive angiomyxoma was first mentioned in the literature in 1983. It was described by Steeper and Rosai and approximately 150 patients were examined (1). It is generally locally infiltrative and distant metastasis is rare and but there are death cases reported in the literature(2). It is 6 times more common in women than in men (3), it is more common in inguinal and scrotal regions, in the 6th-7th decades in men (4-5).

CASE REPORT

The patient is a 35-year-old single, virgo female patient. She came to the clinic with a complaint; painless left labium majus mass that has been slowly growing for about 1 year. On physical examination, 3 cm soft, mobile mass from the surrounding tissue was palpated in the left labium majus, and homogeneous, hypoechoic appearance was observed on USG. Gartner cyst?, lipoma? with the preliminary diagnosis, was recommended excision under general anesthesia. The patient was underwent excision under general anesthesia.

In macroscopy, material was seen 3x2.5 cm, with a solitary 17x20 mm structure covered with gray-white capsuled tumor tissue, 2 mm away from the wall In microscopy, the tumor tissue surrounded by a pseudocapsule consists of spindle and round cells and the number of mitosis is 2 in 10 large magnification areas. Immunohistochemical examination revealed positive staining with vimentin, desmin, estrogen receptor (ER) %40, epithelial membrane antigen (EMA), focal staining with Ki67,P53, and negative staining with CD34,S100. With these findings, the patient was diagnosed with aggressive angiomyxoma, clinical follow-up was recommended due to the risk of recurrence; she was called for check-ups every 3 months.

DISCUSSION

Aggressive Angiomyxoma is a benign tumor of connective tissue origin that grows slowly and has an extremely low risk of distant metastasis (6). The main treatment is local wide excision, and recurrence rates after excision have been reported as 30-40% in the literature (7). Aggressive angiomyxoma presents as a slowly growing and painless gelous mass. Depending on its location and appearance, misdiagnoses may be made as Gartner cyst, Bartholin cyst, lipoma, etc. The main diagnosis is made by pathological examination and immunohistochemical staining. In previous cases, tumor sizes were reported to be between 5 and -23 cm (8). In many cases, estrogen and progesterone receptor positivity is present; in our case, the estrogen receptor was 40% immunoreactive. Successful results have been achieved with Gnrh analogues in both primary and recurrent cases (9,10), but side effects should not be forgotten in long-term treatments.

Keywords: Aggressive Angiomyxoma,mesenchymal,locally infiltrative

OS-27

A case of paratubal cyst mimicking hydrosalpinx

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Introduction

Paratubal cysts (PTC) are non-neoplastic, mesonephric or mesothelial originated masses. PTC are incidentally seen on ultrasonography or noticed during abdominal operations performed for other reasons. Ovarian cysts, peritoneal inclusion cysts and hydrosalpinx can be considered in the differential diagnosis. In hydrosalpinx, a swollen, elongated, filled serous fluid, thin walled mass is observed as a result of obstruction in the fimbria and ostium depending on the pelvic inflammatory disease in the tube. In this case, we aimed to present a patient with myoma uteri who applied with menometrorrhagia, had a paratubal cyst that appeared as a hydrosalpinx on ultrasonography.

Case report

A 51-year-old patient, who had a history of three caesarean sections and tubal ligation, applied with menometrorrhagia. On ultrasonography, multiple myomas, the largest one was 10 centimeters, a 25 mm cyst in the right ovary, a 55 mm cyst in the left ovary, and an adjacent 84x38 mm cystic mass that appeared to be hydrosalpinx was observed. In the MRI(Magnetic resonance imaging), the left tube was reported as hydrosalpinx. Its diameter was measured 48 mm at its widest point. (Figure-1, 2) Tumor markers were normal. The result of endometrial biopsy was proliferative endometrium. We performed total abdominal hysterectomy and bilateral salpingo-oophorectomy to the patient who completed her fertility(Figure-3). It was reported as multiple myomas, left paratubal 13.5x5.5 cm cyst, and hemorrhagic simple serous cyst in both ovaries in histopathological evaluation.

Discussion

Paraovarian cysts, which are usually benign, are mostly diagnosed in the third and fourth decades of the life. The incidence of paraovarian and paratubal cysts is estimated to be 5%-20% of all adnexal masses. Their anechoic structure, without any solid component, indicates that they are benign.

PTC originate from the remnants of paramesonephric (müllerian) or mesonephric (Wolffian) ducts. They are usually detected by coincidence in reproductive age during pelvic sonography or surgery, due to being small in size and asymptomatic. It is diagnostic that a unilocular, containing serous fluid anechoic cyst surrounded by a thin wall seen adjacent to a normal ovary. Although most of them are smaller than 3 centimeters, they can reach very large sizes and may cause pain or torsion and may require surgery. When PTC are seen intraoperatively, cystectomy is usually performed.

Eccentrically located paraovarian masses may suggest hydrosalpinx which is a postinflammatory process in which fluid fills the fallopian tube. A hydrosalpinx should be suspected when a dilated, tubular cystic structure, sometimes with partial septa, is seen adjacent to the ovary on ultrasonography. It may cause infertility and pelvic pain.

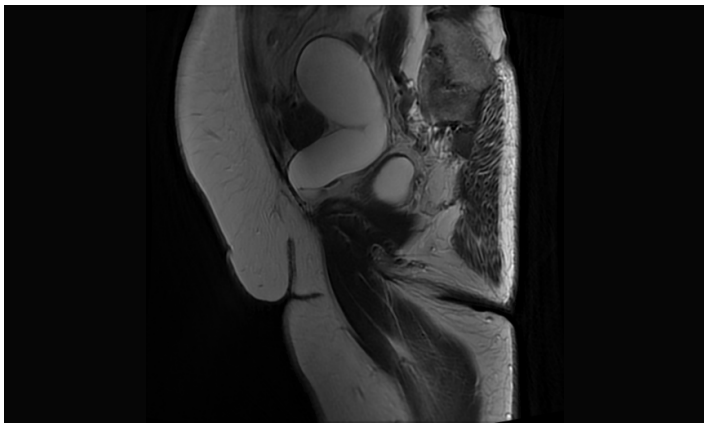
In our case, the PTC was large, asymptomatic and seemed to be

hydrosalpinx on ultrasonography. Although MRI can be useful in preoperative evaluation sometimes the definitive diagnosis can only be made postoperatively.

CONCLUSION: Paratubal cysts, which are usually asymptomatic, can also be diagnosed in the perimenopausal period as a result of increase in the size. Paratubal cysts should be considered in the differential diagnosis of simple-looking paraovarian cystic masses.

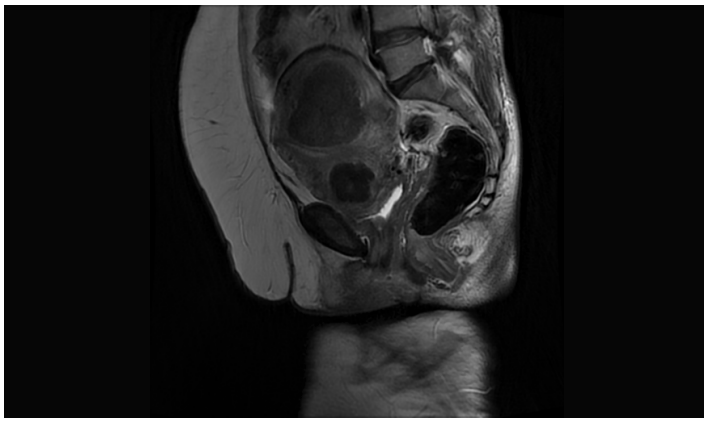
Keywords: Hydrosalpinx, paraovarian cyst, paratubal cyst

Figure 1



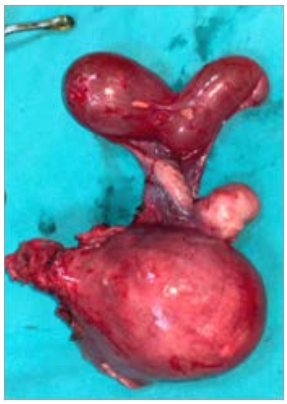
Pelvic MRI of the cysts

Figure 2



Pelvic MRI of the myomas

Figure 3



Postoperative image of the left paratubal cyst

OS-28

Hepatic ischemia due to uterine atony developing after cornual placenta increta

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PURPOSE: Placenta increta is more common in cases of previous cesarean section and placenta previa. However, placental invasion anomalies in the cornual region may be overlooked. We aimed to emphasize that serious complications can be prevented with early diagnosis.

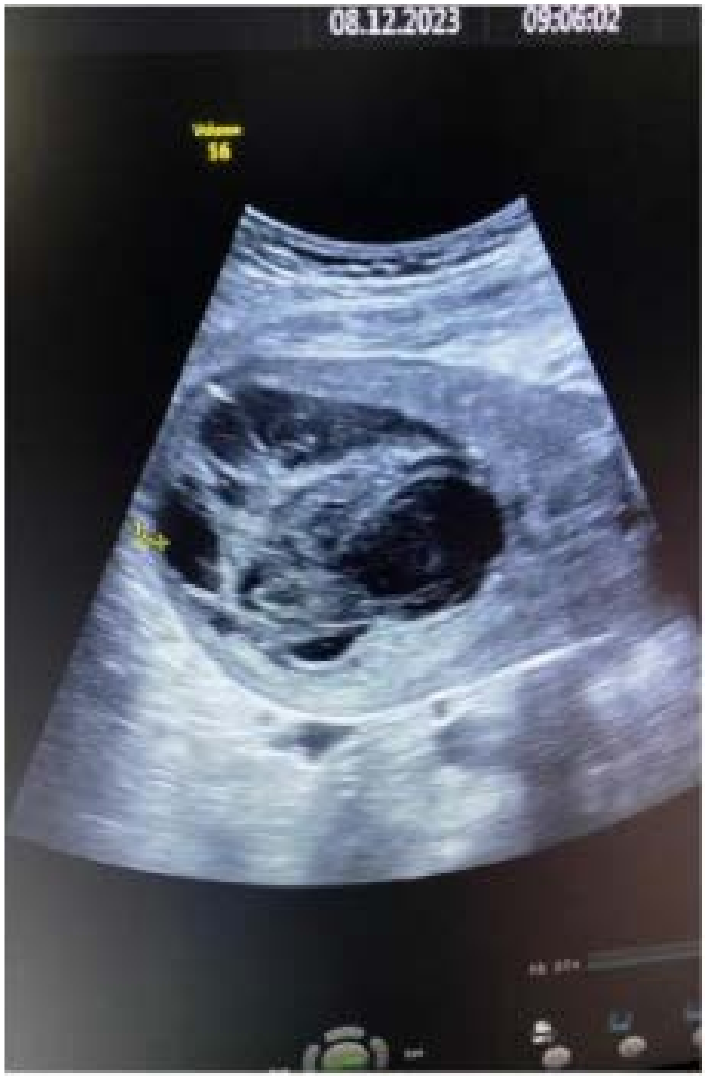
METHOD: As is known, the diagnosis of placenta increta can be made ultrasonographically. In order to detect invasion anomalies in the cornual region, not only the cervical os surroundings but also the entire placenta must be evaluated.

RESULTS: The patient was 38 years old and had a 39-week pregnancy according to her last menstrual period. The patient had undergone elective cesarean section (G2 P1) 12 years ago and laparoscopic tubal fimbrioplasty surgery 8 years ago. On ultrasonography, the fetus was in breech presentation, amniotic fluid was normal, and the placenta was located fundal. Preoperative blood tests were normal (Hb: 12.3, AST: 8, ALT: 22…). The patient, who received anesthesia approval with the ASA II score, underwent spinal anesthesia under elective conditions. A single baby girl, weighing 3150 grams, 9-10 Apgar, was delivered by cesarean section. It was separated manually because the placenta did not separate despite cord traction. Bimanual uterine strangulation was applied to reduce the severe bleeding observed during separation. In the first observation, the uterus was atonic and myometrial thinning was observed in the left cornual region. The patient was administered 100 µg carbetocin, 0.2 mg methyl ergonovine maleate, 250 mg tranexemic acid, and 800 µg misoprostol. After this treatment, adequate tone was achieved in the right half of the uterus and the lower segment. Since the hemoglobin value was 3.9, three units of erythrocyte suspension and fresh frozen plasma were transfused peroperatively. The control value was 7.3. Since she remained hypotensive in the surgical intensive care unit, norepinephrine infusion was started. In addition to 3 grams of fibrinogen, one unit each of erythrocyte suspension, fresh frozen plasma and platelet suspension was transfused postoperatively. At the sixth postoperative hour, Hb: 9.6, AST: 37, ALT: 177. Liver enzymes tended to increase until the fourth postoperative day due to hepatic ischemia secondary to bleeding (AST: 786, ALT: 820). The patient was discharged from the hospital on the 15th postoperative day with his vitals and blood values stable (Hb: 10.1, AST: 32, ALT: 35).

CONCLUSION: Placental invasion anomalies, most of which occur in the lower uterine segment along with placenta previa, are associated with serious maternal morbidity and mortality. It can also be seen less frequently in other parts of the uterus. For this reason, even in elective cesarean section cases, the entire placental bed should be evaluated in terms of placental invasion anomalies.

Keywords: Hepatic ischemia, uterine atony, cornual placenta increta

Image of the hematoma in the left cornual region and the thinning cornual myometrial layer on the first postoperative day



OS-29

Chronic Myeloid Leukemia in Pregnancy: Case Presentation

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INTRODUCTION: Chronic Myeloid Leukemia (CML) is a myeloproliferative disorder characterized by the monoclonal proliferation of hematopoietic stem cells in the bone marrow. It is rarely observed during pregnancy, with an estimated annual incidence of 1 in 10,000. Among leukemias occurring during pregnancy, CML accounts for less than 10%. The disease has a biphasic or triphasic course and is characterized by leukocytosis. In the chronic phase of the disease, there is proliferation of fully matured myeloid cells, and a decrease in myeloid differentiation, leading to a poor prognosis with the potential progression to an accelerated phase or blast crisis. Due to the nonspecific nature of symptoms in early pregnancy, the diagnosis is typically made in the second or third trimester. In this case presentation, we aim to describe the clinical management of a rare case of CML in pregnancy, resulting in postpartum demise.

CASE: A 40-year-old woman presented to an external facility with a persistent cough lasting 20 days. Elevated D-dimer levels (1.9) prompted investigations for deep vein thrombosis and pulmonary embolism, but both lower extremity venous Doppler and chest CT scans was interpreted as normal results. Subsequent deterioration in non-stress test (NST) results led to an emergency cesarean section at 30 weeks of gestation without awaiting complete blood test results. Postoperatively, the patient, with a white blood cell count (WBC) of 274,000, was referred to our hospital. Her medical history revealed her as a multigravida (gravida: 7, parity: 6, abortus: 1) with a previous cesarean section and a persistent cough for approximately 20 days. Physical examination indicated a distended abdomen with diffuse tenderness. Ultrasound revealed a 5 cm hematoma adjacent to the rectus sheath and hepatosplenomegaly. CT scan results showed 5 cm hematomas in both rectus sheaths, retroperitoneal hematoma in the left para-aortic and mesenteric roots, and multiple pathological lymphadenopathies in the bilateral inguinal region.

Consultation with internal medicine resulted in admission. Peripheral smear analysis revealed leukocytosis with 10% blast-like mononuclear cells and leukoerythroblastosis. Deterioration in general condition, decreased urine output, tachypnea, tachycardia, and metabolic acidosis necessitated transfer to the intensive care unit. Urgent leukapheresis and treatment for metabolic acidosis were initiated. Hematology consultation confirmed Chronic Myeloid Leukemia (CML). Despite interventions, the patient's condition worsened, leading to intubation, norepinephrine infusion, and initiation of Meropenem, Vancomycin, Clindamycin, and antifungal therapy by the Infectious Diseases team. On the 10th day, despite high-dose dual inotropic support, the patient remained hypotensive and eventually experienced cardiac arrest, resulting in an unfortunate outcome.

CONCLUSION: The coexistence of pregnancy and Chronic Myeloid Leukemia (CML) is exceptionally rare. Managing such

cases, especially in pregnant patients without a known diagnosis, requires a multidisciplinary and collaborative approach across different medical specialties. In our case, the absence of a known diagnosis, coupled with a history of emergency surgery and the subsequent development of septic shock, further complicated the management, ultimately resulting in the unfortunate loss of the patient's life.

Keywords: Chronic Myeloid Leukemia, Leukocytosis, Pregnancy

OS-30

A case of partial trisomy 16q, monosomy 16p: Prenatal diagnosis and cytogenetics

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Introduction

Trisomy 16 is the most common chromosomal abnormality in humans. It accounts for approximately 15 per cent of all chromosomal abnormalities and one third of all trisomic spontaneous abortions. Segmental trisomy of 16q is usually described in combination with a partial monosomy of another chromosome and is often caused by a parental balanced translocation. Patients reported with partial trisomy involving 16q have a wide range of congenital anomalies including dysmorphic features, central nervous system malformations, growth retardation, hypotonia, joint contractures, ambiguous genitalia and anorectal malformations. Here, we aimed to present the prental findings and management of a case of partial trisomy 16q, monosomy 16p which was evaluated in detail by molecular cytogenetic techniques.

Case

23 years old, G1, referred to perinatology outpatient clinic with suspicion of fetal cardiac anomaly. There is no consanguineous marriage between the spouses and no history of drug use or radiation exposure during pregnancy. The first trimester combined screening test result is in the low risk group for aneuploidy. Second trimester ultrasonography showed facial hypertelorism, dilated right atrium and coronary sinus. Cardiac axis was deviated to the left and persistent left superior vena cava was noted in three vessel sections. The aortic valve appeared dysplastic and poststenotic dilatation was noted. Estimated fetal weight was less than 3p and increased resistance was detected on umbilical artery Doppler. Amniocentesis was done. Structural analysis revealed a new configuration on the short arm of chromosome 16. FISH analysis of the related region revealed deletion of the 16p subtelomer region and trisomy of the 16q subtelomer region. This result was associated with multiple congenital anomalies including mental retardation, fetal growth retardation and cardiac anomalies and termination of pregnancy was offered as an option to the family due to unfavourable prognosis.1220 gram ex baby girl delivered by hysterectomy. Parental karyotyping revealed inv16 in the father.

Discussion

In our case, FISH analysis of amniotic fluid cells revealed a rare partial trisomy 16q, monosomy 16p. Prenatal diagnosis of monosomy 16p or trisomy 16q alone is rare, and only a few cases of de novo translocation involving chromosome 16 have been reported.

Prenatal ultrasonography revealed fetal growth retardation, dysmorphic face (hypertelorism), aortic stenosis and bilateral pes equinovarus deformity. Puhl et al. detected fetal growth retardation, facial dysmorphism (hypertelorism, midface hypoplasia, prominent forehead), cerebellar and limb abnormalities, congen-

ital heart defects, facial features and genital hypoplasia in a case of monosomy 6p or trisomy 16q. In our case, phenotypic aspects of the foetus included clinical features consistent with both cytogenetic abnormalities. FISH analysis of the related region revealed deletion of the 16p subtelomer region and trisomy of the 16q subtelomer region.

Nowadays, prenatal diagnosis of such chromosomal abnormalities allows parents to prepare for the condition much earlier and in such severe cases, termination of pregnancy can be offered as an option to the family. In addition to FISH and standard karyotype examination in cases with ultrasound findings, advanced genetic tests such as microarray and whole exome analysis are becoming more important.

Keywords: monosomy 16p, partial trisomy 16q, prenatal diagnosis

OS-31

A rare case after abortion: artero-venous malformation of the uterus

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OBJECTIVES: Arteriovenous malformations (AVMs) of the uterus are rare but frequently misdiagnosed conditions that can lead to significant morbidity, especially in the postpartum period. Characterized by an assembly of dysplastic blood vessels forming abnormal connections between arteries and veins, uterine AVMs pose diagnostic and therapeutic challenges. Although their etiology is usually idiopathic, recent literature suggests a possible association with pregnancy and puerperium. In this case report, we aimed to summarize the clinical course of an AVM case referred to our clinic with a diagnosis of placental residue after abortion, from radiologic and hysteroscopic diagnosis to the final successful intervention through interventional radiology.

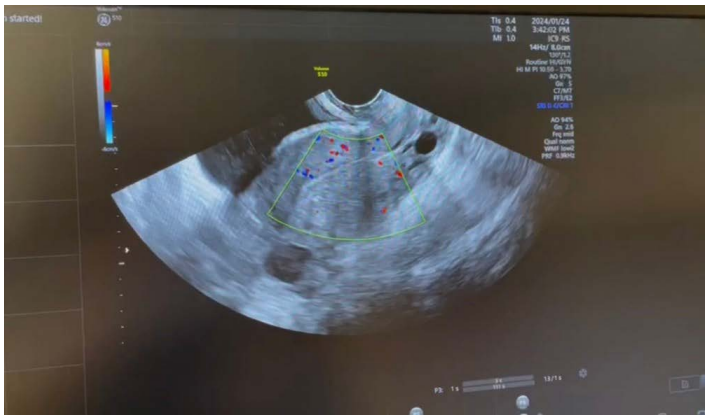
METHODS: A 33-year-old patient with a history of 1 D&C and 1 C/S delivery was admitted to our clinic with the complaint of vaginal bleeding 1 week after the abortion of her 15-week pregnancy and subsequent revision curettage. Transvaginal USG imaging of the patient showed a 48*22 mm Doppler blood supply in the uterine endometrial cavity, which was suspicious for placental residue.

FINDINGS: Pelvic arteriography was performed after hysteroscopic evaluation and IV contrast-enhanced MR imaging showed no appearance compatible with placental residue and raised the suspicion of AVM. AVM originating from both uterine arteries and extending to the endometrium was diagnosed. Liquid-based embolization treatment was performed 2 times with 3-month intervals under the guidance of interventional radiology. Control evaluations showed that the patient's complaints had resolved and the suspicious image disappeared on ultasonographic doppler imaging.

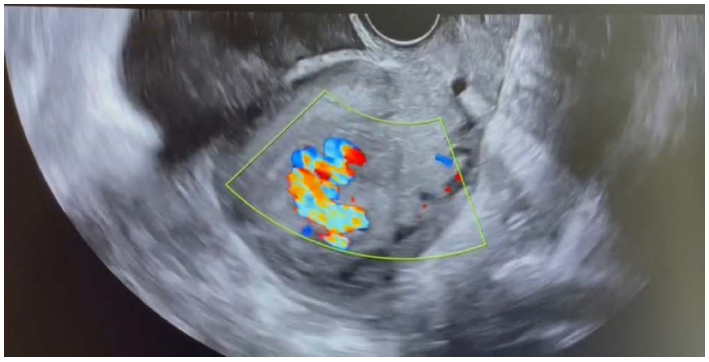
CONCLUSIONS: This case report focuses on the post-pregnancy presentation of AVMs and highlights the diagnostic challenges, including misdiagnosis, which is also emphasized in the literature as another post-abortion complication. Clinical findings are often not sufficient for the diagnosis and imaging modalities are utilized. The first imaging modality of choice is color Doppler ultrasound. Characteristic findings include a hypervascular lesion with low resistance and high peak systolic velocity. When in doubt, additional invasive procedures such as computed tomography (CT) and magnetic resonance imaging (MRI) or hysteroscopy and angiography have been reported in the literature. Our case is valuable in that it is one of the rare post-abortion cases in the literature, the diagnosis was confirmed by hysteroscopy and angiography, and the treatment was successful after liquid-based embolization. It is important to raise awareness among clinicians about post-pregnancy uterine AVMs and emerging innovations in their effective management.

Keywords: Abortion, Arterio-venous malformation, Placental residue, Hysteroscopy, Embolization

Ultrasonographic image after treatment



Ultrasonographic image at the time of diagnosis



OS-32

Life-threatening massıve hemoperıtoneum secondary to spontaneous rupture of a uterıne leıomyoma: a case report

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Uterin fibroids or leimyomas are the most common benign neoplasm of the uterus in reproductive age women.They occur in 75% of women above the age 30. The development of myomas increases with age and can be found in almost 80-90% of all women by age 50 years. (3) Although it is a relatively common tumorous condition in women, it is often small in size and remains asymptomatic or they can cause pain, excessive menstrual bleeding or infertility but serious complications are rarely reported. Such complications include thromboembolism, acute pain due to degeneration or torsion of a pedunculated fibroid, acute urinary retention and subsequent renal failure, and acute intra-abdominal blood loss. Hemoperitoneum secondary to rupture of a uterine leiomyoma is an extremely rare complication of this exceedingly common tumor. We report a case of hemoperitoneum secondary to spontaneous rupture of a uterine fibroid. We present the case of a 32-year-old, nullipara woman with acute onset of abdominal pain. She was hemodynamically unstable and transvaginal ultrasonography revealed abundant fluid collection in the peritoneal cavity, suggesting hemoperitoneum. Additionally, a 12 x 7x 8 cm hypoechoic lesion was observed in the uterine fundus, which was thought to be connected to the uterus. The operation was started laparoscopically, but due to observation of 1000 cc of organized and 1000 cc of free hemorrhagic fluid in the abdomen, laparotomy was performed. During emergency exploratory laparotomy, 8 cm pedunculated myoma originating from uterine fundus and the subserosalvein overlying a uterine fibroid was identified as the source of bleeding. Hemostasis was accomplished with fibroid excision. The patient received 3 erythrocyte suspensions and 2 fresh frozen plasma transfusions. The patient was discharged cured on the 4th postoperative day. Spontaneous hemorrhage originating from a uterine fibroid is extremely rare, but may lead to life-threatening conditions. To 2019, Less than 30 cases resulted from rupture of a superficial vein.As such, the condition is often misdiagnosed, which can lead to mortal consequences.Therefore, in female patients with acute abdominal pain and hemoperitoneum, uterine fibroid may be a potential etiology and emergency exploratory laparotomy should be considered.

Keywords: hemoperitoneum, leimyoma, rupture,

OS-33

An examınatıon of anxıety and stress levels of pregnant women ın NST (Non Stress Test)

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Although pregnancy is a process that is awaited with excitement and hope, it is not only a physiological Pregnancy is an important process that causes not only changes but also psychological changes, which are considered as an important transition period in the life process. It is important that the pregnant woman is followed up by a physician and nurse/midwife based on a holistic health approach throughout the pregnancy. In addition to maternal and fetal health, pregnant women should be evaluated and followed up in terms of anxiety, stress and depression. Changes in maternal mood and mood disorders pathologically affect the fetus (Garafova et al., 2023). There are some tests to assess fetal health. The easiest and most reliable of these is the non-invasive Non-Stress Test (NST), which is performed from the 32nd week (Mucuk, 2021). NST (Non- Stress Test) is a method used to check the health of the fetus. It is an assessment tool used from 32 weeks of gestation until delivery to determine whether there is a risk of intrauterine death, high-risk pregnancies or suspected fetal hypoxemia, neonatal complications, and the presence of fetal movements and fetal heart rate (Umana, 2024). In cases where fetal movements are reactive during NST, during fetal sleep, it may be necessary to turn the mother to the left side, give oxygen and hydrate her, and the extraction process is extended for 20 minutes. This process can cause anxiety and stress in the pregnant woman (Unterscheider, et al., 2014). In these situations, the nurse can reduce anxiety and stress in pregnant women. should provide information on how to eliminate the obstetric problems. The aim of this study was to design a prenatal necessary to be aware of the anxiety states experienced during the period and to help pregnant women during the NST (Non-Stress Test) of pregnant women in order to develop interventions the level of anxiety and stress.

Keywords: Nursing, NST, stress, pregnant,

OS-34

A rare case of ruptured ectopic pregnancy with a negative beta hCG value

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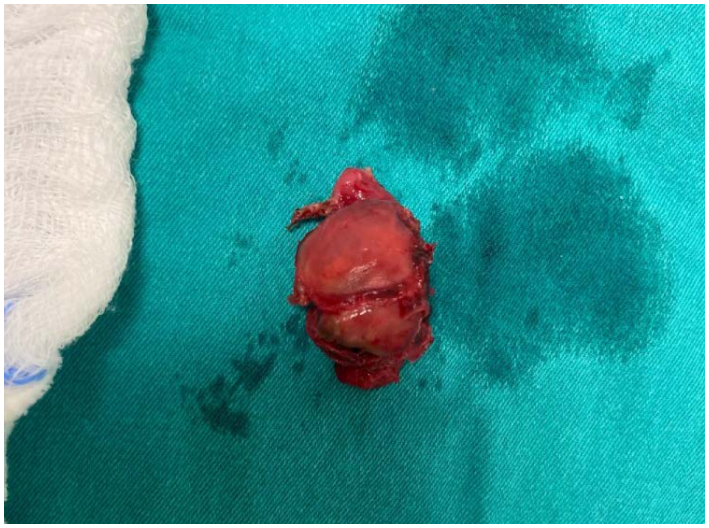
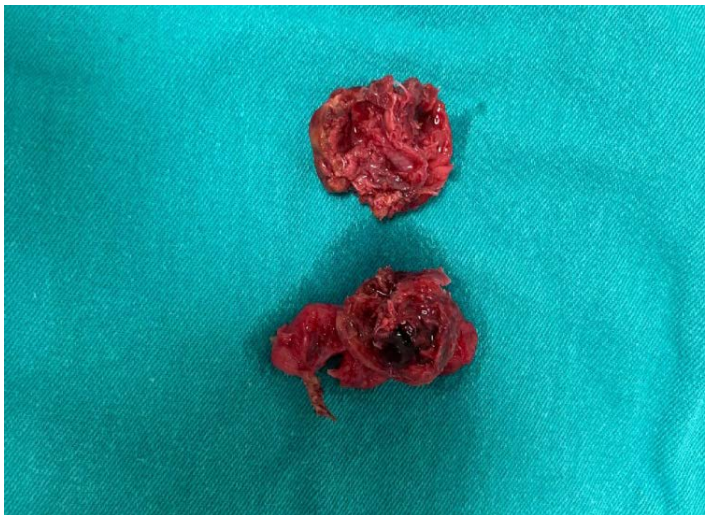
INTRODUCTION: An ectopic pregnancy is defined as the growth of an embryo outside the uterus, with the most common site being the fallopian tube (95%).[1] It is one of the most common gynecological emergencies in clinical practice. The incidence of ectopic pregnancy (EP) is 2%, and it is among the leading causes of maternal mortality and morbidity.[2] Ectopic pregnancy (EP) ruptures are the leading cause of maternal mortality within the first trimester of pregnancy, with a rate of 9%–14% and an incidence of 5%–10% of all pregnancy-related deaths[1]. Often, the diagnosis is made based on a combination of exam findings, transvaginal ultrasound, and a positive pregnancy test. When the beta hCG value in the blood is negative, pregnancy is usually excluded, leading to the diagnosis of ectopic pregnancy being missed. In such cases, the correct diagnosis is often only established following laparoscopy or even histologically after the operation. In this case, we present a rare instance of a female aged 34 who had a life-threatening ruptured ectopic pregnancy, despite her negative beta-hCG value. CASE: A 34-year-old multiparous woman presented to the emergency department due to acute abdominal pain. Physical examination findings were consistent with acute abdomen. In blood analysis hemoglobin level was 10.8 g/dl, white blood cell and CRP levels were between normal ranges, and beta-human chorionic gonadotropin (bhCG) value was negative. Upon abdominal imaging, free fluid was observed within the abdomen, along with a 2 cm cystic structure in the left adnexal area. Based on these findings, the preliminary diagnosis of ovarian cyst rupture was made, and the patient was admitted. During follow-up in the ward, despite medical treatment, the bleeding did not stop, and the patient was taken to emergency diagnostic laparoscopy. During the operation, it was observed that the bleeding originated from the mass in the left tube, leading to a left salpingectomy. The final pathology report confirmed an ectopic pregnancy. CONCLUSION: In the current literature, there are only a few reported cases of ectopic pregnancy presenting with ruptured conditions alongside negative serum/urine hCG levels.[3] Additionally, there are instances of chronic ectopic pregnancies that were diagnosed late due to being initially overlooked because of negative beta-hCG levels, leading to complications such as pelvic inflammatory disease and infertility.[4] Our case involved a patient who underwent surgery for what was preliminarily diagnosed as cyst rupture but was found intraoperatively to have a tubal rupture. This case, along with other reported instances of chronic ectopic pregnancy, underscores the significance of clinical and imaging findings in conjunction with serum hCG levels in monitoring ectopic pregnancies post-treatment.

Keywords: acute abdomen, chronic ectopic pregnancy, negative beta hCG level, ruptured ectopic pregnancy

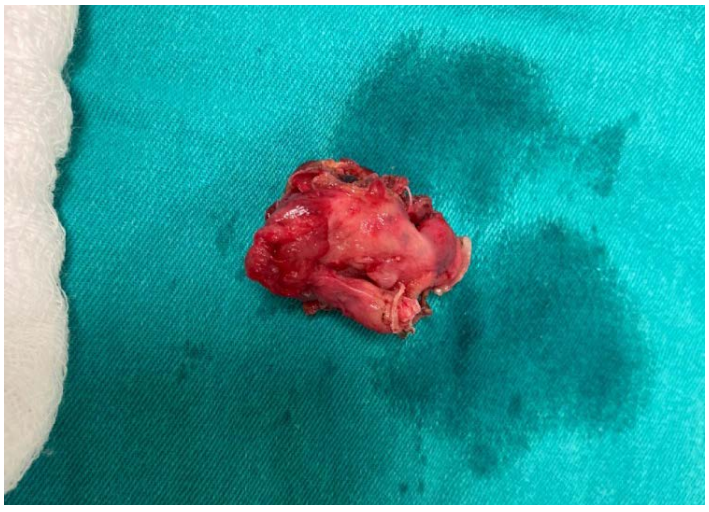
left tuba uterina



left tuba uterina



left tuba uterina



OS-35

Postmortem caesarean section in a pregnant woman with cardiac arrest

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OBJECTIVE: It was aimed to protect the survival of the fetus with postmortem caesarean section in arrest patient undergoing cardiopulmonary resuscitation and to draw attention to the increase in response to resuscitation by reducing aortacaval compression.

Materials and METHODS: Postmortem caesarean section of a cardiac arrest patient during cardiopulmonary resuscitation under emergency conditions

Findings

A 30-year-old multigravid patient was brought to the emergency department with 112 as cardiopulmonary arrest after a fall in the bathroom at the 30th week of pregnancy.CPR was performed in the emergency red area and it was learnt that the patient had gravia 2 parity 1 normal delivery.The pregnant woman was resuscitated by the emergency team and postmortem caesarean section was decided in the 25th minute of the arrest due to a positive fetal heartbeat on ultrasonography. Pfannenstiel incision was made in the abdomen and a live fetus weighing 940 g was delivered in the emergency department. Apgar score 1-6 was given to the neonatal team. The baby intubated by the neonatal team was taken to the intensive care unit and the abdominal folds were closed properly. The patient did not respond to cardiopulmonary resuscitation and died. The fetus is being followed up intubated in intensive care. Postmortem caesarean section is an intervention that can be performed in pregnant women with arrest in the 3rd trimester due to the high chance of fetal survival in the 3rd trimester. The fetus is adapted to tolerate hypoxia to a certain extent. Delivery of the foetus eliminates aortacaval compression and aims to reduce uterine compression on the vena cava supeiror and increase venous return to the heart, i.e. preload. It is clinically necessary to deliver the foetus in order to increase cardiopulmonary return in the patient and to increase the response to resuscitation. Thus, postmortem caesarean section is recommended both to save the life of the foetus and to increase the resuscitation response of the mother.

CONCLUSION: Maternal cardiac arrest causes interruption of utereoplacental blood flow. The time from maternal cardiac arrest to delivery is an important issue for fetal survival. In order to save both the fetus and the mother in a pregnant woman with cardiac arrest, we presented a case in which we performed a postmortem caesarean section without losing time with sterility and urinary catheter application in the shortest possible time.

Keywords: cardiopulmonary arrest,postmortem,caesarean section

Postmortem caesarean section

OS-36

Perioperative Double J Stent Application in a Total Laparoscopic Hysterectomy: A Detailed Analysis of Complex Postoperative Outcomes

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This report examines complex postoperative complications after Total Laparoscopic Hysterectomy (TLH), Unilateral Salpingo-Oophorectomy (USO), Salpingectomy, and Double J stent insertion.The patient, readmitted for nausea and vomiting, developed suspected stent malfunction, significant infection, and respiratory distress.A multidisciplinary approach, involving general surgery, urology, interventional radiology, and internal medicine, was critical in management.This case highlights the importance of vigilant postoperative surveillance and a coordinated strategy in complex surgical situations, aiming to enhance understanding and management of potential complications in similar cases.
INTRODUCTION: Total Laparoscopic Hysterectomy (TLH) represents a significant advancement in gynecological surgery, offering a minimally invasive alternative to traditional methods.TLH is preferred for its reduced pain, shorter hospitalization, and quicker recovery.However, it involves risks, such as urinary tract injuries.The use of Double J stents in TLH is a strategy to mitigate ureteral injury risks. This case illustrates the challenges in managing postoperative complications, emphasizing the importance of a multidisciplinary approach.

Case Report

45 y, G5P4A1 ♀,the patient underwent TLH, Left USO, Right Salpingectomy for 10 cm left ovarian endometrioma, obliterated the pouch of Douglas, and Double J stent insertion, the latter being a pre-surgical decision in anticipation of extensive adhesions and potential ureteral damage.On Postoperative Day (POD) 4,she was readmitted with nausea, vomiting, and fever of 38.5°C.This led to a provisional diagnosis of possible ileus or perforation, warranting an Abdominal X-Ray, CT scan, a broken Double J stent was detected and Ceftriaxone and Metronidazole iv had been started for the patient.The CT findings, assessed by the general surgery team, revealed no contrast leakage or air-fluid levels.However, a urology consultation suggested a possible Double J stent malfunction and hydronephrosis.After consulting with Urology, additional CT Urography was conducted. Subsequently, a Nephrostomy was planned and executed.As the case developed, the patient showed increased CRP levels and persistent fever, leading to an updated treatment plan with Piperacillin-tazobactam.A cardiology consultation was also sought due to pretibial and pulmonary oedema, although no pulmonary embolism was detected. The case's complexity was further highlighted when the Urology department conducted cystoscopy and successfully removed the broken part of the Double J stent.This intervention, along with the ongoing infection treatment and monitoring for potential respiratory issues, was crucial in managing the patient's condition.The patient was discharged on the POD 19 with both nephrostomy and Foley catheter producing a daily output of 2000 cc of clear urine.

Discussion

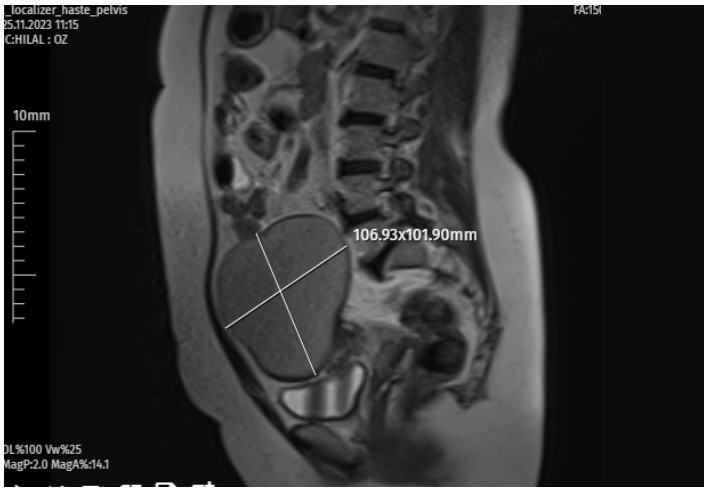
This case underscores the complexity of postoperative care in gynecological surgery, particularly after TLH.The involvement of multiple

specialties was critical in managing the range of complications,with each contributing significantly to comprehensive care.Timely intervention by the Urology team and continuous multidisciplinary collaboration were pivotal. The prompt action of the urologists in extracting the broken stent piece via cystoscopy was a decisive moment in the patient's management, highlighting the importance of specific procedural expertise within multidisciplinary teams.

CONCLUSION: The case exemplifies the necessity for vigilant monitoring and adaptability in treatment plans, especially in managing postoperative complications. It also highlights the vital role of collaborative care among various medical specialties in ensuring patient safety and recovery.

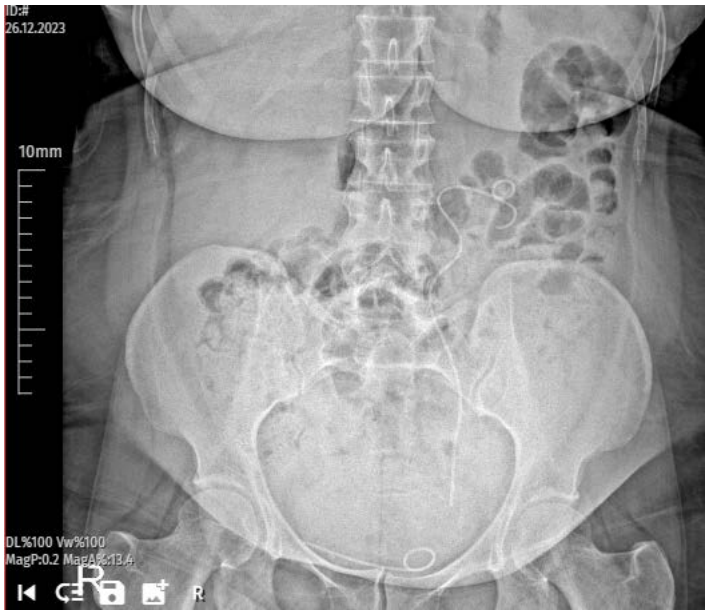
Keywords: TLH, Postoperative Complications, Double J Stent, Multidisciplinary Management, Gynecological Surgery

Figure 1



Preoperative MRI view of an endometrioma

Figure 2



Postoperative X-Ray. Double J catheter fragment. Broken inside the bladder.

OS-37

Uterine Prolapse During Pregnancy: A Case Report

Sümeyye Nur Ünsal, Mustafa Can Akdoğan, Yusuf Üstün
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Herniation of pelvic organs from the urogenital hiatus due to weakening of the pelvic support tissue for any reason is called pelvic organ prolapse. Pelvic organ prolapse (POP) is a condition that affects the anterior, posterior and apical aspects of the vaginal walls. Although uterine prolapse is a rare complication of pregnancy, it is a serious condition that can lead to cervical dryness and ulceration, urinary incontinence, urinary tract infection, abortion, preterm birth, fetal death and maternal sepsis. As the pregnancy progresses, the prolapse level may increase or disappear completely. There is no accepted standard treatment method for uterine prolapse seen during pregnancy. Bed rest and pessary application are the main accepted treatment methods. In the postpartum period, prolapse mostly resolves spontaneously.

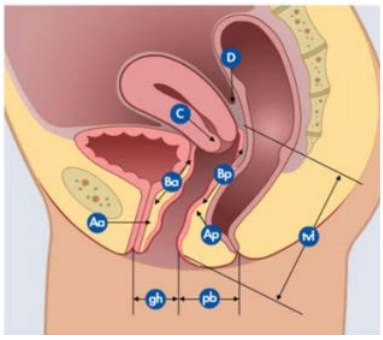
Case Report: A 41-year-old patient, gravida 8, parity 4, ectopic pregnancy 1, dilatation and curettage 1, abortion 1, last menstrual period was June 15, and ultrasonographic measurements were compatible with 20 weeks, was admitted to our antenatal outpatient clinic with the complaint of a palpable mass in the vagina. The patient had 4 normal spontaneous vaginal births in her history. There was a history of salpingectomy due to ectopic pregnancy, the side of which was unknown. The patient declared that there were no problems during her previous births. The patient's last smear available in the system was dated 2022. It was negative for intraepithelial lesion or malignancy. He had no other additional features in his story. During the outpatient clinic examination, stage IV total uterine prolapse was observed according to the POP-Q staging system. In the ultrasonographic examination of the patient, a single live pregnancy was observed, whose measurements were compatible with 18 weeks. A pessary was recommended to the patient throughout this process. Antepartum complications include hypoxia caused by cervical edema, abortion and preterm birth, urinary tract infection, acute urinary retention and even maternal death. The main intrapartum complications are cervical laceration, uterine rupture, fetal death and maternal morbidity, and inadequate cervical dilatation in the lower uterine segment. Postpartum bleeding and uterine tenderness due to puerperal infection are common consequences of postpartum pelvic organ prolapse.

It is important to identify prolapse at an early stage and determine its treatment. When conservative treatment fails or long-term bed rest is not possible, laparoscopic uterine suspension performed by experienced physicians appears as another treatment option (8). In cases with uterine prolapse, the management of birth should be individualized, taking into account the degree of prolapse, gestational age, parity and the patient's preference. When the literature is examined, the use of pessary is not effective if uterine prolapse occurs in the last trimester of pregnancy. It was observed that bed rest and slight trendelenburg position were applied. In cases where the cervix protrudes from the introitus, drying and ulceration of the cervix may occur.

In light of this information, treatment in cases of uterine prolapse during pregnancy should be evaluated on an individual patient basis. Patients should be closely monitored and informed about treatment options.

Keywords: cervix lacerations, pregnancy, preterm birth, prolapse, suspensorium surgery

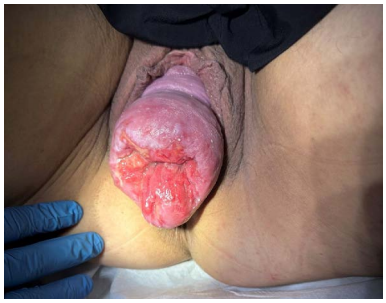
Figure-1: POP-Q Staging System



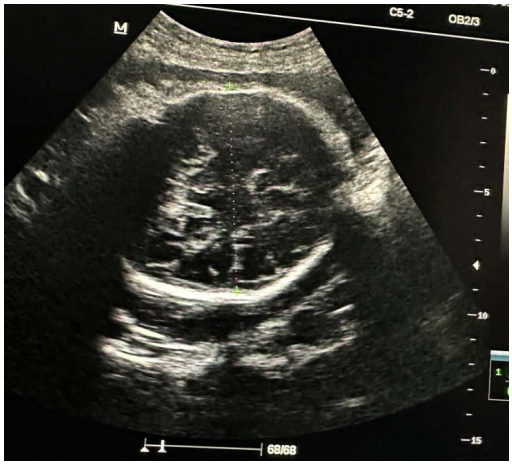
Aa and Ba: Anterior (Front wall) Ap and Bp: Posterior (Back wall) C: Cervix or Cuff D: Posterior Fornix gh: Genital hiatus pb: Perineal body tvl: Vaginal length

Picture-1: 18 weeks pregnancy stage IV total uterine prolapse.

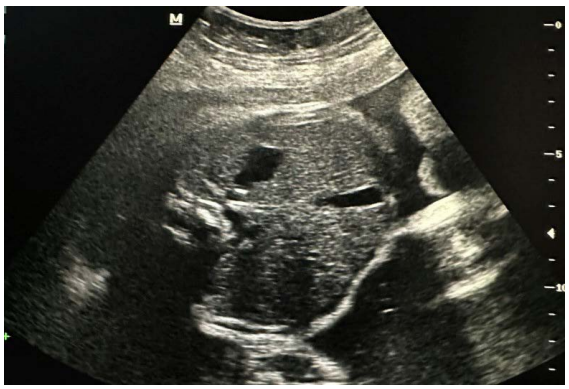
Picture-2: 24 weeks pregnancy stage IV total uterine prolapse



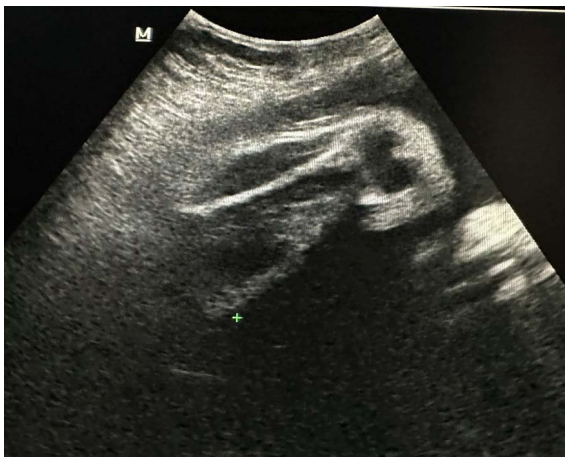
Picture-3: Biparietal Diameter (BPD)



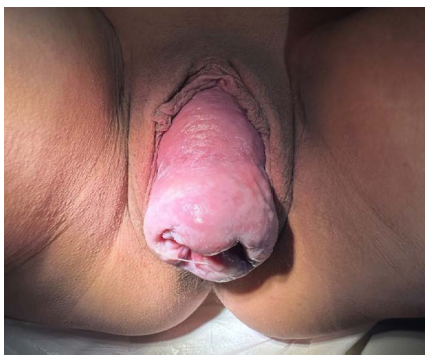
Picture-4: Abdominal Diameter (AC)



Picture-5: Femur Length (FL)



Picture-6: 30 weeks pregnancy stage IV total uterine prolapse



Evaluation of Pelvic Organ Prolapse According to POP-Q Classification

Stage 0	Points Aa, Ba, Ap and Bp are at -3 cm.
Stage 1	The most distal part of the prolapsed part is 1 cm above the hymen (< -1 cm).
Stage 2	The most distal part of the prolapsed part is in the range 1 cm above and below the hymen (≤ +1 cm and ≥ -1 cm).
Stage 3	The most distal part of the prolapsed part is 1 cm below the hymen, but the TVL is less than -2 cm prolapsed.
Stage 4	The most distal part of the prolapsed part has prolapsed at least TVL -2 cm or more from the hymen (≥ TVL -2 cm).

Table-1: Evaluation of Pelvic Organ Prolapse According to POP-Q Classification

OS-38

Medical and Surgical Approaches for Patients Experiencing Abnormal Uterovaginal Bleeding While Undergoing Antithrombotic Therapy: Three Case Reports

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The International Federation of Gynecology and Obstetrics has classified the causes of abnormal uterine bleeding (AUB) into 9 categories(PALM-COEIN).Abnormalities of the uterus that cause AUB include polyps(P),adenomyosis(A),leiomyoma(L),and malignancy(M) or hyperplasia.Other causes include coagulopathy(C),ovulatory dysfunction(O),endometrial dysfunction(E), iatrogenic etiologies(I),and those not yet classified(N).Balancing the risk of recurrent ischemia and bleeding among patients who undergo percutaneous coronary intervention (PCI) is challenging. We have focused on aspirin and clopidogrel as they are among the most widely used antiplatelet agents.We presented the characteristics of the three patients in table format.

Case Report 1

A 50-year-old woman,G6P5A1,was started on clopidogrel and aspirin as antiplatelet therapy 14 months ago after PCI+stent placement. The patient presented with an Hgb of 6.5 g/dL, Hct of 19.5%. Subsequently,a cardiology consultation was requested,indicating that if the patient remains free of acute coronary events for 1 year after the stent placement, clopidogrel can be discontinued.In case of an emergency operation,it is appropriate to perform the procedure under aspirin and the procedure is moderately risky.Antiplatelets should be discontinued 7 days before elective surgery. Subcutaneous DMAH is recommended at a dose of 2x1.The patient should continue using other medications prescribed for heart health. Hemoglobin levels should be maintained at least around 8 g/dL.Following the treatment protocol,the Hgb level increased to 9.2 g/dL.Due to the indication of AUB-PALI,surgery was performed under elective conditions.In the early period,antiplatelet therapy was resumed,and DMAH was stopped.

Case Report 2

A 62-year-old woman,G4P4,was started on clopidogrel and aspirin 3.5 months ago following PCI+stent placement.A cardiology consultation was sought.The advice was as follows:'Within the first year,aspirin and clopidogrel should not be discontinued. If emergency surgery is considered,aspirin and clopidogrel treatment can continue,and high-risk procedures can be planned.'The patient,who had used antiplatelets 24 hours before,underwent urgent intervention due to abnormal uterine bleeding (AUB-PM). Post-procedure,due to bleeding,and tranexamic acid,hydroxyprogesterone caproate,platelet suspension,and FFP were administered.The final pathology revealed endocervical adenocarcinoma, and the patient,was referred to Gynecologic Oncology.

Case Report 3

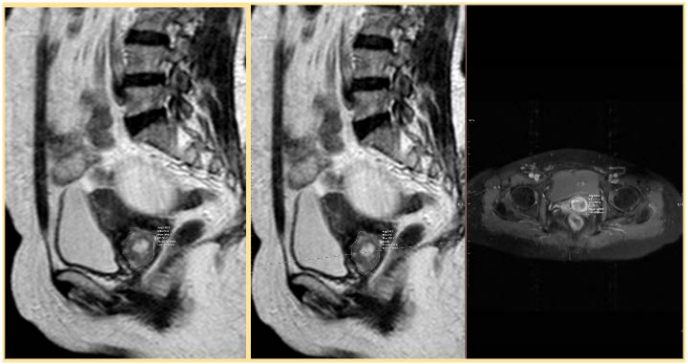
A 43-year-old woman,G2P2,presented to the district hospital.She had received a left ventricular pacemaker due to a post-myocardial infarction (Post-MI) event 1.5 years ago and was started on clopidogrel and aspirin.An emergency cardiology consultation suggested that fresh frozen plasma (FFP) could be administered based on the risk-benefit ratio,but it was not considered a priority. In the emergency department, beta-hCG was >10,000, and 1 hour later,Hgb was 9 g/dL,and Hct was 24.7%.Due to the prolonged referral process to the central hospital,misoprostol,oxytocin infusion,and suction curettage were performed under local anesthesia.Hydroxyprogesterone caproate was administered to stop the bleeding.

Discussion

The first patient was treated under elective conditions based on the recommendation of Cardiology, while the other two patients received an emergency approach.It was observed that synthetic progesterone was effective.The oncology process for the second patient continued with chemoradiation. Despite the risks, the third patient continues to smoke, does not take the situation seriously, and prefers not to use active contraception.Mefenamic acid is used as the first choice in all cases of abnormal bleeding. CONCLUSION: Postprocedural antithrombotic therapy aims to reduce the risk related to cardiac disease,with acceptable risks of bleeding ib other systems.

Keywords: antithrombotic therapy, abnormal uterine bleeding, hydroxyprogesterone caproate, urgent surgery, aspirin, klopidogrel

Figure 1



MRI findings of the 2nd patient. Cervical pathology

Table 1

Cases	1	2	3
Age	50	62	43
Cause	abnormal uterovaginal bleeding	postmenopausal bleeding, vaginal discharge	abnormal uterovaginal bleeding
Period	4 days	20 days	2 hours
LMP	3 months ago	10 years ago	1.5 months ago
Obstetrical history	G6P5A1	G4P4	G2P2
Previous operations	C/s	N/A	Total thyroidectomy
Cardiac intervention	PCI-stent*, 14 months ago	PCI-stent, 3.5 months ago/3 vessels	Post MI-left cardiac pacemaker, 1.5 years ago
Medical history	DM,HT,CAD*	CAD, Hyperlipidemia	Hyperthyroidism, HT, Behçet's disease
Drugs	Clopidogrel, aspirin (100 mg), metformin, insulin, atorvastatin, ramipril, nebivolol	Clopidogrel, aspirin, atorvastatin, metoprolol	Clopidogrel, aspirin, ramipril, spironolakton, azathiopirine, atorvastatin
Gynecological examination	a 4-5 cm mass lesion with an extruded stalk from the cervix	extruded from the cervix, bleeding, a 3-4 cm mass lesion	partial bleeding outside the uterus
TV-US	Uterus AVF, adenomyotic, hypertrophic, EL (endometrial thickness): 5 mm, regular, adnexa (adnexal structures) normal	Uterus AVF, adenomyotic, EL (endometrial thickness): 4 mm, regular, 8 cm anechoic cystic lesion in the left adnexa	Uterus AVF, myomatous uterus, EL (endometrial thickness): 17 mm, irregular
Laboratory findings	Hgb: 6,5 g/dL, Hct:19,5 %, INR:1,3 beta hcg: negative	Hgb: 10,4 g/dL Hct: 32 % INR:1 beta hcg: negative	Hgb:11 /dL Hct: 34,9 % INR:1,34 beta hcg: >10000
Transfusion of blood and blood products	4 U ES, 2 U TDP	1 U TDP	N/A
Medical treatment	methylergonovine, mefenamic acid, tranexamic acid	tranexamic acid, hydroxyprogesterone caproate	misoprostol, oxytocin, hydroxyprogesterone caproate
Surgical approach	vaginal myomectomy, endometrial&endocervical curettage	cervical polypectomy, endometrial&endocervical curettage	suction curettage
Final pathology results	Ecc (endocervical curettage): chronic endocervicitis F/c: Non-specific chronic endometritis and compatible with leiomyoma	Ecc: Chronic cervicitis, F/c: Non-specific chronic endometritis and an endocervical polyp, endocervical adenocarcinoma developed on the polyp base, and it is associated with HPV	F/c: desidual reaction

The characteristics of the three patients.

OS-39

In the differantial diagnosis of adnexal masses: Case presentation of 'Appendiceal low-grade mucinous neoplasm'

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OBJECTIVE: Mucinous neoplasms of the appendix are rare tumors that do not exhibit infiltrative growth and are characterized by dysplastic mucinous epithelium. Typically diagnosed in the 5th and 6th decades of life, these tumors are slightly more common in women compared to men. Patients are often asymptomatic, and the diagnosis may be incidentally made through radiological imaging performed for nonspecific symptoms. The biological behavior and clinical course of appendiceal mucinous neoplasms are heterogeneous. Although there are no specific laboratory findings, elevated levels of tumor markers (CA19-9, CEA, CA125) may be observed in these patients.

In our case report, we aimed to emphasize the consideration of appendix masses in the differantial diagnosis of adnexal masses, particulary after laparoscopic identification of an appencieal mucinous tumor in a patient initially diagnosed with a right adnexal mass, and subsequently scheduled for surgery. Our intention is to highlight the importance of taking into appendix masses in the differantial diagnosis of adnexal masses.

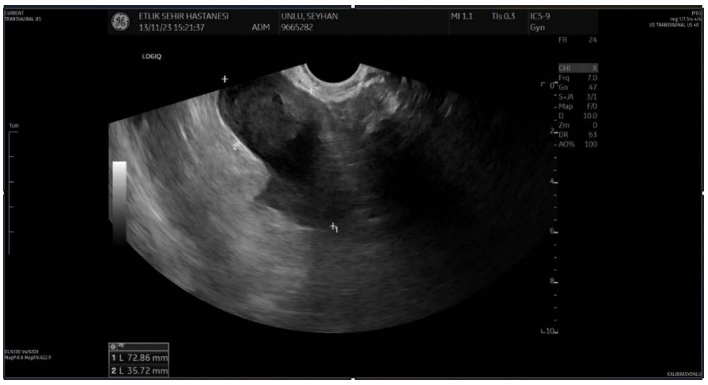
METHODS: A 61-year-old patient who had been in menopause for 7 years, presented to the gynecology outpatient clinic at Ankara Etlik City Hospital with the complaints of postmenopausal bleeding and right-sided pelvic pain. Following clinical examination,laboratory assesments, and radiological imaging, laparoscopic surgical intervention was planned with a provisional diagnosis of a right adnexal mass.

FINDINGS: Transvaginal ultrasonography revealed a dense tubuler lesion measuring 75x35 mm in the right adnexal region, adjacent to the iliac vascular structures. The primary consideration in the differantial diagnosis focused on right tubal pathologies. Additionaly, a 10x5 mm hyperechoic nodular lesion extending into the left cornual area of the endometrial cavity was noted. Laboratory assesment revealed normal levels of tumor markers, including CA125, CEA, CA19-9, and AFP. Mucoid material was observed in the endometrial sampling performed due to postmenopausal bleeding. Diagnostic laparoscopy revealed a uterus with 4 cm type 7 myoma, normal bilateral ovaries, and tubes. However, the appendix appeared to be 8x4 cm in size, tense, and demonstrated an edematous semisolid appearance. No macroscopic pathology was observed in other intra-abdominal organs. The patient underwent a general surgical procedure, transitioning to laparotomy, during which an appendectomy was performed. The intraoperative rapid pathological examination reported a low-grade mucinous neoplasm with no gross extra-appendiceal spread. Subsequently, the patient underwent total hysterectomy, bilateral salpingo-oophorectomy, and complementary right hemicolectomy.

CONCLUSION: The occurence of paraovarian tubular masses often prompts consideration of pathologies associated with the fallopian tubes, especially in cases featuring heterogeneous appearances. This case is noteworthy for underscoring the importance of accurately differentiating adnexal masses, given the potential for intraperitoneal and extraperitoneal masses to be located within the adnexal region. Furthermore, during gynecological surgeries, comprehensive evaluation of all intra-abdominal organs is essential, not limited to the uterus and ovaries, In the differential diagnosis of pelvic and adnexal masses in the anatomical context of the female reproductive system, appendiceal neoplasms should be considered. In instances of clinical suspicion, patients should undergo a multidisciplinary assesment, and treatment strategies should be shaped through intraoperative frozen section examinations.

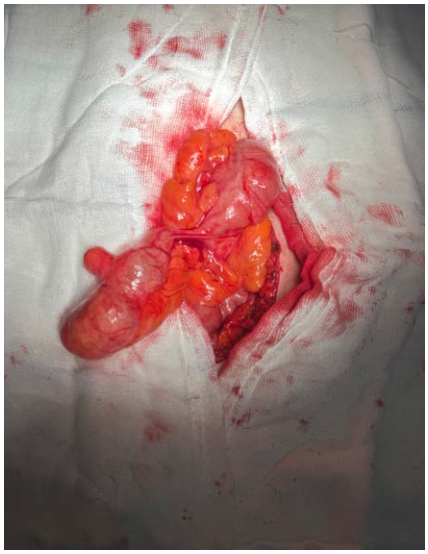
Keywords: adnexal mass, appendiceal tumors, low grade mucinous neoplasm

adnexal mass



ultrasound image of right adnexal mass

mucinous neoplasm of the appendix



macroscopic view of the appendix

OS-40

Synchronous double primary endometrial and gastric cancer: a case report

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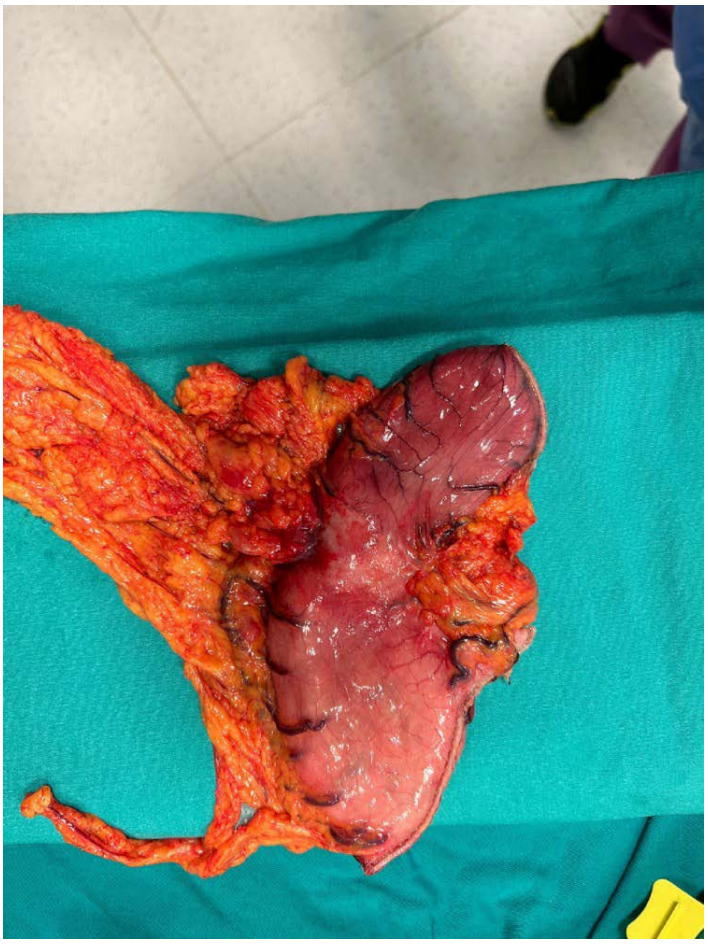
INTRODUCTION: Synchronous primary malignant neoplasms are the coexistence of two or more unrelated malignancies.

CASE: A sixty-five-year-old case (G2P2, body mass index: 24.9 kg/m2) was admitted to the gynecology outpatient clinic due to postmenopausal bleeding. The endometrial biopsy result was detected as endometrioid adenocarcinoma, grade 1. There was no palpable mass on gynecological examination. Transvaginal ultrasonography revealed a mass lesion 5 cm deep within the uterine cavity with signs of myometrial invasion. Serum tumor markers were normal. Abdominopelvic magnetic resonance imaging revealed a 4.5 cm clearly enhancing mass lesion in the uterine corpus fundus. Total abdominal hysterectomy + bilateral salpingo-oophorectomy, bilateral pelvic and para-aortic lymphadenectomy were performed. Intraoperatively, a tumoral mass obliterating the 3 cm lumen was detected in the greater curvature of the stomach. The patient underwent radical distal gastrectomy, roux-ny gastrojejunostomy, jejuno-jejunostomy, perigastric lymph node dissection and omentectomy. As a result of the pathology, the endometrial tumor was reported as serous carcinoma and the stomach tumor was reported as poorly differentiated signet ring cell adenocarcinoma. Tumor size was 5x3 cm, subserosal invasion (PT3), lymphovascular and perineural invasion were detected as positive. Surgical margins were observed to be safe. There were adenocarcinoma metastases in perigastric lymph nodes (2/11). No tumor was found in the omentum. As a result of the immunohistochemical study performed on the uterus, P16 (+), Cerb B2 (-), CK 20 (-), P53 (-), ER (+), PR (-) and CK 7 (+) were detected, while neoplastic cells were found in the stomach tumor. There was no loss of immunoexpression for MLH1, MSH2, MSH6, and there was loss of immunoexpression for PMS2. Also Cerb B2 (-) and PAN CK (+). No residual disease was detected in the positron emission tomography taken after the operation. Due to the risk of recurrence, the patient was started on systemic capecitabine and oxaliplatin after adjuvant pelvic radiotherapy. After six cures of treatment, the patient had no additional problems during observation. Follow-up continues at the 12th postoperative month without any signs of recurrence.

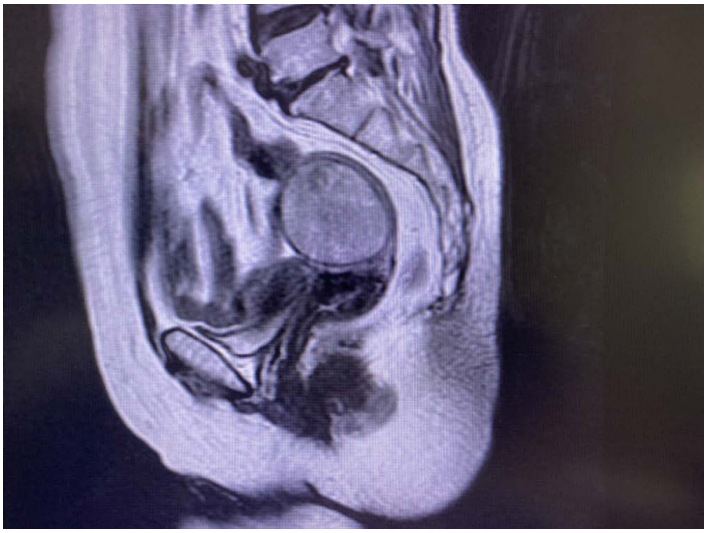
CONCLUSION: Synchronous primary endometrial and stomach cancer is a very rare condition. When detected, surgical management is possible intraoperatively. During gynecological malignancy surgeries, careful evaluation of intra-abdominal findings and treatment of detected tumors with a multidisciplinary approach is possible.

Keywords: endometrial cancer, synchronous tumor, stomach cancer

Synchronous tumor - gastric cancer



Synchronous tumor MRI Image



OS-41

Common iliak artery aneurysm presenting as an adnexial mass

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INTRODUCTION: Most of common iliak artery aneurysyms(-CIAA) are associated with abdominal aortic aneurysms (AAA). Whereas isolated CIAA's are uncommon and are seen in less than 2% of all cases. Generally the common iliac artery is involved (70%), while the internal iliac artery is involved in 25% of the cases. The involvement of the external iliac artery is very rare. The normal diameter in women for common iliac artery is <1.7cm. Even if there is no consensus when to intervene, it is commonly accepted to take through a surgical procuder when it is >3.5cm, hence the greater liklihood of rupture. A spontonous rupture of the common iliac artery is associated with high mortality rate (>70%).

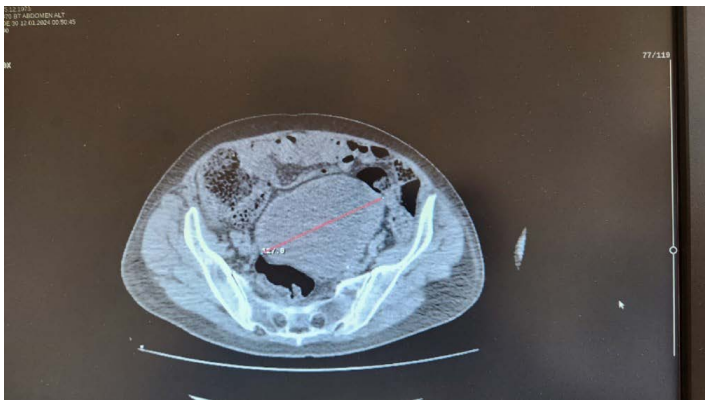
CASE: A 50-year-old woman has G2P2, known for HT and DM. The patient applied to the medical center with abdominal pain, flatulence and digestive problems. And was referred to Kayseri city hospital to gynocological oncology unit for adnexial mass?

FINDINGS: In our physical examination we found a mass from left ovary expanding to the umblicus. In our sonography an adnexial mass of approximately 10 cm with no pathological doppler flow was seen. For further examination we performed an abdominal CT which shows 12 cm diameter a left pelvic ovarian mass. A laparoscopic intervention was planned. In our exploration, no pathological findings where seen in the uterus and ovaries. Instead an isolated CİAA was ascertained. We switched to an open surgery. The common iliac artery was ligated and cut. The dilated part was dissected appropriately and roughly a 16/8 mm dacron greft of 8cm was placed. The currency of the greft was controlled and after inserting the drain, the case was closed.

RESULTS: The patient was transferred to the intensive care unit for closer observation. After the patient was stabilized (in postop 4th day,). 5 mg of warfarin(po 4) and enoxaparin 2x6000 units were started upon the recommendation of the cardiovascular surgeon. The patient was discharged postoperative 7th day. Isolated common iliac artery aneursyms are very rare seen conditions. And they generally don't present in big diameters. In adnexial masses it is recommended to perform preoperative screening methods with contrast enhanced and it also recommended to perform this surgical intervention in a hospital where multidisciplinary team approach.

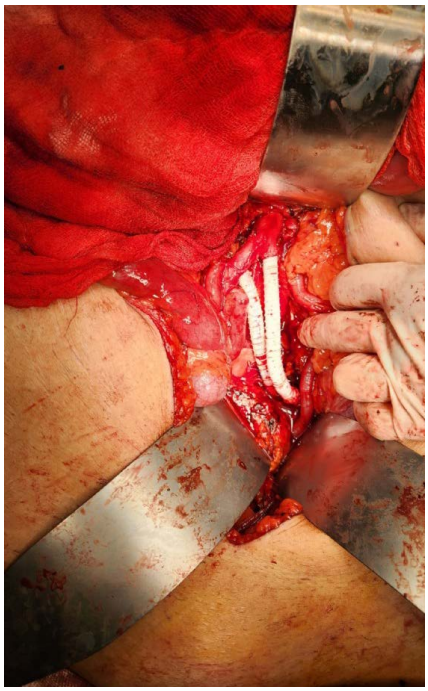
Keywords: Common iliac artery aneursym, adnexial mass, greft,

Abdominal CT

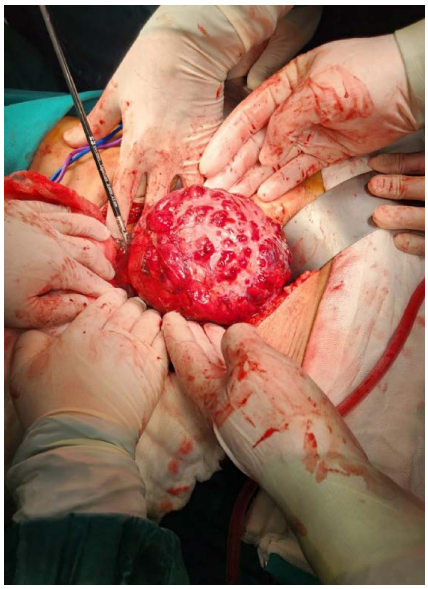


Left common iliac artery aneurysm

After greft replacement



Intraoperative findings



OS-42

Prenatal diagnosis and managemet of fetal ovarian cyst: a case report

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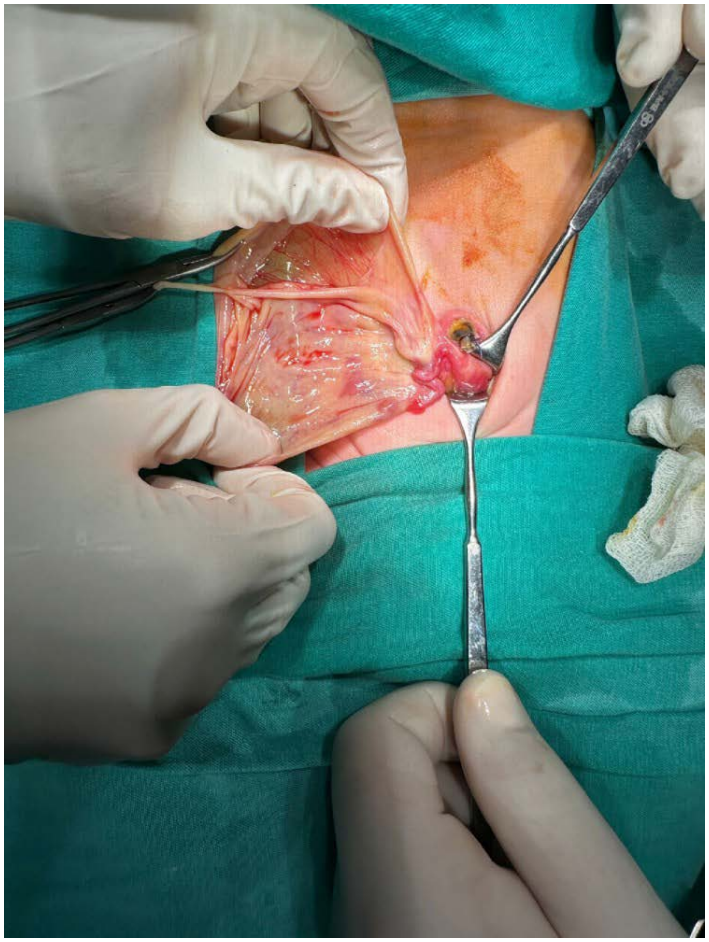
INTRODUCTION: Ovarian cysts are the most common abdominal anomalies diagnosed in female fetuses, with an estimated incidence of about 1 in 2600 pregnancies. The pathophysiology is not determined; however, a widely accepted mechanism is follicle production and maturation from fetal ovarian stimulation by placental and maternal hormones. They are diagnosed most often during the third trimester. The highest priority in perinatal management is careful follow-up to avoid ovarian torsion. However, no definite treatment plan exists for antenatal ovarian cysts. In this case we aimed to present prenatal follow-up and postnatal management of ovarian cyst diagnosed in the third trimester.

Case

A 27-year-old woman was referred to our prenatal centre at 35 weeks of gestation following the ultrasonographic detection of a fetal cystic mass in the abdomen. The cyst measured 67*75*55 mm in diameter, had anechoic content and the thin wall was located in the right lower fetal abdomen; these features suggested a simple ovarian cyst. The patient was informed about the condition and serial ultrasonographic scans were performed weekly. Subsequent ultrasound examination showed anechoic cyst measuring 9*8*7 cm in the fetal abdomen, prompting hospitalization due to an increase in cyst size. Cesarean section was decided with the risk of torsion and breech presentation indication. The woman underwent cesarean section at 38 weeks of gestation and a 3020 g sized female infant was delivered with apgar score of 8 and 9, at 1st and 5th minutes, respectively. The baby was admitted to the neonatal service for further evaluation and treatment. An abdominal ultrasound of the baby revealed a natural left ovary and an assumed thin-walled anechoic cystic lesion measuring 96*95*100 mm extending from the pelvic region to the epigastric region within the abdomen. This single walled cystic lesion was not considered to be an enteric duplication cyst due to its size, with the primary possibility being a mesenteric cyst and the secondary possibility an ovarian cyst. The case was managed by the pediatric surgery department, and a right salpingo-oophorectomy was performed. The pathology result indicated a follicular cyst and a normal tubal segment on histomorphology. CONCLUSION: In the differential diagnosis of pelvic masses detected during the prenatal period, ovarian cysts should be considered. During prenatal monitoring, careful attention should be paid, particularly to cyst rupture and ovarian torsion. Asymptomatic complicated ovarian cysts diagnosed prenatally should be closely monitored. Close monitoring should also continue in the postnatal period. Spontaneous reduction in cyst size may occur, but surgical intervention is recommended in cases of increasing cyst size and intestinal obstruction during follow-ups.

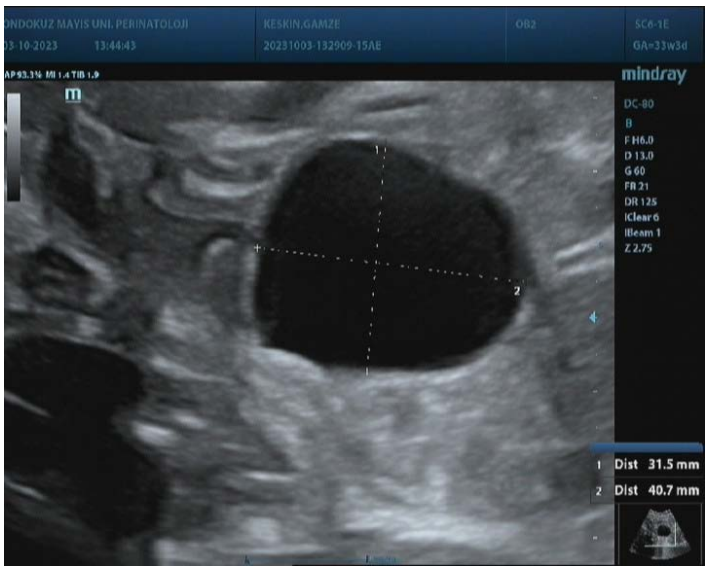
Keywords: ovarian cyst, mesenteric cyst, histological examination,prenatal diagnosis.

ovarian cyst



ovarian cyst

ovarian cyst



Fetal ovarian cyst ultrasound image

OS-43

'Complete septate uterus with duplicated cervices and longitudinal vaginal septum' diagnosed after missed abortion: case report

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INTRODUCTION: Mullerian anomalies are rare developmental anomalies of the female reproductive tract. There are various proposed classification systems for Mullerian anomalies. Of all of these, the American Fertility Society (AFS) Classification is the most widely known and practiced. The advantage of this classification is that it is relatively easy to recognize and anomalies classified in similar groups have similar pregnancy outcomes. While the prevalence of Müllerian anomalies is approximately 5% in unselected patients, it is more frequent in women with reproductive problems, with a prevalence of 8% in infertile women and 13% in women with a history of miscarriage. While arcuate uterus is most frequently observed in the unselected group, uterine septum is the most frequent anomaly in the high-risk population In the ASRM 2021 classification of müllerian anomalies, complete septate uteruses are categorized in two separate groups as duplicated cervices and septate cervix (1). Hysteroscopic surgery of complete uterine septum comprises excision or preservation of the cervical septum (2). In a randomized study, reproductive outcomes were comparable in cases with and without preservation of the cervical septum (3). However, in a case series, an additional need for cerclage was found in patients who underwent cervical septum resection due to cervical shortening.

CASE: A 23-year-old nulliparous woman was admitted to our hospital after her 8-week pregnancy resulted in miscarriage. Vaginal examination revealed a complete longitudinal vaginal septum extending from the vaginal introitus to the cervix and two separate cervixes. 3D ultrasonography revealed a complete uterine septum and normal uterine fundus without any indentation. The patient has undergone both vaginal and hysteroscopic surgery. The complete longitudinal vaginal septum was excised with a bipolar handpiece (LigaSure™) all the way to the cervix. Then, hysterometry was applied from the right cervix to the right uterine cavity from two separate cervixes. After the left cervix was dilated up to 10 hegar spark plugs, the left uterine cavity was entered with a hysteroscope. Hysterometry in the right cavity was performed by mobilizing the hysterometer carniocaudally and the septum to be excised was determined. The uterine septum was excised with bipolar energy and the cervical septum was spared.

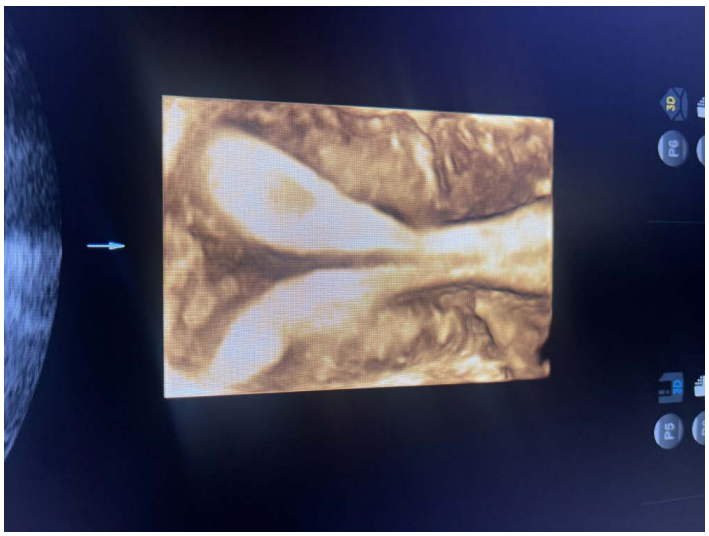
CONCLUSION: Mullerian anomalies may be diagnosed delayed and may be subjected to inappropriate or inadequate surgical procedures. In cases of complete uterine septum, metroplasty with sparing of the cervical septum may be performed in those with duplicated cervix. More studies are needed to determine the appropriate surgical technique.

(Figure 1: Complete uterine septum with preoperative 3D ultrasonography.

Video 1: Vaginal and hysterocopic surgery of the uterovaginal septum with sparing of the cervix)

Keywords: uterovaginal septum, septum resection, miscarriage, cervical duplication, duplicated cervix

Complete uterine septum with preoperative 3D ultrasonography.



OS-44

Ectopia Cordis: Case Report

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INTRODUCTION: Ectopia cordis (EC) is a rare defect where in a portion of the heart or its entirety is located outside the thoracic cavity. The annual incidence of EC ranges from 5.5 to 7.9 per million live births. EC accounts for 0.1% of all heart defects. (1)

The causation of ectopia cordis is a failure of appropriate maturation of mid-line mesoderm and ventral body wall (chest) formation during the development of embryonic, but the precise reason for this abnormality is stil unknown. (2)

Ectopia cordis may occur as an isolated condition; however, it has a strong association with congenital heart diseases or other mid-line defects. Omphalocele is the most common abdominal defect associated with ectopia cordis.(4)

Ectopia cordis may be grouped into cervical (3%), cervicothoracic (<%1), thoracic (60%), thoracoabdominal (7%), or abdominal type (30%). Thoracoabdominal EC has a beter prognosis, whilst only a few patients with the thoracic type have survived and the cervical type is not compatible with life. (3)

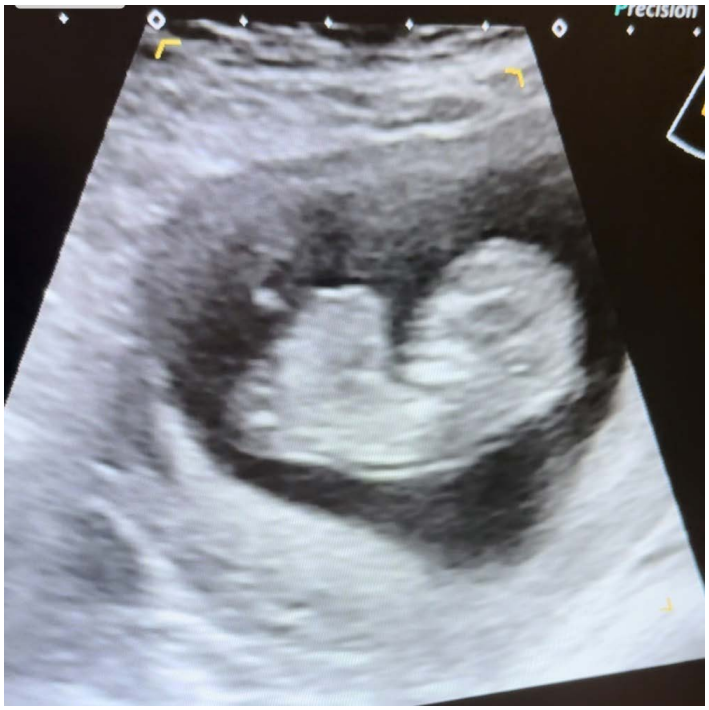
CASE: A 23-year-old healthy primigravida was referred to our antenatal clinic to undergo a nuchal translucency thickness scan at 12 weeks' gestation. She has no previous history of smoking, medical illness or specific medications. A detailed transabdominal ultrasound scan revealed a live fetus with a crown–rump length of 4.5 cm, consistent with a gestational age of 12 weeks. The nuchal translucency thickness was 0.2 cm. The ultrasonography showed a pulsating heart outside of the thorax with loss of anterior chest wall. A large anterior abdominal wall defect with supra-umbilical omphalocele and additionally clubfoot, marginal umbilical cord insertion were noted. The amniotic fluid volume was normal.

The patient counseled about the high likelihood of miscarriage, stillbirth, or neonatal/infant demise, since the abnormality is generally considered lethal. Options discussed include pregnancy termination, continuation of pregnancy with neonatal/infant palliative care and the possibility of repair. We offered chorionic villus sampling and microarray as this information can be helpful for parental decision-making, even though the anatomic findings alone are prognostic of a lethal outcome. Considering that this diagnosis was considered to be incompatible with life, the patient decided to proceed with a termination of pregnancy.

Outcomes: Ectopia cordis is associated with high mortality rates and intra-cardiac/extra-cardiac defects. (1) Even after initial stabilization and corrective surgery, patients with ectopia cordis face considerable long-term morbidity and mortality. (6) Prenatal detailed assessment of EC is important in intrauterine diagnosis and fundamental to antenatal parental counseling.(1) Since their prognosis is poor in the postnatal period, detection of such cases before viability is important in terms of ease of pregnancy termination, low complications and especially psychogenic positive effects on the mother. (5)

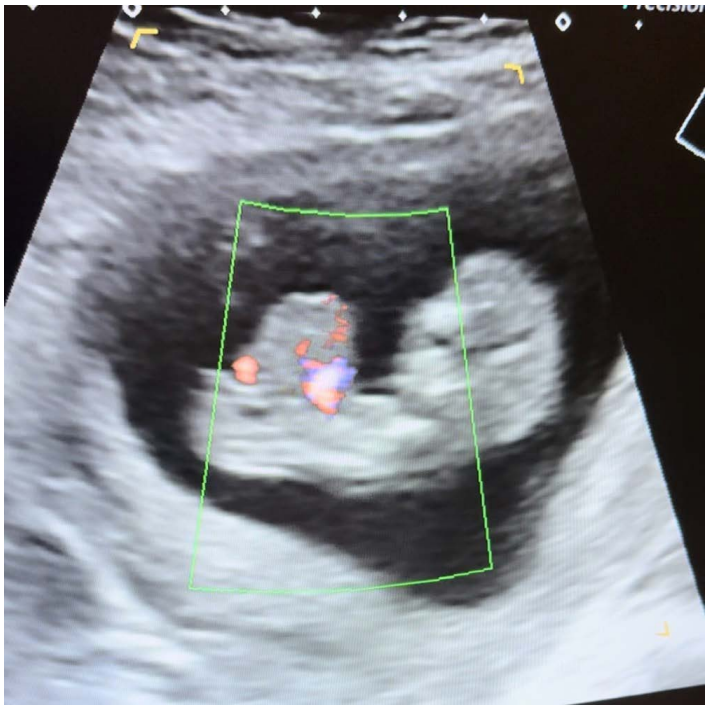
Keywords: Ectopia Cordis, Omphalocele, Club Foot, Marginal Umbilical Cord Insertion

Figure 1



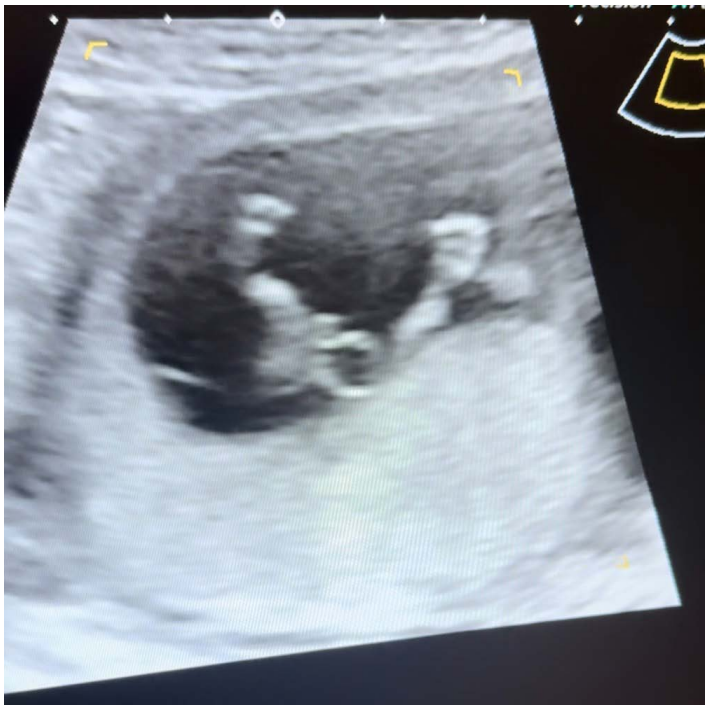
Supra-umbilical omphalocele with ectopia cordis

Figure 2



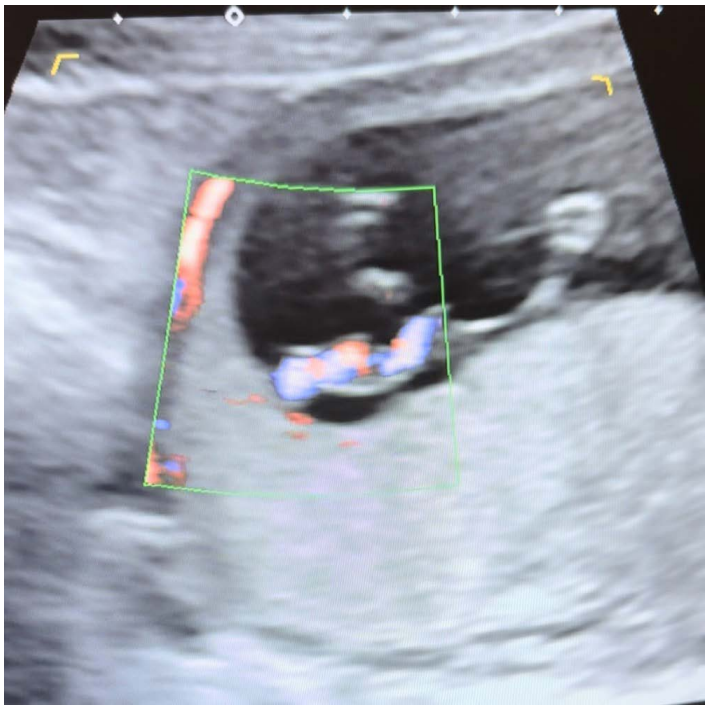
Ectopia cordis with doppler

Figure 3



Club foot

Figure 4



Marginal cord insertion

OS-45

Otohiysterectomy? Anterior And Posterior Wall Uterine Rupture Case

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INTRODUCTION: A clear idea about determining the time of elective cesarean section could not have been established in cases with repeated one. In terms of neonatal outcomes, if there is no additional indication for preterm delivery, it is thought that elective cesarean section should not be planned before the 39th week. In the case of obstetric outcomes, there is no consensus on week of delivery for elective repeat cesarean sections unless there is an additional condition complicating pregnancy.

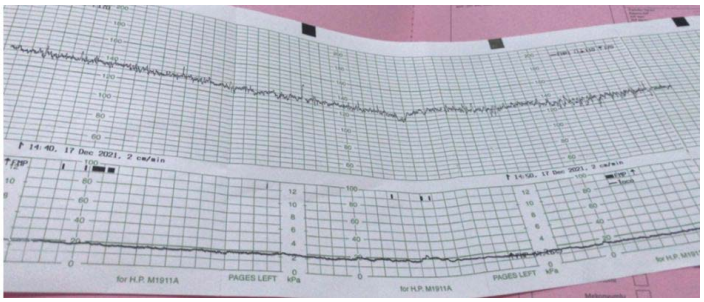
In a case, 38-year-old patient, g7p2a4, observed that no known comorbidity and no history of operation other than 2 cesarean section were found. When the gestational age was 38w3d, the patient applied to the pregnant outpatient clinic. Following that preoperative blood tests were performed for elective cesarean section, the patient was called again to make an appointment with the results on the same day. But in contrast, the patient applied to the pregnant outpatient clinic 8 days later (39w4d) to get the results and to make an appointment for elective cesarean section. She stated that pain had been present for 3 days in her outpatient clinic application and had felt good infant motions. The patient was pale, but his vital signs were extremely stable. As a result of nonreactive monitoring of NST, obtained before hospitalization, the patient was admitted to the delivery room. During the examination, performed in the delivery room, the heart rate was measured as 95/minute, the blood pressure was noticed as 110/70 mmHg and the body temperature was obtained as 36.5 °C. The patient was transferred to emergency surgery due to the negative fetal heartbeat on USG and suspected uterine rupture. The abdomen was entered with a pfannenstiel incision. The uterus was ruptured from the anterior and posterior walls and in addition to the fetus, 2000cc of coagulated and defibrillated blood was detected visually in the abdomen. The fetus was removed and delivered to the waiting neonatal resuscitation team, However, it was accepted as exitus after the examination and intervention. The patient's uterus was noticed to rupture from the anterior and posterior walls along the lower segment, including the old incision line, the only tissue observed was the left uterine artery. Approximately 3cm length, including the uterine artery was not ruptured on the right side. total hysterectomy and bilateral salpingectomy were administered to the patient. Totally 4 units of red blood cells and 3 units of plasma were transfused to the patient with a hemoglobin value of 7.6 at the beginning of the operation. At the end of 4 days, she was discharged with a stable HB of 10.3 and vital signs.

Discussion and CONCLUSION: Further studies are needed in order to make the appropriate timing, considering neonatal outcomes and maternal complications, while planning an elective cesarean section in patients with 2 or more previous cesarean sec-

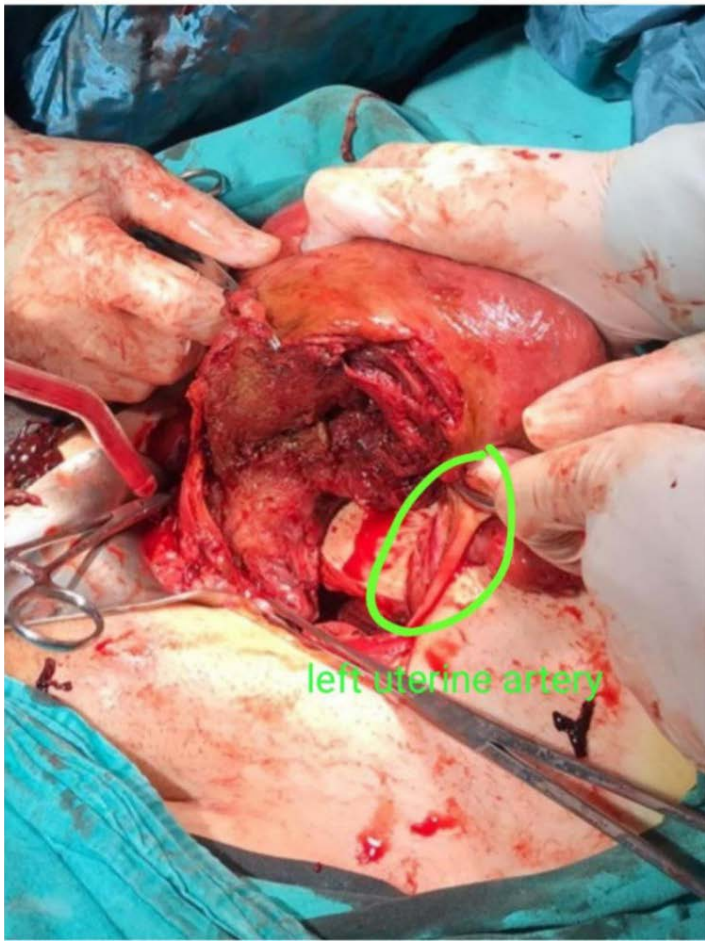
tions and not to encounter a picture such as uterine rupture that threatens the life of the fetus and mother.

Keywords: uterine rupture, repeated cesearean, pregnancy

nst



uterine rupture



OS-46

Gossipiboma detected late as a complication of peripartum hysterectomy with indication of bleeding after cesarean section

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PURPOSE: Gossipiboma is defined as a foreign object (such as surgical instruments, sponges, surgical pads and compresses) forgotten in the operation area after surgery. It is possible to prevent gossipibomas, but in cases where this cannot be achieved, we aimed to emphasize that morbidity and mortality can be prevented with early detection of gossipibomas.

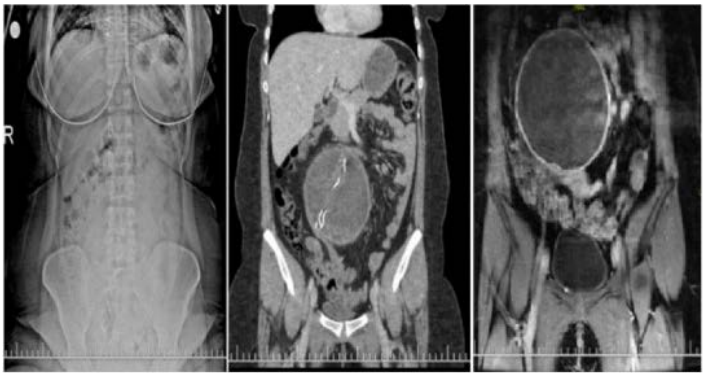
METHOD: In suspicious cases, gossipibomas can be detected with imaging methods such as ultrasonography, magnetic resonance, and computed tomography. Compresses with radio-opaque strips can be identified with certainty even with a very simple imaging method such as plain radiography. It should not be forgotten that there may be imaging findings in favor of abscess in those diagnosed late.

RESULTS: The patient was a 21-year-old nulliparous pregnant woman with a 36-week pregnancy. She was referred to us due to intrauterine growth retardation and elevated liver enzymes (AST: 242, ALT: 308). In addition to the detection of five-week growth retardation and oligohydramnios on ultrasonography, the patient underwent cesarean section due to liver enzymes that continued to increase during follow-up. A male baby with an Apgar score of 8-9 and a weight of 1790 grams was delivered by cesarean section. It was observed that amniotic fluid decreased significantly and thick meconium was observed. The patient had intense vaginal bleeding in the second postoperative hour. On examination, the uterus was atonic. Bakri Balloon was applied to the patient, who received a partial response to uterotonic treatment, under ultrasonography guidance. As bleeding continued and the patient's vital signs worsened, laparotomy was performed. Compression sutures were applied because the uterus was atonic. Bilateral uterine and hypogastric arteries were ligated. Hysterectomy was performed when a Couveliare uterus was observed and bleeding continued. During the surgery, the patient was given 2 units of erythrocyte suspension, 4 units of fresh frozen plasma and 2 grams of fibrinogen. The patient was discharged in stable condition on the ninth postoperative day. The patient, who was admitted to the hospital due to pain, had a direct radiograph taken in the seventh postoperative month. The suspicion of a foreign body (radio-opaque strips) was confirmed as a 12*10 cm mass on computed tomography and magnetic resonance imaging. With the preliminary diagnosis of abscess and foreign body, the patient underwent relaparotomy through a subumbilical median incision. During surgical observation, a conglomerate, hard, dense mass, approximately 10 cm in size, surrounded by omentum, was observed between the small intestines. The mass was separated from the surrounding tissues with blunt and sharp dissections. No early complications were observed. The pathology result was compatible with abscess and foreign body. The patient was discharged on the 15th day after the third operation.

CONCLUSION: Gossipiboma can cause serious morbidity and mortality. Early diagnosis and relaparotomy are very important in cases of Gossipiboma.

Keywords: Gossipiboma, peripartum hysterectomy, cesarean section

Figure: Postoperative plain radiography, computed tomography and magnetic resonance images



OS-47

Use of a vaginal stent to prevent stenosis following vaginal brachytherapy, how long?

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INTRODUCTION: The long-term sequelae of vaginal brachytherapy (VBT), which can be used as an effective local treatment option for vaginal embryonal rhabdomyosarcoma (ERMS), is the risk of radiation-induced fibrosis and stenosis assumed to persist for up to 6 months after completion of therapy. We aim to report the long-term use a foley catheter as a vaginal stent in a girl underwent VBT.

CASE: A two-year-old- girl presented with a mass protruding through the introitus diagnosed with vaginal ERMS and treated with chemotherapy (CHT) alone due to complete response. Six months after the last CHT dose, because of the development of local recurrence, second-line CHT was initiated and the patient was referred to our institution for a local treatment plan. Following three cycles of CHT, intracavitary VBT was administered at different time periods with a total dose of 36 Gy. Six weeks after completion of VBT, vaginoscopy was performed with no evidence of residual disease and a nonlatex 22 French foley catheter placed in the vagina (Figure1). The patient continued to receive CHT for about six month. With follow-up vaginoscopy performed every 3 months, the stent was replaced in the same fashion and remained in place for a total of 6 months. Since vaginal stenosis was detected 3 months after the stent was removed (Figure2), the stent was placed again and remained in place for another 6 months. The patient did not develop any stent-related complaints. After 18 months of follow-up, control vaginoscopy revealed normal vaginal mucosa with no lesions or erosions.

CONCLUSION: Vaginal dilation, used as the primary method to prevent vaginal stenosis due to VBT in adults, is a traumatic method for young children. Our report shows that long-term use of vaginal stents up to 1 year may prevent the development of BT-induced vaginal stenosis.

Keywords: adolescent gynecology, brachytherapy, rhabdomyosarcoma

OS-48

Miyom ve gebelik komplikasyonları

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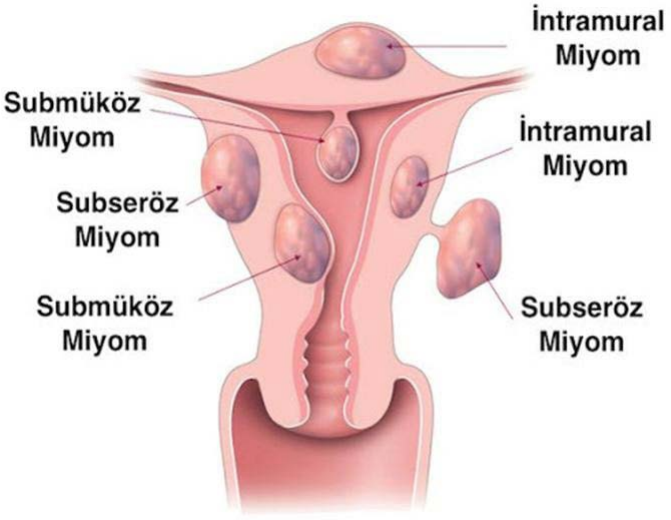
kahramanmaraş sütçü imam unıversıty obstetrıcs and gynaelogy

Uterine myomas are benign tumors of unknown etiology originating from the uterine smooth muscle. It is reported at a rate of 3-12% in pregnant cases. In pregnant women with myoma uteri; The incidence of threatened miscarriage, threatened preterm labor, placental abruption, malpresentation, pelvic pain, and cesarean delivery has increased. It may cause prolonged bleeding in the postpartum period. Cases with uteri myoma should be followed carefully for possible complications during pregnancy, birth and the postpartum period. Most patients with fibroids do not experience any complications related to fibroids during pregnancy. Submucous myomas, which make up approximately 5% of all myomas, originate from the muscle layer just below the endometrium. They can disrupt a woman's natural menstrual balance and also affect her chances of fertility. When complications occur, pain is the most common complication and is related to its size. Size and location pose risk factors for pregnancy complications, with retroplacental fibroids associated with an increased risk of miscarriage, placental abruption, fetal growth restriction, bleeding, and premature birth. In pregnant women with small fibroids, myoma volume tends to increase during pregnancy. The change in myoma volume during pregnancy may also be affected by maternal characteristics such as age, race or ethnicity, parity, and history of miscarriage. Surgical removal of fibroids during pregnancy should be avoided due to the risk of significant morbidity (bleeding). Caesarean section is performed for standard obstetric indications (e.g. malpresentation, non-progressing labor), including obstruction of the birth canal by fibroids. Fibroids have been associated with an increased risk of placenta previa and abruption. Prior hysteroscopic removal of a submucosal fibroid may increase the risk of placenta accreta spectrum.

Keywords: pregnancy, Leiomyoma, diagnosis, cesarean section, treatment

myom

myom



OS-49

Managing malign melanoma as an adnexal mass

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Introduction

Genitourinary melanoma accounts for approximately 0.5% of all melanomas. It is a highly aggressive skin malignancy that often presents with metastasis. Malignant melanomas affecting the vagina and vulva are believed to originate from perineal skin tissue and may metastasize in pelvic lymph nodes. Ovarian malignant melanomas are believed to mostly arise from ovarian teratomas. However, there are isolated cases where these malignancies are not associated with any primary teratoma. Here we present a case of an adnexal mass as a malignant melanoma with an unknown origin.

Case presentation

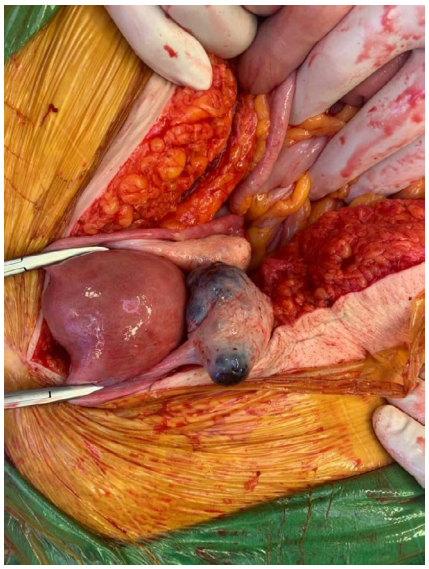
A 40-year-old patient was referred to our department following the results of a PET-CT scan revealing multiple adnexal masses, the largest of which measured 7.3x5.5 cm and showed typical malignant features such as central necrosis. Additionally, multiple pelvic lymph nodes were identified as possible metastases. The patient had no primary gynecological symptoms. Apart from a previous brain metastasectomy due to malignant melanoma, there were no significant gynecological features in her medical history. During the pelvic exam, a fixed mass was palpated in the right fornix posterior. Transvaginal ultrasonography revealed a right adnexal mass containing cystic and necrotic forms measuring 7.5x5 cm. The left ovary was enlarged and showed signs of high vascularity. The tumour markers, apart from LDH which was 445, were negative. During the surgery, which was performed with a median incision, we observed a 4 cm mass included the left ovary (figure 1), a 7 cm retroperitoneal lymph node in the right pelvic area (figure 2), and two metastatic small bowel tumours (figure 3). Intraoperative frozen section consultation confirmed the presence of melanoma as expected (figure 4). Surgery continued with debulking, followed by total abdominal hysterectomy, bilateral salpingo-oophorectomy, pelvic paraortic lymph node dissection (figure 5), omentectomy, small bowel wedge resection for two masses. The patient was discharged on postoperative day 9 without complications. Perminant pathology revealed malignant melanoma, origin unknown, and as suggested by the multidisciplinary board, the patient underwent both chemotherapy and immunotherapy. At 3-month postoperative follow-up, although PET-CT showed cerebellar recurrence, there was no evidence of active abdominopelvic lesions.

Discussion

Malignant melanoma of the pelvis is often found in the retroperitoneal lymph nodes due to a primary melanoma in the skin of the lower extremities.Transformation from mature cystic melanoma is considered the main theory for ovarian malignant melanoma. Clinicians should be alert for atypical presentations and appropriate management, as the etiological risk factors and epidemiological trends are not well established due to the rarity of this condition. Given the presence of an adnexal mass and a history of melanoma, it is important to suspect an ovarian metastasis. The optimal treatment for pelvic malignant melanoma remains to be defined, but literature suggests a primary role for surgical resection of all tumours. This case highlights the potential importance of recognition and management of adnexal masses and debulking surgery in the prognosis of malignancies of unknown or unclassified origin.

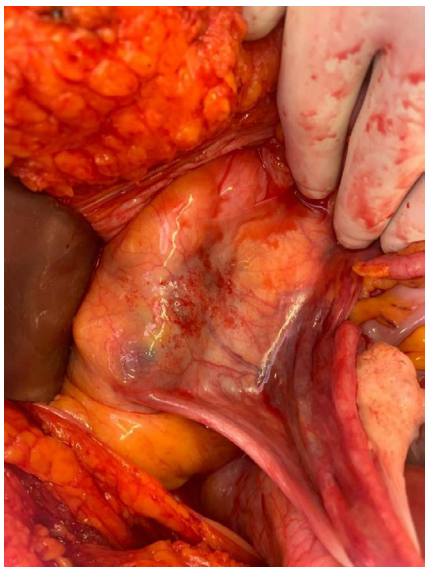
Keywords: Adnexal mass, Debulking surgery, Malignant melanoma, Ovarian cancer

figure 1



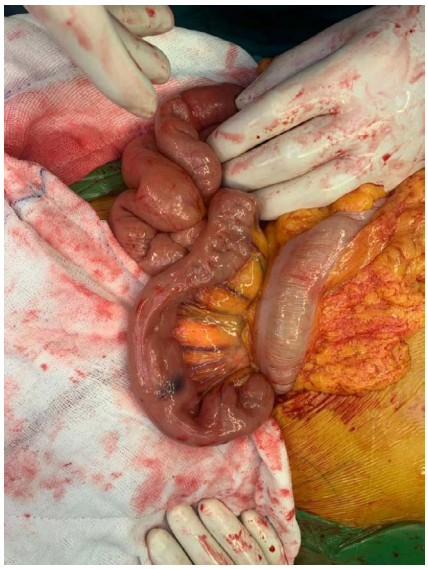
Left ovarian mass

figure 2



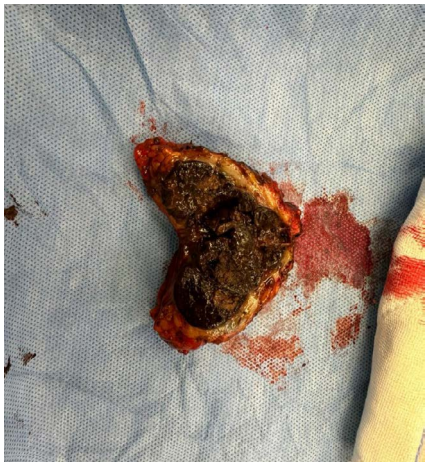
Retroperitoneal lymph node in the right pelvic area

figure 3



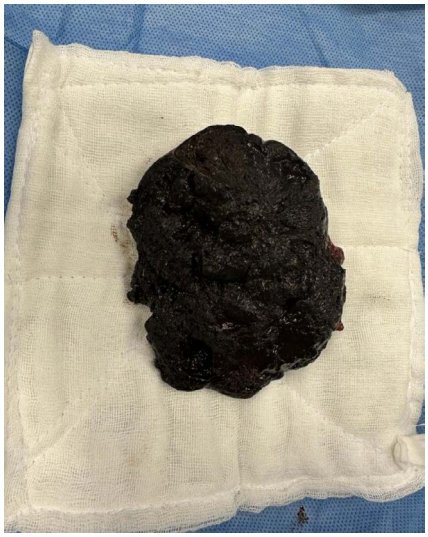
Metastatic small bowel tumour

figure 4



Left adnexal mass

figure 5



Right pelvic lymph node, dissected

OS-50

A Rare Case Following IVF Treatment: Heterotopic Pregnancy

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Purpose: Heterotopic pregnancy is the concurrent occurrence of intrauterine and extrauterine pregnancies. Its incidence ranges from 1 in 100 to 1 in 30,000. With the increased use of assisted reproductive techniques, the frequency of heterotopic pregnancies has risen to between 1% and 3%. Due to its rarity, there is no standard monitoring or treatment protocol for heterotopic pregnancy. Although various treatment approaches have been described, the traditional approach is surgical intervention. In our case, we aim to present a rare but significant instance of heterotopic pregnancy following IVF treatment, particularly notable for causing acute abdominal symptoms in the first trimester. This case underscores the importance of considering heterotopic pregnancy in the differential diagnosis, through a review of the literature.

Method: A 35-year-old woman, on her first pregnancy, after her 4th attempt at IVF, presented to our emergency department with complaints of dizziness and vomiting, corresponding to 6 weeks and 5 days of gestation. Ultrasound examination revealed an intrauterine CRL of 5.5mm (compatible with 6 weeks and 6 days of gestation) with a positive fetal heartbeat, and a 6 cm mass was observed in the Douglas pouch. In the left adnexal region, a 25*17mm hyperechoic area compatible with an ectopic pregnancy, surrounded by edematous tubal tissue, and abdominal defense in the patient led to a preliminary diagnosis of heterotopic pregnancy, prompting the decision for emergency laparoscopy.

Findings: Following the diagnosis of heterotopic pregnancy based on ultrasound findings and clinical presentation, emergency laparoscopy revealed ruptured ectopic pregnancy material in the left tubal isthmic region and approximately 600 cc of defibrinated blood in the abdomen. The patient underwent peritoneal lavage, aspiration, and left salpingectomy. The removed material was sent to pathology. Pathological examination identified chorionic villi, interpreting them as ruptured ex-utero material. Postoperatively, the patient's intrauterine pregnancy continued healthily. The patient was discharged on the second postoperative day with recommendations.

Conclusion: Although spontaneous heterotopic pregnancy is quite rare, it is a condition with high maternal and fetal mortality and morbidity. In all first trimester pregnancies presenting with groin pain and signs of peritoneal irritation, especially those resulting from assisted reproductive techniques, heterotopic pregnancy should be considered in the differential diagnosis. Even if an intrauterine pregnancy is observed via ultrasound in patients presenting with these complaints, the entire pelvis should be carefully examined, and heterotopic pregnancy should be considered in the differential diagnosis. Our case is significant as a rare instance of this condition and underscores the importance of timely intervention based on a preliminary diagnosis of heterotopic preg-

nancy, leading to a successful outcome. Currently, the patient's pregnancy is ongoing at 22 weeks with a healthy gestation, and follow-up is still being conducted by us.

Keywords: heterotopic, IVF, rupture

Figure.1 The image of intrauterin pregnancy

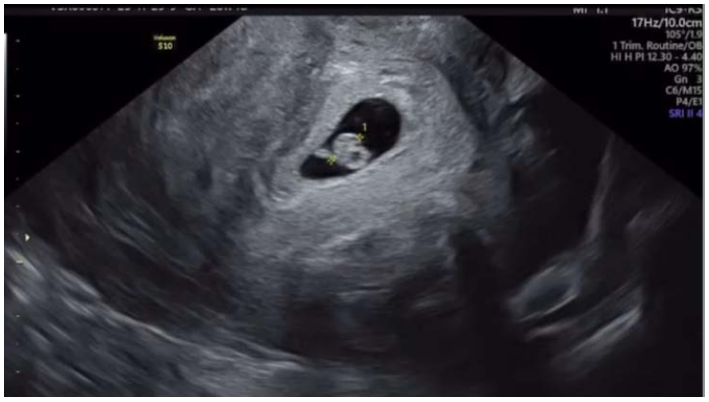


Figure.2 The ultrasonographic image of intraabdominal hemorrhage in the adnexal lodge and Morrison

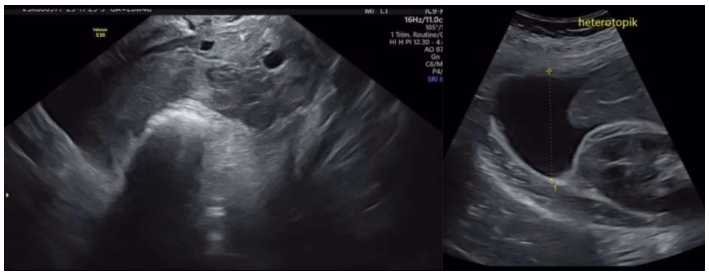


Figure.3 The image of tubal rupture in laparoscopy

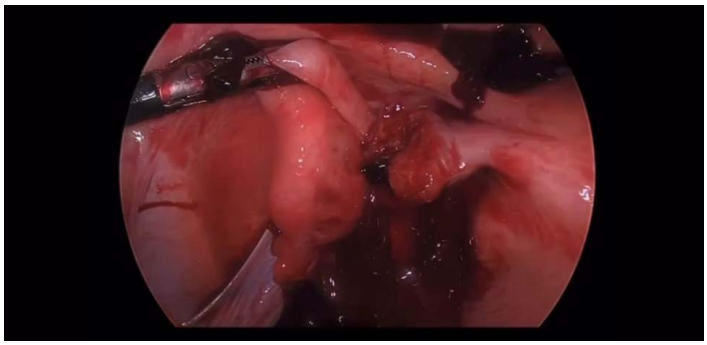
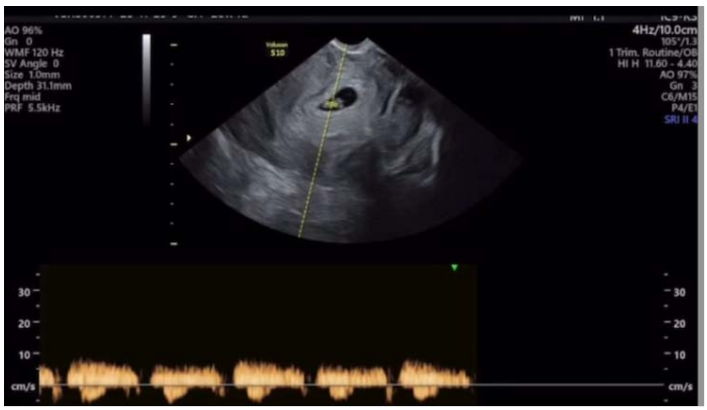


Figure.4 The Fetal Heart Rate After Operation



OS-51

A novel FRAS1 gene mutation linked to Fraser Syndrome: Case report of a consanguineous couple with recurrent renal agenesis and a review of the literature

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OBJECTIVE: Fraser Syndrome (FS), Cryptophthalmos-Syndactyl Syndrome, a rare congenital disease inherited in an autosomal recessive manner. The characteristic features of this disease are cryptophthalmos, syndactyly, laryngeal atresia, renal agenesis, cleft lip and palate, and congenital heart disease. It results from a homozygous or heterozygous mutation in the FRAS1, FREM2, or GRIP1 genes and shows extreme clinical variability. We present a prenatal case of Fraser syndrome suspected at 18 weeks of gestation with bilateral renal agenesis, oligohydramnios, and congenital high obstruction airway syndrome in consanguineous parents with two affected children with renal agenesis.

METHODS: At 18 weeks of gestation, a 24-year-old patient was referred to our Perinatology Department for further evaluation due to fetal renal agenesis and oligohydramnios. The parents, who are consanguineous, had a history of similar renal agenesis in two previous pregnancies. Ultrasound examination revealed significant oligohydramnios, bilateral renal agenesis, and fetal ascites. Additionally, there were signs of hyperechoic enlarged lungs and an inverted dome shape of the fetal diaphragm. The trachea and bronchi appeared dilated, suggesting the presence of congenital high airway obstruction syndrome (CHAOS). Although the heart was anatomically intact, it showed signs of central compression. Abdominal distension due to ascites and a low-set insertion of the umbilical cord were also observed (Figure 1). Given these ultrasound findings combined with the family's history of renal agenesis, we suspected Fraser syndrome. We discussed the syndrome's characteristics and poor prognosis with the parents, offering the option of pregnancy termination, which they chose. After the termination, the fetus, weighing 325 grams, presented with several phenotypic abnormalities: hypertelorism, bilateral cryptophthalmos, downslanting palpebral fissures, micrognathia, microstomia, dysmorphic low-set ears, atresia of the external auditory meatus, cleft palate, symbrachydactyly of both hands, abdominal distension due to ascites, low insertion of the umbilical cord, non-identifiable labia majora, and clitoromegaly indicating ambiguous genitalia. (Figure 2). Considering the findings in the case we presented, the diagnosis was compatible with Fraser syndrome according to the revised diagnostic criteria by Van Haelst et al. (Table 1).

RESULTS: The tissue sample was collected from the fetus for the genetic testing. The karyotype analysis resulted in 46, XX. Given the diagnosis of Fraser syndrome, sequencing of the FRAS1, FREM2, and GRIP1 genes was performed using the next-generation sequencing method (Illumina NextSeq 500 System, USA). This analysis identified a novel homozygous missense variant, NM_025074:c.8258G>A (p.Cys2753Tyr), in the FRAS1 gene.

CONCLUSIONS: FS is a genetically and phenotypically heterogeneous syndrome. Collaboration between specialists in fetal medicine and genetics in prenatal diagnosis is crucial. The presence of renal agenesis, CHAOS on ultrasound, and a relevant family history should raise suspicion of FS. Due to the syndrome's heterogeneity, each additional anomaly and newly discovered gene mutation enriches our understanding and preventative strategies for future cases. Molecular confirmation enhances patient and family understanding of the phenotype, enabling informed reproductive decisions.

Keywords: Cryptophthalmos, Fraser syndrome, FRAS1 gene, Renal agenesis

Figure 2. Clinical features of fetus: (a) abdominal distention from ascites, low-set ears (b) Fetal facial features included abortive cryptophthalmos, hypertelorism, microtia and cutaneous syndactyly and brachydactyly of the hand (c) low insertion of

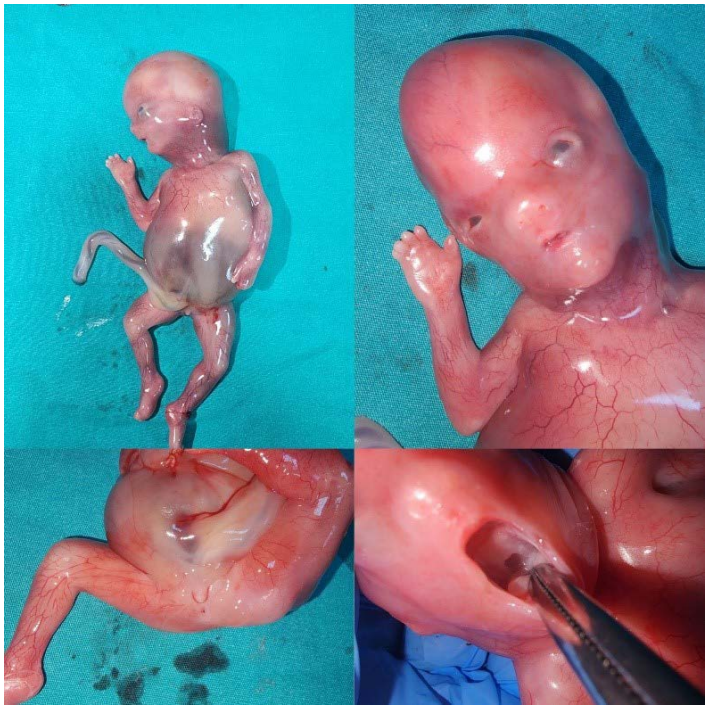
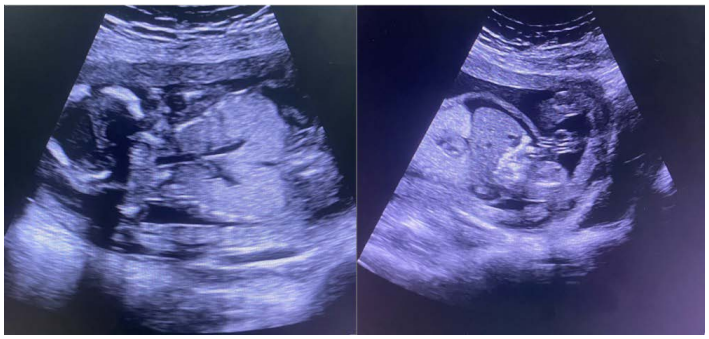


Table 1. Diagnostic criteria for Fraser syndrome porposed by van Haelst et al. in 2007

Major Criteria	Minor Criteria
Syndactyly	Anorectal defects
Urinary Tract Abnormalities	Skull ossification defects
Laryngeal And Tracheal Anomalies	Nasal anomalies
Positive Family History	Nasal anomalies
Cryptophthalmos Spectrum	Dysplastic ears
Ambiguous Genitalia	

Figure 1. (a) Coronal scan of the fetal thorax. The lungs were enlarged, hyperechogenic; trachea, and bronchi are dilated with an inverted diaphragm (CHAOS) (b) The low insertion of umbilical cord and abdominal distention from ascites



OS-52

Performing uterus-sparing surgery during cesarean section in a pregnant woman diagnosed with placenta perkreta who is in late term pregnancy and has had a previous cesarean section, Case Report

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Intraduction: Placenta percreta is a life-threatening obstetric emergency characterized by the abnormal invasion of chorionic villi into the uterine wall. It is related to the previous uterine scars including caesarian sections, prior intrauterine infections and uterine curettage (1). Although there are various treatment options; subtotal or total abdominal hysterectomy is the life saving procedure in most of the cases. Avoidance of severe hemorrhage can be achieved by performing classical caesarean section, leaving the adherent placenta in situ and either immediate hysterectomy or hysterectomy after 2-6 weeks of delivery. Late hysterectomy may be a good option as keeping the placenta in situ and may allow for the involution of the uterine vascularity, decrease the blood loss and facilitate the hysterectomy especially by avoiding bladder injuries (2,3). Embolisation of the uterine arteries and treatment with methotrexate have also been described as alternative treatment techniques. Preserving fertility by avoiding hysterectomy is very difficult in those patients with abnormal placentation (4-6). Surrounding resection technique of the placenta percreta can be a good treatment option in cases with placenta has partially or focally invaded the myometrium layer.

CASE: In this case, surrounding resection technique with bilateral uterine artery ligation is described as an option in selected cases who desire fertility.

CONCLUSION: In appropriate and selected cases with focal placenta percreta surrounding resection technique can be used by an experienced and equipped surgical team.

Keywords: Fertility preservation, obstetric surgical procedure; placenta percreta, uterine artery ligation

Figure 1: First view of the uterus after removal of a well-circumscribed area of placenta percreata in a slightly circular manner.

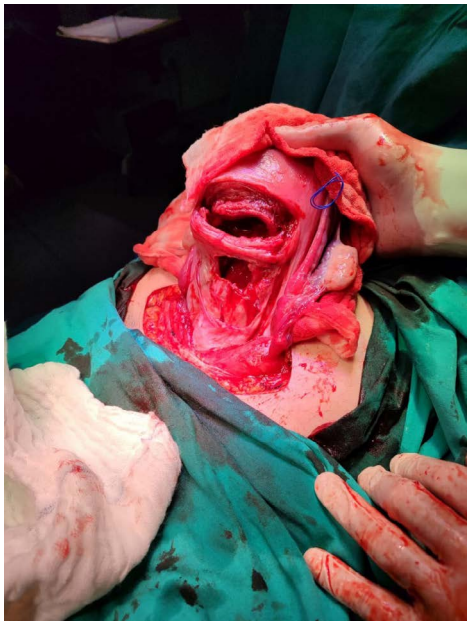


Figure 1: First view of the uterus after removal of a well-circumscribed area of placenta percreata in a slightly circular manner.

Figure 2: Final view of the uterus after bilateral uterine artery ligation and repair of the uterus one by one with z suture technique resulted in uterine sparing surgery

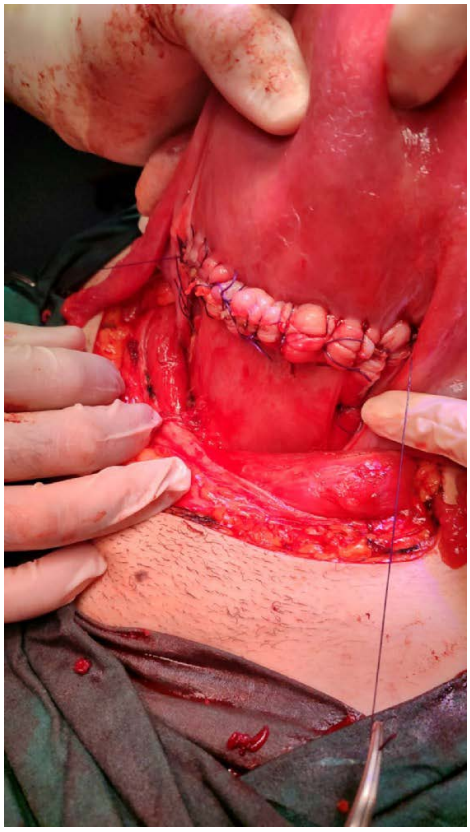


Figure 2: Final view of the uterus after bilateral uterine artery ligation and repair of the uterus one by one with z suture technique resulted in uterine sparing surgery

OS-53

Paratubal Kist Torsiyonu

Alev Özer, Nazife Çınarlıdere, Pelin Küpeli, Beyza Kırlangıç
KSÜ FACULTY OF MEDİCİNE

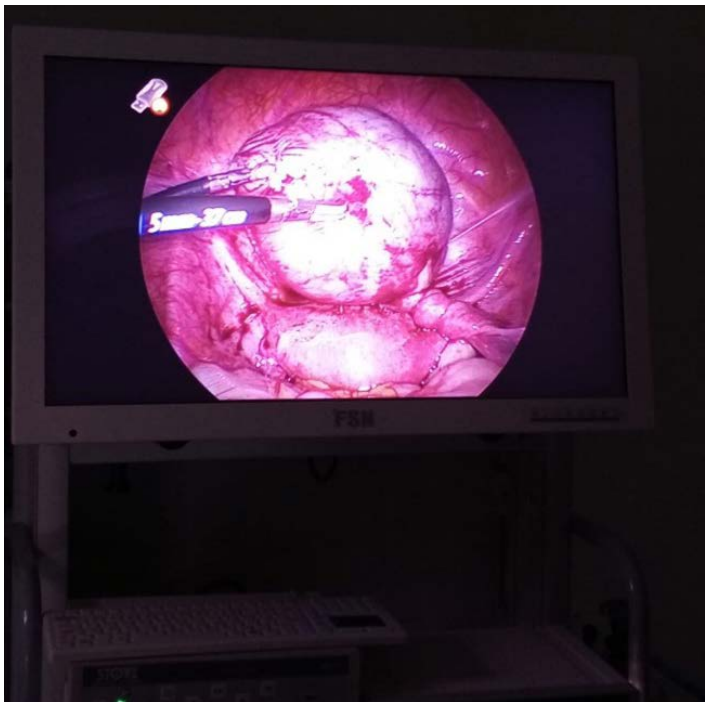
Paratubal cyst torsion: Para-tubal cysts are very common lesions and account for approximately 10% of adnexal masses. (1) Their embryological origin may be from mesonephrotic wolfian remnants, paramesonephric duct remnants or mesothelial inclusions. (2) The most common paratubal cyst is the Morgagni hydatid cyst, which is typically stalked and hanging at the end of the fimbria. Neoplastic paraovarian cysts are rare and histologically resemble tumors of ovarian origin. They are usually cystadenomas or cystadenofibromas and are rarely malignant. (3) Complications of paratubal cysts are rare. Rare cases of para-tubal cyst torsion have been reported in the literature, and the percentage of progression to neoplasia was recorded as low (2% in the study of Stein et al.). Paratubal cysts are usually asymptomatic. It is detected incidentally during surgery or USG for other gynecological problems. If symptoms develop, the symptoms are similar to ovarian cyst symptoms. Bleeding, rupture and torsion are rare complications Treatment of torsion of paratubal cyst is surgery.

Bu yazımızda akut batınla başvuran ve cerrahi yapılan paratubal kist torsiyonu olgunun sunumu amaçlanmaktadır.26 yaşında kadın hasta karın ağrısı vajınal akıntı şikayeti ile tarafımıza başvurdu. Gravida 1, parite 1 abort 0 yaşayan 1 eski sectio olan hasta mensleri düzenli 25 günde bir mens oluyor 7 gün sürüyor.mens dönemlerinde şiddetli ağrı atakları geçirdiğini ifade ediyor. Sat 5 kasım. Ek hastalık yok (dm: yok ht: yok allerjı: yok kullandığı ilaç: yok geçirilmiş operasyon: 1xc/s) Hastanın yapılan batın muayenesinde defans pozitif, rebound yok. Vajınal muayenede beyaz süt kesiği akıntısı mevcut. Tarafımızca yapılan transvajınal usg'de uterus antevert, sol overde 4 cm anekoik kist mevcut sağ over doğal, sağ over komşuluğunda 8x7 cm düzgün sınırlı ince cidarlı anekoik kistik lezyon izlendi. Hasta bulantı kusma şikayetinin olması, ağrılarının şiddetlenmesi genel durumunun ve vital bulgularının bozulması nedeniyle acil laparoskopi planlandı. Hastaya laparoskopik detorsiyon+sağ salpenjektomi yapıldı Postop 2. Günde kliniği düzenlenen hasta antibiyotik ile taburcu edildi.

Sonuç: Paratubal kist torsiyonu nadirdir ve tanısı çok zordur, ancak hasta yakın zamanda benzer ataklar geçirmişse pelvik ağrı açısından takip edilip ayırıcı tanılarının yapılıp kliniği kötüleştiğinde acil cerrahi gerekebilir

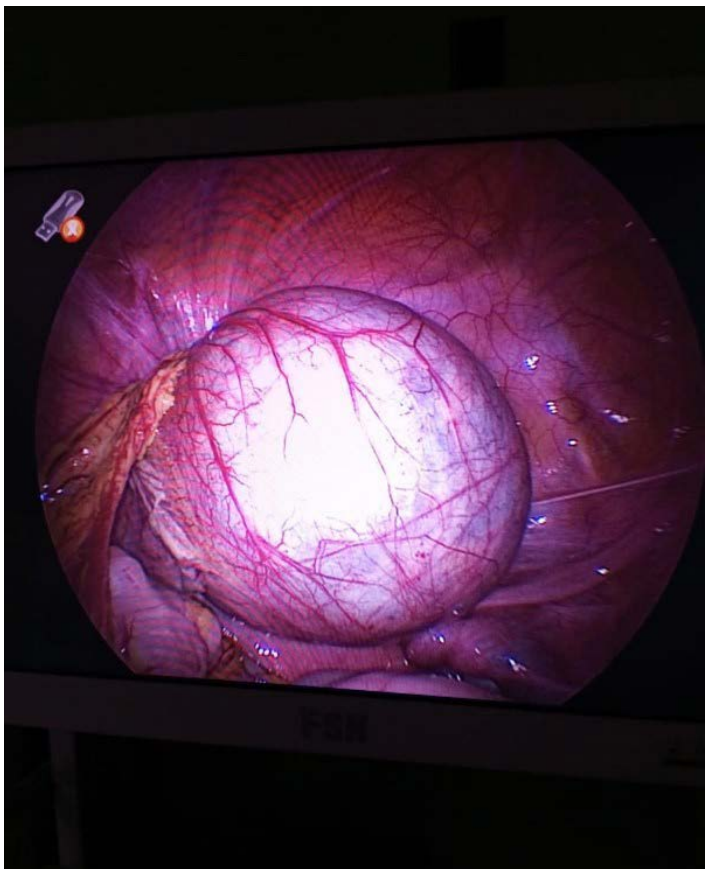
Keywords: Paratubal, cyst, torsion

PARATUBAL KİST TORSİYONU



PARATUBAL KİST TORSİYONU

PARATUBAL KİST TORSİYONU



PARATUBAL KİST TORSİYONU

OS-54

A case report of hysterectomy with segmental colon resection

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OBJECTIVE: Around 190 million women worldwide are affected by endometriosis. Number of patients who are diagnosed intra-operatively is quite high. In this article, we aimed to present a case in which a patient who was scheduled for hysterectomy due to myoma uteri required bowel resection due to endometriosis.

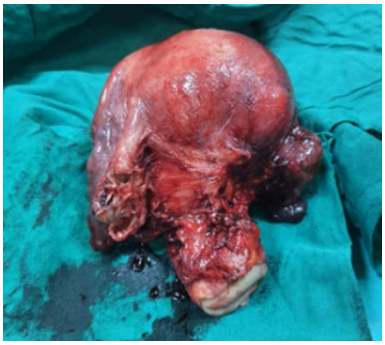
CASE: A 51 year old woman attended to our outpatient clinic with complaints of pelvic pain, dysmenorrhea, and menometrorrhagia. During the vaginal examination, vagina and cervix was normal. Transvaginal ultrasound revealed multiple myomas in uterus, size of the myomas corresponded to 12 weeks. The patient's medical history was unremarkable. The result of the smear test was benign, HPV negative, and result of the endometrial biopsy was also concluded to be benign. There were no other pathological findings in the patient with CA125 77 in the laboratory tests. Patient was scheduled for total hysterectomy. During the operation, the abdomen was entered with a Pfannenstiel incision. Myomas were observed in the uterus, bilateral tubes and ovaries were seen adherent to the sigmoid colon in the posterior of the uterus. There were endometriosis foci. A general surgery was invited to the case, and sigmoid colon was dissected posterior to the uterus. A proper hysterectomy was performed according to the procedure.In the colon, a mass was found that extended into the lumen. Colon resection was performed where the mass was located.Distal and proximal colon anastomosis was performed. One drain was placed in the pelvis. The ureters were checked. After bleeding control operation was concluded. No pathological findings were found in postoperative follow-up. On the 3rd postoperative day, the drain was removed and the patient was discharged with bowel movements and a recommendation to follow-up in the outpatient clinic. The pathology result was reported as leiomyoma, endometriosis in the right ovary and tube, and in the colon containing endometriosis foci.

DISCUSSION: Endometriosis is a chronic, inflammatory,gynecological disease characterized by the presence of endometrial tissue outside the uterus. The disease can also affect the bladder, bowel, pelvic nerves,ureters, anterior abdominal wall, diaphragm,pleura, lungs,pericardium, and brain. Intestinal endometriosis is observed in 3.8% to 37% of women with endometriosis. The most common areas affected are the sigmoid colon and rectum. Due to non-specific findings, the diagnosis of endometriosis is often delayed. It can take 10 years to reach diagnosis. Most women with uterine leiomyomas are asymptomatic; symptoms such as abnormal uterine bleeding, anemia, pelvic pain, and pressure symptoms occur in 30% of them. Hysterectomy is the definitive treatment for leiomyomas in patients who do not desire fertility. Although the most common reason for hysterectomy is leiomyoma, it should be considered that it may be associated with endometriosis.

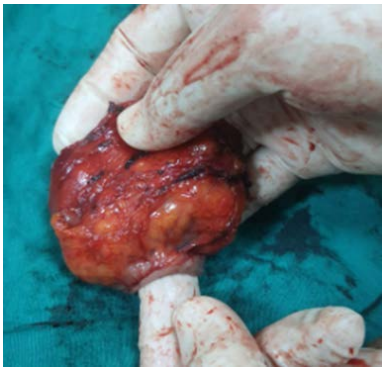
CONCLUSION: Managing endometriosis,which costs the world more than $80 billion a year, requires a multidisciplinary approach. In cases of endometriosis affecting other organs except the ovaries, as in our patient, collaboration with other branches is essential to complete the surgery. In patients with intestinal endometriosis, resection of affected bowel segment and anastomosis is widely accepted as the best approach.

Keywords: Hysterectomy, bowel resection, endometriosis.

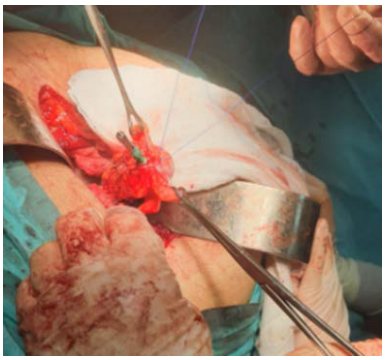
figür 1



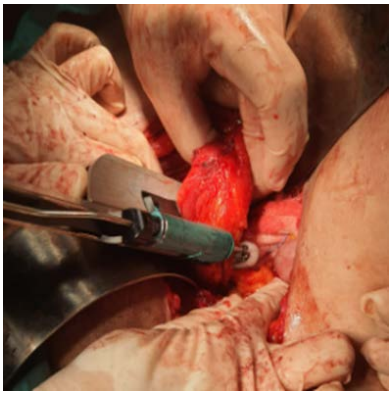
figür 2



figür 3



figür 4



OS-55

Management of large uterine myoma in a patient in the postmenopausal period, Case report

Sadettin Oğuzhan Tutar
Giresun University Faculty of Medicine, Department of Gynecology and Obstetrics

Uterine leiomyomas are the most common tumors of the female genital system originating from smooth muscle. The incidence of uterine fibroid increases during the reproductive period and decreases after menopause (1,2). Leiomyoma is detected in approximately half of the women over 35 years of age (1,2). Myomas can be microscopic in size or reach giant sizes. Uterine fibroids can cause the following complaints, depending on their size and number; abnormal uterine bleeding, abdominal distension, dyspepsia, chronic pelvic pain, constipation, pollakiuria, urinary retention. Patients with large myomas may present to the hospital with a wide variety of clinical findings briefly. Sometimes they can reach giant sizes, completely filling the abdominal cavity. Especially, giant myomas are very rare in developed countries (3). Myomas rarely spread excessively to the lungs and other surrounding organs and if they apply pressure, they can lead to dangerous consequences. If appropriate surgical treatment and careful perioperative care can be provided, postoperative good results can be achieved in myomas (4). We aimed to present the clinical and surgical management of a 51-year-old patient with a very large myoma that extends approximately 4 cm above the umbilicus level.

Keywords: Large uterine myoma, wide variety of clinical findings, surgical treatment.

Figure 1: Image of the large myoma before it was removed from the uterus

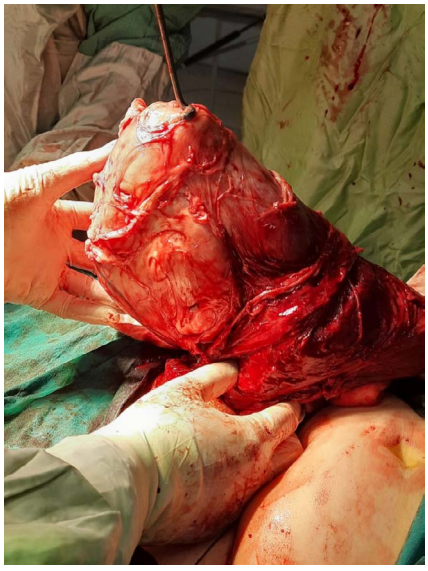


Figure 1: Image of the large myoma before it was removed from the uterus

Figure 2: Image of the large myoma after total excision from the uterus

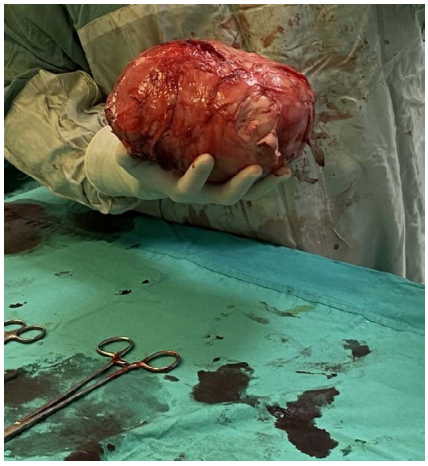


Figure 2: Image of the large myoma after total excision from the uterus

Figure 3: Total abdominal hysterectomy and bilateral salpingo-oophorectomy material and myomectomy material were arranged side by side on the operating table.

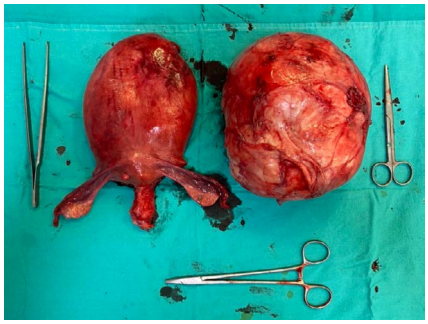


Figure 3: Total abdominal hysterectomy and bilateral salpingo-oophorectomy material and myomectomy material were arranged side by side on the operating table.

Figure 4: Appearance of the Pfannenstiel skin incision on postoperative first day and after the first dressing

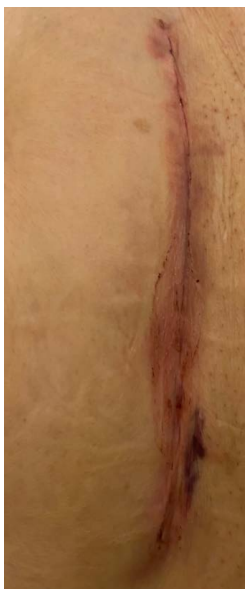


Figure 4: Appearance of the Pfannenstiel skin incision on postoperative first day and after the first dressing

OS-56

Multidisciplinary management of primary abdominal pregnancy with a live fetus

Hale Çetin Arslan
Sağlık Bilimleri Üniversitesi, Kanuni Sultan Süleyman EğUniversity of Health Sciences, Kanuni Sultan Süleyman Training and Research Hospital, Gynecology and Obstetrics Clinic, Istanbulitim ve Araştırma Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, İstanbul

INTRODUCTION: Abdominal pregnancies are rare cases responsible for severe morbidity and mortality of up to 95%. It is essentially an abnormal embryo implantation into the peritoneal cavity, which can be observed as primary or secondary depending on the occurrence. In countries with low socioeconomic levels, such as sub-Saharan countries, its prevalence varies as high as 1/654, and inadequate antenatal follow-up is considered the cause.

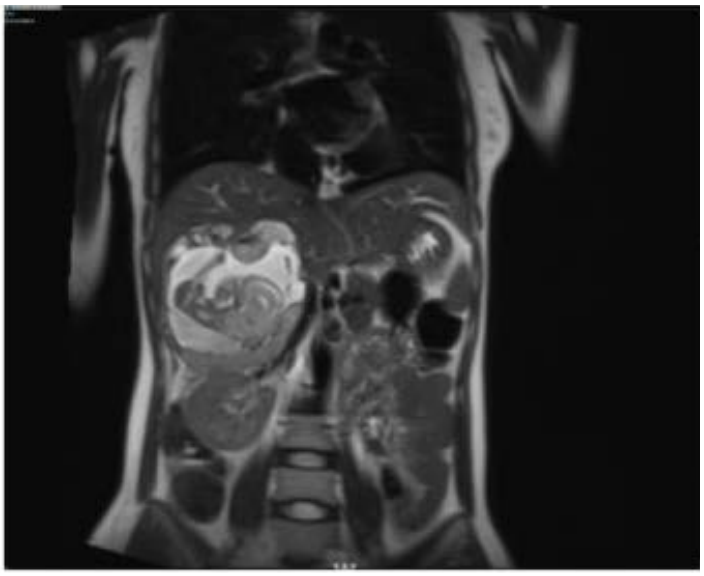
Case presentation: A 25-year-old woman, gravida 5 para 4, has three healthy children and previously normal vaginal deliveries. She presented to the emergency department for the first time in the 21st week of pregnancy with complaints of nausea, vomiting, and abdominal pain. Abdominal examination revealed a swollen abdomen with mild tenderness. Transvaginal ultrasound showed an empty, bulky uterus, normal ovaries, and approximately 3*4 cm of fluid in Douglas. Contrast-enhanced MRI showed a gestational sac of approximately 96*103*102 mm in size, adjacent to the liver posterior, superior to the right kidney, inferior vena cava, and lateral to the common bile duct (Figure 1). The appearance of a live fetus with a BPD of 42 mm was observed in the gestational sac (Figure 2). The placenta was localized on the posterior and medial walls. It has been observed that the placental vascular structure is most likely originating from the right renal artery to the abdominal aorta. It was accepted as a primary abdominal pregnancy case.

Laparotomy was performed under general anesthesia in cooperation with general surgery. The fetus was seen in an intact amniotic sac adjacent to the superior right kidney after opening the abdomen with median and paramedian incisions. The placenta was implanted in the liver. The connections of the placenta with the vena cava and common hepatic artery were coagulated. Cholecystectomy was performed due to damage to the gallbladder during the separation of the placenta invading the liver. The placental attachment site was bleeding, and it was too difficult to arrest bleeding just by compression. Packing was decided because there was diffuse bleeding from the posterior segments of the liver. A drain was placed in the left pelvic region. The patient was admitted to the intensive care unit intubated. There was an average of 1500 - 2000 ml blood loss intraoperatively, and five units of blood transfusion, fibrinogen, and plasma infusion were required. The next day, the patient was re-operated for depacking. No active bleeding was observed in the posterior segments of the liver. The patient was discharged on her 15th postoperative day.

CONCLUSIONS: Term abdominal pregnancy is extremely rare and is associated with severe mortality that requires clinician suspicion for diagnosis. Life-threatening bleeding often occurs where the placenta separates. Preoperative evaluation should be done well, and an experienced team should manage the process. The newborn's examination should also be detailed in terms of congenital anomalies.

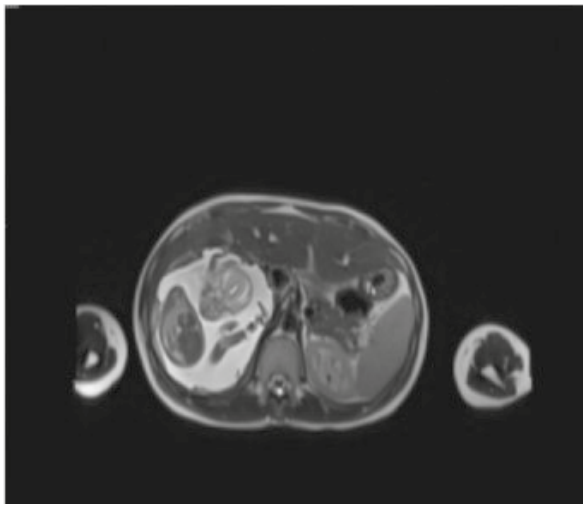
Keywords: Abdominal pregnancy, diagnostic imaging, ectopic pregnancy,

Figure1



MRI findings of advanced abdominal pregnancy. The gestational sac was adjacent to the liver posterior, superior to the right kidney, inferior vena cava, and lateral to the common bile duct.

Figure2



The appearance of the alive fetus with a BPD of 42 mm was observed in the gestational sac.

OS-57

Vulvar lymphangioma: a case report

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AIM: In this report, we present a case of a rare condition known as vulvar lymphangioma circumscriptum.

METHODS: A case report.

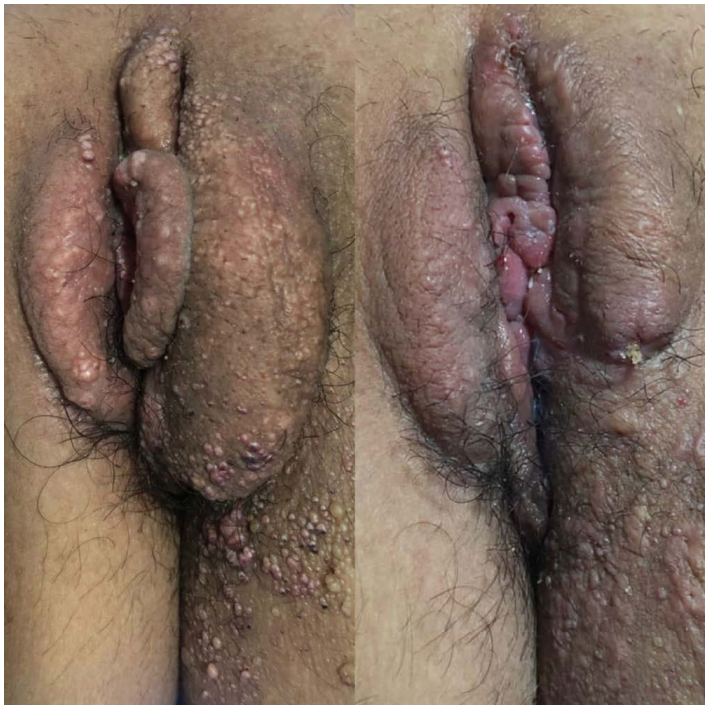
RESULTS: A 24-year-old woman presented to our clinic with a palpable itchy lesion in the vulvar region for two years. Physical examination revealed a painful, edematous and papullamatous lesion on palpation in the left labium majus and clitoral region. Multiloculated, fluid-filled cysts measuring 2-3 mm in diameter were found on the left labia majora (Figure 1). These lesions were not limited to the labium and clitoral region but were also localized in the left perianal region and the inner surface of the left leg. After the lesions were removed through excisional biopsy, the pathology report indicated that the patient had vulvar lymphangioma.

Following the surgical removal of the affected area, the patient was scheduled for a follow-up appointment ten days later (Figure 2).It was discovered that the patient did not follow the prescribed regimen of rest and medication. As a result, a second revision surgery was necessary following the reopening of the incision site.

CONCLUSION: Although lymphangioma circumscriptum in the vulvar region is rare, it should be diagnosed clinically and histologically.

Keywords: lymphangioma circumscriptum,vulvar lymphangioma,lymphedema

Figure 1-2



OS-58

The rare case of pelvic actinomycosis presented as tubo-ovarian abscess

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The actynomyces infection is a rare cause of chronic pelvic inflammation, which can be manifested in multiple ways. It is caused by the actynomyces bacteria,which can be a part of the normal flora of the genital tract in patients who use intrauterine device (IUD). There are atypical manifestations and presentation of infections of the genital tract, severe pelvic adherent syndromes, tubo-ovarian complexes (abscesses) barely symptomatic and in the case of intraoperatory suspicion of pelvic carcinomatosis among others.

A 52-year-old female patient, G3P2A1, presented with right lower abdominal pain persisting for 3 days. The patient's last menstrual period was 5 years ago. The patient underwent IUD for contraceptive purposes 15 years ago.

During the examination, cervical discharge was observed on the speculum. Transvaginal ultrasound revealed 7x5 cm irregular heterogeneous mass originating from the right ovary and extending posteriorly was detected. There was no tenderness or warmth on vaginal palpation, and the cervix was fixed. The patient's laboratory tests showed a white blood cell (WBC) count of 19,000 and a C-reactive protein (CRP) level of 271.3 mg/L. The patient was admitted with the indication of tubo-ovarian abscess (TOA). The patient's vaginal, urine and blood cultures had taken. Smear and endometrial sampling were performed. The patient had treatment with meropenem, doxycycline, and metronidazole as per the recommendation of the infectious diseases clinic.

The tumor markers for the patient were negative. In the MRI, A lesion measuring approximately 85x40mm with contrast enhancement extending towards the rectovesical area is observed in the right ovary.Inflammatory changes extend to the mesorectal fascia adipose planes.

There was no growth observed in the patient's cultures. On the 7th day of antibiotic therapy, the decision was made to proceed with a total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH-BSO). A infraumbilical median incision was made to enter the abdomen, where widespread serous yellow fluid was observed. A sample of the fluid was sent to microbiology for direct examination and culture. Upon exploration, the right tube and ovary were conglomerated and adhered posteriorly. As the adhesions were dissected, widespread membranous structures indicative of an abscess pocket in the Douglas pouch were observed. The serosa of the uterus appeared extensively inflamed. Following adequate exploration, TAH-BSO was performed. The operation concluded without complications.

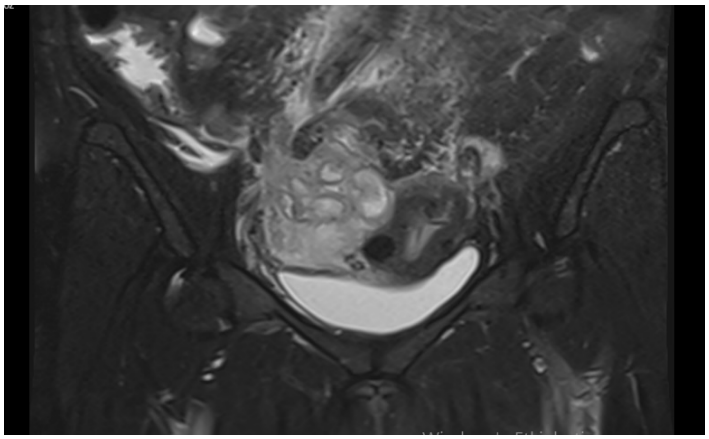
The results of endometrial sampling and smear were consistent with actinomyces infection. Postoperatively, the patient continued treatment with antibiotic. The patient was discharged on the 7th

day postoperatively with oral amoxicillin-clavulanate for maintenance therapy.

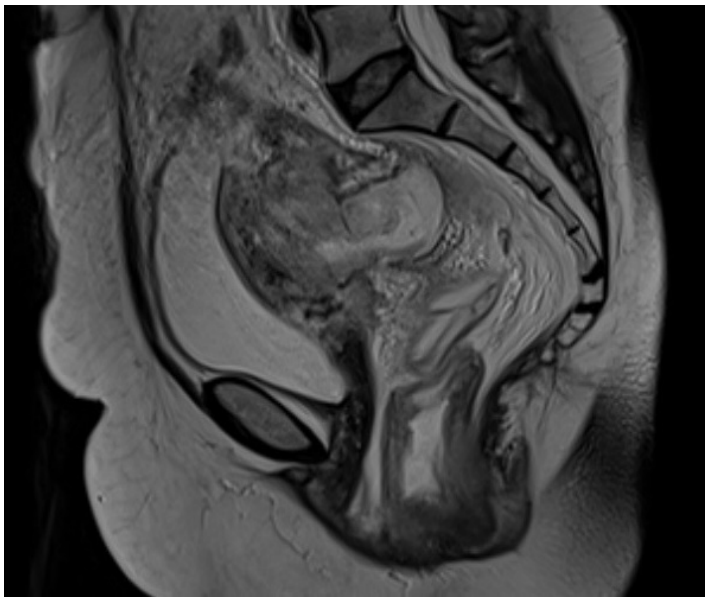
The preoperative diagnosis is hard to achieve due to the finding of the microorganism by culture or immunofluorescence studies of vaginal secretion without being pathologic or any association to abdominal pain or sepsis. Although the chance of making a precise diagnosis is very attractive because it could change the therapeutic options, these facts we must consider: it is a nonmalignant process; it is a microorganism very sensible to B-lactams antibiotics; the radical surgery in some cases can be complicated with dissection of the intestinal and urinary tract.

Keywords: actynomyces, tubo-ovarian complexes, tubo-ovarian abscess

MRG



MRG 2



OS-59

Laparoscopic hysterectomy for uterine didelphys, bicollis and longitudinal vaginal septum: Pushing the boundaries for better results - Case Report

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OBJECTIVE: To review the critical steps in laparoscopic hysterectomy and longitudinal vaginal septum excision in a patient with uterine didelphys in essential steps, focusing on tips to safely perform surgery for ureterolysis, uterine vascularity, colpotomy, vaginal septum resection and vaginal stump closure.

METHOD: Transvaginal ultrasonography and pelvic MRI images of the patient who suffered from menorrhagia for about a year were consistent with uterine didelfis, bicollis and longitudinal vaginal septum. Preoperative endometrial sampling from both uterine cavities were benign. Laparoscopic hysterectomy was planned for the patient who had a history of endometrial cancer in her mother and sister. After septum resection with the assistance of a vascular closure system (Ligasure), one disposable, resterilized grasper was inserted through both cervixes to assist manipulation and to maintain maximum vaginal length while performing colpotomy. The ceramic cup of the Clermont-Ferrand uterine manipulator was placed around the graspers and the graspers were connected to each other by their shafts. Both ureters were identified at the beginning of the hysterectomy. The origin of the uterine artery from the uterus was identified. A bladder flap was created. Laparoscopic hysterectomy was successfully performed and the specimen was retrieved from the vagina. After the closure of the vaginal stump, both ureteral tracings were visualized.

RESULTS: The patient had gas expulsion and spontaneous miction on the first postoperative day and was discharged on the second postoperative day without any complaints.

CONCLUSION: Laparoscopic hysterectomy can be considered as an alternative treatment option in women with symptomatic congenital major uterine anomalies in which fertility potential is not considered important. The minimally invasive approach offers demonstrated benefits compared to open surgery but is difficult to perform owing to abnormalities in normal anatomy.

Keywords: didelphys uterus, hysterectomy, laparoscopy, management

OS-60

Physıologıcal use of hot serum ın laparoscopıc huge dermoıd cystectomy

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Ovarian dermoid cyst (ODC) is one of the most common benign ovarian neoplasms and constitute up to 20% of all ovarian tumors. Such cysts are usually benign teratomas that often contain diverse types of tissue including fat,hair, teeth, thyroid parenchyma, and cystic components. Laparoscopic cystectomy the first choice of treatment for dermoid cysts. The reason is to avoid complications such as torsion and spontaneous rupture and also for less post operative pain, minimally invasive technique, better cosmetic results and shorter hospital stay afterwards.Laparoscopic stripping is the standard laparoscopic method for these ovarian tumors.The major concern with performing this procedure laparoscopically is spillage of cyst contents into the peritoneal cavity with the risk of granulomatous peritoneal reaction.It is known that the risk of rupture and spread during cystectomy is higher in immobile cysts that are large (>5 cm) and have dense fat content, thin-walled, peripheral adhesions. Therefore, we think that our technique, which is based on diluting the cystic content with the hot water method, is easy to use, inexpensive and comfortable.

We usually use a method for aspirating benign dermoid cysts enables removal of the collapsed cyst wall without the need for extending laparoscopic incisions or opening the pouch of Douglas. An atraumatic forceps is applied on the cyst through the lateral ports for traction and countertraction along its long axis We perform cystectomy of cysts above a certain size (>5 cm) and with dense content. We take it into the endobag so that it can be taken out of the abdomen intact. The material taken from the anterior surface of the abdomen is ruptured in a controlled manner and aspirated by giving sterile saline at a temperature of 40-60 degrees. Thus, with the increase in the solubility of the adipose tissue above body temperature, suction- irrigation is facilitated, and the reduced lesion can be safely removed with the method we have described.

In conclusion, we believe that in underdeveloped or developing countries, cystic lesions with dense contents can be successfully removed with our hot water method, with less cost and shorter learning curve, by endoscopic methods. Thus, we can see that better cosmetic results are obtained when the technique we describe is added to the minimally invasive methods. We advise surgeons to use this tecnique in a less traumatic manner and be cautious about cystic rupture to prevent spillage. (7,8) Since we are a tertiary center, we have been successfully applying this method for a long time, especially in cases of dermoid cysts of certain sizes in patients referred to us for endoscopic surgery.

Keywords: cystectomy, dermoid, hotwater, laparoscopy, teratomas

OS-61

Management of MRSA positive intra-abdominal infection causing septic shock after cesarean section with Open Abdominal Applications and vacuum-assisted closure technique

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A 17-year-old patient,40 weeks pregnant,at term with pain, was admitted to our clinic for delivery.On admission, effacement was 80 percent dilated; It was 4 cm.During the labor follow-up, a diagnosis of non-progressive labor was made and a cesarean section decision was made at the 11th hour of hospitalization. The 3600 g, 49 cm baby girl was delivered alive and was taken to the hospital bed without any early complications. During postoperative follow-up;On the 2nd postoperative day, temperature: 37.6, pulse: 106, TA: 80/120, control CRP: 213, pulse was tachycardic. On examination:Minimal redness with discharge was detected in the wound. The wound was opened and wet wound dressing was started.To the current ceftriaxone 2x250 mg treatment; Wet wound dressing with rifocin and metronidazole 3x500 mg were added. On the 5th postoperative day, the patient refused treatment and left the hospital. The patient was advised to come for daily check-ups.On the 6th postoperative day, the patient applied to our emergency clinic with increased complaints of discharge from the wound site. In the physical examination;Since there was suspicion of a 2 cm opening in the corner of the fascia, the patient was hospitalized and general surgery was consulted.The decision was taken to evaluate the wound site and fascia under general anesthesia. In the surgery performed jointly with the General Surgery clinic, the wound site was: necrotic, infected, and the fascia was completely opened upon observing 2 cm of fascia detachment from the right corner. In the abdomen; Approximately 4 cm of abscess drainage and excision of necrotic tissue from the uterus were performed in a location that corresponded to the Pfannenstiel suture line on the anterior surface of the uterus. Culture samples were taken from the abdomen and the wound site. With infectious diseases consultation, the patient was started on tazocin and an open abdomen vac system was applied. Then, abdominal and vac system checks were performed at 48-72 hour intervals.At each intra-abdominal procedure, multiple culture samples were taken again. When MRSA was detected in the first intra-abdominal and wound cultures, targocid was added to the treatment upon the recommendation of the infectious diseases clinic. After the first 72 hours, the culture became negative and the infective appearance of the intra-abdominal tissues disappeared.It was decided to turn off the abdominal vac system in the patient.The peritoneum was closed and 3 cm approximation sutures were placed from both corners of the fascia.The subcutaneous vac system was switched to. In the reoperation performed 48 hours later, the fascia was moved 2 cm closer from the edges and vac care was performed.At the following 48th hour control; The patient's fascia was completely closed by reoperation, a subcutaneous drain was placed and the skin was sutured. After the necrotic debridement,the patient's fascia edges were quite far from each other and it was not possible to close them all at once. The fascia of the patient was successfully closed completely with the gradual fascia approximation technique. The patient was discharged in full recovery 48 hours after the last operation.

Keywords: septic shock, open abdomen, nosocomial infection, fascial approximation

OS-62

Case of Serous Endometrial Intraepithelial Carcinoma (SEIC) Developing on a Polyp Background

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AIM: Serous Endometrial Intraepithelial Carcinoma (SEIC) is a rare intraepithelial lesion of the endometrial epithelium and is characterized by having the same cells as serous endometrial carcinoma. SEIC usually occurs in the setting of an inactive or atrophic endometrium and, surprisingly, is often associated with endometrial polyps (EP), especially in the postmenopausal age group. Approximately 10-34% of endometrial cancers arising in the postmenopausal age group have associated EPs. It is important to understand that SEIC is a unique carcinoma capable of distant metastasis even in the absence of demonstrable invasion. In this article, we aimed to present a case of SEIC in the setting of EP.

METHODS: We evaluated and presented the case of a patient who presented to our Gynecology Oncology Clinic of Ankara Etlik City Hospital in December 2023 with postmenopausal bleeding.

RESULTS: A 65-year-old patient who had been in menopause for 21 years was admitted to our clinic with the complaint of bleeding. No cervical pathology was detected on examination and ultrasound revealed a 30x25 mm mass in the endometrial cavity. Hysteroscopic examination of the patient revealed a 3 cm mass with abnormal vascularization in the cavity. The mass was resected with a resectoscope and sent to pathology. Pathology result; Although the presence of diffuse expression with P16, ER and PR negativity together with histomorphologic findings primarily suggested serous carcinoma, the possibility of mixed carcinoma (Serous ca + Endometrioid adenocarcinoma grade 1) accompanied by endometrioid adenocarcinoma could not be ruled out due to the presence of wild pattern in P53 in a few small superficial foci. Pelvic MRI and Thoracoabdominal CT of the patient; No pathology was detected. The patient was preoperatively prepared and underwent laparoscopic hysterectomy, bilateral salphingoophorectomy and pelvic lymph node sampling in January 2024. Frozen examination of the intraoperative specimen was interpreted as SEIC. The sentinal lymph node examination also performed during the operation was interpreted as a tumor-negative lymph node. The final pathology result was consistent with the frozen diagnosis and interpreted as SEIC.

CONCLUSIONS: Endometrial serous carcinoma arises from the background of an atrophic endometrium or from a polyp. Although the incidence of malignancy arising from an endometrial polyp is very low in the premenopausal age group, the risk increases in postmenopausal women. The reported incidence of malignant transformation of endometrial polyps in postmenopausal women is around 2.84. As in the literature and in our case, the most common presenting complaint is postmenopausal bleeding. Malignancy should always be ruled out in postmenopausal bleeding.

Keywords: endometrial cancer,postmenopausal bleeding,serous carcinoma

OS-63

Spontaneous expulsion of a huge uterine leiomyoma from the vagina

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Introduction: Leiomyoma is a benign common pathology that affects up to %80 of premenopausal women. Clinical presentation of leiomyomas may vary depending on location and size. Expulsion of uterine leiomyomas is a rare situation that typically occurs following uterine artery embolization or as a complication of pregnancy. However, spontaneous expulsion without these preceding factors is exceedingly uncommon.This report details a case of a 42-year-old multiparous woman who experienced the spontaneous expulsion of a huge necrotic leiomyoma from the vagina, contributing to the knonwledge on the natural history and management of uterine fibroids.

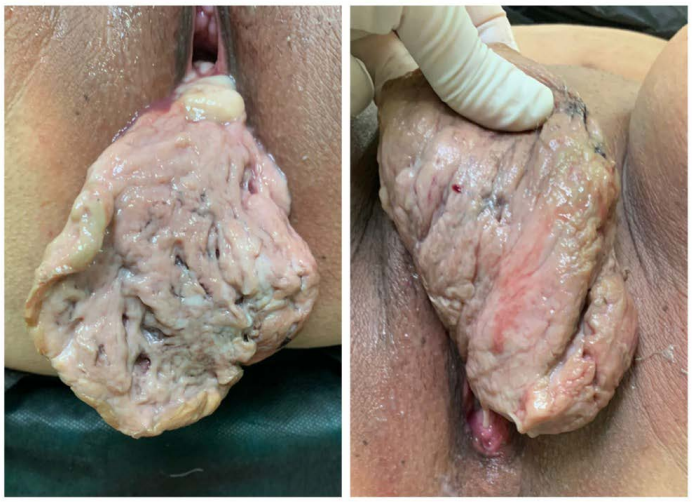
Case report: A 42-year-old multiparous woman admitted to the emergency service with complaints of a palpable mass extending from the vagina and fever. At the time of admission, a mass of 21x8x1.5 centimeters in size protruding from the vagina, characterized by a foul-smelling, necrotic, and irregular appearance was detected by inspection (Figure 1). A speculum examination indicated that the mass appeared to originate from the internal uterine cavity. Aside from a temperature of 38.2°C, her general physical examination was unremarkable. She had previously consulted the gynecology clinic a few days earlier due to abnormal uterine bleeding, where an intrauterine mass was detected via ultrasound. A probe curettage had been planned but was not performed before the mass spontaneously expelled. Subsequent to the examination, an excision of the mass was planned. Under sedation, the mass was successfully removed, followed by a uterine curettage. The postoperative course was uneventfull, and the patient was discharged three days after the myomectomy and antibiotic therapy. Pathological analysis identified the mass as a pedunculated, necrotic leiomyoma.

Conclusion:The spontaneous expulsion of a uterine leiomyoma is a rare situation, particularly without the preceding interventions such as uterine artery embolization or the influence of pregnancy-related changes. This case underscores the varied presentations of leiomyomas and highlights the importance of considering spontaneous expulsion in the differential diagnosis of acute vaginal masses accompanied by symptoms such as fever or abnormal bleeding. Management of spontaneously expelled leiomyomas involves ensuring complete removal of the mass, managing any accompanying symptoms such as infection or bleeding. Vaginal myomectomy is recommended as the initial treatment for the cases prolapsed submucosal or cervical myoma. If the root of the myoma was too broad or there was a severe bleeding during the

dissection additional operation could be considered. In our case, only vaginal myomectomy was perfomed and it was sufficient. This case also emphasizes the importance need to early treatment of intrauterine mass for preventing possible infection. Another importance of this case is that it is one of the few huge prolapsed leiomyomas reported in the literature.

Keywords: spontaneous expulsion, huge fibroid, necrotic leiomyoma

Figure1



The huge pedunculated fibroid

OS-64

Complications After Laparoscopic Surgery Rupture of Transverse Colon Case Report

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INTRODUCTION: Salpingectomy is currently recommended as an alternative to tubal ligation for sterilization. Precursor of ovarian carcinoma can be found in fallopian tubes; that's' why it can decrease the incidence of salphenjectomy. (2,4) Most complications occur during the entrance into the intraabdominal cavity complications include vascular injuries such as the intestines, bladder, or liver.; preperitoneal insufflation; inability to reach pneumoperitoneum; and uterus perforation. During minimal invasive surgery, incidence of bowel injury is %0,13 - %0,54 and mostly it occurs in small bowl. In addition to injury during intraabdominal cavity entry or trocar placement, colon injuries may also occur during dissection. (8,9) Risk factors include the presence of adhesions, previous surgeries that cause distorted anatomy, and tumors or endometriotic implants lining the colon. (1,2) The incidence of colon injury in laparoscopic surgery varies between 0.2 per 1000 and 2 per 1000. (3,6,11)

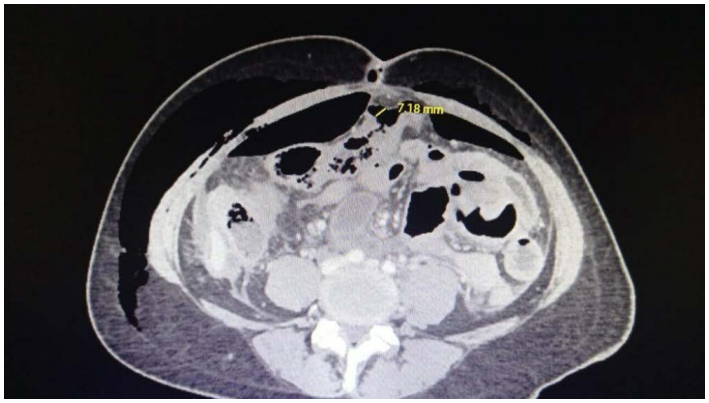
CASE: A 42-year-old G2P2 patient applied to our clinic requesting sterilization and bilateral salpingectomy was planned for the patient. The patient had a history of 2 cesarean sections and an appendectomy. Preoperative hemogram value was 12.2. The patient was not given an enema as preoperative preparation. Prophylactic antibiotics were administered. The patient had gastric aspiration before the operation and had to be placed in Trendelenburg position. It was entered via the open method via the umbilicus. Omentum was observed as attached to umbilicus. Intestines were observed intact. Salpingectomy was performed on the left tubal, but due to previous appendectomy, the patient's right tube was severely adhered to the ascending colon. Only ligation was performed on the right tubal. The operation was terminated because the intra-abdominal structures were observed naturally by inspection. The patient had gas in the first 24 hours, but since the abdomen was distended and she had severe pain, the patient had an CT performed directly. CT showed wall thickening in the transverse colon, transverse colon rupture, and free air in the abdomen. The patient was taken into surgery by general surgeons. Rupture in the transverse colon was observed laparoscopically. Surgery was converted to laparotomy. The patient's transverse colon was sutured. In the postoperative follow-up the patient was able to release gas. Tube thoracostomy was performed on the patient by the thoracic surgeon due to the progression of pleural fluid, the patient's fever, increasing symptoms, and increased infection markers. The patient was discharged after her symptoms and all parameters decreased to normal values.

Outcome: When intestinal injury is noticed during the first laparoscopic procedure, laparoscopic primary suturing may be attempted, although laparotomy may be required. (4,9) Therefore, in our case, the general surgeon detected the colon rupture laparoscopically and proceeded to laparotomy due to the width of the su-

ture and intra-abdominal infection. The patient's adhesions, which developed secondary to the previous intra-abdominal operation, caused transverse colon rupture. Since this is a tough situation for the patients and reduces their quality of life, access techniques must be decided by taking into account the patient's previous operations, weight, gastric lavage and the patient's position.

Keywords: Salpingectomy, Colon Injuries, Laparoscopic Surgery

Figure 1



Transverse colon rupture image on CT

OS-65

Resorbable Oxidized Cellulose Meshwork Granuloma Mimicking Endometrial Cancer Recurrence

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In this case report, we present Resorbable Oxidized Cellulose Meshwork mimicking endometrial cancer recurrence.

A 48-year-old female patient (gravida:8 parity:8) was admitted with intermittent abnormal uterine bleeding for 6 months in January 2023. The endometrial biopsy result was reported as high grade adenocarcinoma developing on the background of endometrial intraepithelial neoplasia (EIN). FDG-PET CT showed metastasis in the left adnexal lobe and bilateral external iliac lymph nodes. The patient underwent total abdominal hysterectomy, bilateral salpingoopherectomy, and systematic pelvic and paraaortic lymph node dissection in May 2023. The pathology was reported grade 3 endometrioid type endometrial carcinoma. The long diameter of the tumor was 5.5 mm and focal lymphovascular space invasion was observed. The tumor infiltrated the cervical stroma and outer 1/2 of myometrium. Metastasis was observed in the bilateral ovaries but not in the pelvic and paraaortic lymph nodes (stage 3A) The patient was planned adjuvant EBRT and brachytherapy simultaneously with 3 cycles of cisplatin. During the follow-up, a 2*1 cm central low-density thick-walled lesion with a central low density was observed in the left pariliac area on pelvic CT taken in September 2023 (postoperative 5th month). PET imaging performed in October showed pathologic activity accumulations in the external iliac lymph nodes (SUVmax: 12.9). Laboratory findings including acute phase reactants and tumor markers were normal. Recurrence was considered. Interventional radiology was consulted and biopsy was taken from the lesion. The pathology result was reported as no findings in favor of malignancy, the appearance compatible with oxidized regenerated cellulose fibers may be due to local hemostatic agent (Sugicel) that may have been used during the surgical operation. Tumour relapse in the patient has been excluded and follow-up continues.

Keywords: endometriumcancer, recurrence, resorbableoxidized-cellulosemeshwork

OS-66

Faktör 2 (Protrombin) eksikliği olan gebenin cerrahi yönetimi: sezaryen deneyimi hakkında bir olgu sunumu

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AMAÇ: Faktör 2 (protrombin) eksikliği, genelllikle protrombin genindeki mutasyonlara bağlı hipoprotrombinemi veya çok daha nadir durumlarda normal düzeyde fakat fonksiyonel olmayan protrombin düzeyleri ile karakterize disprotrombinemi nedeniyle ortaya çıkan; prevalansı 2 milyonda 1 olan oldukça nadir, otozomal resesif geçişli kalıtsal bir pıhtılaşma bozukluğudur. Kanama, hemofililere kıyasla benzer faktör eksikliği düzeyine rağmen daha az görülür ve erkeklerle kadınlar eşit oranda etkilenir. Ancak, menstrüasyon dönemi ve doğum nedeniyle, kanama kadınlarda daha sık görülen bir bulgudur.

YÖNTEM: Kliniğimizde bilinen faktör 2 eksikliği olan bir gebenin, sezaryen planlaması ve preoperatif / postoperatif dönemde uygulanan yönetim aşamalarını sunmayı amaçladık.

BULGULAR: 31 yaşında, g3p2y2 gebe hasta, erken gebelik haftalarında takip amacıyla tarafımıza başvurdu. Hasta, 2009 yılında gerçekleşen ilk gebeliğinde, makat geliş nedenli dış merkezde operatif sezaryen doğuma alındı. O dönemde ek şikayeti olmayan hasta, doğumdan 2 yıl sonra başlayan ve 6 ay boyunca devam eden hipermenore şikayeti nedeniyle kanama diyatezi açısından incelendi ve faktör 2 eksikliği tanısı kondu. Olgunun kız kardeşinde de da faktör 2 eksikliği bulunmaktadır. 2015 yılında yapılan Operatif sezaryen doğumu tarafımızca gerçekleştirildi. Hastaya preoperatif dönemde 4'lü koagülasyon faktör konsantresi replase edildi, laboratuvar olarak normal aralıkta pt-aptt düzeyleri ile sezaryene alındı ve sezaryen esnasında herhangi bir komplikasyon gerçekleşmedi. Postoperatif dönemde ek replasman ihtiyacı olmadı. 2023 yılında yapılan operatif sezaryen doğumu yine tarafımızca gerçekleştirildi. Preoperatif dönemde 4'lü koagülasyon faktör konsantresi replase edildi, laboratuvar olarak normal aralıkta pt-aptt düzeyleri ile sezaryene alındı, sezaryen esnasında herhangi bir komplikasyon gerçekleşmedi. Postoperatif takiplerinde kanama ped takibinde artış ve laboratuvar sonuçlarında pt-aptt artışı olması üzerine ek faktör konsantresi ve taze donmuş plazma replasmanı yapıldı. Hastanın kanaması kontrol altına alındı, laboratuvar ve klinik olarak stabil hale geldi. Hastamız, postoperatif üçüncü gün taburcu edildi.

SONUÇ: Protrombin eksikliği oldukça nadir görülen bir kanama diyatezi olmasına rağmen, klinik seyri hayatı tehdit eden kanamalarla gidebilmektedir. Protrombin eksikliği bulunan gebelerde, doğum sonrası meydana gelen kanamaların tedavisinde, spesifik bir faktör 2 ajanı bulunmasa da, 3 veya 4 faktörlü protrombin kompleks konsantresi (PCC) ve taze donmuş plazma (TDP) tedavide kullanılabilir. Preoperatif ve postoperatif dönemde PCC ve TDP replasmanı ile olası kanama diyatezi açısından bu olgulara müdahale edilebilir ve ek komplikasyon olmadan hastalar klinik olarak stabil hale getirilerek taburcu edilebilir.

Keywords: Cerrahi yönetim, Faktör 2 eksikliği, Olgu sunumu, Protrombin eksikliği

OS-67

Vulvar Lymphangioma Circumscriptum

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CASE: Lymphangioma circumscriptum (LC) is a benign entity caused by the developmental abnormal dilatations of the lymphatics in the deep dermal and subcutaneous layers as a complication of pelvic lymphatic obstruction without specific etiology (1,2). Vulvar LC is categorized as primary and as acquired, secondarily to malignancies treated with a radical hysterectomy, pelvic lymphadenectomy, pelvic radiation, or non-malignant conditions like Crohn's disease or tuberculosis, all of which may harm the lymphatic system. Primary (congenital) vulvar LC Vulvar LC is a rare disorder of the vulvar lymphatic system's developmental abnormality (3).

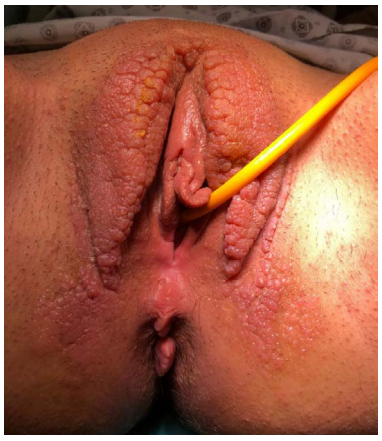
It can clinically present with pain, pruritus, rugose, swelling, verruciform, or polypoid several small, bleb-like lesions that resemble "frog spawn" and may ooze watery fluid. Recurrent infections can aggravate several situations. Reactive epidermal alterations are common, and occasionally they appear reddish masking the underlying vascular problem. Therefore, it may be impossible to diagnose vulvar LC clinically resembling condyloma linked to the human papillomavirus (HPV), other viral or fungal diseases like genital warts, molluscum contagiosum, or certain dermatoses such as dermatitis herpertiformis, when it manifests as many, highly verrucous lesions of varying sizes. In this regard, a biopsy is necessary to confirm the LC diagnosis for the quality of life and also a distressing cosmetic factor that can affect one's social and sexual life causing psychological issues (3,4).

In this case report our objective aim is to raise awareness about this rare disease and its frequent misdiagnosis as condyloma acuminatum. A 21-year-old virgin girl who had been experiencing vulvar pain for two years came to our outpatient clinic. As the diagnosis was condyloma acuminatum, she underwent a number of medical treatments before being referred to our clinic as a refractory case. She was unable to request aid at the first sign of lesions due to embarrassment, but as time went on, the pain became intolerable, and she was in distress. There was no history of genital surgery, other treatments, or inflammatory or chronic diseases. Both the ultrasound of her pelvis and the physical examination were normal.

There were no additional lesions or lymphedema anywhere else. Bilateral labium majors were verrucous, swollen, and rugose during the genital examination. The lesion was extending 2 cm downward through the legs and had thick, reddish skin. The lesion was quite painful and sensitive. A vulvectomy is planned. Written consent is obtained after disclosure of the diagnosis, surgical technique, risks, and anticipated outcomes. Bilateral major labiaectomies, including those of the submucosal layer, are carried out in the lithotomy position under the appropriate sterile conditions, and the main skin closure is then performed. No wound discharge has occurred post-operatively. The incision appeared to be fully healed without any drainage. No recurrence or additional issues were found after a year.

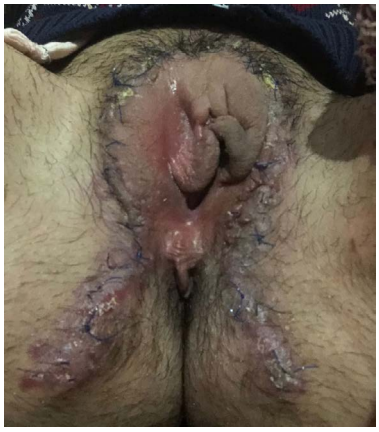
Keywords: Vulvar Lymphangioma Circumscriptum Vulvar Lymphangioma Circumscriptum Vulvar Lymphangioma Circumscriptum Vulvar lymphangioma, circumscriptum, condyloma

1-PREOP PHOTO-2022-VULVAR LYMPHANGIOMA CIRCUMSCRIPTUM



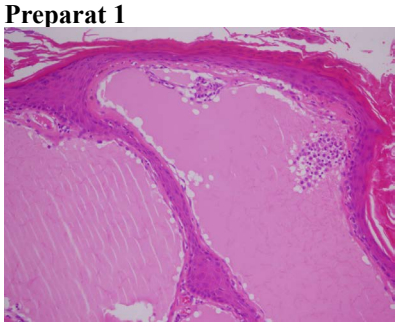
Preoperatif fotoğraf

2-POSTOP-PHOTO-2022



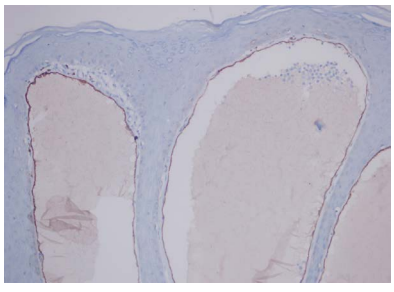
Postoperatif görünüm

Preparat 1



histopatolojik görünüm1

preparat 2



Histopatolojik görünüm 2

OS-68

Case Report: Should We Perform Frozen Section Analysis on A Postmenopausal Woman with An Ovarian Cyst?

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Borderline ovarian tumors (BOT) account for approximately 10–20% of all epithelial ovarian cancers. Prognostic factors include the International Federation of Gynecology and Obstetrics (FIGO) stage, presence of peritoneal implants, micropapillary pattern (for serous histology), microinvasion and intra-epithelial carcinoma (for mucinous histology). According to the FIGO classification from 1971 BOTs are considered to be tumors of low malignant potential, the latest WHO classification describes them as atypical proliferative tumors. Clinically BOT present similarly to other adnexal mass with often typical features according to the IOTA criteria in the transvaginal ultrasound. Serum CA 125 is recommended preoperatively and in the follow-up setting, however not all women with BOT have elevated serum levels pre-operatively.

INTRODUCTION: Borderline ovarian tumors are uncommon but not rare epithelial ovarian neoplasms, intermediate between benign and malignant categories. Serous borderline tumors (SBT) share molecular and genetic alterations with low-grade serous carcinomas and can present at higher stages with peritoneal implants and/or lymph node involvement, which validates their borderline malignant potential. All other (non-serous) subtypes of BOT commonly present at stage I confined to the ovary(ies) and are associated with overall survival approaching that of the general population. Borderline tumours are similar to other types of adnexal masses.

Case Report

A 49-year-old female patient, gravida 3, para 2, abortus 1, with a history of two previous cesarean sections, presented to the emergency department due to abdominal pain. Transabdominal ultrasound and computed tomography (CT) imaging revealed a well-defined cyst measuring 10 cm in diameter in the left adnexa. Subsequently, the patient was referred to the gynecology clinic. Following gynecological examination and laboratory investigations, including tumor markers and intravenous pelvic magnetic resonance imaging (MRI), laparoscopy was planned for the indication of a left ovarian cyst. Laparoscopic cystectomy was performed. Macroscopic evaluation of the cyst's contents was conducted in the operating room, and tissue samples were sent for frozen section analysis. Based on the frozen section analysis revealing a serous borderline ovarian tumor in the left ovary, the procedure was concluded with Total Laparoscopic Hysterectomy and bilateral salpingooferectomy. The final pathology results have been added below.

Discussion

The initial plan for laparoscopic cystectomy was prioritized based on the patient's history, gynecological examination, as well as the findings from ultrasound (US), computed tomography (CT), and magnetic resonance imaging (MRI), which did not indicate malignancy criteria. Additionally, tumor markers were negative. However, following the excision of the cyst and macroscopic evaluation of its contents, a decision was made to proceed with frozen section analysis.

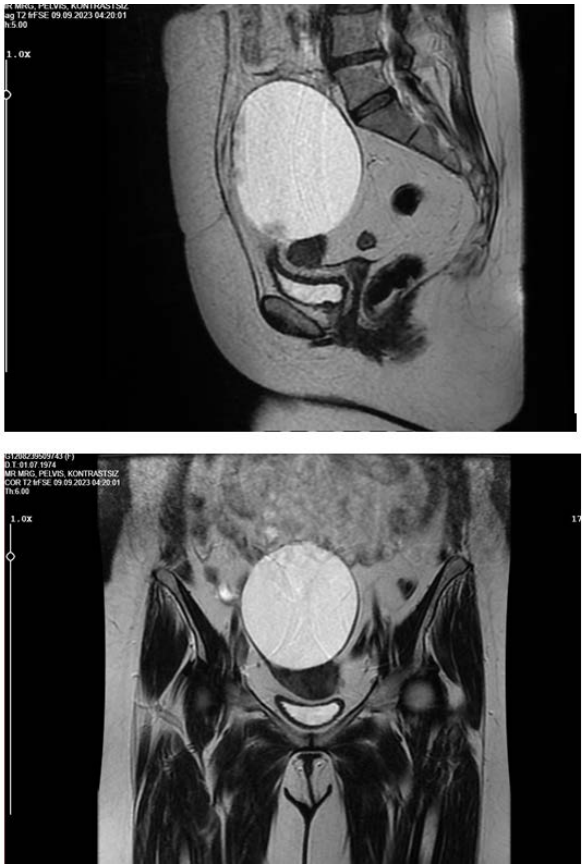
It is recommended to perform surgery for ovarian cysts larger than 8

cm in premenopausal and larger than 5 cm in postmenopausal women. In this group of patients, imaging methods and laboratory tests may not be sufficient for the diagnosis of borderline ovarian tumors.

CONCLUSION: With this case presentation, we aimed to draw the attention of gynecologists to the importance of surgeons examining cysts measuring 8 cm and above intraoperatively, and requesting frozen section analysis if necessary.

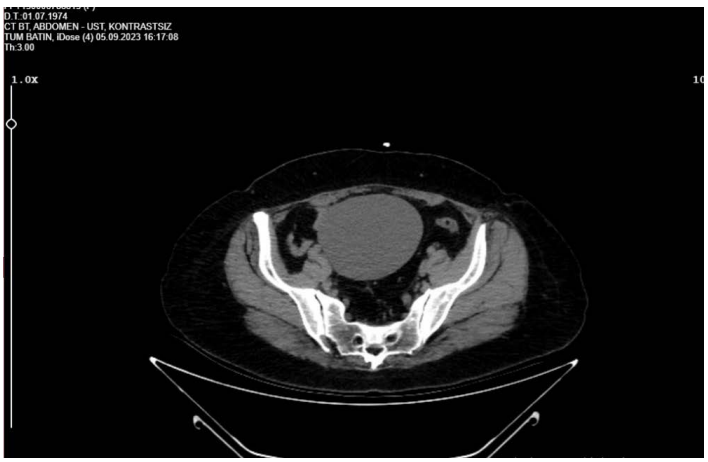
Keywords: borderline ovarian tumor, laparoscopic cystectomy, total laparoscopic hysterectomy, FIGO classification, IOTA criterias

Figure 1



Preoperative MRI findings.

Figure 2



CT findings in an emergency department.

Figure 3

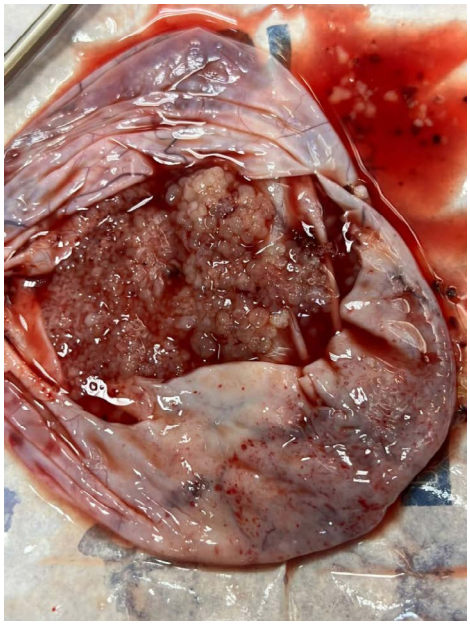
BÖLGE BİYO-HORMON

	Parametre Adı	Sonuc	Birim	Normal Değerler		Önceki Sonuc
	CEA	1.38	µg/L	0	3.8	Grafik.
	Sigara içenlerde: 0 - 5.5					
	CA-125	15.3	kU/L	0	35	Grafik.
	CA-15-3	11.5	kU/L	0	26.4	Grafik.
	CA-19-9	6.01	kU/L	0	27	Grafik.

	Tarih/Saat	Kullanıcı
İstem Tarihi	25.10.2023 10:15	Op.Dr. TURAL ISMAYILOV

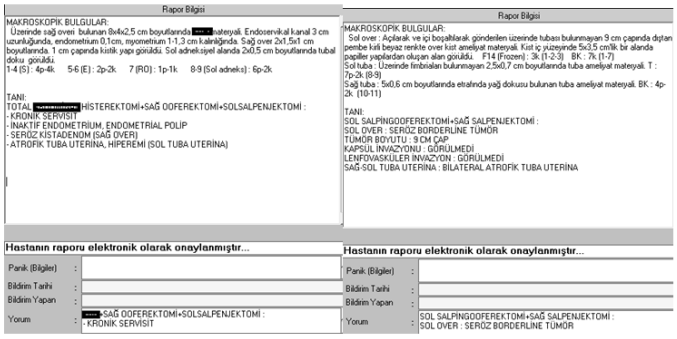
Preoperative tumor marker levels.

Figure 4



Intraoperative macroscopic view of the cyst.

Figure 5



Frozen section and final pathology findings. Serous borderline ovarian tumor (left ovary), serous cystadenoma (right ovary)

OS-69

Giant Bartholin Cyst Case Report

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[2]Giresun Gynecology and Pediatrics Training and Research Hospital

Bartholin gland cysts are common masses in the vulvar region that can range from asymptomatic to large and infected, requiring treatment (1). In this case report, we wanted to discuss a case of a large Bartholin gland cyst that presented with painless genital swelling, dysuria, recurrent urinary tract infection especially caused by Escherichia Coli and dyspareunia to our clinic and its treatment. A woman in perimenopausal age of 45 presented with a large mass in the vulva, and physical examination revealed an 120 x 100 mm mass originating from the left labia majora. Preoperative MRI confirmed the mass, and the initial diagnosis was Bartholin gland cyst. The cyst was surgically excised totally under the operating room conditions and sent for histopathological examination. Although Bartholin gland cysts can present in various sizes and clinical features, cysts of this size are rare and can be confused with malignant masses.

Keywords: Bartholin cyst, labial cyst, female reproductive system, giant vulvar mass, recurrent urinary tract infection

Figure 1: Macroscopic appearance of the left vulvar mass on physical examination in the first evaluation.

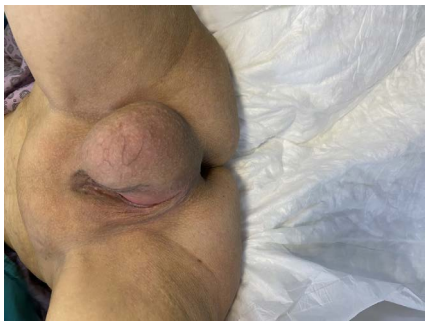


Figure 1: Macroscopic appearance of the left vulvar mass on physical examination in the first evaluation.

Figure 2: Final appearance of the mass just before surgical excision begins.

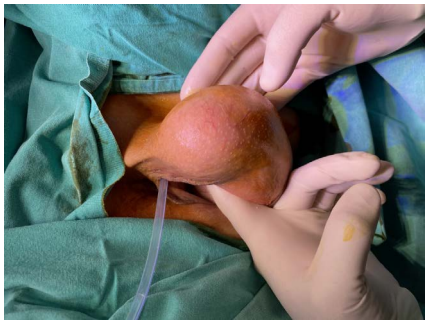


Figure 2: Final appearance of the mass just before surgical excision begins.

Figure 3: When performing total excision without compromising the integrity of the mass.

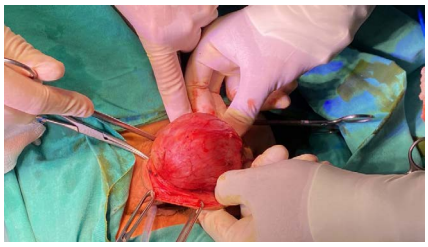


Figure 3: When performing total excision without compromising the integrity of the mass.

Figure 4: After the mass is completely excised without damaging its entirety.

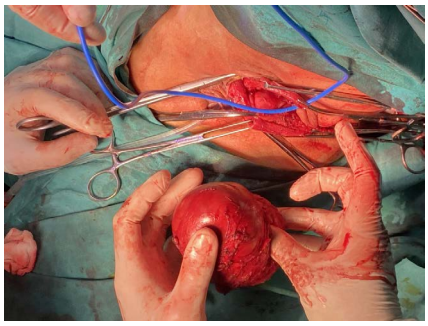


Figure 4: After the mass is completely excised without damaging its entirety.

Figure 5: Final view of the wound site after surgical site repair is completed.

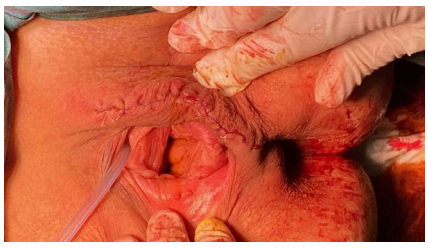


Figure 5: Final view of the wound site after surgical site repair is completed.

OS-70

Pelvic inflammatory disease, ectopic pregnancy rupture

Alev Özer, Nazife Çınarlıdere, Yağmur Güler, Mahmut Menduh Öztop
KSÜ FACULTY OF MEDICINE

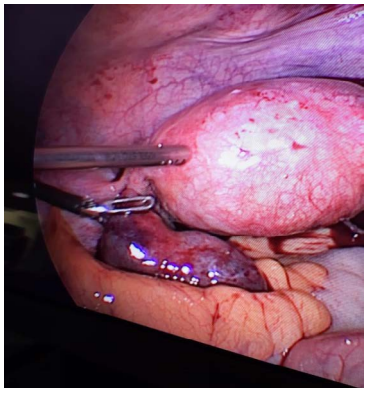
Pıd is often associated with young, sexually active women but can occur throughout the life course in the absence of identifiable risk factors. A diagnosis of pıd can be prompted by high clinical suspicion. Per cdc guidelines, broad-spectrum antibiotics should be initiated empirically and without delay. Patients with mild to moderate symptoms who can tolerate oral antibiotics can be treated on an outpatient basis and should follow up with a provider to evaluate clinical response 72 hours after starting treatment. Patients with severe pıd, which includes concurrent pregnancy or toa, should be admitted to the hospital for parenteral antibiotics and procedural intervention if indicated. Patients with toa are more likely to require surgical intervention if they are older, are overweight, or have an abscess greater than 6 cm in diameter, leukocytosis, or elevated crp. When patients with toa fail initial antibiotic treatment, ır drain placement is an effective method for obtaining source control and should be used when available. PID is seldom life threatening. The risk of mortality is significantly less than 1%. Deaths attributed to PID occur from severe sepsis usually associated with a ruptured TOA or from hemorrhage resulting from a ruptured ectopic pregnancy.

Hastanın tarafımıza başvurdu tarihi: 26.11.2023

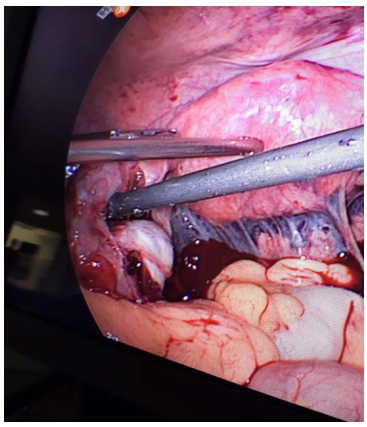
Bu olgumuzda 24 yaşında kadın hasta ateş, kasık ağrısı, vajınal kanama nedeniyle tarafımıza başvurdu. Gravide 2, parite 1, abort 0 yaşayan 1 çocuğu olup normal doğum. Hastanın mensleri düzenli son mens tarihini bilmiyor.15 kasımda dış merkezde istemli terminasyon ile gebelik sonlandırılmış.Son bir yıldır geçmeyen sarı vajinal akıntı, pelvik ağrı, dismenore, disparoni şikayeti ile ilaç kullandığını belirtiyor. Hastanın ek hastalık yok allerjı yok kullandığı ilaç yok geçirilmiş operasyon yok. Ateşi 37.5 tansiyonları 100/60 yapılan muayenesinde spekulumda aktif vajınal kanama yok, vajen kanla bulaş görünümde, vajınal tuşede servikal hassasiyeti mevcut.transvajınalultrasonografide ek ince 4 mm düzenli, sağ adneksiyal bölgeden douglasa uzanım gösteren 75*52 mm abse görünümü mevcut.karın ağrısı ve ayırıcı tanı için çekilen kontrastlı bt radyoloji bölümü tarafından sağ adneksiyal bölgede 8*2,5 cm boyutta heterojen görünümde hipoekoik alan izlendi. (apse?) Olarak yorumlandı. Bakılan tetkiklerde betahcg:478 crp:190 wbc: 25 olan hasta tubaovaryan abse ön tanısıyla yatırıldı. Geniş spektrumlu antibiyoterapi başlandı. Takipler sırasında beta hcg 543(478) ve crp 236(190) yükselen, antibiyoterapiye rağmen kliniği bozulan hastaya acil laparoskopi kararı alındı.Laparoskopide yapılan gözlemde uterus sol tuba ve over doğal izlendi. Geçirilmiş tekrarlayan enfeksiyonlara bağlı douglas rektuma dens yapışık izlendi. Sağ tubada kendini sınırlayan rüptüre ektopik gebelik izlendi. Yapışıklıklar keskin ve künt diseke edildi. Ligasure enerjısı yardımıyla sağ salpenjektomi yapıldı.douglasa dren yerleştirildi. Kanama kontrolu sonrası işleme son verildi.Hastaya postoperatif geniş spekturumlu antibiyotik tedavisi başlandı Hemogram, beta hcg vajınal kanama dren takibi yapıldı. Postoperatif 1. Gün genel durum iyi vital bulgular stabil vajınal kanama yok. Hemogram takipleri stabil.gaz gaita çıkışı mevcut drenden geleni olmayan hastanın dreni çekildi. Crp betahcg değerleri takipler sırasında düştü. Hastaya antibyoterapisi düzenlenerek poliklinik kontrol önerisi ile taburcu edildi.

Keywords: Pelvic, inflammatory disease, ectopic pregnancy

Pelvik inflamatuar hastalık// ektopik gebelik rüptürü



Pelvik inflamatuar hastalık// ektopik gebelik rüptürü



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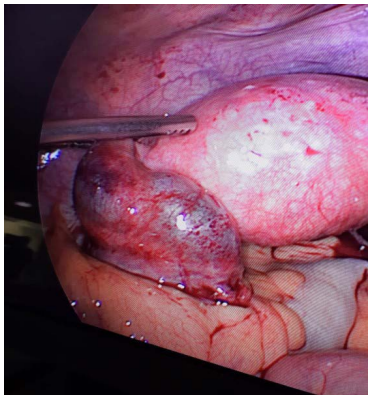
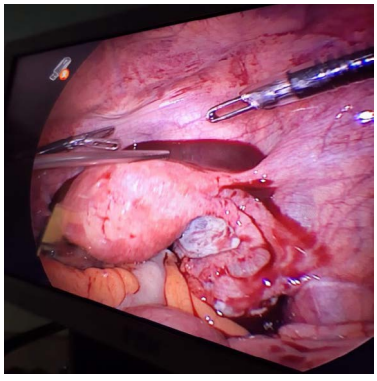


Pelvik inflamatuar hastalık// ektopik gebelik rüptürü



OS-71

Successful myomectomy during cesarean section. a case report

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Department of Obstetrics and Gynecology, Akdeniz University School of Medicine,Antalya,Turkey

In our research we aimed to evaluate intra-operative and post-operative risks and complications of myomectomy cases under the guidance of literature, during cesarean delivery in our clinic and we targeted to foresee the approach to recurring myoma cases

A 44-year-old pregnant woman with a history of 3 abortions and 1 dilation and curettage presented at our clinic at 37 weeks and 3 days of gestation. She had been followed up in our outpatient clinic due to an 11x7 cm myoma located in the isthmus area, which corresponded to the projection of the old cesarean section incision site on the anterior uterus. Elective cesarean section with myomectomy was planned. The patient had no significant medical or obstetric history, and she did not report any medication use during pregnancy. Throughout her pregnancy, she received regular follow-ups at our clinic.

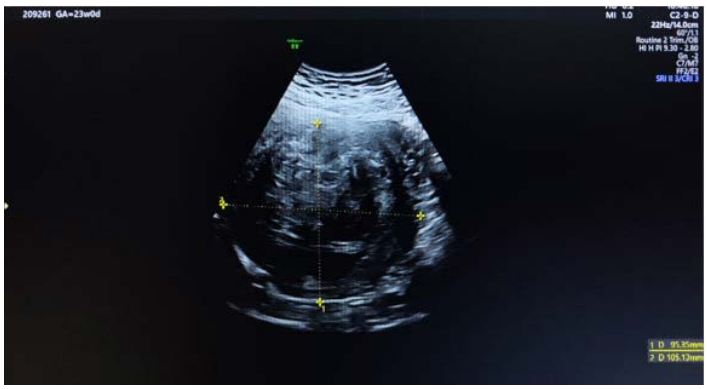
Obstetrically, the placenta was located anteriorly, consistent with the gestational age. On the scheduled date for the elective procedure, a midline vertical incision was made below the umbilicus during cesarean section. The uterus was entered through a transverse incision in the lower uterine segment, and the baby was delivered without complications.The placenta was also successfully removed.

Uterus was mechanically occluded using a uterine lower segment tourniquet after being brought out of the abdominal cavity. Hemorrhage control was achieved. A cleavage was made from the endometrial inner surface for the excision of the myoma located on the anterior wall of the uterus. The 11cm myoma was excised with controlled bleeding using Ligasure. Layers were sutured primarily and continuously. Following suturing and hemorrhage control, the cesarean section and myomectomy procedures were completed.

During cesarean section, performing myomectomy is a debated topic in the obstetric field. Many obstetricians avoid performing myomectomy during cesarean section, particularly due to the risk of bleeding and subsequent need for hysterectomy. Generally, only small-sized myomas that are subserosal or pedunculated are removed. When myomectomy is performed during cesarean section by experienced surgeons in well-evaluated cases, it is considered a safe procedure.

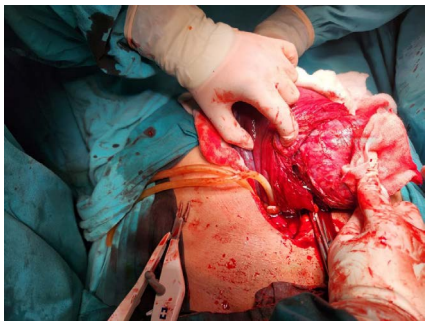
Keywords: cesarean delivery, leiomyoma, myomectomy

fig 1



Ultrasound examination of our patient

fig 2



Myometctomy procedure after uterine lower segment tourniquet application

fig 3

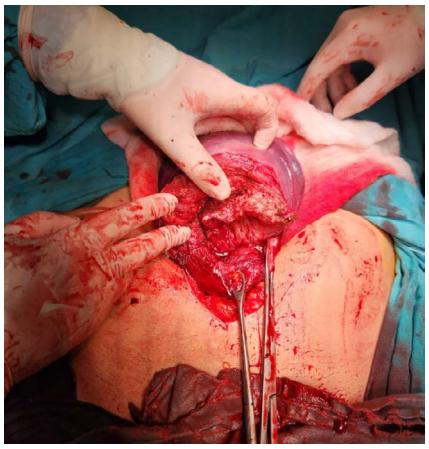
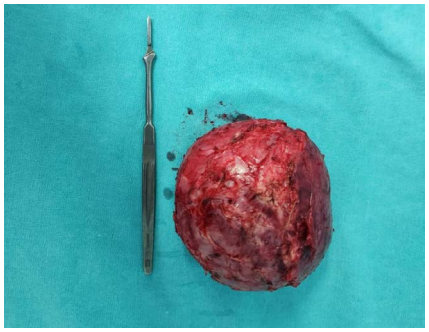


fig 4



Specimen

OS-72

Office hysteroscopic myomectomy without myoma extraction

Hilal Gökçen Çin Ergin, Mustafa Onur Kamani
department of obstetrics and gynecology, Bartın state hospital, Bartın, Turkey

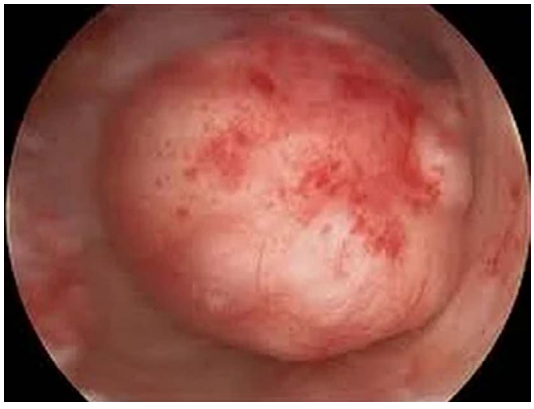
INTRODUCTION: Myomas are defined and classified according to the classifications of the European Society of Gynecological Endoscopy (ESGE) and the International Federation of Gynecology and Obstetrics (FIGO). Submucous myomas constitute approximately 15% of all uterine fibroids and can lead to irregular bleeding, pelvic pain, and infertility. The hysteroscopic approach stands as the gold standard in the surgical treatment of submucosal myomas, involving the resectoscopic dissection of the myoma followed by its removal from the uterine cavity. This procedure necessitates the dilation of the cervical canal and anesthesia. By opting for hysteroscopic myomectomy without the extraction of the myoma, it circumvents the process of disintegrating and extracting the myoma, resulting in reduced anesthesia and surgery time. Moreover, this method helps prevent cervical injuries by eliminating the need for repeated passage through the cervical os during the extraction of myoma pieces.

Case: A 31-year-old patient sought consultation at the outpatient clinic for abnormal uterine bleeding. She has no known diseases. Her medical history includes a G1P1 normal vaginal delivery. Ultrasound examination revealed increased endometrial thickness and the suspicion of an intracavitary myoma or polyp. Consequently, a diagnostic hysteroscopy was planned. During the procedure, a submucosal myoma, approximately 3 cm in size, was observed within the uterine cavity. The myoma was mechanically separated from its connection to the uterine cavity without using any energy modality and left inside the cavity. No intracavitary bleeding was observed, and the hysteroscopy was concluded. The patient, having no active postoperative complaints, was discharged. Follow-up ultrasound after two menstrual cycles showed no signs of the myoma.

RESULTS: Enucleation of submucous myomas without mass extraction may be safer, have better patient tolerance, and be faster and easier in terms of surgery, compared to hysteroscopic removal. However, whether this approach is superior to myoma removal, its feasibility and safety need to be determined. For this, randomized clinical studies involving a large number of patients are needed.

Keywords: myoma,submucosal,office hysteroscopy

submucosal myoma hysteroscopy image



OS-73

The Use of Desogestrel in First and Second Trimester of Pregnancy with Relation to Clitoromegaly: Case Report

Irem Pıçakcı
Ankara Atatürk Sanatorium University Of Health Science Training and Research Hospital, Gynecology and Obstetrics Clinic, Ankara

INTRODUCTION: Clitoromegaly (or macroclitoris) is an abnormal enlargement of the clitoris. It is a congenital or acquired condition, in which it accours due to an exposure to an excess level of androgen during fetal life. (1)

Virilization of an XX individual with typical ovarian and adrenal function can result from exposure to maternal androgens or synthetic androgenic progestins. Because the placenta produces the aromatase enzyme, which converts androgens to estrogens, only very high levels of maternal androgens can overcome placental aromatase to cause virilization of the fetus. (2)

During pregnancy serum androgen levels rises. (3)

In a female fetus, elevated androgen exposure between the 7th and 12th weeks of development may result in partial or complete labial fusion and clitoral hypertrophy. After the 12th week of gestation, clitoral hypertrophy remains as a risk, but labial fusion does not occur. The development of the male fetus is unaffected by maternal hyperandrogenism. (4)

CASE: A 26-year-old healthy multigravid patient was admitted to the outpatient clinic after having a positive Plano test at home. The patient's previous pregnancies were, one normal vaginal delivery, one cesarean section due to oligohydramnios, and she had no gestational diabetesmellitus or gestational hypertension throughout her both pregnancies. This is her third pregnancy. She can not recall her last menstrual period date. Based on ultrasound criteria, the estimated gestational age was measured as 25 weeks and 3 days.She has no known comorbidities in her medical history, no history of surgery, no smoking,and no known allergies were recorded in her anemnesis. However, it is knowns that she has used desogestrel throughout her pregnancy.

The patient was referred to the perinatology outpatient clinic due to her history of desogestrel use throughout her pregnancy.The ultrasonograph examination in the perinatology clinic revealed that, the clitoris is larger than normal. She was monitored until birth for clitoromegaly and it was recommended to discontinue desogestrel. During perinatology follow-ups, no significant clitoromegaly was observed in the later weeks of pregnancy. In addition, no clitoromegaly was observed in the baby during postnatal pediatric controls.

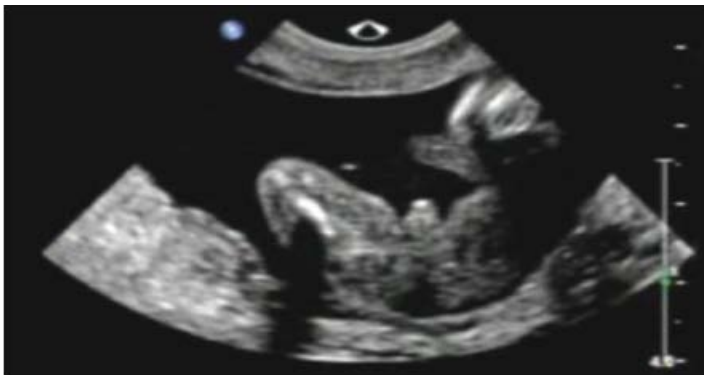
Outcomes: The possibility of developing rare side effects such as clitoromegaly in the fetus should be taken into consideration in pregnant women who use oral contraceptives during pregnancy. Patients should be informed about the potential side effects of oral contraceptive use during pregnancy.

More research is needed to have a specific and sensitive result on the effects of oral contraceptive use during pregnancy on clitoro-

megaly. Such cases are important in terms of contributing to the literature and creating a database for more comprehensive studies in the future.

Keywords: Clitoromegaly, Desogestrel, Pregnancy

Example of Clitoromegaly, The Ultrasonograph Examination



Example of Clitoromegaly, The Ultrasonograph Examination

OS-74

Fertility preserving surgery in placenta increta

Mehmet Kağıtcı, İlknur Merve Ayazoğlu
Recep Tayyip Erdoğan Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum ABD, Rize

INTRODUCTION: Placental invasion anomalies remain an important problem in obstetric practice as they can lead to life-threatening bleeding. In this article, we aim to present fertility preserving surgery in the management of a patient diagnosed with placenta previa and placenta increata.

CASE: A 35-year-old G3P2Y2 patient hospitalized with the diagnosis of placenta previa totalis, at 37 weeks of pregnancy according to her last menstrual period. In the ultrasonography, there was a single alive pregnancy compatible with 37 weeks and it was determined that the placenta completely covered the internal cervical os. In the doppler examination, it was seen that the sonolucent area between the myometrium and the placenta was not observed. The treatment options explained to patient. The patient asks to preserve her uterus and did not want a hysterectomy. The patient was operated under elective conditions. The abdomen was entered through with Phannesteil incision. In the surgery it was observed that there were signs of placental invasion on the serosal surface of the uterus and the bladder was not infiltrated. To avoid placental incision, the uterus was opened through a transverse incision in the middle part of the uterus. A single alive fetus was delivered. Then, the cord was clamped and slight traction was performed to placenta. The placenta was waited for spontaneous detachment. The undetached areas of the placenta were palpated by entering the uterus with the fingers of the left hand. The detached parts of the placenta were excised with scissors (Figure 1). Segmental resection was performed on the uterus and the placenta and invasive myometrium were removed (Figure 2). The patient was given 1 unit of erythrocyte suspension during the operation. Bakri balloon was placed trans abdominally. The tissue defect in the uterus was repaired with continuous locked suture and the operation was terminated. Postoperative follow-up was uneventful and the patient was discharged at the postoperative 3rd day.

DISCUSSION: Placenta increata is defined as the invasion of placental tissue into the myometrium. There is no infiltration in the surrounding tissues in these patients. Radical methods such as hysterectomy can be applied to avoid life-threatening bleeding after cesarean section. However, alternative methods should be considered in patients who want to preserve their fertility. In cases of placenta increata, after excision of the infiltrated parts of the uterus, life-threatening bleeding is not expected in the remaining parts of the uterus. For this reason, segmental resection may be considered in these patients. However, it is possible to occur bleeding during resection due to the increase in vascularity of the uterus. For this reason, the operation must be performed with blood preparation.

CONCLUSION: Segmental resection of the invaded parts of the uterus may be a life-saving and fertility-preserving method in cases of placenta increata. It can be considered as an alternative method that can be performed instead of hysterectomy in a clinic where

blood transfusion can be performed and where there are surgeons experienced in this field.

Keywords: Fertility Preserving Surgery, Placenta Increta, placental invasion anomaly

Figure 1: Excision of detached part of the placenta

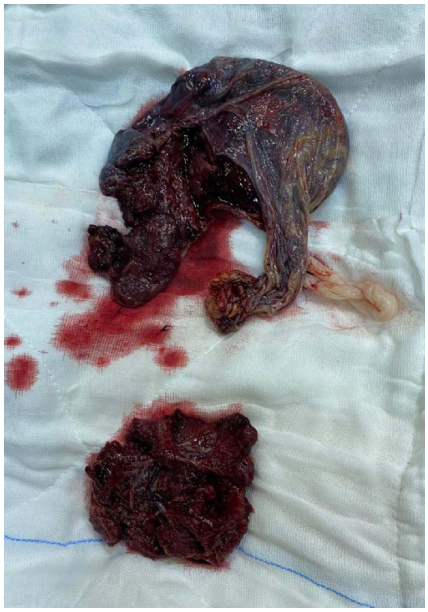
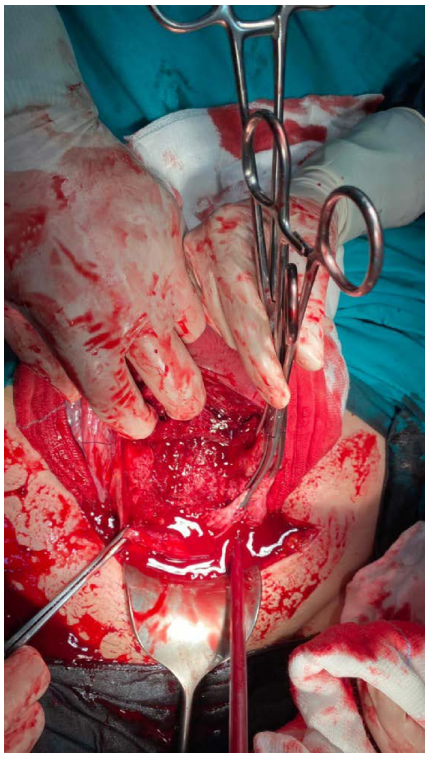


Figure 2: Segmental resection of the uterus



OS-75

A Rare Case: Uterine Tumor Resembling Ovarian Sex Cord Tumor

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INTRODUCTION: Uterine Tumor Resembling Ovarian Sex Cord Tumor (UTROSCT) represents a distinct category of uterine neoplasms that mimic ovarian sex cord tumors histologically, but lack identifiable endometrial stroma. The cell of origin for UTROSCT remains unidentified. The diagnosis of UTROSCT typically relies on positive immunohistochemical staining for at least two markers commonly associated with ovarian sex cord-stromal tumors, including inhibin, calretinin, CD56, melan-A, CD99, FOXL2, or SF-1. These neoplasms are often found during the evaluation of abnormal uterine bleeding or as an incidental discovery of a uterine mass. Given the rarity of sarcomas, differential diagnoses such as benign leiomyoma or endometrial carcinoma are often initially considered more likely. Diagnostic work-up for patients with suspected UTROSCT includes a detailed medical history, pelvic examination, endometrial sampling, and imaging techniques. Imaging assists with staging before surgery or when post-hysterectomy analysis unexpectedly reveals UTROSCT. While there are no specified protocols for staging UTROSCT, it is generally accepted to utilize the 2017 AJCC/UICC TNM and FIGO staging systems employed for uterine sarcomas. Treatment strategies vary as no standardized protocol exists for UTROSCT; the typical approach involves a hysterectomy, with or without bilateral salpingo-oophorectomy. Given the nature of UTROSCT, which is often deemed of indeterminate or low malignant potential, adjuvant therapies such as radiation, chemotherapy, or endocrine treatment are not routinely indicated.

Case Report: We present the case of a 53-year-old multiparous woman (G3P1) reporting postmenopausal bleeding over the past year. Endometrial sampling characterized the presence of atrophic and metaplastic epithelial fragments on the endometrial surface. A total laparoscopic hysterectomy with bilateral salpingo-oophorectomy was the elected course of action. The histopathological examination post-surgery revealed a lesion exhibiting selective staining for inhibin and calretinin, hallmarks compatible with UTROSCT. Follow-up TAP-CT imaging demonstrated no evidence of metastatic disease or recurrence.

CONCLUSION: The successful management of this case through surgical intervention without the need for adjuvant therapy exemplifies the potential for a favorable prognosis when UTROSCT is appropriately identified and treated. Continued surveillance of the patient is essential due to the limited data on the long-term behavior of UTROSCT. This case contributes to the growing compendium of UTROSCT literature, which is vital for the development of evidence-based guidelines to optimize patient outcomes. Future studies are warranted to better understand the pathogenesis, behavior, and optimal management strategies for UTROSCT.

Keywords: endometrial stromal sarcoma, postmenopausal bleeding, utrosct

OS-76

Rare Cervical Lipoleiomyoma Case Report

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INTRODUCTION: Lipoleiomyoma is a benign mesenchymal tumor and its incidence is 0.03-0.2%. They are often called the leiomyoma variant. Histologically, they contain varying amounts of smooth muscle, fibrous tissue and mature fatty tissue components. Although its pathogenesis has not been fully explained, the most common view is the lipocytic differentiation of primitive connective tissue cells. Although they are often seen in the uterus corpus, lipoleiomyomas located in the cervix uteri have been reported in a small number of literature. In this case report, a patient presented to our clinic with a pelvic mass and abnormal uterine bleeding and had cervical lipoleiomyoma after the operation. A diagnosed case will be discussed. CASE: A 47-year-old patient applied with complaints of vaginal bleeding and abdominal pain that had been going on for 2 months. In the transvaginal ultrasound examination of the patient, a 7.3 cm myomatous structure was observed in the uterine cervix. Laboratory findings were examined and the patient's Hb level was 5.7, so 3 units of ES and 1 unit of TDP were replaced. After hemodynamic stability was achieved, the decision for Total abdominal hysterectomy and bilateral salpingooferectomy was made. The surgical material pathology resulted as Cervical Lipoleiomyoma and Uterine Leiomyoma. DISCUSSION: Our case was diagnosed with lipoleiomyoma, a rare benign mesenchymal tumor of the uterus. Since lipoleiomyomas are located in the cervix uteri, which is less common in terms of their location, and there are few cases of lipoleiomyomas located in the cervix uteri reported in the literature, our case was prepared to contribute to the literature. Key Words: Cervix, Pelvic Mass, Lipoleiomyoma

Keywords: Cervix, Pelvic Mass, Lipoleiomyoma

OS-77

Approach To Retroperitoneal Hematoma in The Puerperal Period - Case Report

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Among hematomas that develop during the puerperal period, those that develop in the retroperitoneal region are rare and can lead to serious life-threatening complications.Conservative or surgical treatment can be applied to these patients. When puerperal hematoma develops, bleeding can be fatal if the patient is not cardiac and hemodynamically stable. There are many methods available for the treatment of puerperal hematomas.Among these; These include close observation, surgical drainage, finding and ligating the bleeding vessel, and compression of the vagina with gauze tamponade. Rectal packing, hysterectomy and internal iliac artery ligation are also less frequently applied treatment methods. Angiographic embolization is also among the newly defined techniques.In this case, we are talking about a 31-year-old gravida 2 parity 1 patient who developed a 120*56 mm hematoma in the retroperitoneal region after vaginal delivery.

CASE

31 years old, gravida 2 parity 1 39 weeks pregnant, after vaginal birth performed by opening a mediolateral episiotomy in an external center; hematoma on the side wall of the vagina?, abscess? When he arrived, he was referred to us on the intraoperative day. The patient, whose vitals were stable and general condition was good, was hospitalized for follow-up and treatment.The postpartum state of the uterus was observed in the abdominal ultrasonography. Intra-abdominal free fluid was not observed. The patient underwent contrast-enhanced tomography of the lower abdomen. In the footage taken; A hematoma measuring 120x56 mm was detected, which was thought to be in the extraperitoneal distance between the cervix and the right pelvic wall, sitting on the right lateral wall of the perirectal fascia in the posterior and extending inferiorly along the anorectal junction and the right lateral wall of the vagina on the inner surface of the levator ani. The patient's prenatal hemoglobin was 11.2 gr/dl, but her control hemoglobin was 7.4 gr/dl. 2 units of erythrocyte suspension (ES) were inserted. After ES, hemoglobin was detected as 9.6 g/dl. He was followed closely.No surgical intervention was planned for the patient, whose vitals were stable.The patient was called for a check-up 1 week later and was discharged on the 5th postoperative day.During the control examination,it was determined that the hematoma had regressed.

DISCUSSION

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.Episiotomy has been reported at a rate of 85% to 93% in cases with puerperal hematoma. Vaginal hematomas occur more frequently with mediolateral episiotomies. Management of puerperal hematomas is diverse and controver-

sial. Some authors recommend monitoring especially hematomas smaller than 3 cm.Conservative approach without intervention in large hematomas may cause local infection, sepsis, necrosis, serious hemorrhage, and even death. According to another study, if the hematoma is large and expanding, bleeding should be prevented and hypovolemia should be corrected by surgery. In this case, a follow-up decision was made because the patient was hemodynamically stable and the hematoma did not expand. Surgical treatment was not planned for the patient, who was followed closely, as the hematoma resolved.

Keywords: retroperitoneal, hematoma, puerperal

OS-78

Pedinculated Subserosal Myoma Torsion: A Rare Cause of Acute Abdomen

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Pedinculated subserosal myoma torsion is a rare complication of uterine leiomyomas, which are common pelvic tumors in women of reproductive age, with a prevalence ranging from 20% to 50%. Leiomyomas can occur submucosally, intramurally, subserosally, or within the broad ligament. Occasionally, subserosal leiomyomas can become pedunculated. Due to most torsion cases being reported as individual instances in literature, the true incidence remains uncertain. Diagnosis is often made intraoperatively due to imaging limitations in detecting acute torsion of pedunculated subserosal leiomyomas. This case report discusses a patient presenting with acute abdominal pain who was diagnosed with torsion of a pedunculated myoma based on literature review.

Case Presentation: A 45-year-old, gravida 2, para 2, with a history of cesarean section, presented with abdominal pain persisting for approximately 20 days. Initial evaluation at an external emergency department revealed a cystic lesion in the left ovary, prompting admission with a preliminary diagnosis of pelvic inflammatory disease. No improvement occurred after a week of hospitalization. Repeat ultrasound suggested left ovarian torsion, leading to surgical recommendation, which the patient declined. Upon persistence of symptoms, she presented to our emergency department. Vital signs were stable, with tenderness in the left lower quadrant. Diagnostic laparoscopy revealed torsion of a pedinculated myoma originating from the anterior left lateral wall of the uterus, with successful excision.

DISCUSSION: Torsion of a pedinculated subserosal leiomyoma is a rare acute complication of uterine leiomyomas, often leading to delayed diagnosis and significant morbidity. Risk increases with thin pedicles and larger leiomyomas, but the exact size threshold for torsion remains unclear. Diagnosis is challenging due to limited imaging capability and lack of specific clinical signs. Ultrasonography, the most commonly used method, may suggest torsion but often misses thin pedicles. In our case, accurate diagnosis was achieved through ultrasound. Although challenging, diagnosing torsion of a sessile subserosal leiomyoma is essential to rule out other emergency pathologies and prevent morbidity.

CONCLUSION: Torsion of a pedinculated subserosal leiomyoma is rare but should be considered in women presenting with acute abdominal pain. In cases where imaging fails to provide a definitive diagnosis or symptoms persist, diagnostic laparoscopy is crucial. Early diagnosis and surgical intervention are vital to prevent complications and ensure patient well-being.

Keywords: pedinculated subserosal myoma, torsion, Acute Abdomen

OS-79

Emergency Cesarean Section Following Uterine Rupture

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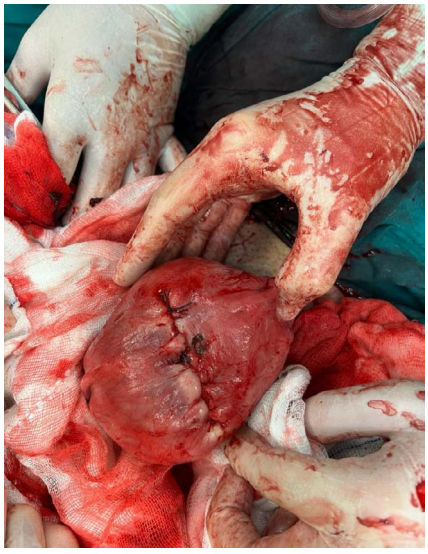
Abstracts: Emergency cesarean section after uterine rupture The patient presents to the emergency department due to labor. On examination, the patient is taken to emergency cesarean section (c/s) with the prediagnoses of previous cesarean section, uterine rupture and labor. When the abdomen is entered, the baby is in the abdomen and a 5-6 cm rupture area extending vertically in the fundus and bleeding is observed. The placenta is removed from the uterine rupture area. The thinned tissue in the rupture area is resected and closed with a baseball stylet.

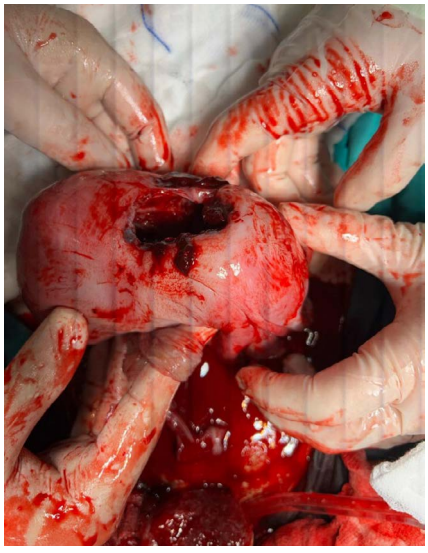
Keywords: Emergency Cesarean Section, Cramping, Uterine Rupture

rupturonarimi



Rüptür onarımı

uterinruptur



Uterin rüptür resmi

OS-80

Risc of ureteral damage in patients undergoing hysterectomy due to cervical myoma

Deniz Taşkıran, Sadettin Oguzhan Tutar
Giresun Kadın Doğum ve Çoçuk Hastalıkları Hastanesi, KADIN HASTALIKLARI VE DOĞUM ABD,GİRESUN

Summary: Due to the anatomical proximity of the uterus to the bladder and ureter, there may be a risk of ureter damage during hysterectomy. Two case reports in which ureter damage occurred during hysterectomy in patients with cervical myoma are shared.

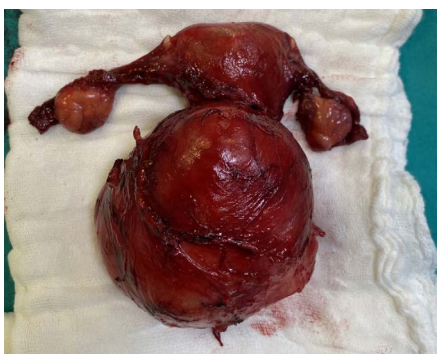
Aim: The risk of ureteral injury is higher with abdominal hysterectomy compared with vaginal hysterectomy. Although the actual incidence is not clearly known, studies show that the rate of ureteral damage due to gynecological procedures is between 0.5 and 1%. The anatomical shape of the region, diseases involving the pelvic region (endometriosis, cervical myomas, etc.), and oncological surgical procedures change this rate. In gynecological surgeries, ureter damage occurs most frequently in the lower third.

CASE - A 65-year-old, G4P4ND4, postmenopausal patient applied with complaints of vaginal bleeding, pelvic pain, chronic constipation and frequent urination. As a result of the examinations, a 96x80 mm solid lesion (myoma?) originating from the uterocervical region was detected in the patient. The patient underwent total abdominal hysterectomy + bilateral salpingo-oophorectomy. Since the patient described right flank pain on post-operative day 2, the creatinine value in the kidney function tests was 1.4 mg/dL, and ultrasonography revealed grade 2 pelvicalyceal enlargement in the right kidney and dilatation in the ureter. The patient was consulted to urology. With the cystoscopy + URS performed on the patient, suture material was observed in the region near the distal end of the ureter and it was observed that the lumen was narrowed by 50-60%. Since absorbable suture material was used, a DJ catheter was inserted into the patient to provide lumen opening and there was no need for additional surgery. The DJ catheter was removed from the patient in the 2nd month post-op and the patient recovered.

CONCLUSION: Complications that may occur in the risky patient group should be followed up, taking into account the preoperative and postoperative periods. In case of suspicion of complications that may occur in patients, it is vital to determine the necessary tests and procedures at the earliest stage.

Keywords: cervical myoma, hysterectomy, ureteral damage

cervical myoma



OS-81

Large Fibroepithelial Polyp of Uterine Cervix and Ovarian Gynandroblastoma in an Adolescent with DICER1 Syndrome

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INTRODUCTION: Gynandroblastoma is a rare subtype of sex-cord stromal tumors (SCSTs) with morphological evidence of both female and male sex cord differentiation and is known to be associated with DICER1 mutations. We describe a case of large protruding fibroepithelial polyp of uterine cervix and ovarian gynandroblastoma in a 15 year-old-girl as a manifestation of the DICER1 syndrome.

CASE: A 15-years-old girl presented with a mass protruding from the vagina. She also had a history of irregular menstrual periods, excessive hair growth and acne since menarche. On physical examination, she had mild hirsutism, severe inflammatory acne with no signs of virilization. The inspection of vulva revealed a large polyp-like mass protruding from the vaginal introitus and otherwise normal external genitalia (Figure 1). Laboratory investigations revealed moderately elevated testosterone levels around 1.1 ng/ml. Pelvic ultrasound revealed a approximately 8 cm multicystic complex adnexal mass on the right. Magnetic resonance imaging (MRI) also showed multicystic-solid complex adnexal mass in the right ovary with marked contrast enhancement without any other abdominal lesion. Serum tumour markers were normal. Laparoscopic right salpingo-oophorectomy was performed following peritoneal washing and meticulous inspection of the contralateral ovary and the peritoneal cavity (Figure 2). The right ovary was removed through a small abdominal incision with using an Alexis retractor without any damage to the ovarian capsule. Histopathologic examination revealed FIGO stage 1A gynandroblastoma of the right ovary. Adjuvant chemotherapy was not indicated due to early stage of the disease. Genetic testing revealed a DICER1 mutation.

CONCLUSION: This report highlights the importance of investigation for hormone-secreting tumors in the presence of high testosterone levels, even if there is no sign of virilization. This rare presentation also reminds us of screening for a germline DICER1 mutation in the presence of the early-onset features of this syndrome.

Keywords: adolescent gynecology, cervical polyp, gynandroblastoma

OS-82

Fetal death in utero after urachal cyst rupture

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The urachus normally involutes, resulting in a fibrous cord between the umbilicus and the bladder in the preperitoneal space. Disruption of this process can lead to a spectrum of rare anomalies. One of these rare anomalies is urachal cyst. Patency in the midduct with closure at both the umbilicus and the bladder results in a urachal cyst. The cyst can present as a mass. Prenatal sonographic findings include increased thickness of the umbilicus, and can be observed as an extra-abdominal cystic mass. This case presentation is about a 24-year-old woman, gravida 1, para 0, was referred to our hospital at the gestational age of 12 + 1 weeks with suspicion of cyst. The size of the cyst was measured about 22 mm x 18 mm at her first visit to our hospital. The ultrasound found a connection between the cyst and bladder, and we observed no hernia of the intestine from the abdominal wall or other gross anomalies with the fetus. Therefore, we suspected an urachal cyst and recommended genetic testing. After we performed CVS successfully and the results of karyotyping and chromosomal microarray were totally normal, at the gestational age of 15 + 4 weeks, she was readmitted to our hospital with vaginal bleeding and cramping. The urachal cyst was no further visible on ultrasound examination. Accordingly, we assume that the urachal cyst was ruptured in utero spontaneously and resulted in fetal death. For the purpose of make a better understanding of embryology and fetal development of urachus and one of its rare anomally, the urachus cyst, this case presentation is designated.

Keywords: urachal anomalies, urachal cyst, urachus, cyst rupture

OS-83

Case report of tuba, ovary and ovarian cyst in the inguinal hernia sac accompanied by uterine bicollis in a patient seeking fertility: A case report

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Context: Inguinal hernias are one of the most common surgeries performed by general surgeons. Omentum, small intestines and pelvic organs can often be found in the herni sac. Although ovarian and tuba uterina can also be seen in the ovarian and tuba uterina sacs in the pediatric age group, these cases are very rare in the adult age group.

Case Report: In this case, we present the inguinal hernia, which consists of ovaries and tubas, accompanied by uterine anomaly in the adult patient.

CONCLUSION: As a result, we found that over and tuba may be seen in the hernia sac in the patient with uterine anomally.

Keywords: Hernia, inguinal, Infertility, Uterus

Figure 1. Over and Tuba inside the hernia

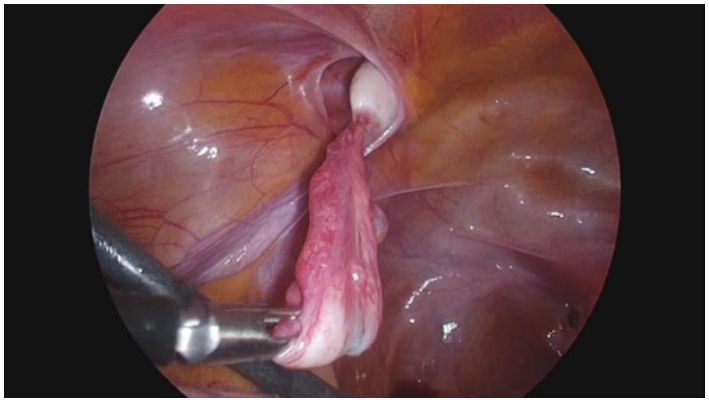


Figure 2. Uterus bicollis, right tuba and round

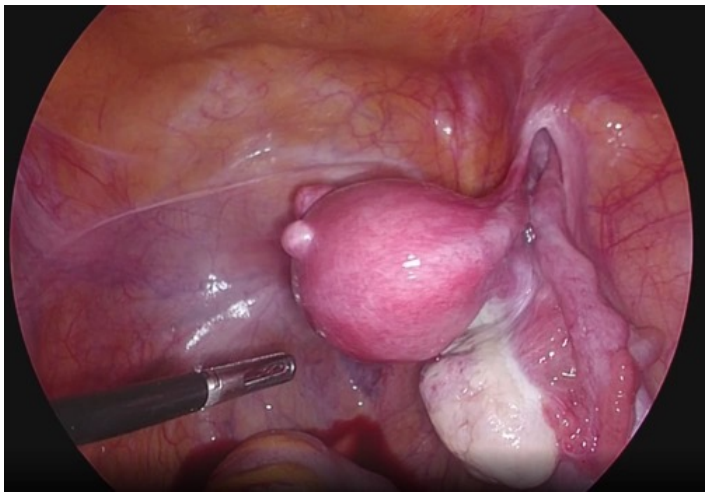
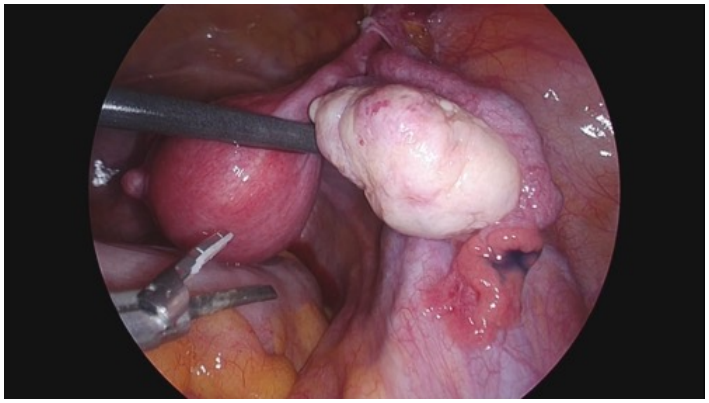


Figure 3.Methylen Blue movement at the right tuba



POSTER SUNUMLARI

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

PS-01

Evaluation Of The Results Of Loop Electrosurgical Excision Procedure Surgical Margin Positivity And Recurrence

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Cervical cancer is among the preventable cancers worldwide and in our country through screening methods. Precursor lesions of cervical cancer are defined as cervical intraepithelial neoplasias (CIN). CINs can be identified through smear and colposcopic biopsy, and interventions can be performed without the need for advanced surgical procedures using conization methods (cold conization, LEEP). We aimed to assess the impact of applying the LEEP method, used in the diagnosis and treatment of CIN, under general or local anesthesia, on surgical margin positivity and disease recurrence.

Data from 122 patients who met the inclusion criteria and underwent LEEP between 01.01.2016 and 31.12.2021 at the Muğla Sıtkı Koçman University Education and Research Hospital's Gynecologic Oncology Clinic were retrospectively examined. Demographic data (age, body mass index (BMI), alcohol and smoking habits) were recorded from patients' files and discharge summaries. Additionally, gynecological history including gravidity, parity, number of living children, abortion figures, menopausal status, type of contraceptive method, and the presence of additional metabolic diseases (hypertension, diabetes, coronary artery disease) were documented. LEEP indications and pre-LEEP HPV information were noted. Procedure details for LEEP, such as the anesthesia method used (general or local anesthesia), the rate of positive surgical margin (considered positive when CIN II/III was identified at the resection margins of the ectocervical and/or endocervical areas), size of the excised piece (anteroposterior length, transverse length, height, volume), and pathology results were recorded to analyze factors affecting margin positivity.

It was determined that the type of anesthesia applied (general or local), patient age over 40, menopausal status, dimensions and volume of the excised piece during LEEP had no effect on margin positivity. However, it was shown that high-grade pre-LEEP cervical cytology, the presence of endocervical gland involvement, and multiple passes during excision increased the risk of margin positivity.

Our study identified high-grade pre-LEEP cervical cytology, the presence of endocervical gland involvement, and multiple passes during excision as risk factors predicting positive surgical margins; however, we found that the type of anesthesia did not impact the surgical margin.

Keywords: Cervical intraepithelial neoplasia, HPV, LEEP

The Effect of Demographic Characteristics on Margin Positivity

Variables	Group 1 Margin positive (n=61)	Group 2 Margin negative (n=61)	P value
Age>40 a	14 (23.00)	19 (31.10)	0.415
Body Mass Index (kg/m²) b	25.80±4.17	26.09±4.22	0.887
Menopause a	8 (13.10)	18 (29.50)	0.045
Vaginal Delivery a 1 ≥ 2	11 (36.70) 19 (63.30)	14 (42.40) 19 (57.60)	0.797
Alcohol consumption a	18 (29.50)	16 (26.20)	0.840
Smoking a	25 (41.00)	25 (41.00)	1.000
Use of intrauterine device a	7 (11.5)	7 (11.5)	1.000

a Frequency values (percentage rates) b Mean values ± Standard deviation

Effect of Pathology Material on Margin Positivity.

	Group 1 Margin positive (n=61)	Group 2 Margin negative (n=61)	P value
LEEP Material a Length (mm) Width (mm) Height (mm) Volume (cm³)	23.88±5.89 11.01±2.36 17.6±3.67 1.62±0.84	24.6±5.87 10.83±2.48 17.8±3.56 1.67±0.89	0.873 0.885 0.820 0.709
Pathology result b CIN II CIN III	23 (37.70) 38 (62.30)	43 (70.50) 18 (29.50)	0.001 0.001
Endocervical b Positivity Negativity	15 (24.60) 46 (75.40)	3 (4.90) 58 (95.10)	0.004 0.004

a Mean values ± Standard deviation b Frequency values (percentage rates)

Evaluation of Age, Anesthesia Type, Endocervical Positivity, Menopausal Status, Transformation Zone Type and Pathology Results on Margin Positivity According to Single and Multiple Analysis of Variance.

Variables		Univariate Analysis			Multivariate Analysis	
	Hazard rate	95% CI	P value	Hazard rate	95% CI	P value
Age (≤40y or>40y)	1.51	0.67-3.39	0.310	1.12	0.27-4.58	0.870
Anesthesia Type (General or Local)	1.46	0.67-3.14	0.330	1.29	0.53-3.16	0.560
Endocervical positivity (present or not)	0.15	0.04-0.58	0.005	0.168	0.04-0.67	0.011
Menopausal status (present or not)	1.97	0.76-5.11	0.160	1.12	0.21-5.99	0.890
Number of transitions	0.35	0.15-0.77	0.009	0.41	0.17-0.98	0.040
Transformation Zone Type	1.31	0.68-2.52	0.410	1.14	0.51-2.53	0.730
Pathology	0.23	0.11-0.50	0.0002	0.24	0.10-0.59	0.001

PS-02

A case of diaphragmatic eventration mimicking diaphragmatic hernia

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INTRODUCTION: Eventration of the diaphragm in newborns is a rare disease in which all or part of the diaphragm muscle is replaced by fibroelastic tissue, leading to thinning and elasticity of the central part of the diaphragm. It is the result of inadequate development (congenital) or atrophy (acquired) of the diaphragm.

Patients with partial defects usually have mild or no significant findings, while those with complete defects have significant respiratory and gastrointestinal symptoms. Typically, the most severely affected patients present as neonates. Decisions regarding the need for intervention are made according to clinical findings. We will present a case of diaphragmatic eventration, which mimics postnatal diaphragmatic hernia, and in which no pathology was detected in the anenatal follow-up.

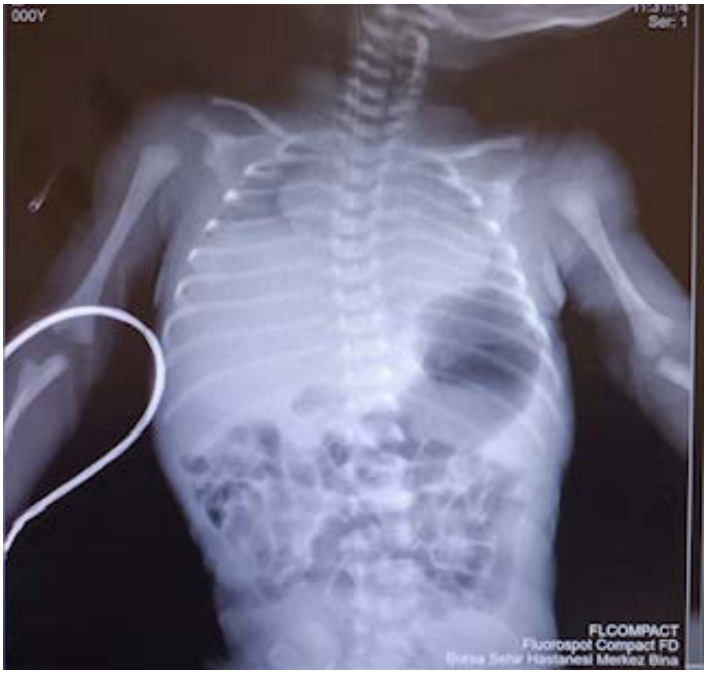
Case: The 29-year-old gravida 3 parity 1 patient, came for pregnancy follow-ups regularly, and no obvious sonopathological findings were observed in the obstetric ultrasound performed at 21 weeks and 5 days. In the 1st trimester, anti-cytomegalovirus immunglobuline (CMV IG-M) was borderline and anti-CMV IG-G positivity was detected. As CMV IGG avidity results remained high, the patient was informed about the possibility of recurrent CMV infection. The patient did not accept screening tests during pregnancy follow-up.The patient was referred to the perinatology outpatient clinic, where polyhydramnios and borderline high blood pressure were detected in the sonograms in the third trimester. In the USG performed in the perinatology outpatient clinic at 36 weeks and 5 days of age, no sonographic features were detected other than macrosomia and polyhydramnios. The patient's oral glucose tolerans test value was within normal limits.

The patient was taken for elective cesarean section at term. A lmale newborn weighing 3270 grams was delivered, with an Apgar score of 7 at the 1st minute and 8 at the 5th minute. Following the development of tachypnea in the newborn, the patient was intubated, and according to the results of the chest X-ray (Figure 1), he was admitted to the neonatal intensive care unit with the preliminary diagnosis of right diaphragmatic hernia with the liver at the top. However, no sonographic findings suggestive of diaphragmatic hernia were observed in the patient's antenatal follow-up, and no change in the location of the intra-abdominal organs was observed in the patient's repeated chest radiography and abdominal ultrasound while intubated. In the fluoroscopy performed, both diaphragmatic movements were evaluated as symmetrical and normal. Diagnosis changed to diaphragmatic eventration. The patient is being followed intubated and no emergency surgery is planned. The decision to operate under elective conditions was taken.

CONCLUSION: Diaphragmatic eventration is a rare entity that is difficult to diagnose antenatally. There are 12 cases diagnosed in the prenatal period in the literature so far. In our case, no markers such as displacement of intra-abdominal organs to the thorax or deterioration in the cardiac axis were observed in antenatal sonography, other than polyhydrmanios. Other anomalies that may accompany the fetal period may increase the incidence of diagnosis. It is important to keep this in mind in the differential diagnosis of diaphragmatic hernia in the neonatal period.

Keywords: diaphragmatic hernia, diaphragm eventration, prenatal diagnosis

Lung X-ray of neonate



PS-03

Graft-versus-Host Disease-Associated Vaginal Stenosis after Bone Marrow Transplantation

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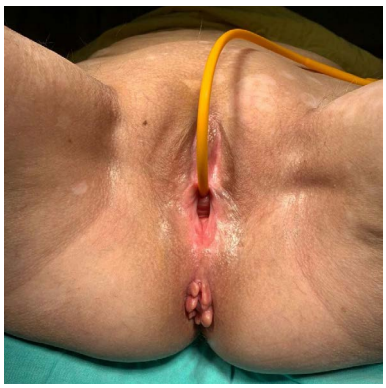
Graft-versus-host disease (GVHD) is an immunological reaction against normal tissue and can occur as a complication of allogeneic stem cell transplantation. In women, sclerotic changes and mucosal abnormalities may occur in the genital system secondary to GVHD-related immunological reactions. It is seen in 25-49% of patients after allogeneic bone marrow transplantation (BMT). Local estrogen, local immune suppressive agents, surgical procedures and vaginal dilators can be used in the treatment of chronic GVHD-related vaginal stenosis. Vaginal reconstruction plays a crucial role in the treatment of GVHD-mediated vaginal obstruction to ensure continuation of hormone replacement therapy (HRT) and facilitate sexual intercourse. We prepared a case report of vaginal reconstruction after vaginal stenosis that developed 1 year after BMT in a 43-year-old patient who underwent BMT with the diagnosis of acute lymphoblastic leukemia (ALL).

Keywords: Bone marrow transplant, graft-versus-host disease, vaginal stenosis

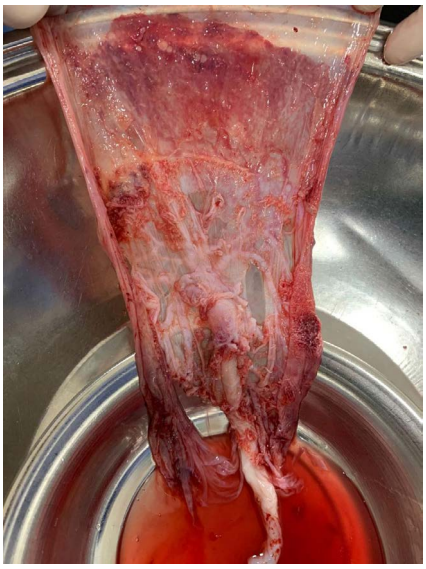
Before second surgery



Diagnostic signs

Location	Vulva	Vagina
Diagnostic signs		
Synechia	5	5
Reticular with lines	8	1
Teleagiectatic area	4	1
Reddened	4	
Sore vaginal string		3
Distinctive signs		
Red + white spots	11	
Fissure	6	
Signs not specific to genital cGvHD		
Thin	17	3
Dry	6	2
Red spots (no white)	3	3
White spot (no red), edema	2	
Reddened		1

Amniotic membrane preparation 1



Clinical score of genital GVHD

Clinical score of genital cGvHD adjusted from NIH 2005 consensus criteria. Clinical scoring is used to classify the impact of cGvHD on the affected organ by combining signs and symptoms into one of four categories (Score 0–3).

Score 0	Score 1	Score 2	Score 3
Asymptomatic independent of signs	Symptomatic[1] with mild signs[2]; no effect on coitus or minimal discomfort at gynecologic examination	Symptomatic[3] with moderate signs[4]; mild dyspareunia or discomfort with gynecologic examination	Symptomatic[3] with advanced signs[5]; pain with coitus or inability to insert vaginal speculum

[1] "rarely" symptoms like itching, pain, swelling, fissures/wounds, dryness
[2] reticular white lines, teleangiectatic areas, redness, red and white spots
[3] "occasionally" symptoms like[1] + "rarely to occasionally" pain, burning, fissures
[4] vulvar/vaginal synechia, sore intravaginal fibrotic strings, fissures and erosions
[5] "often to always" symptoms like [1,3]
[6] widespread vulvar/vaginal synechia, partial and total stenoses

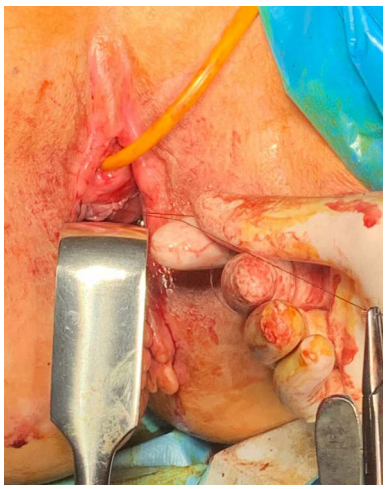
Amniotic membrane preparation 2

Treatment

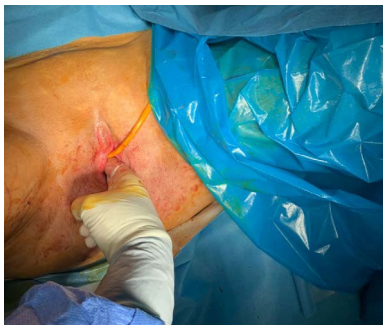
Ointment \ Week	1-4	5-8	9-10	11-14	15-18	19-22	23[a] →
Estrogen[b]	Twice a week	Twice a week	Twice a week	Twice a week	Twice a week	Twice a week	Twice a week
Tacrolimus 0.1%[c]	Every other day	Every other day					
Tacrolimus 0.03%[c]			Every other day	Twice a week	Twice a week	Once a week	Once a week
Clobetasol 0.05%[c]	Every other day	Twice a week	Twice a week	Twice a week	Once a week	Once a week	Not used
Vaginal dilator[d]	Once a week to twice a day						

[a] Maintenance treatment.
[b] Vulvar and vaginal estriol or estradiol – daily use for two weeks before maintenance treatment twice a week. Or an estradiol vaginal ring (7.5 µg/24 h).
[c] Keep the amount as low as possible (0.25-0.5 cm).
[d] Gentle painless use includes lubricant, slow insertion, waiting for muscular contractions to relax before continuing insertion and leaving the dilator in the vagina for 3 to 5 minutes.

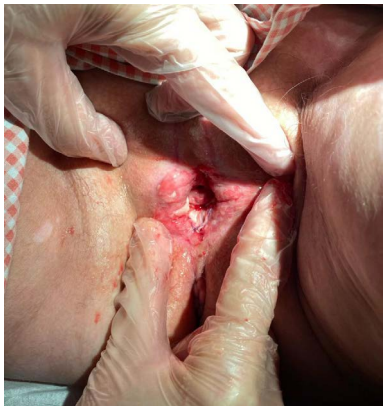
Amniotic membrane transplantation



Postoperative vaginal width



Examination on the 7th postoperative day



PS-04

A Case Report Of Ectopic Pregnancy In The Ipsilateral Distal Stump After Partial Salpingectomy

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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.

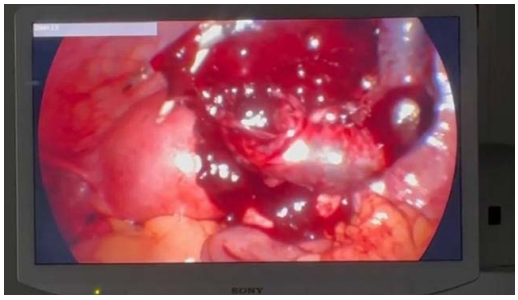
CASE: A 31-year-old female patient presented with vaginal bleeding and right lower abdominal pain six weeks after her last menstrual period. She had a history of laparoscopic segmental isthmus resection surgery performed 10 years ago due to an ectopic pregnancy. The patient underwent laparoscopy with 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

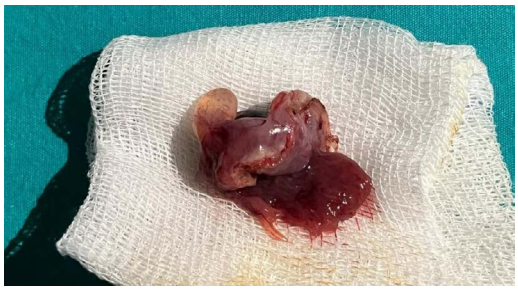
to sterilization, enough tissue should be removed to leave enough gap between the both of stumps and the risk of ectopic pregnancy should be reduced by coagulating both stumps using bipolar coagulation and preventing recanalization.

Keywords: ectopic pregnancy, distal stump, post-partial salpingectomy

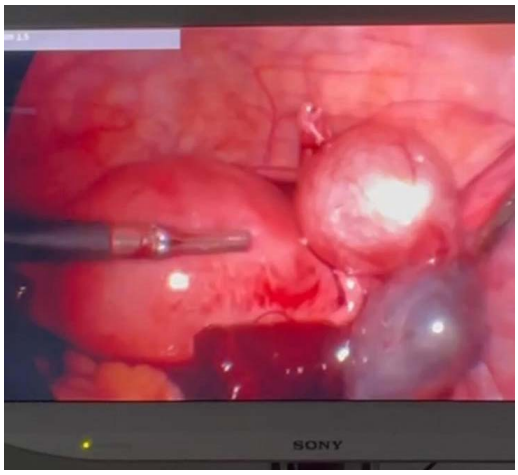
exu 2



exu 3



exu1



PS-05

Extensive ecchymosis on the skin following a cesarean section

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Ahi Evran University Faculty of Medicine, Kirsehir

OBJECTIVE: Sharing experiences about postoperative skin ecchymosis covering almost half of the abdomen

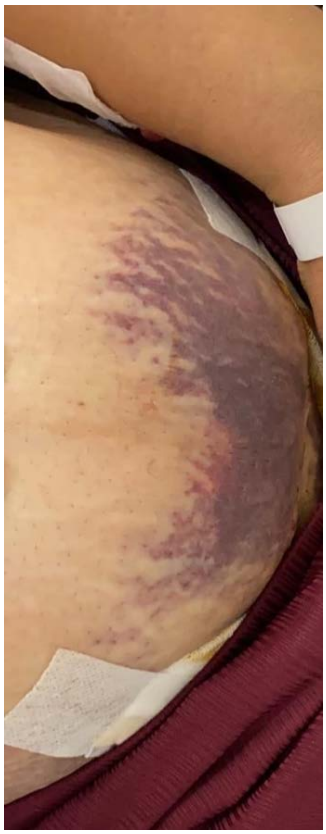
CASE: A 35-year-old patient in her third pregnancy, with a gestational age of 38 weeks and 3 days based on the last menstrual period, underwent an elective cesarean section due to a history of previous cesarean sections. The body mass index was 33.7 and the patient did not have any chronic illness requiring medication. 1 gram of cefazolin was administered intravenously immediately before the skin incision during the operation. The fascia was closed using a continuous suture technique with 1.0 Vicryl, and the skin was closed with 2.0 Vicryl subcutaneously. The total duration of the cesarean section was 12 minutes. There were no intraoperative complications. The patient was started on 6000 IU of Anti-Xa subcutaneously once daily for postoperative thromboembolism prophylaxis. The patient presented to the outpatient clinic on the second postoperative day with complaints of bruising around the wound. Complete blood count, international normalized ratio (INR), activated partial thromboplastin time (aPTT), D-dimer and fibrinogen values were normal. The cream containing chondroitin polysulfate was started at a dosage of 2 times daily. At the follow-up visit two days later, it was observed that the bruising on the skin had become widespread. Over a total of 16 days, the bruising on the skin resolved after applying chondroitin polysulfate twice daily.

RESULTS: The areas of petechial bleeding may occur in the scar area after surgery. Due to some etiologies, these pathologies can turn into widespread ecchymotic areas.

CONCLUSION: It was considered that the condition was due to a reaction to the daily 60 mg enoxaparin sodium application, as there were no perioperative complications and no pathology to explain the widespread bruising in the laboratory.

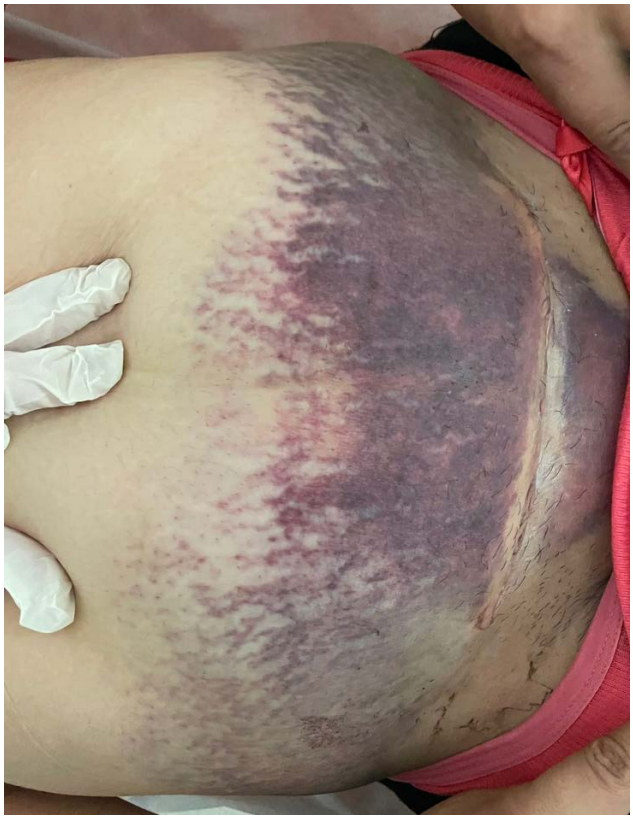
Keywords: cesarean, ecchymosis, enoxaparin, wound complication

Picture 1



Postoperative 2nd day

Picture 2



Postoperative 4th day

PS-06

A case of vaginal cuff infection after total abdominal hysterectomy

Çiğdem Can Bayrak, Esra Güner, Mustafa Tutumlu
Obstetrics and Gynecology, Burdur Bucak State Hospital, Burdur, Turkey

OBJECTIVE: Hysterectomy is one of the most common gynecologic procedures. Complications of hysterectomy are not uncommon either intraoperatively or postoperatively. We aimed to present a case of vaginal cuff infection after total abdominal hysterectomy, which was performed with meticulous surgical discipline.

CASE: A 45-year-old G6P6 patient with no active complaints was admitted to our clinic due to HPV follow-up for 5 years. Vaginal examination of the patient revealed no pathologic findings. Transvaginal ultrasonography revealed normal uterus and no pathology in bilateral adnexal areas. HPV 16, ASCUS, colposcopic biopsy revealed 'high grade squamous intraepithelial lesion (CIN II/III)'. With these findings, CIN II/III was diagnosed and TAH+BSO was decided. After all preoperative preparation, the abdomen was entered through phannesteil incision under general anesthesia. Intra-abdominal, uterus and bilateral adnexal areas were observed as normal. The uterus, tubas and ovaries were duly removed and the vaginal cuff was sutured continuously with 1/0 vicryl. Following bleeding control, the abdomen was closed according to the anatomy and the operation was terminated. Diuresis was good and clear. Postoperative follow-up was stable and the patient was discharged on the 2nd day with healing. On the 3rd postoperative day, the patient was readmitted to our clinic from the emergency department with complaints of fever, abdominal pain and chills. The general condition of the patient was moderate, vital signs were fever 38 0C, pulse rate 90 beats/min, blood pressure 100/70 mmHg. Laboratory tests revealed no pathologic findings except CRP 134 mg/L. Pelvic computed tomographic (CT) imaging showed '54x30 millimeter and 44x26 millimeter interrelated collection area (pelvic abscess) in the douglas'. The patient was started on 10-day vancomycin and meropenem treatment. After completion of antibiotherapy, regression of abscess formation was observed on control pelvic CT. Histopathologic examination of the operative material was evaluated as 'CIN II/III in the cervix, leiomyoma uteri and adenomyosis in the myometrium'.

DISCUSSION: Complications of hysterectomy vary depending on the surgical technique used and the method of operation. These complications may be recognized intraoperatively or postoperatively. The most common complications encountered are infection, adjacent organ injuries (such as genitourinary-gastrointestinal system), bleeding, venous thromboembolism, nerve injury, vaginal cuff separation. Infections after hysterectomy develop due to unexplained fever, operation area, incision line, pelvic region, urinary system and pneumonia. Once the etiology is determined, the infection should be eliminated with appropriate antibiotherapy. The majority of hysterectomy complications do not require reoperation. However, it should be kept in mind that they may cause serious morbidities.

CONCLUSION: Surgical technique and the method used in hysterectomy have an important place in terms of complications. The best approach is to determine the risk factors and predict complications without going beyond surgical discipline and to apply appropriate management if complications develop.

Keywords: hysterectomy complication, cuff infection, surgical discipline

PS-07

Ruptured C-Section Scar Pregnancy

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Sakarya University Training and Research Hospital, Obstetrics and Gynecology Clinic

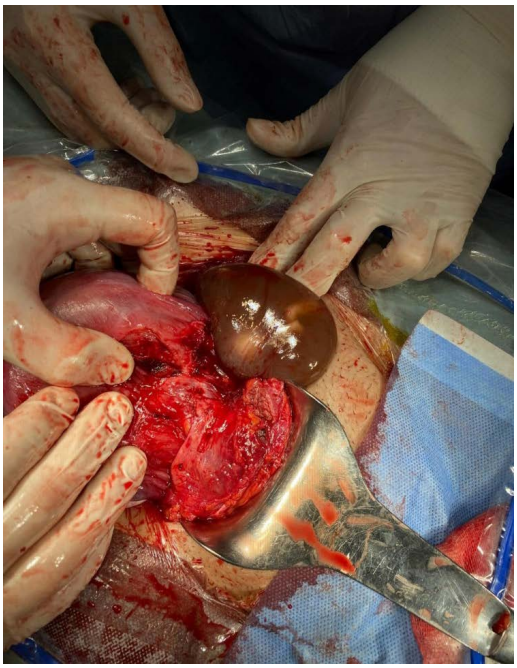
OBJECTIVE: Scar pregnancies occur at a rate of 1:1,800 to 1:2,216 of normal pregnancies. Common gestational age range 5w-10w. Painless vaginal bleeding is the most frequent symptom. Endovaginal ultrasonography is the most preferred diagnostic method in this cases, with a sensitivity of 84.6% [1]. Scar pregnancies are predisposed to uterine rupture. Uterine rupture, during the first or second trimester of pregnancy, occurres in 9.9%.[2] Our case summarizes the clinical course of a patient who underwent an emergency laparotomy due to acute abdomen chart.

Method: A 35 years old patient who had a missed abortion, multiparous (3×cs), applied to the hospital for vaginal bleeding and was hospitalized. ultrasound imaging was performed and intrauterine crown-rump length 12 weeks and 2 days, 60 mm pregnancy who had no heartbeat was seen. After hospitalization, 200 mcg sublingual and 200 mcg intravaginal misoprostol was medicated. Following day, abdominal pain had been occured. During transvaginal sonography, the pregnancy material had seen lateral sight of the former cesarean scar line. Urgently laparotomy was decided.

Findings: Transvaginal ultrasonography revealed incomplete ruptured scar pregnancy. There were dense adhesions and adhesiolysis was performed. Laparotomy showed that there was incomplete rupture on the left lateral of old kerr incision.(Figure 1) The pregnancy material was removed completely. Bilateral tubal ligation was performed according to patient requested. After draining the hematoma and controlling the bleeding the surgery was completed without complications. The patient was discharged on the 2nd postoperative day in good general condition. CONCLUSION: Uterine rupture is a rare but potentially deathful complication of pregnancy. Classically, its signs and symptoms combine pain, fetal heart rate (FHR) abnormalities, and vaginal bleeding. The signs and symptoms of partial ruptures are different. Nearly half of the cases may be asymptomatic. In our case, there was no fetal heartbeat but there were abdominal pain,vaginal bleeding and ultrasound findings. Scar pregnancy can be confused with missed abortion during follow-up. Recurrent cesarean sections pose a big risk for cesarean scar pregnancy. The clinicians has to be aware of this kind of risks as ruptured scar pregnancies. Our case emphasizes that, while making a diagnosis, radiology and clinic should be evaluated together.

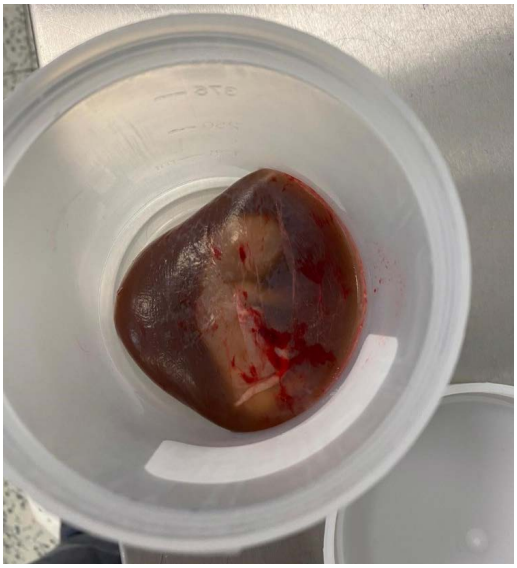
Keywords: scar pregnancy, uterine rupture, laparotomy

Figure 1



intraoperative appearance of ruptured scar pregnancy

Figure 2



pregnancy material which had no fetal heartrate

PS-08

Postpartum Tuberculosis

Retibe Gök, Arif Güngören, Ahmet Beyazıt
Kadın Hastalıkları ve Doğum, Mustafa Kemal Üniversitesi Tayfur Sökmen Tıp Fakültesi, Hatay, Turkey

1.introduction

Tuberculosis infectious disease caused usually mycobacterium tuberculosis.It is transmitted through the air. The TB bacterium affects different parts of the body. Pulmonary tuberculosis accounts for 85% of all TB cases, while the remaining 15% constitute extrapulmonary tuberculosis cases.This leads to the formation of other forms of TB. 28% of extrapulmonary tuberculosis cases involve lymph nodes, 22% pleural, 15% genitourinary, 9% bone-joint, 9% miliary, 4% meningeal, 4% peritoneal, with the remaining 9% distributed among other forms of TB. TB in organs other than the lungs is rare.

2.Case presentation

The patient presented to us due to wound infection and discharge at the site of cesarean section. The patient had undergone cesarean section at an external center 4.5 months ago. Abdominal ultrasound revealed widespread mycobacterial infections in the abdomen. Postoperative hemorrhage, malignancy, and infection were considered, and the patient was admitted to the ward. WBC/CRP taken during admission was 5.21/44.3, and HGB/HCT/PLT were 8.1/24.7/32.8. The patient was started on IV iesef 1 gr 2*1 and flagly 500 mg 3*1. The patient had no symptoms such as fever or cough. Laparotomy was planned for the patient with discharge at the wound site and widespread mycobacterial infections in the abdomen. Midline incision was made for abdominal entry. During exploration, widespread serous fluid was observed in the abdomen. Widespread implant? nodular lesions were observed in the small intestine wall, peritoneum, and anterior abdominal wall. General surgery was consulted, considering malignancy. It was suggested to take pathological samples. No additional suggestions were made. Samples were taken for cytology and culture from the free fluid in the abdomen, and biopsies were taken from the intestinal wall and peritoneum. One drain was placed in Douglas. The peroperative images of the patient were as attached. Due to suspicion of tuberculosis post-laparotomy, the patient was consulted with infectious diseases and chest diseases.

Infectious diseases recommended testing for tuberculosis PCR, ARB, and brucella, and monitoring fever and infectious parameters while continuing current antibiotic treatment.

Chest diseases suggested that since the patient had no active respiratory symptoms, no known lung pathology, and no family history of tuberculosis, the PAACG of the patient was evaluated as normal. It was recommended to culture the tissue sample taken peroperatively for tuberculosis and send it for pathology.

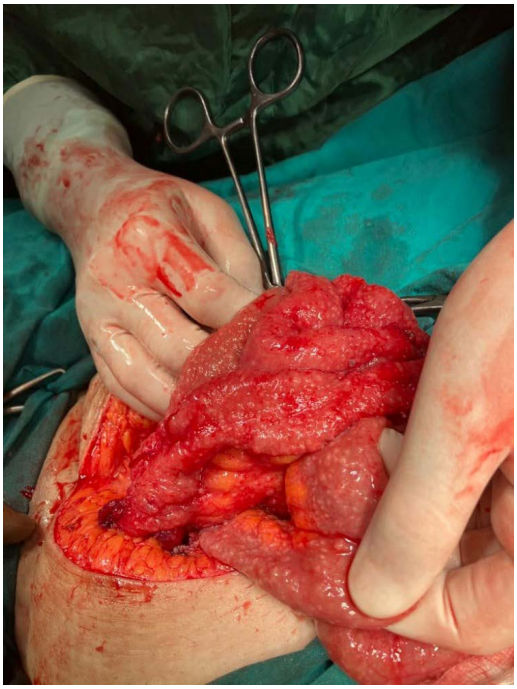
On the postoperative 1st day, 900 cc of serous fluid was drained from the drain. The drain was removed on the 3rd day postoperatively when the drainage decreased to 20 cc. The patient was referred to the tuberculosis dispensary. At the tuberculosis dispensary, the patient was started on rifcap 300mg 2*1 and isoniazid 300mg 1*1 and has been using it for 4 months.

Cytology RESULT: DIAGNOSIS: BENIGN CYTOLOGY REACTIVE MEZOTEL PROLIFERATION

Due to the earthquake on 06/02/2023, ARB, brucella, and TB cultures could not be performed at our hospital affected by the earthquake.

Keywords: malignensi,postpartum tuberculosis, wound infection

İnce bağırsak duvarında perioperatif nodüler lezyonlar görüldü



Pathology:Caseos granulomatous ınflammatıon

PS-09

Biochemical Pregnancy Rates of Ovulation Induction and Intrauterine Insemination Cycles Before, During and After Covid-19 Pandemic

Elif Aylin Taşkın, Didem Çeviker, Rümeysa Ayas Surucu, Yaprak Engin Ustun
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OBJECTIVE:

Although we cannot be precise, vast majority of our population is speculated to be infected with SARS-Co V2 at least once either asymptomatically or clinically. As SARS-Co V2 uses Angiotensinogen Converting Enzyme 2 (ACE2) receptor which is also present in male and female reproductive tract tissues such as Fallopian tubes, endometrium and ovaries (1). Based on this data, any possible detrimental effect of this infection on human reproduction deserves investigation (2). Therefore. we aimed to demonstrate the effect of Covid-19 pandemic on results of ovulation induction (OI) and intrauterine insemination (IUI), if there is any.

Method

We searched hospital records of patients who had OI and IUI before (years 2016 and 2018), during (2021 and 2022) and after (2023) the Covid-19 pandemic and calculated biochemical pregnancy rates. All OI cycles ended with IUI were included, ovarian stimulation with either oral agents or gonadotropins. Partners were tested for Covid-19 during 2021before the OI and positive cases were postphoned. Ovulation was triggered with rHCG 6500IU when at least 1 follicle reached 18mm diameter and cycle cancellation criteria are not met. IUI was planned at 36th hour of ovulation trigger. Semen was prepared with density gradient centrifugation. Luteal support was given to all patients as micronised progesterone 100mg three times per day intravaginally. Biochemical pregnancy is defined as positive serum pregnancy test 12 -15 days after IUI.

RESULTS: OI+IUI cycles conducted before, during and after the pandemic period were found to be similar (Table 1)

Discussion

Our results did not demonstrate any detrimental effect of Covid-19 pandemic on OI-IUI cycle pregnancy rates. Although many of our patients were thought to be infected with SARS- C0V2 before the OI-IUI cycle, none were clinically infected patients during the cycle. That means, even if Covid-19 infection has a detrimental effect on oocyte quality, fertilisation or implantation, this effect is not permanent or can be overcome with our routine OI+IUI+luteal support protocol.

References

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Keywords: Coronavirus,Covid-19,Intrauterine Insemination,Pandemic, Pregnancy

Table 1.

Years	No. of OI + IUI	No. of pregnancies	Rate of biochemical pregnancy (%)
2016	1238	157	12.68
2018	1214	130	10.70
2021	452	56	12.38
2022	580	61	10.51
2023	742	85	11.45

Biochemical pregnancy rates after OI+IUI according to years.

Table 1. Biochemical pregnancy rates after OI+IUI according to years.

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2023	742	85	11,45

OI+IUI cycles conducted before, during and after the pandemic period were found to be similar (Table 1).

PS-10

An unexpected cause of abdominal pain in pregnancy: Acute pancreatitis

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INTRODUCTION: Acute pancreatitis, which is more common in the third trimester, affects every 1000–12, 000 pregnant women [1]. Although it is not common, it is important because of its association with high maternal and fetal mortality and morbidity. Here, we present a case of acute pancreatitis during pregnancy, which was diagnosed only in the postoperative period.

Case

A 30-year-old patient with gravida 5, parity 3, abortion 1 presented to the emergency department with complaints of nausea, vomiting, and epigastric pain. The patient's body mass index was 28.65 (kg/m²). On physical examination of the patient, body temperature, blood pressure, and heart rate were 36.7 °C, 100/60 mmHg, and 96/minute respectively and there was tenderness in the epigastric region. At admission the patient's gestational age was 35 weeks and five days. In the ultrasonographic evaluation, a 37 weeks and three days fetus with the cephalic presentation was observed. In the patient with a history of 3 previous cesarean sections, regular uterine contractions were present in reactive cardiotocography without any cervical dilatation. The patient, whose contractions became more frequent in the follow-up, was taken to an emergency cesarean section in the 5th hour of hospitalization due to the deterioration of her general condition. In the postoperative period, the patient's oral intake was stopped, antiemetic and proton pump inhibitors were started. Due to the lipemic serum in the blood parameters taken at the patient's hospitalisation, many results could not be obtained. Based on this, the serum lipid profile of the patient with no known history of hyperlipidemia was studied. There was no skin xanthoma on physical examination. During the cesarean section, diffuse purulent fluid was detected in the abdomen. Histopathological evaluation of the placenta and its membranes was performed with the suspicion of chorioamnionitis, but no signs of infection were found. The edematous and hypoechoic pancreatic tissue observed in the abdominal ultrasound in the postoperative period was consistent with acute pancreatitis. In the postoperative first month of control, it was observed that the pancreatic tissue returned to normal ultrasonographic appearance.

Dicussion

Historically, it was accepted that acute pancreatitis during pregnancy was associated with high maternal and fetal mortality. With the developments in medical management, in a recently published meta-analysis, maternal and fetal mortality rates after acute pancreatitis were reported as 2.8% and 12.3%, respectively [2]. Acute pancreatitis is more common, especially in the third trimester [2]. The most common cause of pancreatitis is cholelithiasis, followed by hypertriglyceridemia [2]. Our patient also developed acute pancreatitis associated with hypertriglyceridemia, with no previous diagnosis. In acute pancreatitis, fasting and gastrointestinal decompression are the mainstays of treatment [3]. As in our case, achieving glycemic control with insulin treatment is possible.

The patient's laboratory values during the follow-up period are shown in Table 1.

Keywords: fetus, hyperglycemia, pregnancy, pancreatitis

Table - 1

Results / Time	1st Examination	1st Day	2nd Day	1st Week	1st Month	3rd Month
Hemoglobin	14,4	12,8	11,9	10,5	12,4	12,1
Hemotocrit	33,9	33,9	32,4	30,5	34,7	34,1
Platelet	207	244	206	257	270	261
WBC	11,2	20,4	19,2	10,5	6,35	7,12
CRP	21,9	-	-	19,9	3,1	1,2
AST	19	22	Lipemic	16	-	-
ALT	11	18	Lipemic	10	-	-
Na	Lipemic	Lipemic	128	136	-	-
LDL	Not Calculated	-	-	Not Calculated	120	101
Triglyceride	Lipemic	Lipemic	-	988	270	198
HDL	<3	27	-	30	51	52
D-dimer	-/1,17	-	-	-	-	-
Total Cholesterol	1117	1002	-	371	241	202
Lipase	477	-	656	302	121	70
Amylase	243	-	508	288	103	68
LDH	153	-	319	-	-	-
ALP	50	-	44	-	-	-
K	3,7	3,5	3,7	-	-	-
Total Protein	53,2	-	47,9	-	-	-
Albumin	29,3	-	25,0	-	-	-
Urea	5,8	5,3	15,6	-	-	-
Creatinine	0,17	0,21	0,39	-	-	-
Glucose	168	323	279	221	127	89
HbA1c	-	-	7,32	-	6,4	5,9
INR	Lipemic	0,95	-	-	-	-
PT	Lipemic	8,27	-	-	-	-
APTT	Lipemic	31	-	-	-	-
Anti - HCV	0,04	-	-	-	-	-
Anti - HIV	0,21	-	-	-	-	-
HBsAg	0,23	-	-	-	-	-

Laboratory values during the 3-month follow-up period

PS-11

Hypercalcemia during pregnancy: Health threats, clinical management strategies and its effects of maternal- fetal health

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INTRODUCTION

The main cause of hypercalcaemia in pregnancy is primary hyperparathyroidism (PHPT). Other important causes of hypercalcaemia include familial hypocalciuric hypercalcaemia (FHH), milk-alkali syndrome and parathormone (PTH)-related peptide-mediated hypercalcaemia due to malignancy or pregnancy itself. PHPT occurs as a result of excessive PTH secretion and is characterised by marked hypercalcaemia. PHPT is rare in women of reproductive age and its prevalence is approximately 5/10.000. It is difficult to diagnose PHPT in pregnancy because the symptoms are often non-specific or similar to pregnancy-related symptoms. If not recognised and treated, it causes significant fetal and maternal morbidity. PHPT is mostly caused by solitary parathyroid adenomas (approximately 85%).

CASE

A 29-year-old patient was admitted to the endocrinology service in the 27th week of pregnancy due to hypercalcaemia and consulted to us. It was the patient's first pregnancy and the complaint of nausea and vomiting had been continuing since the beginning of pregnancy. The patient was referred to endocrinology after a PTH value of 589 and a calcium value of 13.5 in routine controls. In the neck USG performed on the patient, "There is an oval hypoechoic lesion with a diameter of 8x8x7 mm at the level of the lower pole of the thyroid on the right, which is bloody in Doppler and is significant in terms of parathyroid. No ectopic parathyroid gland adenoma was seen in other areas of the neck." The patient who was consulted to ENT was taken to surgery for excision of the lesion but the lesion could not be reached. Non-contrast MRI of the neck-mediastinum was performed for ectopic focus and thymic origin cyst and cystic parathyroid adenoma were suspected. Surgery was planned to remove the parathyroid adenoma focus in the mediastinum. The patient continued his treatment in an external centre. The cyst of thymic origin and parathyroid glands were excised and postoperative calcium and parathormone values returned to normal limits.

DISCUSSION

Diagnosis is difficult because 80% of the association of PHPT and hypercalcaemia in pregnancy is asymptomatic and the symptoms are similar to the symptoms of hyperemesis gravidarum. In addition, there is physiological overproduction of PTH Related Protein (PTHrP) from the placenta or breast tissue in pregnant women. Therefore, differential diagnosis is important in pregnant women with hypercalcaemia. Complication rates related with PHPT in pregnancy have been reported as 67% maternal and 80% fetal. Fetal complications include low birth weight, intrauterine fetal death, intrauterine growth retardation, neonatal death and neonatal hypocalcaemic tetany. Maternal complications may include nephrolithiasis, nausea, hyperemesis, vomiting, fatigue, muscle weakness, mental changes, pancreatitis, bone diseases, polyhydramnios, preeclampsia, constipation, hypertension and hypercalcaemic crisis. When intervention is necessary, surgery is the primary treatment option for PHPT.

CONCLUSION

PHPT detected during pregnancy is a life-threatening condition for both mother and fetus. Parathyroidectomy in the second trimester should be the treatment of choice especially in patients with symptomatic hypercalcaemia. Patients with asymptomatic hypercalcaemia can be followed up if calcium levels can be kept below 11 mg/dl with medical treatment.

Keywords: Hpercalcemia, Primary Hyperparathyroidism, Parathyroidectomy, Preeclampsia, Fetal Complication, Maternal Complication

Hypercalcemia during pregnancy: management and outcomes for mother and child

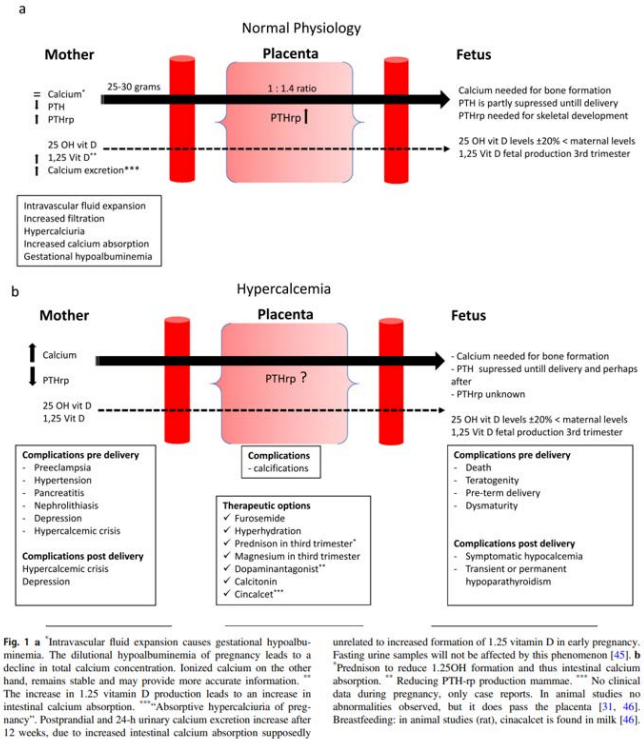

Fig. 1 a *Intravascular fluid expansion causes gestational hypoalbuminemia. The dilutional hypoalbuminemia of pregnancy leads to a decline in total calcium concentration. Ionized calcium on the other hand, remains stable and may provide more accurate information. ** The increase in 1.25 vitamin D production leads to an increase in intestinal calcium absorption. ***"Absorptive hypercalciuria of pregnancy". Postprandial and 24-h urinary calcium excretion increase after 12 weeks, due to increased intestinal calcium absorption supposedly unrelated to increased formation of 1.25 vitamin D in early pregnancy. Fasting urine samples will not be affected by this phenomenon [45]. b *Prednison to reduce 1.25OH formation and thus intestinal calcium absorption. ** Reducing PTH-rp production mammae. *** No clinical data during pregnancy, only case reports. In animal studies no abnormalities observed, but it does pass the placenta [31, 46]. Breastfeeding: in animal studies (rat), cinacalcet is found in milk [46].

Appelman-Dijkstra, N. M., Ertl, D. A., Zillikens, M. C., Rjenmark, L., & Winter, E. M. (2021). Hypercalcemia during pregnancy: management and outcomes for mother and child. Endocrine, 71(3), 604-610. doi:10.1007/s12020-021-02615-2

Pregnancy and neonate details

No.	Age	Parity	k	Diagnosis	Maternal iCa Dx (mmol/L)	Maternal iCa end (mmol/L)	Maternal Ca_{corr} (mmol/L)	Maternal PTH (pmol/L)	Maternal u. Ca:Cr	Neonatal iCa (mmol/L)	Bthwt (g)	Surg
1	42	0	26	PHPT	1.46	1.42	2.98	5.7	0.9	1.21	3777	20wks
2	34	0	16	PHPT	1.54	1.56	3.02	4.4	0.8	1.02*	3836	PP
3	34	1	10	PHPT	1.5	1.56	2.86	11	1	1.15	3538	20wks
4	26	0	12	PHPT	1.54	1.57	2.87	10.8	0.9	1.31	2950	PP
5	31	0	6	PHPT	1.33	1.35	2.73	3.5	0.7	1.53	2764	
6	25	0	26	PHPT	1.39	1.49	2.9	13	0.8	1.29	3656	
6	27	1	0	PHPT	1.49	1.48	2.88	13.1	0.8	1.61	3150	
7	28	0	14	PHPT	1.4	1.46	2.9	7.3		1.2	2746	
8	27	0	0	PHPT	1.53	1.51	3.17	14	1.1	0.89*	2900	PP
9	37	0	26	PHPT	1.39	1.4	3.35	25	1.5	1.1	3334	PP
10	39	0	0	PHPT	1.63	1.63	3.3	25	1.4	1.1	3660	34wks
11	31	1	30	PHPT	1.39	1.39	2.81	12.3	0.5	1.42	1400	
12	31	3	0	PHPT	1.38	1.4	2.53	8.1	0.7	1.12	3190	
13	22	0	32	PHPT	1.35	1.34	2.74	5.5	0.8	0.99*	3380	
14	24	0	6	PHPT	1.37	1.37	2.69	4.6	0.8	1.23	3550	
15	38	0	6	PHPT	1.35	1.35	2.83	9.6	0.8	1.21	3884	
16	22	0	26	PHPT	1.34	1.34	2.7	5.2	0.9	1.17	4008	
16	24	1	0	PHPT	1.35	1.33	2.74	5.3		1.56	3530	PP
17	36	1	13	PHPT	1.5	1.41	2.76	10.5	1.2	1.19	2990	
18	33	0	6	PHPT	1.42	1.39	2.82	5.5	2.1	1.64	3730	PP
19	39	0	26	PHPT	1.43	1.43	2.62	9.9	1.4	1.28	3414	PP
20	21	0	30	PHPT	1.34	1.33	2.63	3.4	0.7	1.3	3350	
21	21	0	29	PHPT	1.33	1.32	2.89	5.2	0.8	1.26	2135	
21	23	1	0	PHPT	1.33	1.34	2.87	6.2	0.7	1.12	2592	
22	36	0	28	PHPT	1.4	1.41	2.85	16.4	1.5	1.2	3542	31wks
23	27	0	23	PHPT	1.36	1.4	2.81	5.8	1.2	1.38	2780	
24	38	1	0	FHH	1.49	1.49	2.93	2.3	0.01	1.19	3402	
25	38	0	38	MAS	1.8	1.8	3.43	<0.5	1		2448	
26	30	1	38	MAS	1.52	1.52	3.28	<0.5			3102	

k-gestation at diagnosis (0 preconception); FHH- familial hypocalciuric hypercalcaemia ; MAS- milk alkali syndrome; iCa Dx- maternal ionised calcium at diagnosis; iCa end-maternal ionised calcium at end of pregnancy (or prior surgery); Ca_{corr}- peak maternal corrected calcium ; PTH-maternal parathyroid hormone level; u Ca:Cr- maternal urine calcium:creatinine ratio (non-pregnant reference 0.05-0.45mmol/mmol) ; Neonatal iCa - nadir neonatal ionised calcium; Bthwt- neonatal birthweight; Surg- gestation of neck exploration surgery; PP- postpartum.

Gehlert J, Morton A. Hypercalcaemia during pregnancy: Review of maternal and fetal complications, investigations, and management. Obstet Med. 2019 Dec;12(4):175-179. doi: 10.1177/1753495X18799569. Epub 2018 Dec 11. PMID: 31853257; PMCID: PMC6909300

PS-12

Management of pathological hydronephrosis in high-risk twin pregnancy: A case report and literature review

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INTRODUCTION: Management of hydronephrosis can be challenging by high-risk pregnancies and may require a collaborative effort with the urologist, radiologist, infectious disease specialist and obstetrician to maximise the health of mother and fetus both. In this case report, we aimed to convey the conservative approach we applied in a risky pregnant woman. METHODS: We performed further investigations in a 29-year-old patient with twin pregnancy after detecting bilateral hydronephrosis and calculi. In the light of Pubmed and Cochrane data, a literature review was conducted on hydronephrosis in pregnancy.

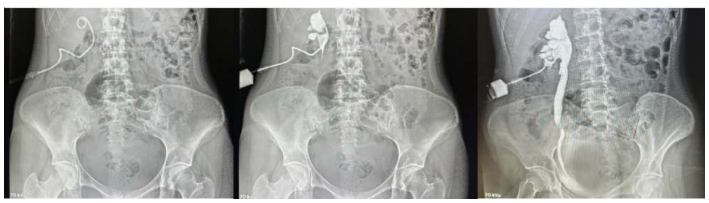
CASE PRESENTATION: A 30-week high risked twin pregnancy presented with inguinal pain, vaginal bleeding,hydronephrosis and urinary calculi. After pathological hydronephrosis was detected, conservative treatment was initiated during pregnancy. In the postpartum period, consistent hydronephrosis was treated successfully with percutaneous nephrostomy catheter.

DISCUSSION: Approximately 90% of pregnant women have an average of 15 mm of pelvicalyceal dilatation in the right kidney and an average of 5 mm in the left kidney. It is important to distinguish between physiological and pathological hydronephrosis in pregnancy. Presence of symptoms and suspicious history for anatomical obstruction are warnings for pathological hydronephrosis. It should be known that pathological hydronephrosis is rare.

CONCLUSION: During high risk pregnancy, pathological hydronephrosis can be detected. Thus situated, conservative treatment with antibiotics can be given considering pregnancy risks. When the safety of both mother and fetus is assured, ureteral drainage can be provided by ureteral stent, percutaneous nephrostomy or ureterorenoscopy.

Keywords: Endourology, High-risk Pregnancy, Obstetrics, Perinatology, Symptomatic Hydronephrosis, Urolithiasis

Antegrade Pyelography



On the first week of percutaneous nephrostomy, we performed antegrade pyelography. Antegrade pyelography showed normal pelvicalyceal structure and uretheral passage.

PS-13

A case of ruptured ectopic pregnancy developing in the distal tuba of a patient who underwent bilateral tubal ligation mimicking acute abdomen

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OBJECTIVE: Ectopic pregnancy is defined as implantation of the blastocyst anywhere outside the uterine cavity. It can still be associated with maternal morbidity and mortality. Tubal sterilization is seen as an important complication in ectopic pregnancy. In this case report, we aimed to present a case of ruptured ectopic pregnancy occurring in the distal tuba in a patient who underwent bilateral tubal ligation (BTL).

CASE: A 30-year-old, G2P2Y2 patient with a history of two normal vaginal deliveries was admitted to our clinic from the emergency department with complaints of sudden onset of diffuse abdominal pain and vaginal spotting. At the time of presentation, general condition was moderate, vital signs were blood pressure 90/50 mmHg and pulse rate 120 beats/min. On transvaginal ultrasonography, the uterus was normal in size, endometrial thickness was fine-regular, the right adnexal area was normal, and an ectopic focus with a diameter of approximately 5x3 cm was detected in the left adnexal area. A mean of 20 mm of generalized free fluid was detected in the duct. Abdominal examination revealed diffuse tenderness, defiance-rebound. In the history of the patient, it was learned that she had a history of BTL with laparoscopic electrocoagulation technique 2 years ago, she did not use any other contraception method during this period and she did not know her last menstrual date. Laboratory tests performed in our clinic revealed no additional pathologic findings except beta HCG level of 10227 mIU/ml. ith these findings, emergency laparotomy was decided with a prediagnosis of ruptured ectopic pregnancy. After all preoperative preparation, the abdomen was entered through GAA phannesteil incision. On exploration, bilateral tubal ligation lines were clearly separated. A ruptured ectopic focus approximately 5x3 cm in size was detected in the left distal tuba. Approximately 200 cc of hemorrhagic fluid was observed in the abdomen.

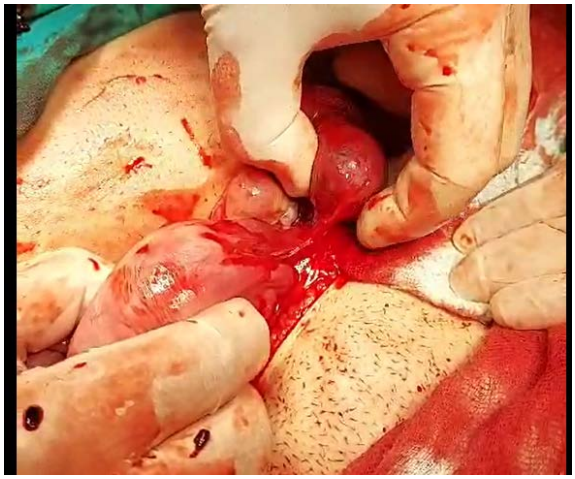
Salpingectomy was duly performed starting from the left distal tuba. Following bleeding control, the abdomen was closed according to the anatomy and the operation was terminated. Postoperative follow-up was stable and the patient was discharged with healing on the 2nd postoperative day. Histopathological examination was interpreted in favor of tuba uterina containing chorionic villi compatible with ectopic pregnancy.

DISCUSSION: Ectopic pregnancy is an emergency gynecologic pathology with high maternal mortality rates in first trimester pregnancies. It is aimed to minimize mortality with the earliest diagnosis and appropriate treatment approach. Previous tubal surgery has an important place among the risk factors. Among the complications of tubal sterilization, presumed sterilization failure increases the likelihood of extrauterine pregnancy rather than intrauterine pregnancy in patients with a history of 2 years or more.

CONCLUSION: Before tubal sterilization, which is a common method of contraception, patients should be informed in detail about the possibility of a new pregnancy. In this way, maternal mortality can be controlled by predicting ectopic pregnancy.

Keywords: ectopic pregnancy rupture, btl, acute abdomen

picture 1: appearance of ruptured ectopic pregnancy developing in the distal tuba of a patient who underwent bilateral tubal ligation



PS-14

A case of endocervical malignant epithelial tumor mimicking abscess secondary to IUD in the cervix

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OBJECTIVE: Cervical cancers, one of the leading gynecologic cancers, are quite common. Pelvic abscesses should be kept in mind in the differential diagnosis. We aimed to present a case of endocervical malignant epithelial tumor mimicking an abscess that developed secondary to a 20-year copper IUD in the endocervix of a patient who presented with complaints of foul odor and vaginal discharge.

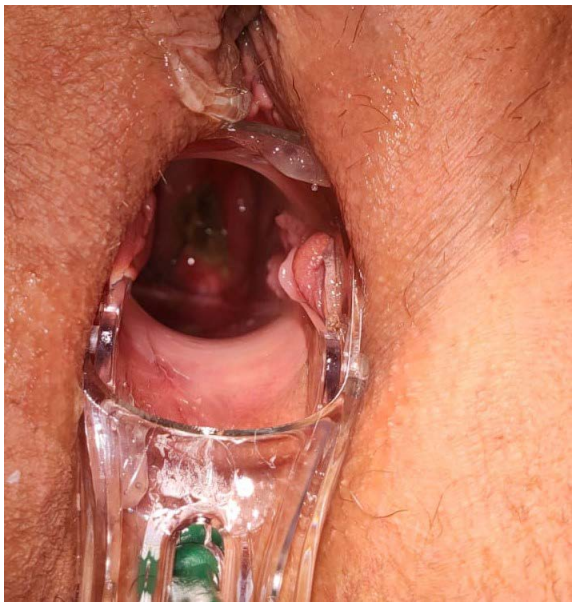
CASE: A 46-year-old G3P3 patient with a 20-year IUD history was admitted to our clinic with vaginal discharge and foul odor. Vaginal examination of the patient revealed an intense anaerobic odor and a lesion thought to be IUD and inflammation. Transvaginal ultrasonography showed normal uterus and bilateral adnexal areas and normal endometrial echo. No free fluid was detected in the douglas. Increased thickness (abscess formation?) secondary to IUD was detected in the cervical canal. Laboratory tests were negative for infection markers. It was learned that she had never had HPV and PAP-Smear tests before. General condition was good, vital signs were stable and a preliminary diagnosis of cervical abscess secondary to foreign body was made with these findings. In this condition, triple antibiotherapy (3rd generation cephalosporin + doxycycline + metronidazole) was started on an outpatient basis after IUD removal and abscess drainage. The patient's complaints regressed during follow-up and ultrasonography showed regressed but persistent thickness in the cervical canal. Cervical and endocervical biopsy of the lesion was decided because vaginal examination revealed spontaneously detached, erosive cervical tissue in the cervix. Histopathological examination of the excisional biopsy material was determined as 'endocervical malignant epithelial tumor'. The patient was referred to gynecologic oncology according to the pathology result.

DISCUSSION: Cervical cancers, which are very common, are confused with many gynecologic pathologies. One of them, abscess, can develop secondary to a foreign body (IUD) and the main predisposing factor for abscess formation is a chronic bacterial infection called actinomyces. The differential diagnosis is made by histopathologic sampling. Treatments vary, but are medical and surgical.

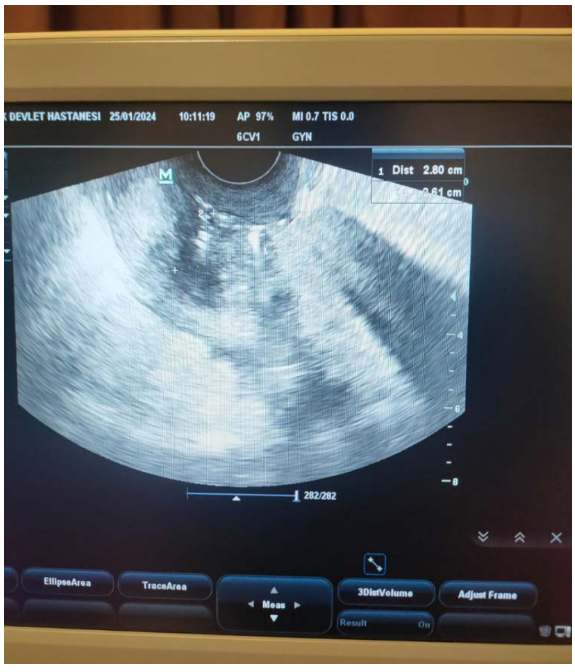
CONCLUSION: Malignancies are gynecologic pathologies that can be confused with many clinics. Especially differentiation with pelvic abscesses should be made with detailed anamnesis, vaginal examination and ultrasonography. In patients presenting with complaints of vaginal discharge and foul odor, as in our patient, the key point was not to diagnose and treat vaginitis in a classical manner, but to invite the patient for follow-up visits at the end of the treatment even if the patient's complaints regressed. In such patients, we should not give up our basic examination method and vaginal speculum examination will be guiding.

Keywords: IUD, malignant epithelial tumor, abscess

picture 1: appearance of abscess formation secondary to ria at presentation



picture 2: malignant epithelial tumor mimicking endocervical abscess formation at presentation



PS-15

Persıstent elevated beta hcg, case report

Aslışah Çetin, Aysel Sadıgova, Tansu Bahar Gürbüz, Kemal Özerkan
Bursa Uludag University Faculty of Medicine, Deparment of Obstetrics and Gynecology

OBJECTIVE: Our aim in reporting this case is to contribute to the recognition of embryonal carcinoma which is a rare condition.

INTRODUCTION: Embryonal carcinomas are extremely rare and are the most malignant tumours arising from the ovary.

CASE: A 22-year-old, single, nulligravid woman with regular menstrual cycles presented to our emergency department with complaints of vaginal bleeding and groin pain. There was no known systemic disease, family history of malignancy. Because of persistently high Beta-HCG values (211-205-194-233- 356-769-537-321-284-404-354-75-481-705-554), ectopic pregnancy was considered in the foreground and 2 times R/C and 3 doses of methotrexate were administered. AFP value among tumour markers was 70. Whole abdominal CT scan was performed. Hypodense cystic structures were observed in the right ovary, the largest of which reached approximately 37 mm in diameter, and in the left ovary, the largest of which reached approximately 21 mm in diameter (follicular cyst?)".No vaginal bleeding was observed on pelvic examination, the uterus was of normal size and bilateral adnexial areas were normal. On ultrasonography; an anechoic cyst with 4 cm diameter in the right ovary with regular borders and without septation and solid areas. No free fluid was observed in the duct. The patient underwent diagnostic L/S in an external centre with a prediagnosis of ectopic pregnancy, the suspicious focus in the left ovary was removed and the final pathology result was mixed germ cell tumour (70% embryonal carcinoma + 30% dysgerminoma). PET-CT scan was performed and showed a 35x30 mm nodular mass lesion in the left adnexal area with increased metabolic activity (SUVmax: 20.87). In the medial neighbourhood of the lesion, an approximately 2 cm dense hypermetabolic (SUVmax: 13.44) lobular appearance with no clear border distinction was noted (adjacent lymph node? lobulation?). A 33x25 mm hypodense area without pathological FDG uptake was observed in the right ovarian lung (ovarian cyst)." and no metastasis was observed. After the removal of the focus, the patient underwent 8.5 cycles of KT and beta-hcg levels decreased to normal limits in the follow-up.

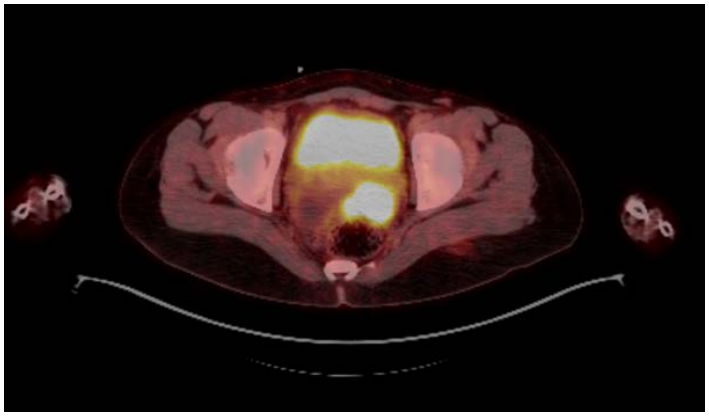
DISCUSSION: Embryonal carcinomas, although rare, are the most malignant tumours arising from the ovary. They constitute 4.1% of malignant ovarian germ cell tumours. It may present with irregular uterine bleeding, pelvic mass, abdominal pain, nausea and vomiting.In our case, the patient who presented with abdominal pain and elevated beta-HCG was initially evaluated for pregnancy and treatment was planned with ectopic pregnancy in the foreground. Due to persistent elevated beta-HCG levels after the treatments, the patient was diagnosed by pathology after the operation was decided. Although symptoms such as elevated beta-HCG levels, absence of gestational sac in the uterine cavity and abnormal uterine bleeding make us suspect ectopic pregnancy, the patient's response to

treatment, persistence of beta-HCG levels despite treatment, ultrasonographic findings should be carefully examined and malignant germ cell tumours of the ovary should be considered in the differential diagnosis.

CONCLUSION: Malignant germ cell tumours of the ovary are rare neoplasms that should not be ignored in clinical practice.

Keywords: malignant ovarian germ cell tumour, embryonal carcioma, ectopic pregnancy, persistent beta-HCG elevation

FIGURE 1



A nodular mass lesion measuring 35x30 mm with intense metabolic activity (SUVmax: 20.87) in the left adnexal area, Adjacent to the described lesion, an approximately 2 cm dense hypermetabolic (SUVmax: 13.44) lobular appearance with indistinct borders.

PS-16

A case of cervical polyp mimicking endometrial cancer in a postmenopausal patient

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OBJECTIVE: Cervical polyps are benign lesions. Cervical polyps may coexist with endometrial pathologies. Here, we aimed to present a case of cervical polyp mimicking the appearance of endometrial malignancy in endometrial echo on ultrasonography in a symptomatic postmenopausal patient in the light of the literature.

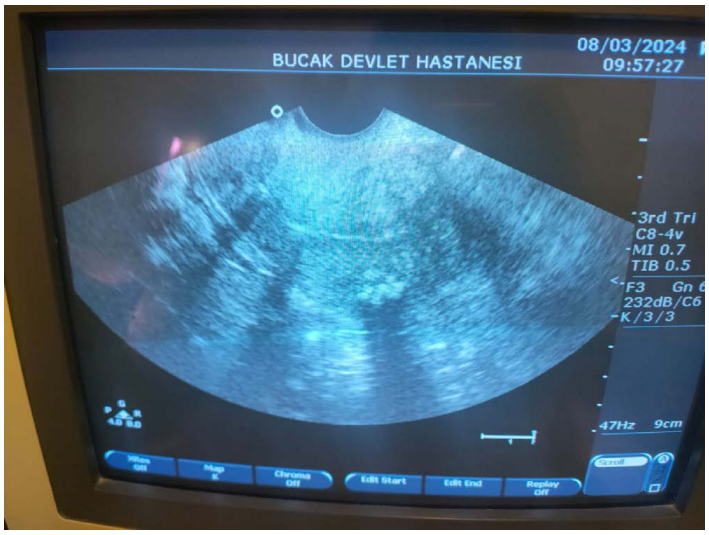
CASE: A 64-year-old postmenopausal multiparous patient presented to the outpatient clinic with complaints of vaginal bleeding for two months. The history of the patient was unremarkable. Vaginal speculum examination revealed a 1 cm cervical polyp-like lesion in the external cervical os. Transvaginal ultrasonography revealed a 3 cm intramural myoma in the posterior uterus. Bilateral ovaries had atrophic appearance. Endometrial thickness was 14 mm and vocalized areas (endometrial malignancy?) were detected. With the suspicion of endometrial malignancy and prediagnosis of cervical polyp, biopsies were taken from the cervical lesion, endocervical canal, cervix and endometrial tissue under local anesthesia and sterile conditions. The lesion taken from the cervical os was approximately 7x3x1 cm in diameter. On post-procedure control ultrasonography, the endometrial thickness was thin and regular in appearance. No additional pathology other than endocervical polyp was detected in the pathologic examination of the materials. It was learned that the patient's complaints regressed during this period. The patient was taken to routine outpatient clinic follow-up.

DISCUSSION: Cervical polyps arising from fibromuscular core and stromal epithelium are benign lesions. Most cervical polyps may be asymptomatic or may present with postcoital, intermenstrual or postmenopausal bleeding. Even if cervical polyps are asymptomatic, they should be excised as soon as they are detected because of the risk of malignant transformation. Although their etiology is not clear, it has been suggested that they may be formed as a response to estrogen stimulation. Although cervical polyps can be seen alone, they may also be associated with endometrial pathologies. Therefore, if detected, they should be carefully evaluated for uterine and endometrial pathologies. In necessary cases, endometrial biopsy should not be avoided to rule out malignancy.

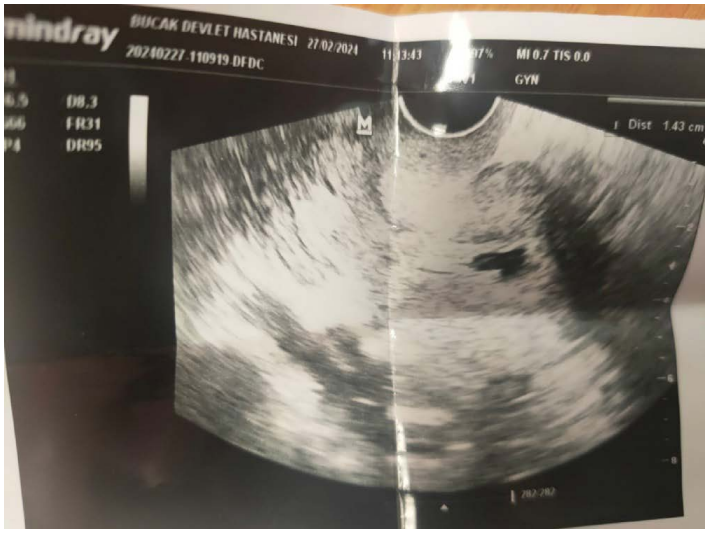
CONCLUSION: Although cervical polyps are benign lesions, caution should be exercised because of the risk of conversion to malignancy. At the same time, the association of cervical polyps with endometrial pathologies should not be overlooked. In asymptomatic or symptomatic patients, especially those presenting with postmenopausal complaints, it should be kept in mind that even if the pathology result is benign after surgical removal, it may recur and follow-up should be continued in case of malignancy.

Keywords: cervical polyp, postmenopausal bleeding, endometrial malignancy

picture 2: endometrial thickness appearance on post-procedure ultrasonography



resim 1: işlem öncesi ultrasonografide endometrial ekoda endometrial malignensiyi taklit eden endoservikal polip görünümü



PS-17

A Rare Case of Adenomyoma Located in the Round Ligament

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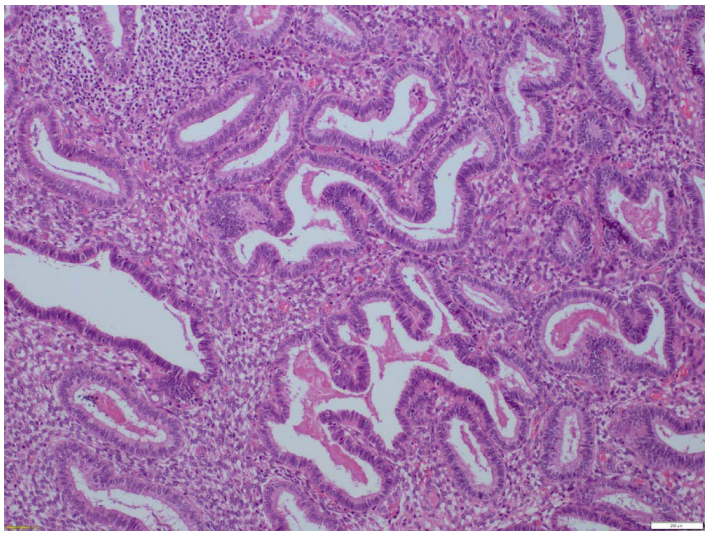
BACKGROUND: Adenomyosis is characterized by the ectopic presence of endometrial glands and stroma within the myometrium, the uterus's muscular layer. Adenomyoma, a localized form of adenomyosis, necessitates histopathological examination for definitive diagnosis. The advent of high-resolution imaging has facilitated preliminary diagnoses. While adenomyomas typically occur within the uterus, they can also be found in extrauterine locations such as the ovary, broad ligament, ovarian ligament, pararectal areas, and even in extrapelvic sites like the liver and abdominal wall.

CASE PRESENTATION: A 46-year-old female presented with a swollen nodule and pain in the right inguinal region. The onset of symptoms was approximately one year prior, with her last menstruation occurring a week before presentation. Her medical history was unremarkable, including no previous surgeries, pregnancies, or chronic diseases, though she reported smoking approximately ten cigarettes daily. Her menstrual cycles were regular, with a duration of 28 days and menstrual bleeding lasting five to six days. Except for a palpable nodule near the right mons pubis, her pelvic examination was normal. The patient noted an increase in pain and nodule size during menstruation. Transvaginal ultrasonography showed no abnormalities in the uterus and adnexa. However, abdominal ultrasonography identified a well-defined, relatively hypoechoic nodule in the inguinal region. Suspecting a subcutaneous endometriotic nodule, surgical excision was decided upon. Surgery revealed a well-circumscribed, solid mass, 1.5 cm in size and located 1 cm below the skin surface in the round ligament. The lesion was excised, and the resultant defect from the partial removal of the round ligament was repaired to prevent herniation. The postoperative period was uneventful, and the patient was discharged the following day. At a one-month follow-up, the patient reported no inguinal pain during menstruation. Pathological examination confirmed the lesion as adenomyoma, with immunohistochemistry results showing CD10 positivity in the stroma and Desmin positivity in the fibroid component.

DISCUSSION AND CONCLUSION: The initial case of extrauterine adenomyoma was reported by Cozzutto et al. in 1981. A 2018 review by Paul et al. highlighted 176 cases, with comprehensive information available for only 34. Cyclical pain and a solid lesion outside uterine structures suggest the possibility of adenomyoma. Although the surgical approach is generally considered safe, the risk of adhesions and damage to adjacent organs during surgery warrants caution. Despite their rarity, adenomyomas should be considered in the differential diagnosis of extrauterine masses. The challenges in establishing a preoperative diagnosis underscore the importance of histopathological confirmation post-surgery. Surgical resection remains the mainstay of treatment, with the need to consider the potential for malignancy in extrauterine adenomyomas guiding a cautious and informed approach to treatment planning.

Keywords: adenomyosis, chronic pelvic pain, extrauterine fibroid, pelvic ultrasonography

20x Magnification, H&E



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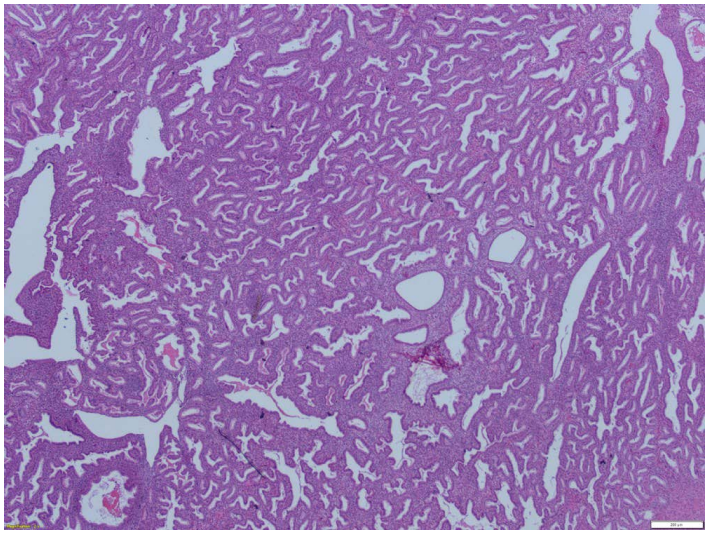
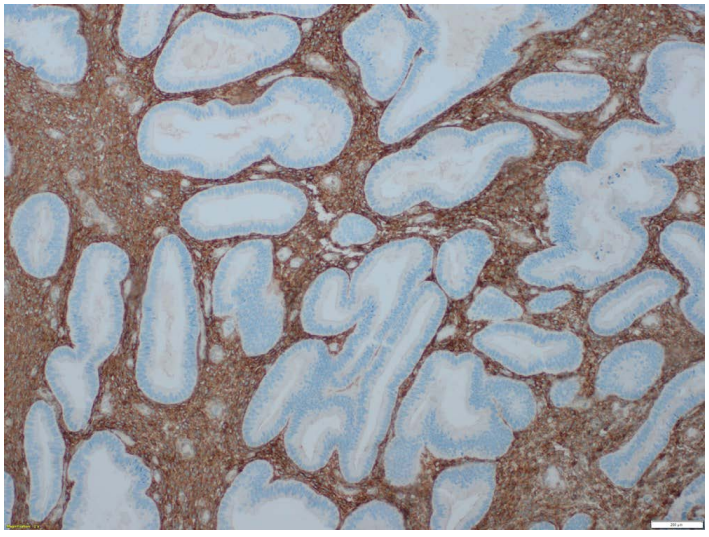
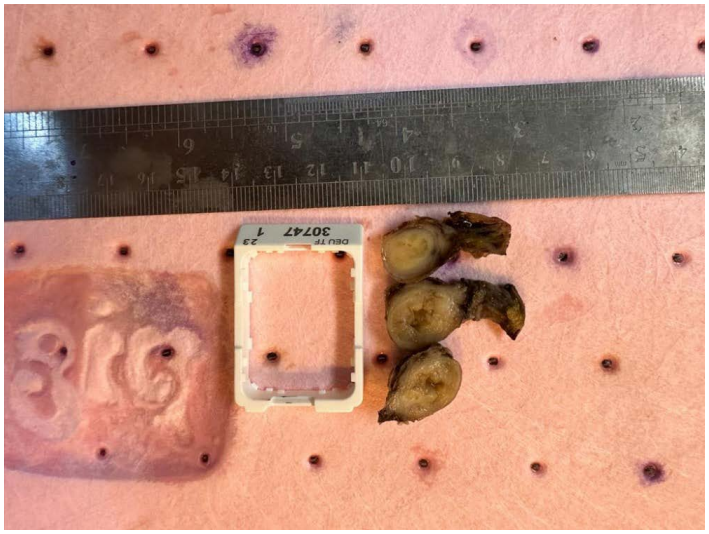


Desmin and CD10 Immunohistochemistry



Macroscopic Appearance

Macroscopic Appearance, Dissected Material



PS-18

Life-threatening overwhelming post-splenectomy infection after cesarean section in a splenectomized patient: a challenging case report

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PURPOSE

The spleen, with vital hematological and immunological functions, has been therapeutically removed following trauma or in hematological diseases since the 1500s. However, removal of the spleen makes patients susceptible particularly to parasitic and encapsulated microorganism infections. This case report aims to illustrate the clinical presentation, and management of an asplenic patient who initially developed surgical site infection (SSI) post-C-section, progressed to septic shock, ultimately progressing to overwhelming post-splenectomy infection (OPSI) triggered by pulmonary infection.

METHODS

A detailed description of the patient's clinical presentation, laboratory findings, imaging results, and management course was provided. The case was managed by a multidisciplinary team.

CASE

A 19-year-old primigravida at 28+2 weeks of gestation, with a history of splenectomy at age five following trauma, underwent C-section under spinal anesthesia due to preterm labour and malpresentation. From her medical history, it was discovered that during her post-splenectomy follow-up, she had not received any vaccinations. Three days postoperatively, she presented with abdominal pain and tenderness at the incision site. Clinical examination revealed localized tenderness without signs of wound dehiscence, erythema, or discharge. Laboratory results indicated leukocytosis (WBC: 55,47x10^3/µL) and elevated CRP levels (421,7 mg/L). Imaging studies ruled out any localized area as the possible source of infection. Empiric antibiotic therapy with meropenem and vancomycin was initiated upon admission. On the second day of hospitalization, purulent drainage was observed from the incision. Despite antibiotic therapy, the patient progressed to septic shock with hypotension, tachycardia and fever. Laboratory investigations revealed leukocytosis (WBC: 66,66x10^3/µL), elevated sedimentation rate (72 mm/hr), elevated procalcitonin (4.04 ng/mL), increased interleukin-6 (13729 pg/mL), increased urea levels (105 mg/dL), and elevated creatinine (1.78 mg/dL), suggesting a worsening of renal function and ongoing systemic inflammation. Intensive care support was initiated promptly, including inotropes, diuretics, and wound debridement. On the 4th day in the Intensive Care Unit, the patient's clinical condition worsened, showing signs of OPSI (overwhelming post-splenectomy infection): pleural effusion, decreased oxygen saturation, and systemic inflammation. The patient's chest x-ray revealed extensive lung involvement with diffuse infiltrates. Thorax CT confirmed bilateral pleural effusion and pulmonary consolidation, indicating a severe pulmonary complication. During clinical deterioration, the patient showed worsening sepsis signs, including increased purulent discharge and palpable abdominal tension. Subsequently, laparotomy was performed, revealing fasciitis and infected tissues along the Kerr incision line, requiring thorough debridement. Intra-abdominal vacuum-assisted closure (VAC) dressing was applied without complications following the procedure. Candida albicans was identified in the patient's tracheal aspirate culture, prompting a modification in antibiotic therapy to include antifungal treatment. Following the alteration in treatment, inflammatory markers improved: CRP decreased to 200.6 mg/L, IL-6 levels reduced to 414.0 pg/mL, and WBC count decreased to 38,97x10^3/µL.

CONCLUSION

This case underscores the intricate management of SSIs post-C-section, especially in splenectomized individuals vulnerable to OPSI. Early recognition, aggressive antibiotic therapy, and multidisciplinary management are essential for optimal outcomes. Heightened awareness among healthcare practitioners regarding the risk of OPSI in splenectomy patients undergoing C-section is imperative for prompt diagnosis and intervention.

Keywords: splenectomy, cesarean section, overwhelming post-splenectomy infection (OPSI), surgical site infection (SSI), septic shock

PS-19

Endometrial Stromal Sarcoma:Case Report

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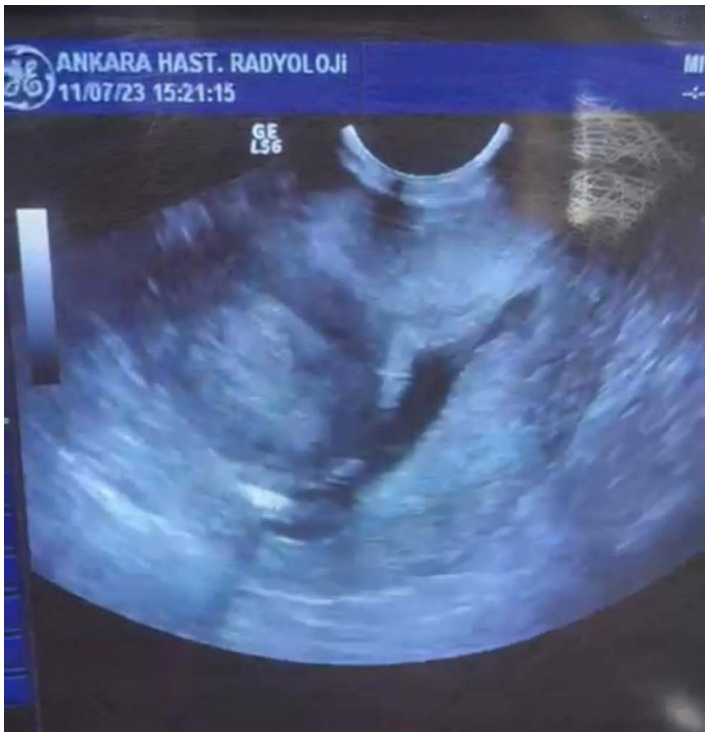
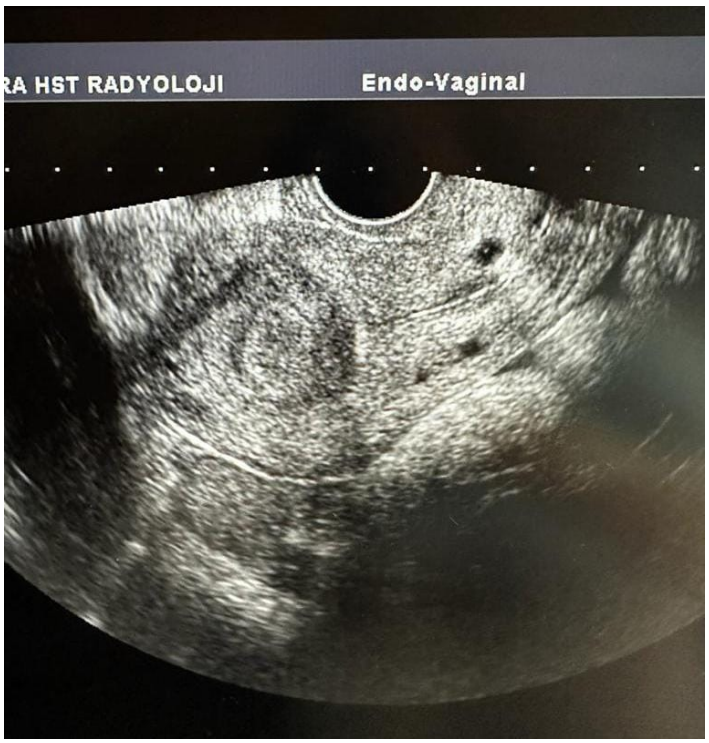
A 38-year-old female patient applied to our clinic with a complaint of abnormal uterine bleeding. On transvaginal ultrasound, an intramural myoma a 32*34 mm was observed in the uterine fundus. Myoma was classified as type 2 according to the Figo classification on ultrasound sonography. Diagnostic probe-C was applied to the patient and the pathology result was reported as endometrial polyp. The pathology result of the patient who underwent myomectomy was reported as endometrial stromal sarcoma. Afterwards, the patient was planned for total abdominal hysterectomy and bilateral salpingo-oophorectomy. The final pathology report reported negative residual tumor. The clinical follow-up of the patient continues by our team. Endometrial stromal sarcoma accounts for 0.2-1% of all uterine malignancies and 10-21% of all uterine mesenchymal tumors. Endometrial stromal sarcomas occur mainly in perimenopausal women between the ages of 45 and 50. It is difficult to diagnose endometrial stromal sarcomas with imaging methods in the preoperative period, and surgical resection is usually performed with the preliminary diagnosis of myoma. Factors that increase the risk of endometrial stromal sarcoma are obesity, diabetes mellitus, tamoxifen use, exogenous estrogen exposure, polycystic ovary syndrome, pelvic radiotherapy exposure, and early menarche. Having given birth is a protective factor against endometrial stromal sarcoma. Abnormal uterine bleeding, pelvic pain and dysmenorrhea are the most common symptoms reported by patients. Endometrial stromal tumors are divided histopathologically and clinically into two groups: low grade and high grade. The prognosis of low-grade endometrial stromal sarcoma is favorable, but late recurrence may occur even in patients with early-stage disease, so long-term follow-up is required. High-grade endometrial stromal sarcoma is clinically aggressive and often has a high probability of being an extrauterine disease at presentation. The 5-year disease-free survival rate is 25%.

Keywords: Endometrial, stromal, sarcoma, myoma uteri

saline ultrasound sonography



ultrasound



PS-20

A case of secondary postpartum hemorrhage; on day 35

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OBJECTIVE: Secondary postpartum hemorrhage is defined as any significant uterine bleeding occurring between 24 hours and 12 weeks after delivery. The most frequent causes are placental retention, subinvolution of the placental bed and infections, while less common causes include bleeding diathesis, uterine artery/internal pudendal artery/vaginal artery/vulvar labial artery pseudoaneurysms, arteriovenous fistulas, cesarean scar dehiscence and choriocarcinoma. A rare case of secondary postpartum hemorrhage on postpartum day 35 is presented.

CASE: A 25-year-old G2P2(2*NSVD) patient was brought to the emergency department by 112 emergency ambulance with the complaint of intense vaginal bleeding at home.. The patient's anamnesis revealed that she had given birth 35 days prior in our hospital via a normal spontaneous vaginal delivery; she was sutured due to severe postpartum hemorrhage from the left posterior vagina. she was discharged from the hospital as stable on the 2nd postpartum day, and no pathology was observed in the control examination performed on the 10th postpartum day. İn the emergency department during the control speculum examination, after an unsuccessful attempt at suturing due to a bleeding area observed on the left side wall of the vagina, the patient was transferred to the operating room Laparotomy was decided for the patient who was thought to be in hypovolemic shock, hysterectomy was performed. And the vaginal artery was ligated. It was believed that the hematoma developed as a consequence of a potential pseudoaneurysm of the vessel that bled and closed following delivery in the lateral left vagina was rebleeding. After hemostasis, no pathology was observed in the bladder and ureters by urology and bilateral double-j-catheters were placed. An intra-abdominal drain was inserted, and a bacri balloon was placed in the pelvis and inflated with 600cc to tamponade the pelvic and cervical region and the case was terminated. A total of 13 units of Erythrocyte Suspension, 4 units of platelets, 7 units of fresh frozen plasma, including 4 units of Erythrocyte Suspension and 2 units of Fresh Frozen Plasma in the intraoperative period, were replaced. The patient was taken to the 3rd level Intensive Care Unit in stable condition.

CONCLUSION: The incidence of secondary postpartum hemorrhage is 0.2-2.5%. Clinically severe bleeding occurs in only 1% of patients and usually in the first 1-2 weeks. Although the number of women affected by sekonder postpartum hemoraji is relatively small compared to the number of women affected by primary postpartum hemorrhage, it can cause serious complications if the diagnosis and appropriate treatments are delayed.The possibility of secondary postpartum hemorrhage should be kept in mind in all vaginal bleeding occurring up to 12 weeks postpartum and clinical investigations should be performed for also its rare causes.

Keywords: hemorrhage, postpartum hemorrhage, secondary

PS-21

A case of vulvar hyperkeratosis acanthosis in a paraplegic patient

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OBJECTIVE: Diseases of the vulvar region are very common in patients presenting to gynecology outpatient clinics. These lesions require a multidisciplinary approach. Here, we aimed to present a case of vulvar hyperkeratosis acanthosis in a paraplegic female patient considering the differential diagnosis of a long-standing vulvar lesion.

CASE: A 44-year-old patient with a history of gravida 1, parity 1 normal vaginal delivery presented to our clinic with the complaint of vaginal discharge. On vaginal examination, bilateral labium majus and minus lesions approximately 5x3 cm in size, reddened, lost skin integrity, atrophic vulva-like lesion was observed. Vagen walls were intact. No discharge was observed on the lesion or in the vagina. Transvaginal ultrasonography did not reveal any pathologic findings. In the patient's history, it was learned that this lesion on the vulva had been present for about a year and she had never been admitted to the hospital because of this lesion before. In the patient's history, it was learned that she had been paraplegic for years as a result of a traffic accident about 20 years ago, so she could not use both extremities and had loss of sensation. Laboratory tests did not reveal any additional pathologic findings except for a minimal elevation in CRP. With these findings, vulvar punch biopsy was decided under local anesthesia from the lesion in the vulvar region. Histopathologic examination of the punch biopsy material was evaluated as 'hyperkeratosis acanthosis, inflammatory granulation tissue development'. There was no evidence of malignancy in the biopsy material. The patient was referred to dermatology outpatient clinic in accordance with the pathology result.

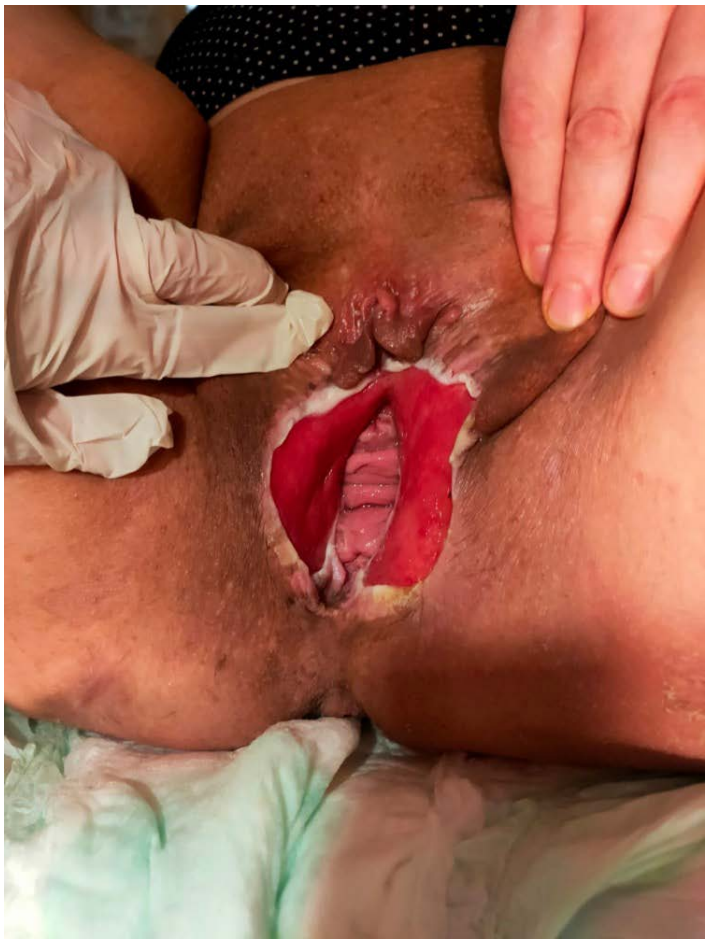
DISCUSSION: Vulvar lesions are very common diseases. There are many diseases affecting the vulva such as tumors, inflammatory dermatoses, infections, pigmentation changes. Although the etiology is not clearly known, the risk of vulvar diseases increases when the structure of the vulvar barrier is disrupted on the basis of an airtight, humid environment and irritation. The most important step in diagnosis is detailed anamnesis and physical examination; however, the definitive diagnosis is made by histopathologic examination. A differential diagnosis should be made when vulvar lesions are observed. Family history, genetic features, characteristics and localization of the lesion are very important. Especially malignancies should be excluded during gynecologic evaluation. In addition, a general examination should be performed in case of lesions found in the genital area in order to rule out the presence of other lesions in different parts of the body.

CONCLUSION: Vulvar lesions are diseases requiring a multidisciplinary approach mainly involving gynecology and dermatology. Detailed anamnesis and physical examination of the patients are of great importance in the diagnosis. As in our patient, it is an easy and important approach to perform the examination steps in

paraplegic patients who may be difficult to go to the gynecology table with the complaint of vaginal discharge and to make differential diagnosis of these lesions by excluding malignancies.

Keywords: vulvar lesion, vulvar hyperkeratosis acanthosis, paraplegic patient

picture 1: a case of vulvar hyperkeratosis acanthosis



PS-22

A look at neural tube defects: fetal acrania, anencephaly and spina bifida case

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OBJECTIVE: The term neural tube defects (NTD) describes problems with neural tube closure during embryogenesis at 3 and 4 weeks of gestation. Although the etiology is unknown, genetic and environmental factors, including mechanical or geographical influences, are thought to be involved. Here, we aimed to present the prepartum, intrapartum and postpartum follow-up of a case with the diagnosis of fetal acrania, anencephaly and spina bifida.

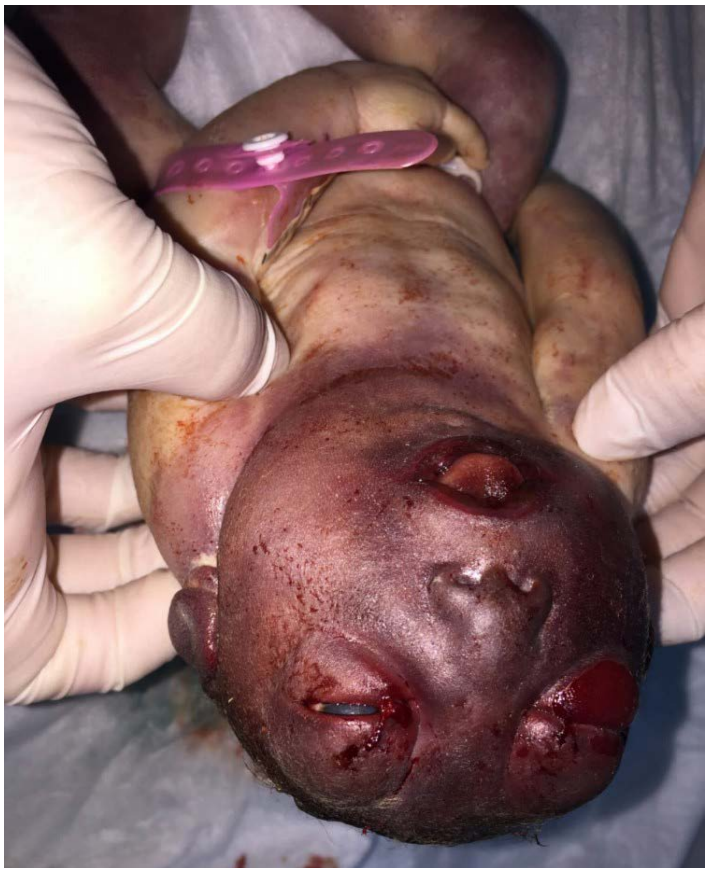
CASE: A 30-year-old, primigravida, 35 weeks' gestation according to SAT was admitted to our clinic with the complaint of vaginal spotting.In the history of the patient, it was learned that she was lost to follow-up until the 20th gestational week and did not use folic acid.The patient was diagnosed with anencephaly, acrania and spina bifida at the 20th gestational week at an outside center and was advised to undergo amniocentesis and termination was recommended with the result of amniocentesis. However, the patient wanted to continue the pregnancy. At the time of admission, the patient's general condition was good, vital signs were stable, obstetric ultrasonography showed a fetus with fetal heartbeat+ fetus in a vertex presentation compatible with 30 weeks. Estimated fetal weight was 1500 grams and amniotic fluid measurement was evaluated as polyhydramnios. Vaginal examination revealed 1-2 cm dilatation, 40% effacement, pouch (-), head was mobile; NST was nonreactive and no contraction was observed. The patient was decided to have vaginal delivery with induction. Four hours before delivery, no intrauterine fetal heartbeat was observed. The patient delivered an 1165 g, female, 30 cm long, 21 cm head circumference, acranic, anencephalic, open type spina bifida baby with a negative fetal heartbeat via normal vaginal delivery. There were no postpartum complications. Postpartum follow-up was stable and the patient was discharged on postpartum day 1.

DISCUSSION: Various NTDs occur depending on the site of neural tube closure. Preconceptional folate supplementation significantly reduces the incidence of NTDs.Anencephaly is diagnosed by ultrasonography in the antenatal period.There is no standard treatment for NTD. The prognosis of the affected fetus is poor. Some of these cases die as a result of abortion, some as a result of intrauterine exitus and some as a result of respiratory or cardiac arrest a few hours after birth. These cases should be terminated after diagnosis in early gestational weeks.

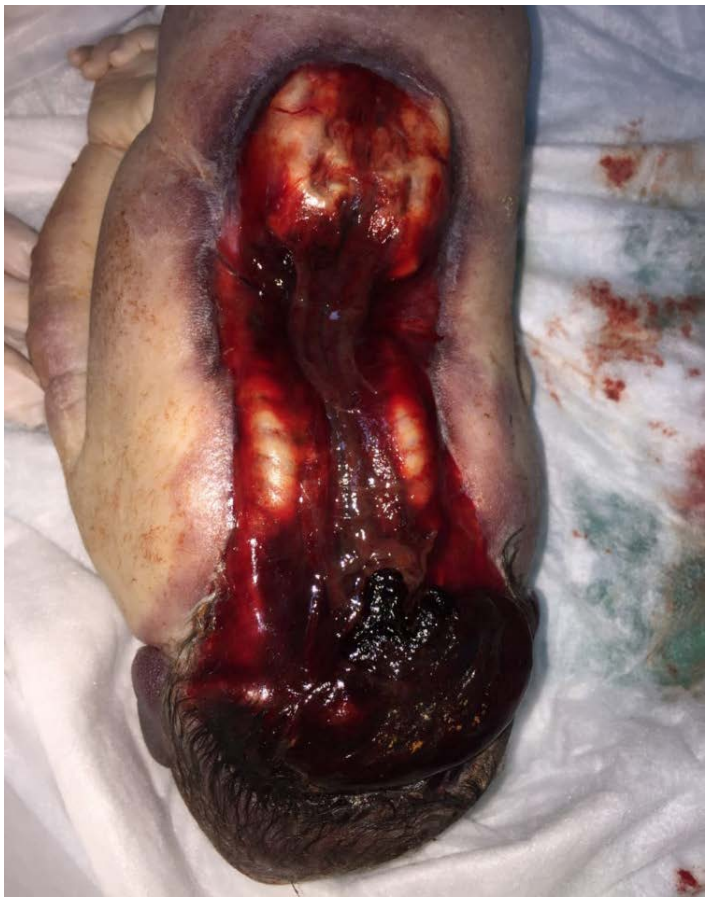
CONCLUSION: NTD can be easily diagnosed by ultrasonography and screening tests in the antenatal period. Significant reductions in NTD can be seen by controlling preventable risk factors such as avoidance of toxins and drugs, controlled diabetes mellitus, weight control, hyperthermia, and folic acid support to be started in the preconceptional period. In this way, the physical and psychological trauma of the mother during and after delivery will be minimized.

Keywords: anencephaly, spina bifida, neural tube defect

picture 1: fetal acrania and anencephaly appearance



picture 2: fetal spina bifida appearance



PS-23

Management of pathological hydronephrosis by high-risk pregnancy: a case report and literature review

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INTRODUCTION: Management of hydronephrosis can be challenging by high-risk pregnancies and may require a collaborative effort with the urologist, radiologist, infectious disease specialist and obstetrician to maximise the health of mother and fetus both. In this case report, we aimed to convey the conservative approach we applied in a risky pregnant woman.

METHODS: We performed further investigations in a 29-year-old patient with twin pregnancies after detecting bilateral hydronephrosis and calculi during pregnancy. In the light of Pubmed and Cochrane data, a literature review was conducted on hydronephrosis in pregnancy.

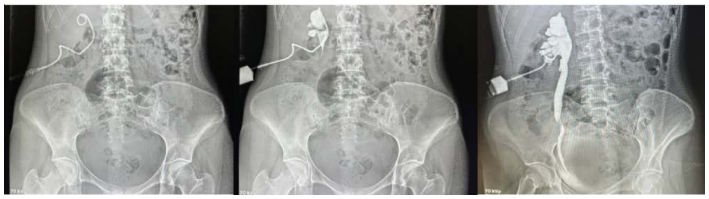
CASE PRESENTATION: A 30-week high risked twin pregnancy presented with inguinal pain, vaginal bleeding,hydronephrosis and urinary calculi. After pathological hydronephrosis was detected, conservative treatment was initiated during pregnancy. In the postpartum period, consistent hydronephrosis was treated successfully with percutaneous nephrostomy catheter.

DISCUSSION: Approximately 90% of pregnant women have an average of 15 mm of pelvicalyceal dilatation in the right kidney and an average of 5 mm in the left kidney. It is important to distinguish between physiological and pathological hydronephrosis in pregnancy. Presence of symptoms and suspicious history for anatomical obstruction are warnings for pathological hydronephrosis. It should be known that pathological hydronephrosis is rare.

CONCLUSION: During high risk pregnancy, pathological hydronephrosis can be detected. Thus situated, conservative treatment with antibiotics can be given considering pregnancy risks. When the safety of both mother and fetus is assured, ureteral drainage can be provided by ureteral stent, percutaneous nephrostomy or ureterorenoscopy.

Keywords: Endourology, High-risk Pregnancy, Symptomatic Hydronephrosis, Urolithiasis

Antegrade Pyelography



On the first week of percutaneous nephrostomy, we performed antegrade pyelography. Antegrade pyelography showed normal pelvicalyceal structure and uretheral passage.

SÖZLÜ SUNUMLAR

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

SS-01

The impact of white noise and silent environment on newborn suckling success

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OBJECTIVE: This study aims to investigate the influence of white noise and silence on the success of newborn breastfeeding.

Materials and METHODS: This study was conducted as a prospective cohort study at the Zübeyde Hanım Service Building of Çekirge Public Hospital, affiliated with the Bursa Public Hospitals Association, between September 4, 2017, and December 19, 2017.The study population comprised newborns born within this timeframe at the aforementioned hospital. Participating mothers and newborns meeting the inclusion criteria formed the sample. Newborns were divided into control (n=30), white noise (n=30), and silence (n=30) groups. Newborns in the white noise group were exposed to white noise during initial breastfeeding and 24 hours thereafter, with breastfeeding success assessed. Meanwhile, newborns in the silence group experienced a quiet clinic and environment during the same breastfeeding sessions. No interventions were made for the control group during these periods, and their breastfeeding success was evaluated. Data collection involved an introductory form for mother and baby and the LATCH Breastfeeding Assessment Tool, administered by the researcher.

RESULTS: The median LATCH scores for the white noise group were significantly higher than those of the silence group for both initial ($p<0.01$) and subsequent ($p<0.01$) breastfeeding sessions. Additionally, the white noise group exhibited higher median LATCH scores compared to the control group for the final session ($p<0.05$). Notably, among participants in the silence group, those with two or more children displayed higher first and last LATCH scores compared to those with only one child.

CONCLUSION: Breastfeeding in the presence of white noise positively impacts newborns' breastfeeding success. The utilization of white noise may be considered to enhance breastfeeding outcomes.

Keywords: white noise, breastfeeding success, breastfeeding, music, newborns,LATCH score

SS-02

Interval ovarian cystectomy in adnexal torsion cases of children and adolescents, when?

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OBJECTIVE: Adnexal torsion (AT) requires timely intervention to preserve ovarian functions. A concurrent adnexal pathology is also present in up to 80% of cases. Although detorsion with a minimally invasive surgery while preserving adnexal structures is the recommended approach, available data on the management of adnexal pathologies at the time of detorsion is limited. We aim to evaluate the relationship between the timing of interval ovarian cystectomy (IC) and occurrence of recurrent torsion in patients with ovarian cyst at the time of torsion and had detorsion alone.

METHODS: We retrospectively reviewed the records of the patients aged under 25 and underwent surgery for suspected AT at a tertiary PAG Service, between 2017 and 2023. Data on age, diagnostic studies, surgical procedure, intraoperative findings, postoperative folow-up and pathological findings were analyzed. We analyzed the recurrence rates of torsion between the patients who had an ovarian cyst and underwent cystectomy at the time of the detorsion (Group 1) and who underwent detorsion alone (Group 2). Timing of IOC and time to recurrent torsion were evaluated in Group 2.

RESULTS: Among a total of 74 cases identified, AT was surgically confirmed in 55 patients (%74). The mean age of the patients was 17.8±4.3 years. All but one patient underwent laparoscopy with ovarian preservation in 53 (96%) of the cases. A cyst was present in 60% (n=33) of these patients and a cystectomy was performed at the time of detorsion in 57% of the cases (Table 1). IOC was performed in 7 of 10 patients who underwent detorsion alone and the median interval between the initial and the second surgery was 9 weeks. One of theese 10 patients, who underwent detorsion alone, oophorectomy is required in 1 patient due to the presence of necrotic ovarian tissue found at the time of IOC. While recurrent torsion was observed in 1 patient in Group 1 (9 months after the surgery), recurrent torsion developed in 4 patients during the IOC planning in Group 2 (P=0.02). For these 4 patients in Group 2, the median interval for the development of recurrent torsion was 12 weeks (range 4-20 weeks), and 3 of these 4 patients were found to have a dermoid cyst and 1 cystadenoma.

DISCUSSION: It seems reasonable to perform cystectomy at the time of detorsion in order to reduce the risk of recurrent torsion. In cases where the ovary is severely edematous and fragile, cystectomy may lead to further ovarian damage and oophorectomy. Our findings suggest that in these cases where scheduled IOC is required, keeping the time between two surgeries as short as 3-4 weeks may reduce the development of recurrent torsion, especially in the presence of cysts known to persist such as mature teratoma.

Keywords: adnexal torsion, ovarian cystectomy, surgical management

SS-03

Double knots versus triple knots facia closure method during cesarean section; is there a difference in pain sensation or cosmetic satisfaction?

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AIM: We compared two different surgical methods in terms of pain and cosmetic satisfaction in our study. This prospective randomized control trial was conducted in a single tertiary center between March 2022 and July 2022.This study aims to compare the effects of two different fascia closure techniques on cosmetic and pain outcomes after a cesarean section.

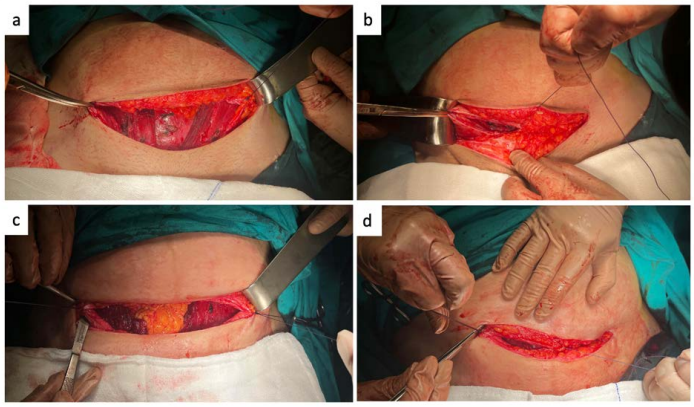
METHOD: Patients planned for cesarean section were randomized into two groups. In Group I (double knots group), the edge of the fascia was identified with a Kocher clamp. A synthetic absorbable multifilament suture was used to close the fascia in a continuous fashion, starting from the opposite side up to the Kocher clamp. The knots were tied with the same single suture. In Group II (triple knots group), the edge of the fascia was fixed with the same suture material instead of the Kocher clamp. The fascia was closed similarly, starting from the opposite corner via the second loop. The loops from the first suture were tied to the second suture. Postoperative pain at and around the incision line was measured on the 1st, and 10th days postoperatively on the NRS (Numeric Rating Scale). Analgesic medication required during hospitalization was also recorded. Patient satisfaction with the final aesthetic results of the incision was assessed using a 10-point scale at the 1st and 3rd months postoperatively.

FINDINGS: A total of 711 patients were enrolled, of which 218 were randomized to each interventional group (109 patients in each of the two groups). There was no significant difference in pain scores between the groups on the 1st and the 10th postoperative days ($p>0.05$). There were significant differences in nonsteroidal anti-inflammatory drugs (NSAIDs) and paracetamol use between groups during the post-cesarean hospitalization. Regardless of the type of drug, patients in Group I required higher doses of pain medication than those in Group II, with median doses of NSAIDs of 3(0-5) vs. 2(0-4) and median doses of paracetamol of 4(1-7) vs. 2(0-6), respectively ($p<0.001$). Group II had significantly higher aesthetic satisfaction scores than Group I in both measurements, with a median score of 9(4- 10) vs. 8(2-10) at the end of the first month and 10 (5-10) vs. 9(3-10) at the end of the third month ($p=0.03,0.02$, respectively).

RESULTS: Rapid recovery after the operation is essential in terms of more comfortable breastfeeding of the mother and establishing a good relationship with the newborn. Although there is no difference in terms of pain scores between the two fascia closure methods frequently used in surgical practice, aesthetic satisfaction,was more striking in Group II. Notably, both groups had high aesthetic scores,and the statistical difference does not always translate to clinical difference. Therefore, our results need to be supported by further studies before they can be considered a practice changer for surgeons using the double suture technique.

Keywords: Cesarean section, Fascia closure techniques,Postoperative pain, Postoperative cosmetic outcome

Figure 1. Surgical photographs of two different fascia closure methods.



a-b; In Group I, the fascia was closed using a continuous synthetic absorbable multifilament suture starting from the opposite side up to the edge of the fascia, which was held in place with a Kocher clamp. The knots were tied with the same suture material (''double knots method''). c-d; In Group II, the fascia is closed by securing one edge with a knot using the same suture material and starting from the opposite corner with a second loop. Once the edges are approximated, the loop from the first suture was tied to the second suture (''triple knots method'').

SS-04

β-Catenin Expression in Endometrioid Type Endometrial Cancer: Expression Patterns and Impact on Disease Outcomes

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OBJECTIVES: Endometrial cancer (EC) is the most common gynecologic malignancy in Europe and the second most common worldwide. Traditional risk factors for recurrence in EC include stage, histological type, grade, age and lymphovascular space involvement (LVSI). Recently, several studies have reported that endometrioid ECs with CTNNB1 exon 3 mutations are associated with higher recurrence rates and poorer disease outcomes. The CTNNB1 gene encodes the protein β-catenin. Mutations in exon 3 of the CTNNB1 gene or activation of the canonical Wnt pathway cause translocation of β-catenin from the cell membrane to the cytoplasm and nucleus, where it accumulates. This leads to the loss of cell-cell adhesions and is supposed to contribute to uncontrolled cell proliferation and metastasis. The new International Federation of Gynecology and Obstetrics (FIGO) 2023 staging system for EC promotes the use of both molecular classification and traditional prognostic factors. However, genome sequencing is an expensive and complex procedure, which poses a significant barrier to the widespread use of molecular classification in clinical practice. Determination of nuclear and/or cytoplasmic expression of β-catenin by immunohistochemistry may be a potential diagnostic method to identify patients with a CTNNB1 mutation and those at risk of disease recurrence.

The aims of this study was to investigate β-catenin expression patterns in hysterectomy specimens of patients with endometrioid endometrial cancer (EC) using immunohistochemistry, and to examine prognostic impact of β-catenin.

METHODS: The study was a single-institutional, retrospective cohort trial enrolling consecutive patients with a postoperative histopathological diagnosis of endometrioid EC who underwent hysterectomy between January 2015 and December 2018. Histopathology slides of 75 patients were stained with monoclonal antibody targeting β-catenin protein. Any percentage of nuclear staining, whether focal or diffuse, was considered “β-catenin nuclear-positive”. Cytoplasmic staining reaction of β-catenin was assessed based on percentage of stained cells and staining intensity. Immune-reactive score (IRS) was determined by multiplying the scores of percentage of staining and staining intensity. IRS values 0 to 2 were considered as negative-expression; 3 to 4 as low-expression; 6 to 8 as moderate-expression; and 9 to 12 as high-expression. Recurrence-free survival (RFS) was used as the prognostic endpoint.

RESULTS: Only 2 out of 75 tissue samples (2.2%) showed nuclear β-catenin expression, with very low staining percentage of 5%. Contrary, cytoplasmic staining was observed in all samples (100%). According to IRS, 1.3% of the samples showed negative cytoplasmic expression, 42.7% low-expression, 38.7% moderate-expression, and 17.3% high-expression. Cox regression analysis revealed that staining with β-catenin, either nuclear or cytoplasmic, had no impact on RFS, whereas stage was the sole independent prognostic factor.

CONCLUSION: β-catenin expression in endometrioid EC is mostly cytoplasmic, with only 2.2% of tissue samples having nuclear expression. β-catenin expression have no impact on disease outcomes.

Keywords: Endometrial cancer, endometrioid histology, β-catenin, prognosis, survival

Clinicopathologic characteristics of patients.

Age, median (range), years	57 (39 – 77)
No. of lymph nodes removed, median (range)	36 (9 – 104)
Tumor size, median (range), cm	3 (0.20 – 15)
Lymphovascular space involvement, n (%)	24 (32.0)
Surgical approach (Open)	50 (66.6)
Surgical approach (Minimally invasive)	25 (33.3)
Surgical approach	7 (9.3)
Surgical approach	18 (24.0)

Disease outcomes of patients..

Follow up time, median (range), months	53 (8 – 105)
Lost to follow-up	3 (4.0)
Recurrence, n (%)	6/71 (8.4)
Time to recurrence, median (range), months	21 (13 – 79)
Survival status Alive with no evidence of disease	60 (83.3)
Survival status Alive with disease	5 (6.9)
Survival status Dead of disease	3 (4.2)
Survival status Dead of other reasons	4 (5.6)
Recurrence-free survival, median (95% CI), months, 48 months, %	80.9
Recurrence-free survival, median (95% CI), months, 60 months, %	74.0
Overall survival, median (95% CI), months 48 months, %	88.0
Overall survival, median (95% CI), months 60 months, %	88.0

Factors associated with disease recurrence or death.

Variables		Univariate			Multivariate	
	HR	95% CI	p	HR	95%CI	p
Lymph node involvement	8.529	1.560–46.628	0.013	-	-	0.405
FIGO stage	4.840	1.667–14.052	0.004	7.012	1.718 – 28.627	0.007
Stage I vs. II-IV	14.602	1.688–26.332	0.015	-	-	-
Stage I-II vs. III-IV	8.109	1.484–44.310	0.016	-	-	-

Immunohistochemical staining features of tumor cells with β-catenin.

Variables	Number of patients (%)
Nuclear staining of tumor cells with β-Catenin	2 (2.7)
Percentage of tumor-cell staining No staining	-
Percentage of tumor-cell staining ≤10%	-
Percentage of tumor-cell staining 11–50%	2 (2.7)
Percentage of tumor-cell staining 51–80%	43 (57.3)
Percentage of tumor-cell staining ≥81%	30 (40.0)
Staining intensity No staining	-
Staining intensity Weak	32 (42.7)
Staining intensity Moderate	30 (40.0)
Staining intensity Strong	13 (17.3)
Immune-reactivity score (IRS) 0-2 (Negative expression)	1 (1.3)
Immune-reactivity score (IRS) 3-4 (Negative expression)	32 (42.7)
Immune-reactivity score (IRS) 6-8 (High-expression)	29 (38.7)
Immune-reactivity score (IRS) 9-12 (High-expression)	13 (17.3)

SS-05

Comparison of postmenopausal osteoporosis in women with a history of surgical and natural menopause

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OBJECTIVE: Rapid bone loss in women, especially in the first 5 years as a result of the sudden decrease in estrogen after menopause, is called postmenopausal osteoporosis.This study aimed to identify the risk factors effective in the development of osteoporosis, which is one of the important problems in the postmenopausal period, to determine the effect of surgical menopause, which is thought to be an important risk factor, on osteoporosis, and to compare this effect with osteoporosis that develops after natural menopause. MATERIALS-METHODS: In our study, 380 patients who applied to the menopause clinic between February 2018-May 2022 were followed retrospectively. It was revealed that 170 patients participating in the study were in surgical menopause and 210 patients were in natural menopause. The patients' demographic characteristics, gynecological and obstetric histories, and diseases that may cause osteoporosis were evaluated, and their bone mineral densitometry(BMD) was measured. L1-L4 T-scores were compared in the evaluated patients. Patients according to their menopause period;Menopause duration is divided into 3 groups: 1-5 years, 6-10 years and >10 years; These groups are based on the age of menopause;They were divided into 3 subgroups:40-45 years, 46-50 years and >50 years. Bone mineral densitometry values of surgical and natural menopause patients were compared in these groups.The presence of known renal disease, long, chemotherapy-radiotherapy, hyperthyroidism, hyperparathyroidism, and Cushing's disease were accepted as exclusion criteria. RESULTS: In the first 5-year postmenopausal period, there was a statistically significant decrease in the surgical menopause group (L1-L4 T-score:1.5±0.7) compared to the natural menopause group (L1-L4 T- score:1.2±0.6). It was determined (p:0.045). When compared to the surgical menopause group (L1-L4 T-score:2.3±0.8) and the natural menopause group (L1-L4 T score:2.4±0.7), there was a statistically significant difference in the group with menopause duration of 6-10 years. was not detected(p:0.135). No statistically significant difference was found in the group with menopause >10 years when compared to the surgical menopause group (L1-L4,T-score 2.8±0.7) and the natural menopause group (L1-L4 T-score:2.8±0.8)(p=0.245). In women whose age at menopause is 40-45, in the first 5-year postmenopausal period, the surgical menopause group (L1-L4 T-score:1.9±0.7) and the natural menopause group(L1-L4 T-score:2.1±0.8).When compared, a statistically significant decrease was found (p:0.039).In women whose age at menopause was 40-45, no statistically significant difference was detected in the 6-10 group and the >10 year group(p: 0.225, p: 0.160). In patients with menopausal age of 45-50 and >50 years, no significant difference was detected in the T-score in the postmenopausal periods of 1-5, 6-10 and >10 years.CONCLUSION: Considering only the duration of menopause, regardless of the age

of menopause; Bone loss occurs more in the surgical menopause group in the first 5-year postmenopausal period. In women whose age at menopause is 40-45, bone loss occurs more in the surgical menopause group in the first 5 years of postmenopause.In light of the findings of our study, it has been revealed that the osteoporotic effects of surgical menopause in the early period are balanced in the long term and lead to results similar to the osteoporotic effects of natural menopause.

Keywords: Natural menopause, Postmenopausal osteoporosis, Surgical menopause

SS-06

Cervical Cancer Management in Pregnancy

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Gynecological examination plays a pivotal role in Obstetrics and Gynecology practice, with cervical cancer ranking as the fourth most prevalent female cancer worldwide. In Turkey, the age-specific incidence rate is 4.3 per 100,000, and the mortality rate is 1.7 per 100,000.This case report explores the management of a 32-year-old pregnant patient presenting with vaginal bleeding, subsequently diagnosed with cervical cancer.Despite ASCPP and ACOG guidelines recommending routine screening for sexually active women from the age of 21, this patient did not seek gynecological consultation for four months.Routine gynecologic examination and screening test during pregnancy, colposcopic biopsy (except ECC) in abnormal cervical cytology positivity, and even LEEP are supported by the guidelines.

INTRODUCTION: Cervical cancer screening, employing Human Papillomavirus (HPV) tests or Pap smears, detects precancerous lesions, allowing timely intervention. In routine examinations, sexually active women over 21 should undergo a smear test every three years. For those over 30, a combined test is recommended. This case emphasizes the significance of routine screening and early intervention.

Case Report: A 32-year-old, G1P0, with a history of bipolar disorder, presented with four months of continuous bleeding.On gynecologic examination, the introitus exhibited hemorrhagic features, with the left parametrium showing palpable shortening. Additionally, a delicate and hemorrhagic mass, measuring approximately 5-6 cm, was identified in the cervix. Transabdominal ultrasound (TA-US) findings were consistent with a gestational age of 15-16 weeks, confirming a singleton pregnancy. The patient was duly informed, and a simultaneous cervical punch biopsy was performed. The biopsy results revealed “squamous cell carcinoma (SCC).”Following an evaluation by the Gynecologic Oncology team at the tertiary center, the patient was clinically staged as 1B3, with additional support from MRI and PET scans. A fetocide procedure was initially carried out by a Perinatologist, followed by a Wertheim operation. The patient was discharged on the 8th postoperative day after the removal of sutures and withdrawal of the Foley catheter.The final pathology report for the patient confirmed the diagnosis of “invasive squamous cell carcinoma, stage 1B3, with endocervical localization.

Discussion: In cases of cervical cancer limited to the cervix, histologically, grade 3 with focal lymphovascular invasion was observed, and the tumor diameter measured 55 mm in the horizontal plane. The deepest invasion into the cervical stroma measured 16 mm, leading to the classification of the patient as having a locally advanced stage (stage 1b3).The patient underwent a classical

treatment approach with a type 3 radical hysterectomy.

CONCLUSION: Cervical cancer is preventable through vaccines and regular screening. Implementing vaccination programs and adhering to screening guidelines can significantly reduce the incidence of cervical cancer. Integrating the HPV vaccine into routine vaccination schedules is crucial for preventing this type of cancer. In conclusion, this case report highlights the critical role of routine cervical cancer screening, especially in pregnant patients, and the importance of timely intervention. It serves as a reminder to healthcare providers and the public about the preventable nature of cervical cancer through vaccination and regular screening.

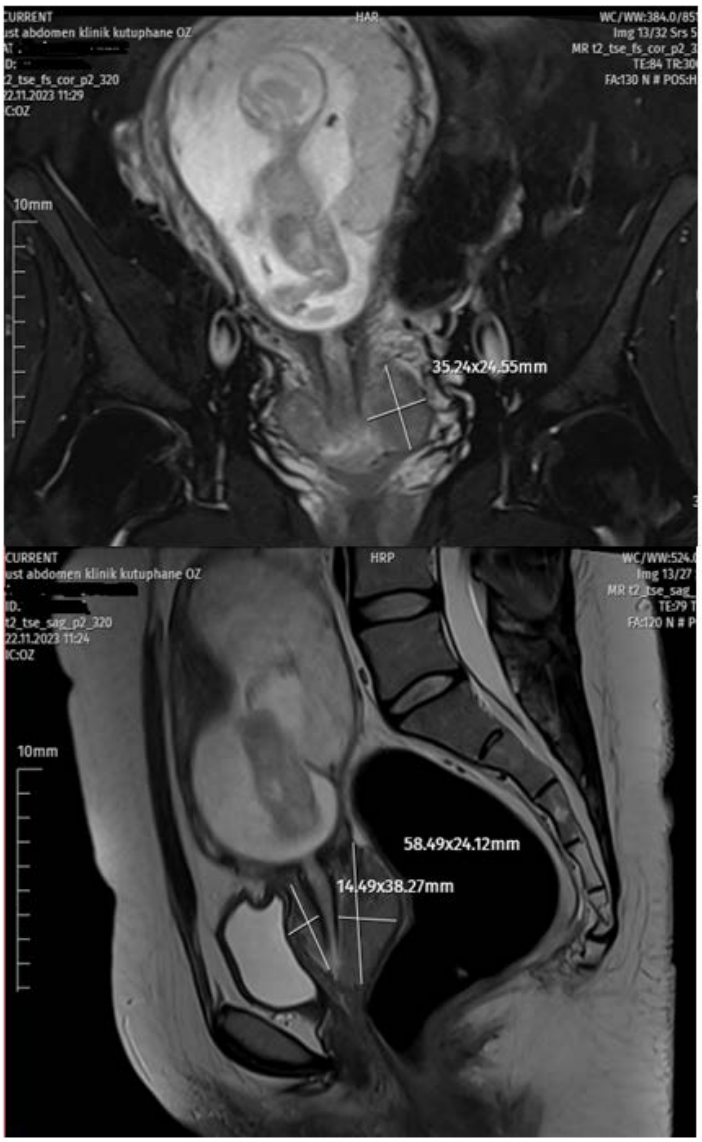
Keywords: cervical cancer, cervical cancer in pregnancy, abnormal cervical cytology, Pap smear test, colposcopic biopsy.

Figure 1

FIGO 2009		FIGO 2018		
Stage	**Description**	**Stage**	**Description**	**Pros and cons**
I The carcinoma is strictly confined to the cervix				**Pros** Clarity on depth of invasion and the relationship between the depth of stromal invasion and incidence of lymph node metastases. Rate of positive nodes of 0.1–0.2%, 0.4–1.9%, and 2.1–7.6% for tumors with depth <1 mm, 1–3 mm, and 3.1–5 mm, respectively[18,19]
IA	Invasive carcinoma diagnosed only by microscopy. Stromal invasion with a maximum depth of 5 mm measured from the base of the epithelium and a horizontal spread of no more than 7 mm. Vascular space involvement, venous or lymphatic, does not affect classification	IA	Invasive carcinoma that can be diagnosed only by microscopy, with maximum depth of invasion ≤5 mm*	
IA1	Measured stromal invasion of no more than 3 mm in depth and **no more than 7 mm in horizontal spread**	IA1	Measured **stromal invasion ≤3 mm in depth**	There was limited guidance in previous FIGO staging systems (1995 and 2009) on measuring horizontal spread[20,21] with no correlation of the tumor width and the risk of nodal metastases. Unifocal lesions are straightforward to measure but unclear if a lesion has multiple invasive foci, which can be as high as 25% of stage IA1 carcinomas,[21] and can be located close together or far apart. There is lack of consensus on how measurement is to be performed (adding the maximum horizontal dimension or measuring individually) which can change disease stage from IA1 up to IB[20-22]
IA2	Measured stromal invasion of more than 3 mm but no greater than 5 mm **with a horizontal spread of no more than 7** mm	IA2	Measured **stromal invasion >3 mm and ≤5 mm in depth**	
IB	Clinically visible lesion confined to the cervix or microscopic lesion greater than IA2	IB	Invasive carcinoma with measured deepest invasion >5 mm (greater than stage IA); lesion limited to the cervix uteri with size measured by maximum tumor diameter†	**Pros** The classification of stage IB tumors into three sub-stages improves the discriminatory ability for outcomes.[23] On multivariable analysis, stage IB2 disease is independently associated with a nearly two-fold increased risk of cervical cancer mortality compared with stage IB1 disease (adjusted HR 1.98, 95% CI 1.62 to 2.41, p<0.001).[24] Survival is significantly different between 2018 FIGO stage IB1 and IB2 disease, with a nearly two-fold increased risk in cervical cancer mortality in stage IB2 disease compared with IB1 disease.[24] Five-year survival in the FIGO 2018 schema was 91.6% (95% CI 90.4% to 92.6%) for stage IB1 tumors, 83.3% (95% CI 81.8% to 84.8%) for stage IB2 tumors, and 76.1% (95% CI 74.3% to 77.8%) for IB3 [25]tumors **Cons** Current staging still provides no clarification as to how tumor size should be measured either microscopically or grossly. This is particularly so for specimen demonstrating microscopic tumor in the conization specimen and subsequent additional tumor in final hysterectomy specimen
IB1	Clinically visible lesion no more than 4 cm in greatest dimension	IB1	Invasive carcinoma >5 mm depth of stromal invasion and **≤2 cm in greatest dimension**	
IB2	Clinically visible lesion more than 4 cm in greatest dimension	IB2	Invasive carcinoma **>2 cm and ≤4 cm in greatest dimension**	
		IB3	Invasive carcinoma **>4 cm in greatest dimension**	

FIGO staging of cervical cancer

Figure 2



MRI findings

Figure 3

PATOLOJİK TANI:
RADİKAL HİSTEREKTOMİ (TİP 3 HİSTEREKTOMİ)+BS MATERYALİ:
TÜMÖR: Endo-ektoserviks yerleşimli invaziv skuamöz hücreli karsinom (Epikrize bakınız)
Histolojik tip: Nonkeratinize tip
Histolojik grade: III
Tümör boyutu: Tümörün horizontal çapı 5,5 cm, vertikal çapı 4,7 cm'dir.
İnvazyon derinliği:
a) Servikal stromal invazyonun maksimum kalınlığı: 1,6 cm
b) Maksimum invazyonun bulunduğu bölgede serviks kalınlığı: 1,8 cm
Multisentrik tümöral odak: Görülmedi.
İn situ karsinom komponenti: Mevcut (Yüzey ve gland epitelinde high grade skuamöz intraepitelyal lezyon-insitu karsinom)
Vasküler invazyon:
Kan damarı invazyonu: Fokal alanda bir kan damarı lümeninde tümör hücre trombüsü mevcut
Lenfatik invazyon: Fokal alanda mevcut
Perinöral invazyon: Mevcut
Vaginal yayılım: Görülmedi
Uterus korpusuna yayılım: Görülmedi
Parametrial yayılım: Görülmedi
Cerrahi sınırlar: Parametrial ve vajinal cerrahi sınırlarda tümör görülmedi. Tümörün vajinal cerrahi sınıra uzaklığı 2,2 cm'dir.
Çevre serviks: Kronik nonspesifik servisit
VAJEN: Yüzey epitelinde fokal alanda erozyon
ENDOMETRİUM: Gestasyonel endometrium
MYOMETRİUM: Gestasyonel değişiklikler, myometrium yüzeyel kısımlarında trofoblastik hücreler
UTERUS SEROZASI: Düzenli yapı
SAĞ VE SOL PARAMETRİUM: Tümör invazyonu görülmedi. 4 adet lenf düğümünde reaktif hiperplazi (0/4)
SAĞ TUBA: Paratubal kistler
SOL TUBA: Paratubal kistler

Final pathology report

SS-07

The relationship between estradiol levels measured on the initiation day of gnrh (gonadotropin releasing hormone) antagonist and clinical pregnancy in patients undergoing antagonist protocol

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OBJECTIVE: To evaluate the relationship between serum estradiol (E2) levels measured on the day of antagonist administration and clinical pregnancy in women undergoing IVF-ET with an antagonist protocol.

METHODS: Data from women undergoing IVF-ET with an antagonist protocol between 2010 and 2024 were retrospectively analyzed. Those with diminished ovarian reserve, cycle cancellations for any reason, and those with unknown serum E2 levels were excluded from the study. Patients were divided into five groups based on serum E2 levels measured on the day of antagonist administration (Group I: E2<400, Group II: 400≤E2<650, Group III: 650≤E2<800, Group IV: 800≤E2<1000, Group V: E2≥1000). After identifying factors that could affect clinical pregnancy in univariate analysis, the independent effect of serum E2 levels on clinical pregnancy was analyzed using an adjusted regression model.

RESULTS: A total of 1625 patients were included in the study. The overall clinical pregnancy rate was 36.1%. The clinical pregnancy rates for Groups I, II, III, IV, and V were 33.2%, 41.1%, 31.0%, 36.1%, and 38.2%, respectively (p=0.049). The highest clinical pregnancy rate was observed in Group II (41.1%). Univariate analysis identified age, antral follicule count, and E2 level as factors predictive of clinical pregnancy. In the adjusted regression model, serum E2 levels measured on the day of antagonist administration <400 (OR: 0.722, 95% CI: 0.555-0.939, p=0.015) and 650≤E2<800 (OR: 0.645, 95% CI: 0.442-0.941, p=0.043) were identified as factors reducing the likelihood of clinical pregnancy, adjusting for age, infertility duration, BMI, cycle number, and number of embryos transferred.

CONCLUSION: The serum E2 level associated with the highest clinical pregnancy rate in women undergoing IVF-ET with an antagonist protocol was found to be in the range of 400-650. Serum E2 levels <400 or in the range of 650-800 were statistically significantly associated with a reduced likelihood of clinical pregnancy.

Keywords: antagonist, estradiol, in-vitro fertilization, pregnancy, protocol

Table 1. Comparison of Clinical Pregnancy Rates and Other Characteristics Among Groups Formed According to Serum E2 Levels

Table 1. Comparison of Clinical Pregnancy Rates and Other Characteristics Among Groups Formed According to Serum E2 Levels						
	GROUP I E2<400	GROUP II 400≤E2<650	GROUP III 650≤E2<800	GROUP IV 800≤E2<1000	GROUP V E2≥1000	p-value
N	591	399	174	155	306	
Age, year	31,5±5,6	30,1±4,8	30.0±5.0	29.9±4,6	30,1±4,6	<0,001
Duration of infertility, months	71±53.6	73±50.5	67±47.3	73±46.8	72±45.7	0,731
Cycle count	1,83±1,08	1,85±1,22	1,66±1,01	1,73±0,93	1,79±1,11	0,321
BMI	27,6±5,16	26,2±4,51	26,0±4,81	25,6±4,30	26,3±4,85	<0,001
Basal E2	44.0±32.6	45,8±20,6	47.7±21.2	46,0±26.2	48.9±19.1	0,092
Antral follicule count	13.4±8,4	14,7±7,8	17,4±8,6	18,3±8,9	21,1±8,5	<0,001
Gn total dose	2479±1027	2068±945	1819±693	1780±684	1651±626	<0,001
Duration of stimulation	10,2±1,6	9,7±1,5	9,8±1,4	9,8±1,4	9,8±1,6	<0,001
GnRH ant start date	5.7±0,9	5,6±1,01	5,8±1,1	5,8±1,2	6,0±1,2	<0,001
E2 on date of hCG	1601±908	2159±1132	2540±1331	2615±1265	3752±2101	<0,001
P on date of hCG	0,85±0,46	0,93±1.00	0,88±0.54	0,82±0,42	1,15±1,28	0,005
Endometrial thickness	10,17±1.93	9,98±1,89	10.00±1,79	10,12±2,18	10,21±2,10	0,606
Retrieved oocyte	9.48±5,82	11,50±6,04	14.10±7,94	13,40±5.91	17.23±8,05	<0,001
Mature oocyte	7.04±4,54	8.55±4,82	10,83±6,51	10.23±4.47	13.02±6.30	<0,001
2pn	3,90±2,89	4,73±3,08	6.03±4,24	5,68±3,48	7.38±4,67	<0,001
Transferred embryos	1.30±0,50	1,35±0,57	1,33±0,56	1.32±0.53	1.33±0,55	0,799
Quality of embryos						
Gr1	0,58±0,66	0,67±0,69	0,62±0,67	0,77±0,70	0,63±0,66	0,022
Gr2	0,48±0,60	0,46±0,63	0,44±0,57	0,37±0,60	0,43±0,60	0,333
Gr3	0,19±0,43	0,17±0,43	0,25±0,49	0,15±0,37	0,23±0,49	0,095
Clinical pregnancy rates, n (%)	196 (33,2)	164 (41,1)	174 (31,0)	155 (36,1)	306 (38,2)	0,049
E2: Estradiol, BMI: Body mass index, GnRH: Gonadotropin releasing hormone, hCG: Human chorionic gonadotropin, P: Progesterone						

Table 2. Univariate Regression Analysis for the Evaluation of Factors Influencing Clinical Pregnancy

Table 2. Univariate Regression Analysis for the Evaluation of Factors Influencing Clinical Pregnancy			
		OR (95% CI)	p-value
Age		0.971 (0.952-0.991)	0.005
Infertility duration		1.002 (1.000-1.004)	0.068
Cycle number		1.009 (0.921-1.106)	0.846
BMI		1.011 (0.990-1.033)	0.288
Basal E2		0.998 (0.994-1.003)	0.468
AFC		1.014 (1.003-1.026)	0.016
Total Gn dose		0.999 (0.999-1.000)	0.053
Duration of stimulation		1.051 (0.985-1.121)	0.136
Endometrial thickness on trigger day		1.018 (0.960-1.079)	0.558
Transferred embryos		1.177 (0.978-1.416)	0.084
Serum E2 on trigger day		1.000 (1.000-1.001)	0.817
Serum P on trigger day		0.976 (0.818-1.164)	0.786
Serum E2 levels on the day of GnRH ant initiation			
	Group I	0.722 (0.555-0.939)	0.015
	Group II	1	
	Group III	0.645 (0.442-0.941)	0.023
	Group IV	0.811 (0.552-1.190)	0.283
	Group V	0.887 (0.654-1.203)	0.441
E2: Estradiol, BMI: Body mass index, GnRH: Gonadotropin releasing hormone, AFC: Antral follicule count, P: Progesterone, OR: Odds ratio			

Table 3. Regression Analysis for serum E2 levels after adjusting for age, cycle number, infertility duration, antral follicule count, body mass index, total Gn dosed, and number of transferred embryos.

Table 3. Regression Analysis for serum E2 levels after adjusting for age, cycle number, infertility duration, antral follicule count, body mass index, total Gn dosed, and number of transferred embryos.

		Adjusted, OR (95% CI)	p-value
Serum E2 levels on the day of GnRH antagonist initiation			
	Group I	0.759 (0.576-0.999)	0.049
	Group II	1	
	Group III	0.591 (0.399-0.875)	0.009
	Group IV	0.735 (0.492-1.098)	0.133
	Group V	0.824 (0.595-1.141)	0.244

E2: Estradiol, OR: Odds ratio

SS-08

The relationship between serum HE4 and ultrasound findings of adenomyosis in infertility patients and its correlation with implantation and pregnancy outcomes in those undergoing IVF-ET

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Aim: Adenomyosis observed in women of reproductive age can present with infertility, particularly as implantation is adversely affected in junctional zone abnormalities. The endo-myometrial invasion in the pathogenesis of adenomyosis has been variously defined based on ultrasound criteria outlined in the MUSA (Morphological Uterus Sonographic Assessment) consensus. In patients with adenomyosis, while implantation rates may remain unchanged in some studies, an increased rate of first-trimester miscarriages has been reported in others. This study was conducted based on the hypothesis that HE4 (Human Epididymis Protein 4) marker may play a role in this potential invasiveness in adenomyosis and negatively affect embryo implantation.

Method: 82 infertile patients diagnosed with adenomyosis based on the MUSA consensus ultrasound criteria were included in our 10-month prospective study. HE4 testing was performed on serum samples collected from the patients. Our primary outcome focused on the association between ultrasonographic findings and the serum HE4 levels. The secondary outcomes comprised assessing the relationship between HE4 levels and the outcomes of implantation and pregnancy in the patients who underwent embryo transfer. In this study, infertile patients aged 20-40 diagnosed with adenomyosis via ultrasonography were included. Patients with a history of myoma or myomectomy, high-dose biotin intake, chronic organ failure, and a history of malignancy were excluded from the study. Ultrasonographic features were documented, and 39 patients underwent frozen embryo transfer. Pregnancy outcomes were categorized as clinical pregnancy or miscarriage for analysis.

Findings: As a primary outcome of the study, a statistically significant correlation between serum HE4 levels and subendometrial linear lines, as indicated in the MUSA consensus ultrasound criterias is found (p=0.015). Logistic regression analysis showed that HE4 independently increased subendometrial linear striations [OR (95% CI) = 1.05 (1.01-1.10); model significance p=0.020]. ROC analysis suggested that serum HE4 levels above the 37.4 pmol/L cut-off value may be associated with the presence of subendometrial linear striations. Although no relationship was found between HE4 levels and implantation rates, statistically significant higher levels of HE4 were observed in cases of miscarriage compared to ongoing pregnancies (p=0.038). Study limitations include reliance on 2D-TVUSG without 3D and Doppler. Enhanced evaluation using 3D-TVUSG and Doppler for JZ and subendometrial areas is recommended. Larger sample sizes could yield more impactful findings.

Conclusions: HE4 correlates with observed subendometrial linear lines, suggesting a link to endo-myometrial invasion. While it doesn't impact transfer cycle implantation rates, it may be linked to higher early pregnancy losses.

Keywords: infertility, adenomyosis, ultrasonography, invasion, human epididymis protein-4

SS-09

Clinical Outcomes of LeFort Colpocleisis: A Single-Center Experience

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OBJECTIVE: Surgical procedures may be required with advancing age in 20% of women with pelvic organ prolapse (POP), a condition seen in approximately 6% of women over 70. Moreover, due the increasing age of the world population, these rates will inevitably rise still further. POP may reduce women's quality of life and cause various adverse outcomes, such as recurrent urinary tract infections. The risk of mortality in patients requiring surgical procedures is approximately 14 times higher due to comorbidities such as hypertension, diabetes mellitus, and chronic pulmonary disease. Although some corrective procedures, such as abdominal or vaginal hysterectomy, anterior or posterior colporrhaphy, sacrocolpopexy, and sacrospinous fixation have been described for POP, these may entail high morbidity and complication rates. Additionally, POP frequently recurs following such procedures. LeFort colpocleisis is a highly effective procedure with low morbidity rates, especially in elderly women who do not wish to engage in vaginal intercourse. Studies have reported a patient satisfaction rate of over 90% in the first two postoperative years. LeFort colpocleisis, a vaginal obliterative surgical procedure, was first described by Leon LeFort in 1877 and is a good surgical option, particularly for older women with POP with comorbidities, because it can be performed using spinal anesthesia, has a shorter operative time than other operations, and involves less blood loss, faster recovery, and anatomically good results. However, although LeFort colpocleisis is a good surgical option because of its low morbidity and mortality, it should also be remembered that it may lead to functional losses, such as impaired sexual function. We aimed to evaluate the sociodemographic characteristics, anatomical outcomes, satisfaction, and clinical outcomes of patients who underwent LeFort colpocleisis for pelvic organ prolapse (POP) in our clinic in the previous 10 years.

MATERIALS-METHODS: One hundred three patients who underwent LeFort colpocleisis for stage III and stage IV POP between January 2010 and December 2022 were retrospectively and consecutively included in the study. The participants' sociodemographic characteristics and clinical outcomes were documented. The Turkish version of the Pelvic Floor Distress Inventory Questionnaire (PFDI-20) was used to determine quality of life.

RESULTS: The patients' mean age was 73.1+26.72 years, BMI 27.4+3.8, parity 4.8+1.5, smoking rate 12.6%, POP-Q stage-III 30.1%, and POP-Q stage-IV 69.9%. Their satisfaction rate was 93.3%. Significant decreases were observed compared to the preoperative period in postoperative constipation (40.7% vs 26.2%, respectively, p=0.038), difficult defecation (22.3% vs 8.7%, p=0.012), fecal incontinence (18.4% vs 7.7%, p=0.039), stress urinary incontinence (25. 2% vs 4.8%, p<0.001), urge incontinence (49.5% vs 27.1%, p=0.001), voiding dysfunction (37.8% vs 23.3%, p=0.002), and urinary retention (42.7% vs 12.6%, p<0.001). Postoperative PFDI-20 scores were also significantly lower compared to the preoperative period (57.19+16.57 vs 21.62 ± 6.96, respectively, p<0.001).

Conclusion(s): This study shows that LeFort colpocleisis has established itself as a surgical procedure with high anatomical success and patient satisfaction rates, minimal complications, and particularly with with advanced POP with age-related comorbidities.

Keywords: LeFort colpocleisis, pelvic organ prolapse, satisfaction

Early and late postoperative complications.

	Early	Late
Urinary tract infection	3 (2.9%)	8 (7.7%)
Urinary retention	-	1 (0.9%)
Pelvic hematoma	1 (0.9%)	-
Gluteal or perineal pain	1 (0.9%)	-
Atrial fibrillation	2 (1.8%)	-

Participants' functional and anatomical outcomes.

	Preoperative	Postoperative	p
Constipation	42 (40.7%)	27 (26.2%)	0.038*
Difficult defecation	23 (22.3%)	9 (8.7%)	0.012*
Fecal incontinence	19 (18.4%)	8 (7.7%)	0.039*
Stress urinary incontinence	26 (25.2%)	5 (4.8%)	<0.001*
Urge incontinence	51 (49.5%)	28 (27.1%)	0.001*
Voiding dysfunction	39 (37.8%)	24 (23.3%)	0.034*
Urinary retention	44 (42.7%)	13 (12.6%)	<0.001*
Vaginal length	-	2.8 + 1.4	-
Perineal body	-	4.6 + 1.2	-
Genital hiatus	-	2.2 + 0.8	-

Participants' satisfaction after LeFort colpocleisis.

	n=103 (%)
1. Very much improved	66 (64.1%)
2. Improved	25 (24.3%)
3. Little improved	5 (4.9%)
4. No change	7 (6.7%)
5. Worse	0 (0%)

Participants' sociodemographic characteristics and associated comorbidities.

	n =103 (Mean+SD) (Median, 25th-75th) (%)
Age (years)	73.12 ± 6.72
BMI (kg/m2)	27.4 ± 3.8
Parity	4.85 ± 1.54
Smoking rate n (%)	13 (12.6%)
POP-Q Stage-III	31 (30.1%)
POP-Q Stage-IV	72 (69.9%)
Blood loss (ml)	78.84 ± 36.52
Operative time (minutes)	91.48 ± 23.82
Hospital stay (days)	2.1 ± 1.2
Follow-up (months)	36 (18 - 84)
Hypertension	57 (55.3%)
Diabetes mellitus	36 (34.9%)
Heart disease	32 (31.1%)
Chronic pulmonary disease	17 (16.5%)
Neurological disorder	13 (12.6%)
Cerebrovascular disorder	5 (4.8%)
Psychiatric disorder	17 (16.5%)

Pelvic Floor Distress Inventory Questionnaire (PFDI-20) results.

	Preoperative	Postoperative	p
PFDI-20	57.19 ± 16.57	21.62 ± 6.96	<0.001*
POPDI-6	28.16 ± 9.41	10.17 ± 4.15	<0.001*
UDI-6	22.41 ± 7.21	7.12 ± 3.24	<0.001*
CRADI-8	8.24 ± 5.32	5.58 ± 3.21	0.041*

SS-10

Awareness of the Relationship between Oral Health and Reproductive and Sexual Health among Healthcare Workers

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OBJECTIVE: Since there is a close relationship between oral health and general health, poor oral hygiene and the resulting oral health can affect the individual's self-confidence and disrupt the partner relationship. It can also cause serious problems such as reproductive and sexual health disorders, and a lack of communication between partners, resulting in psychological disorders, infertility, and even malignancy. In addition, questions are frequently asked such as whether bisphosphonates and oral contraceptives have oral effects and whether mucosal HPV infections, which can also be seen in newborns, can be transmitted from HPV- positive mothers. Since it is very important to guide the patient correctly in this regard, we planned our study to obtain information about the awareness of healthcare professionals on this issue and to examine whether there are differences in their approaches to the issue according to their experience in the profession, the institution they work in and their gender.

MATERIAL-METHOD: 200 forms with 14 questions were prepared to be given to healthcare professionals in many specialties attending the Reproductive and Sexual Health Congress. 105 of the forms filled out voluntarily were returned. Per the results, the Pearson chi-square test, or Fisher's exact test, was used for relationships between categorical variables. The hypotheses were accepted as bidirectional, and statistical significance level was accepted as $p<0.05$.

RESULTS: In the survey, "Do you think there is a correlation between oral health and sexual health?" 96% of the participants answered yes to the question, "Do you think patients are aware that HPV can cause oropharyngeal cancers?" It was observed that 21.4% of gynecologists answered yes and 18.2% of urologists answered yes. "Have you ever had a patient (client) report that their partner is avoiding sexual intercourse due to poor oral hygiene (e.g., halitosis)?" It was observed that the distribution of the answers to the question was statistically significantly different in health professional groups ($p = 0.021$). "Do you think that some medications (e.g., bisphosphonates) used for osteoporosis during menopause may cause negative effects on the mouth, teeth, and surrounding tissues?" It was observed that the distribution of the answers to the question was significantly different in professional groups ($p <0.001$).

CONCLUSION: Due to the results of the survey on the awareness of the relationship between oral health and reproductive and sexual health among health workers, it was observed that the level of awareness varies according to professional groups, time spent in the profession, and the institution where they work, but from

the answers given to most of the questions, it was observed that there was awareness of the relationship between oral health and sexual health among health workers. Conducting more comprehensive studies in this field will be beneficial in guiding patients towards dentists or related specialties, and in transforming the patient health measures into a multidisciplinary guideline.

Keywords: Oral health, reproductive health, women's health, sexual health

SS-11

Distribution of Lesions in Women with Cervical Intraepithelial Neoplasia

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OBJECTIVE: Cervical intraepithelial neoplasia (CIN) is a premalignant disease that is considered the precursor lesion of cervical cancer. While CIN2-3 lesions, which have a high potential to turn into invasive cancer if left untreated, are treated with ablative and excisional methods with similar success rates, follow-up should be done in CIN1 lesions that have a low cancer development potential. The aim of our study is to show the distribution of cervical lesions in terms of localization in patients who were found to have cervical intraepithelial neoplasia as a result of colposcopy-guided biopsy.

MATERIALS-METHODS: Our study included 338 patients who were admitted to our hospital between April 2018 and June 2023, and whose anomaly was detected as a result of the smear and therefore underwent colposcopic biopsy. Colposcopy and biopsy results of the patients were obtained retrospectively from the hospital database. The frequency of lesions detected as cervical intraepithelial neoplasia as a result of colposcopic biopsy and their localization distribution in the cervix were examined. Patients with a known history of LEEP or conization were not included in the study.

RESULTS: Colposcopy results were reported as chronic cervicitis in 98 (28.9%) patients in the study group. Among these patients reported as chronic cervicitis, biopsy indication was found in 70 (71.4%) patients; It was revealed that the smear test results taken in two separate periods were reported as ASCUS. Among the patients with cervical intraepithelial neoplasia detected as a result of biopsy, CIN-1 was detected in 170 (70.8%) patients, CIN-2 was detected in 49 (20.4%) patients, and CIN-3 was detected in 21 (8.8%) patients. CIN-1 lesion in 99 (58.2%) patients; It was detected at the time (10-11-12) and no significant difference was detected between the distribution of CIN-2 lesions in terms of localization. CIN-3 lesion was detected at the clock position (10-11-12) in 9 (42.8%) patients. When all cervical intraepithelial lesions were examined, in 122 (50.8%) patients; Involvement was detected at the hour (10 -11-12) hour level and in 32 (13.3%) patients; Uptake was detected at the (5-6 -7) o'clock position.

CONCLUSION: When the localization of cervical intraepithelial neoplasias relative to the walls is examined; Among the regions, the most frequent uptake was reported at (10 -11-12) o'clock, and the lowest uptake was reported at (5-6-7) o'clock. The reasons for this can be shown as the presence of semen exposure at the time (10-11-12) and chronic contact during intercourse, high blood supply and lymphatic blood flow in the lateral wall, and chronic anatomical deformation on the cervical anatomy caused by the type of birth.

Keywords: Biopsy, Cervical intraepithelial neoplasia, Colposcopy

SS-12

Adding norethisterone (NET) to continuous combined oral contraceptive (COC) treatment in adolescents with persistent abnormal uterine bleeding (AUB): Does ''NET" play a role?

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INTRODUCTION: Heavy menstrual bleeding (HMB) is a common condition among adolescents, and combined oral contraceptives (COCs) as hormonal therapy are most commonly used as the initial treatment of HMB after proper evaluation. COCs containing 30-50 mcg ethinyl estradiol (E2) as initial therapy and treatment continuum after the bleeding cessation for three to six months is commonly recommended. Aims of the study:To evaluate whether adding norethisterone (NET) to the continuous COC treatment regimen of adolescents with persistent AUB would be effective.

METHODS: The study is a prospective study of 16 adolescents aged 10 to 18 years who presented to a tertiary pediatric and adolescent gynecology clinic between 2022 and 2023 with persistent AUB complaints despite started on a continuous COC regimen due to HMB and were administered NET 10 mg/day for 10 days then stepping down to 5 mg/day in addition to the existing therapy. Patients were divided into three groups according to the indications of NET therapy: i)with AUB after stepping down the COC regimen from twice to once a day (group 1), ii)with diagnosed bleeding disorders (group 2), iii)with increased endometrial thickness (group 3).

RESULTS: The mean age at the onset of symptoms was 13.7±2.2 years. Adding NET to existing therapy appeared to cessate the AUB symptoms in all three groups within 24 hours. Group 1 and 2 contained 8 and 5 patients, respectively. Group 3 had 3 patients had continuous spotting and a mean endometrial thickness of 29.6±8.6mm and had 5 mm endometrial thickness at 3 months follow-up after treatment. No additional side effects were reported.

CONCLUSION: Our findings suggest that adding oral NET to a continuous COC regimen appeared well-tolerated and efficacious in the management of adolescents with persistent AUB.

Keywords: adolescent gynecology, bleeding disorders, heavy menstrual bleeding

SS-13

Effect of first trimester vitamin D levels on gestational diabetes

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OBJECTIVE: Gestational diabetes(GDM) is considered an endocrine disease that is common among pregnant women. This risk increases with advanced maternal age, sedentary lifestyle and increased body mass index rates. In the latest meta-analysis, it is said that low vitamin D status may be associated with an increased risk of GDM.Despite a sunny environment, maternal vitamin D deficiency is still a basic health problem in our country. The aim of this study is to determine the possible connection between vitamin D levels and GDM in pregnant women.

METHODS: In our study, 610 patients whose vitamin D levels were checked during the first trimester between December 2018-March 2022 and were found to be low were evaluated retrospectively. 120 patients whose first trimester vitamin D levels were found to be low and who followed their treatment regularly were excluded from the study. All patients diagnosed with vitamin D deficiency have been recommended regular vitamin D supplements of 1500-IU(15 drops) per day, starting from the first trimester. 20 patients with a known diagnosis of Type-1 and Type-2 DM were excluded from the study.Patients whose vitamin D levels were low in the first trimester and who did not receive treatment were included in the study. Data from 470 patients who met the inclusion criteria were retrospectively examined. In this study, women with vitamin D levels<10ng/mL were categorized as severe vitamin D deficiency, women with <20ng/mL were categorized as vitamin D deficiency, and women with <30 were categorized as vitamin D insufficiency.

RESULTS: Vitamin D deficiency was detected in 520(85.2%) of 610 patients whose data were evaluated. Of the 470 patients included in the study, severe vitamin D deficiency was detected in 110(23.4%) patients, vitamin D deficiency in 150(31.9%) patients, and vitamin D insufficiency in 210 (44.6%) patients. GDM was detected in 23(4.8%) patients in the study group. Of the 23 patients with GDM, 13(56.5%) patients were found in the severe vitamin D deficiency group, 7(30.4%) patients were found in the vitamin D deficiency group, and 3(13.1%) patients were found in the vitamin D insufficiency group.A significant relationship was found between vitamin D deficiency measured in the first trimester and the development of gestational diabetes. The presence of GDM was found to be significantly higher in the group with severe vitamin D deficiency compared to the other two groups (p: 0.046).

CONCLUSION: The small number of participants in the study and the fact that the participants were in the same region can be considered a limiting factor. Not including patients with high vita-

min D levels in the study was considered a limitation of the study. However, since it was a 4-year study period, it enabled us to be protected from vitamin D level variability that may be caused by seasonal factors.Although we were located in a sunny geography in our study, the frequent occurrence of vitamin D deficiency is thought to be a remarkable finding. In light of the data of our study, more comprehensive prospective studies are needed on vitamin D levels and effects in our society.

Keywords: Gestational diabetes, First trimester, Vitamin D

SS-14

Comparison of serum magnesium and HBA1c values in the presence of gestational diabetes mellitus

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OBJECTIVE: Gestational diabetes mellitus (GDM) is defined as glucose tolerance disorder that first occurs during pregnancy. However, this definition is sometimes insufficient to distinguish cases of diabetes diagnosed during pregnancy (pregestational diabetes that was not diagnosed before pregnancy) from gestational diabetes cases. Gestational diabetes usually develops after the 24th week of pregnancy due to placental hormones blocking the effects of insulin (increasing insulin resistance). Blood glucose regulation disorder during pregnancy can have negative consequences for both mother and baby, especially in patients with diabetes before pregnancy. Magnesium is an important element that plays a role in regulating blood glucose levels by contributing to the regulation of insulin secretion and activity. The aim of this study is to compare serum magnesium levels and HbA1c values of patients diagnosed with gestational diabetes mellitus and healthy pregnant women.

METHODS: 50 pregnant women diagnosed with GDM and 50 healthy pregnant women, whose pregnancy follow-ups and births were performed in our hospital between January 2020 and February 2022, were included in our study. Patient data were obtained retrospectively from the hospital database. Magnesium (Mg) values of all patients in the study group, measured during OGTT at 24-28 weeks, were compared and HbA1c data were evaluated. For all patients, a reference value of serum Magnesium level >1.7 mg/dl was considered normal. Known diagnosis of Type 1 and Type 2 DM and the presence of renal disease were accepted as exclusion criteria. Patients who were followed up in our hospital but delivered at an external center, or who were referred to us from an external center for delivery, were not included in the study. Patients who received oral magnesium therapy during pregnancy were not included in the study.

RESULTS: The patients in the study group were divided into two: GDM group and healthy pregnant group. While the serum Magnesium level was found to be within normal limits in 42 (84%) patients in the healthy pregnant group, the serum Magnesium level was found to be within normal limits in 32 (64%) patients in the GDM group. The difference between the two groups in terms of magnesium level averages was found to be statistically significant. In terms of magnesium averages, the Mg average of the GDM group was determined as 1.71 mg/dl and the Mg average of the healthy pregnant group was determined as 1.96 mg/dl (p: 0.047). A significant negative correlation was found between magnesium levels and HbA1c levels, regardless of the groups. ($r=-0.372$, $p<0.01$).

CONCLUSION: In our study, serum Mg levels were found to be low in 36% of GDM patients, and a significant difference was observed compared to the healthy pregnant group. It has been revealed that there is a significant negative correlation between serum magnesium levels and HbA1c, and as the HbA1c level increases, Mg levels decrease.

Keywords: Gestational Diabetes Mellitus, HBA1c, Magnesium

SS-15

The effect of laparoscopic and laparatomic approaches on cost and length of hospital stay in the surgical treatment of ectopic pregnancy, tertiary centre experiences

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Ectopic pregnancy is the implantation of the fertilised ovum outside the intrauterine cavity.(1-3) Although most cases of ectopic pregnancy detected early can be successfully treated with minimally invasive surgery or medical treatment, it is an obstetric emergency requiring surgical intervention in an unstable patient. (3) The same surgical modalities can also be performed laparatomically according to the haemodynamic status of the patient and the experience of the surgical team. Studies have reported that laparoscopic salpingectomy or salpingostomy performed by an expert endoscopic surgeon in a well-equipped centre is better than laparotomy. (2-4) It is known that laparoscopic treatment is less costly than laparotomy, postoperative patient recovery rate and comfort are better, and hospital stay is shorter accordingly. The aim of our study was to compare the hospital costs and length of hospitalisation of patients who underwent laparoscopic and laparatomic surgical treatment for tubal ectopic pregnancy in Ankara Etlik City Hospital Gynaecology and Obstetrics Clinic. No significant difference was found between the mean daily cost, total cost and hospitalisation days.

Aim

The aim of our study was to determine the difference between laparoscopic and laparatomic surgical treatment of tubal ectopic pregnancies in terms of cost and length of hospitalisation.

Material & METHODS: Patients who were treated surgically for tubal ectopic pregnancy in Ankara Etlik City Hospital Gynaecology and Obstetrics Clinic between December 2022 and October 2023 were included in the study. Surgical treatment was performed laparoscopically in 75 patients and laparatomically in 9 patients. Hospitalisation days, costs and average daily costs of the two groups were compared. Mann-Whitney U test was used to compare the measured values of two independent groups in data that did not have normal distribution.

RESULTS: The hospitalisation day of the 9 laparotomic patients included in the study was 4,44±2,35 and the median value was 5.(Min.-max. 1-8). The hospitalisation day of the patients treated with laparoscopic surgery method was 3,57±2,50 and the median value was 3.(Min.-max.1-12) There was no statistically significant difference in terms of hospitalisation days in the two groups. (p=0,185) The cost of the patients treated with laparoscopic surgery method was 4646,10±2146,38 TL and the median value was 4031,4 TL.(Min.- max.1595,1 TL-7927,4 TL) In patients treated with laparoscopic surgical treatment method, the cost was 4113,49±2799,59 TL and the median value was 3429,2 TL. (Min.-max. 702,2-17722 TL).There was no statistically significant difference in cost in the two groups.(p=0,322) The mean daily cost in patients treated with laparoscopic surgical treatment method was 1308,31±843,94 TL and the median value was 963,1 TL.(Min.-

max. 405,1-2806,8 TL) In patients treated with laparoscopic surgical treatment method, the mean daily cost was 1617,89±1287,43 TL and the median value was 1283,1 TL.(Min.-max.199,2-6146,7 TL) There was no statistically significant difference in the mean daily cost in the two groups.(p=0,618) (Table 1)

Conclusion

As a result of our study, we concluded that both surgical treatment methods are not superior to each other in terms of cost, hospitalisation time and daily average cost.

Keywords: cost of hospitalisation,ectopic pregnancy,laparatomic surgery, laparoscopic surgery

SS-16

Comparison of Uroflowmetry parameters of patients with and without voiding symptoms, Tertiary Center Experiences

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PURPOSE: Uroflowmetry is one of the methods used today in the evaluation of urination functions and can provide good information. Although uroflowmetry is one of the preferred methods in the diagnosis of lower urinary tract disorders, it must be taken into consideration that this process can be affected by many different factors. Among these, the patient's emotional state, bladder fullness, bladder outlet obstruction, and contraction strength of the bladder detrusor muscles may come to the fore. It is recommended that these factors and patients' complaints be evaluated together to evaluate a standard uroflowmetric examination. In our study, we aimed to compare the uroflowmetry parameters of patients who applied to our urogynecology outpatient clinic according to the presence of urination symptoms.

METHOD: 90 patients who applied to Etlik City Hospital Urogynecology outpatient clinic between January 2023 and January 2024 and underwent uroflowmetric examination for their complaints were included in the study. Demographic data and basic clinical evaluations of the patients were performed. Voiding symptoms (difficulty in initiating urination, intermittent urination, straining to urinate, need to change position to urinate, feeling of not being able to empty the bladder, weak stream urination, dribbling urine after micturition) were evaluated through questions. The patients included in the study were divided into two groups: patients with symptoms and those without. The data were analyzed with descriptive statistics methods.

RESULTS: The patients included in the study were divided into two groups: patients with symptoms (Group1) and those without (Group2). No significant difference was observed between the groups in demographic and clinical data, age, BMI, smoking, uroflowmetry parameters, Maximum flow rate (Qmax), Flow Duration (V time), Average flow rate (Qave), and time to maximum flow rate. (p>0.05) (Table1)

CONCLUSION: As a result of our study, no difference was observed in the uroflowmetry results of the patients included in the study with and without urination symptoms. We think that a holistic evaluation, including anamnesis, clinical examination, and ultrasonographic evaluation, is more valuable in diagnosing patients with pelvic floor pathologies, and that diagnosis should not be made based solely on uroflowmetry results.

Keywords: Uroflowmetry, Urinary system, Urination problems

Table 1 Demographic and clinical data of patients with and without voiding symptoms

	with symptoms n: 37 (%41,1)	without symptoms n: 37 (%41,1)	p
Age	48,72 ± 10,61	50,13 ± 9,84	0,57**
BMI	29,97 ± 4,35	31,30 ± 4,78	0,16**
Smoke No Yes	 29 8	 43 10	0,61***
Qmax	20,35 ± 12,78	18,27 ± 14,37	0,48*
time to maximum flow rate	25,56 ± 59,38	25,88 ± 56,28	0,97*
V time	52,21 ± 63,38	56,83 ± 64,40	0,73*
Qave	8,97 ± 5,87	7,84 ± 6,98	0,42*

**T-test **Mann Whitney-U test ***Ki-kare Test*

SS-17

Availability of Serum Callistatin Level as a Biomarker in The Diagnosis of Tubaovarian Abscess

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Antalya Eğitim Araştırma Hastanesi

OBJECTIVE: Complications such as rupture and sepsis, which can cause significant morbidity and mortality, are observed in 2.5-10% of cases of tubo-ovarian abscess (TOA). Prompt diagnosis and treatment are essential in order to minimize morbidity and mortality. This study investigate the practicability of serum kallistatin as a biomarker in the diagnosis of TOA, since C-reactive protein (CRP) is insufficiently specific for diagnosis.

METHODS: Thirty patients (control group) who presented for elective gynecological surgeries and 30 who were hospitalized due to TOA (study group) at the Antalya Training and Research Hospital Gynecology Clinic, Türkiye, between January 1 and December 31, 2022, were included in the study. Blood samples were collected for the calculation of complete blood count, biochemistry, CRP, and serum kallistatin values, and the results were recorded in a database.

RESULTS: While no significant differences were observed between the control and study groups in terms of age (42.13±11.36 vs 37.5±8.53, respectively, p=0.079) or body mass index [24.0 (22.0-25.0) vs 22.95 (21.85-24.92); p=0.594], significant differences were observed in terms of marital status [single 1 (3.3%), married 29 (96.7%) vs single 15 (50.0%), married 15 (50.0%); p<0.001], number of pregnancies [2.5 (1.0-3.0) vs 3.0 (2.0-4.0); p=0.044], parity number [2.0 (0.75-2.0) vs 3.0 (2.0-4.0); p<0.001], intrauterine device history [0 (0%) vs 22 (73.3%); p=0.005], and previous surgical history [3 (10%) vs 14 (46.7%); [p=0.003]. Serum hemoglobin levels (12.61±1.30 vs 11.47±1.77; p: 0.008), white blood cell [7.9 (6.15±9.7) vs 17.0 (11.6-19.6); p<0.001], neutrophil [4.6(3.6-6.12) vs 13.6(9.25-16.1); p<0.001], lymphocyte (2.51±0.71 vs 2.33±0.69; p=0.307), and platelet counts (285.63±78.0 vs 407.03±131.96; p<0.001), neutrophil-lymphocyte ratio (2.11±0.93 vs 6.18±2.20; p<0.001), neutrophil-lymphocyte ratio (123.16±52.63 vs 184.39±63.90; p<0.001), hs-CRP [1.20(5.55-1.92) vs 240 (138.25-291.0); p:<0.001], kallistatin [7.18±3.15 vs 3.83±3.69; p=0.006), and urine leukocyte values [1 (0.75-3) vs 3 (1-6.5); p=0.038] also differed significantly between the control and study groups.

CONCLUSION: The study findings show that serum kallistatin levels can be used as a biomarker in the diagnosis of TOA. Further studies involving more participants are now needed to test the accuracy of our results.

Keywords: C-reactive protein, kallistatin, tubo-ovarian abscess

SS-18

Maternal and Neonatal Outcomes of Congenital Syphilis at a Tertiary Care Center in Turkey; A Retrospective Cohort Study

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OBJECTIVE: Syphilis is a treponemal disease that can be transmitted sexually, hematogenously, or from mother to baby through vertical transmission. Despite the use of penicillin in treatment for nearly 75 years, the disease still poses a threat to public health. Treponema pallidum, the causative agent of syphilis, is a spirochete measuring 5 to 15 mm in length, and visualization is challenging, requiring dark-field microscopy. The use of opioids and methamphetamines in women of reproductive age increases the prevalence of treponemal infection. Testing for syphilis during pregnancy has been recommended by various medical institutions, such as the Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists, especially for individuals living in high-prevalence areas. A study conducted by the CDC found that failure to perform syphilis testing during the antenatal period and at the appropriate time, as well as insufficient maternal treatment despite diagnosis, can increase the prevalence of congenital syphilis (CS) through late seroconversion. Misinterpretation of diagnostic methods and treatment algorithms can complicate the management of perinatal syphilis. The most significant challenge in syphilis treatment during pregnancy is the absence of a specific test capable of distinguishing recently acquired syphilis from previous infection. A previous study reported that 18 out of 73 pregnant women received inadequate treatment, and that 11 babies were incorrectly diagnosed as CS-negative. A pregnant woman's syphilis test result should therefore be interpreted and evaluated in conjunction with a detailed history and physical examination. Benzathine penicillin G is the recommended treatment for syphilis during pregnancy, with an efficacy rate of approximately 98.7% (10). Other alternative treatments include ceftriaxone, doxycycline, tetracycline, azithromycin, erythromycin, and amoxicillin. Failure to treat syphilis during pregnancy can lead to stillbirth, preterm birth, and a 12-fold heightened risk of congenital infection. We aimed to retrospectively analyze the maternal and neonatal outcomes of pregnant women diagnosed with congenital syphilis (CS).

MATERIALS-METHODS: We accessed the medical records of 64 cases diagnosed with CS between 2020 and 2022 from our hospital database and the perinatology clinic archives in this retrospective cohort study.

RESULTS: The mean age of the patients was 26.4+6.3 years. In addition, 43.75% received adequate maternal treatment, the cesarean delivery rate was 43.25%, 31.25% had preterm births, and the mean birth weight was 2956.36+514.46 g. CS was largely diagnosed during delivery or the postpartum period (43.75%). Fifty percent of patients were in the latent stage, gestational hypertension and preeclampsia were present in four case each (6.25%), gestational diabetes mellitus in eight (12.5%), and labor induction in 16 (25.0%). Twenty babies (31.25%) were admitted to the neonatal intensive care unit, eight (12.5%) had congenital anomalies, 12 had fetal growth restriction (18.25%), stillbirth was present in four (6.25%) case, and early neonatal death in four (6.25%).

CONCLUSIONS: Delayed diagnosis and inadequate treatment of CS can lead to significant maternal and neonatal morbidity and mortality. Well-planned antenatal care services should be provided for all expectant mothers in order to reduce these adverse outcomes.

Keywords: congenital syphilis, neonatal outcomes, pregnancy outcomes

Characteristics of participants with syphilis infection during pregnancy.

	Number (n=64)	%
Time of diagnosis		
Pre-pregnancy	4	(6.25%)
First Trimester	4	(6.25%)
Second Trimester	12	(18.75%)
Third Trimester	16	(25.0%)
Delivery or Post-partum	28	(25.0%)
Stage of Disease		
Primary	8	(12.5%)
Secondary	4	(6.25%)
Early Latent	20	(31.25%)
Late Latent	32	(50.0%)

The participants' sociodemographic and clinical features.

Features	Minimum/ Maximum	Mean ± Standard deviation or Median (25th-75th)	Number (n=64)	%
Age (years)	21-35	26.4+6.3		
BMI (kg/m2)	21.6-27.8	23.36+3.14		
Smoking			20	(31.25%)
Duration of marriage	1-8	4.6+2.2		
Number of pregnancies		2 (2-3)		
Parity number		1 (0-2)		
Number of miscarriages		0 (0-0)		
Number of living children		1 (0-2)		
Preterm delivery			20	(31.25%)
Birth weight (g)	1850-3620	2956.36+514.46		

SS-19

The Importance of CTRP-1 Level in Patients with Polycystic Ovary Syndrome

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OBJECTIVE: CTRP-1 is an adipokine expressed in tissues in the placenta, ovaries, liver, muscle tissue, kidneys and heart muscle, especially in adipose tissue, and is thought to play a key role in glucose and lipid metabolism and insulin signaling pathways. It is known that insulin resistance and hyperinsulinemia resulting from insulin resistance play important roles in the development of PCOS. The relationship between CTRP-1 protein, which is thought to be associated with insulin resistance, and PCOS is a new research topic. Our aim is to understand the place of this newly detected protein in PCOS pathophysiology and to examine its usability in the diagnosis of PCOS.

MATERIAL-METHOD: Our study group included 48 patients diagnosed with PCOS according to the Rotterdam criteria, who applied to the Ankara City Hospital infertility outpatient clinic, and 48 healthy volunteer women who applied to the infertility outpatient clinic for benign reasons. The design of our study was made as a prospective, cross-sectional, case-control, observational study. After being informed about the study, serum samples were taken from the PCOS patient group and the control group, who volunteered to participate in the study and whose verbal and written consents were obtained, in order to determine the CTRP-1 levels. When the study sample size determined as a result of the power analysis was reached, the patient recruitment was terminated. Serum CTRP-1 level was measured using ELISA technique in blood samples taken from PCOS and control groups. Results are reported in ng/ml. For statistical analysis used programs of SPSS22.

RESULTS: In our study, the CTRP-1 level of the PCOS group cases was found to be statistically significantly higher than the control group cases. While a significant positive correlation was found between and CTRP-1 levels, age, SHBG and HDL and a statistically significant negative correlation was found between CTRP-1. CTRP-1 levels were found to be significantly higher in normal weight women with PCOS. High CTRP-1 levels were observed in cases with insulin resistance and were considered statistically significant. When we calculate the cut-off point for CTRP-1 between PCOS and control groups. In determining the cut-off point according to PCOS status, the cut-off point obtained for CTRP-1 was found to be 39.3 ng/ml as a result of evaluations and statistically significant difference was found between PCOS and control groups.

CONCLUSION: In our study, in which we examined the serum CTRP-1 level of 48 patients with PCOS and 48 healthy volunteers, the serum CTRP-1 level was found to be statistically significantly higher in the PCOS group than in the control group ($p<0.001$; $p<0.01$).As a result of this study we conducted to evaluate the importance of CTRP-1 in the diagnosis of PCOS, the sensitivity and specificity evaluation of the CTRP-1 value was found to be significant (100%; 100%). However, there is no study in the literature with CTRP-1 level in patients with PCOS. In order to use CTRP-1 in the diagnosis of PCOS, we think that new studies with longer duration and larger patient and control groups should be conducted.

Keywords: Polycystic ovary syndrome, CTRP-1, Insulin resistance

SS-20

Effect of abdominal hot pack application on gastrointestinal motility recovery after comprehensive gynecologic staging surgery

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OBJECTIVE: To evaluate whether abdominal hot water pack application improves gastrointestinal motility following gynecological oncology surgery.

METHODS: The study was registered at ClinicalTrials.gov (NCT04833699). (https://clinicaltrials.gov/ct2/show/NCT04833699?cond=NCT04833699&draw=2&rank=1). In this randomized controlled trial, participants were randomly assigned (1:1) to the hot water pack group (standardized enhanced recovery protocols plus rubber water bag with a fluffy cover filled with boiled tap water [80°C] and placed on the abdomen at 3, 6, 9, and 12 h postoperatively for 30 min each time) or the control group (standardized enhanced recovery protocols). A subumbilical or supraumbilical vertical midline incision was made to perform staging surgery procedures, including hysterectomy, salpingo-oophorectomy with retroperitoneal lymphadenectomy. The primary outcome was the time to first passage of flatus from the end of the staging procedure.

RESULTS: In total, 121 women were randomized to the control ($n = 62$) or hot water pack ($n = 59$) group. The use of an abdominal hot water pack significantly reduced the mean time to passing first flatus (25.2 ± 3.6 vs. 30.6 ± 3.9 h; hazard ratio [HR] = 4.4; 95% confidence interval [CI]: 2.8-7.1; $P < 0.0001$), mean time to first bowel movements (28.4 ± 4.0 vs. 34.4 ± 4.5 h; HR = 4.9; 95% CI: 3.0-7.9; $P < 0.0001$), mean time to first defecation (33.4 ± 4.9 vs. 41.0 ± 7.6 h; HR = 4.3; 95% CI: 2.1-6.8; $P < 0.0001$), and mean time to tolerating solid diet (2.1 ± 0.6 vs. 2.8 ± 1.0 days; HR = 4.4; 95% CI: 2.2-8.7; $P < 0.0001$) compared to the control group. The postoperative ileus incidence was significantly lower in the hot water pack group (3.4%) than the control group (16.1%) ($P = 0.01$).

CONCLUSION: Abdominal hot water pack application improved gastrointestinal function recovery in women following surgical staging procedures for gynecological malignancy.

Keywords: gynecological oncology surgeries, hot water pack, postoperative ileus

SS-21

The impact of age on stress urinary incontinence outcomes in patients who underwent trans-obturator tape procedure

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AIM: This study investigates the effect of age on stress urinary incontinence (SUI) outcomes in patients undergoing the outside-in trans-obturator tape (TOT) procedure.

METHODS: A retrospective cohort study was conducted on patients who underwent the outside-in TOT procedure (Figure 1) from August 2017 to July 2023. We separated patients into two groups according to age: younger than or equal to 50 years (group 1) or older than 50 years (group 2). All patients were evaluated routinely at least six months after surgery. The patients were contacted according to phone records, and the Patient Satisfaction Questionnaire and International Consultation on Incontinence Questionnaire—Short Form (ICIQ-SF) were administered. The primary outcome was the post-operative recovery rate (cured, improved or failed). Secondary outcomes included patient satisfaction (satisfied, moderately satisfied or dissatisfied), duration of hospital stay, operative time, blood loss, post-operative ICIQ-SF score and complication rate.

RESULTS: There were 77 patients who underwent outside-in TOT surgery, of which 45 (58.4%) patients were in group 1 and 32 (41.6%) patients were in group 2. The presence of comorbidity, which was mostly accompanied by hypertension (52.0%), was statistically significant between groups 1 and 2 (22.2% vs 46.9%, p = 0.021, respectively) (Table 1). Surgical outcomes were evaluated; while cured, improved and failed outcomes were observed in 26 (57.8%), 16 (35.6%) and 3 (6.7%) patients in group 1, these values were 13 (40.6%), 12 (37.5%) and 7 (21.9%) patients in the group 2 (p = 0.105 for both groups). Although the difference was not statistically significant, the overall rate of cure + improvement was higher in the younger age group than the older age group (93.3% vs 78.1%). Similarly, the patients satisfied, moderately satisfied and dissatisfied with the procedure were 28 (62.2%), 13 (28.9%) and 4 (8.9%) in group 1, while these values were 14 (43.8%), 11 (34.4%) and 7 (21.9%) in group 2 (p = 0.085 for both groups). The median post-operative ICIQ-SF score was statistically significantly higher in group 2 (1 vs 7.5, p = 0.003) (Table 2). The total complication rate was 41.6% (32 patients) out of both groups, while the rate was 37.8% (17 patients) in group 1 and 46.9% (15 patients) in group 2 (p = 0.286) (Figure 1-2 and Table 3).

CONCLUSIONS: Although the treatment success of and patient satisfaction with the TOT surgery were relatively high in the younger age group, the difference was not statistically significant. In addition, the post-operative ICIQ-SF score was significantly higher in the older age group, which had a worse impression of improvement of their urinary tract condition.

Keywords: age, stress urinary incontinence, trans-obturator tape, midurethral slings

Figure 1. a. Midurethral vaginal incision. b. Dissecting the tract for the trocar and mesh. c. Making groin incisions and inserting the trocars. d. Adjusting sling tension and closure of incisions (our own operation images were shared with the consen

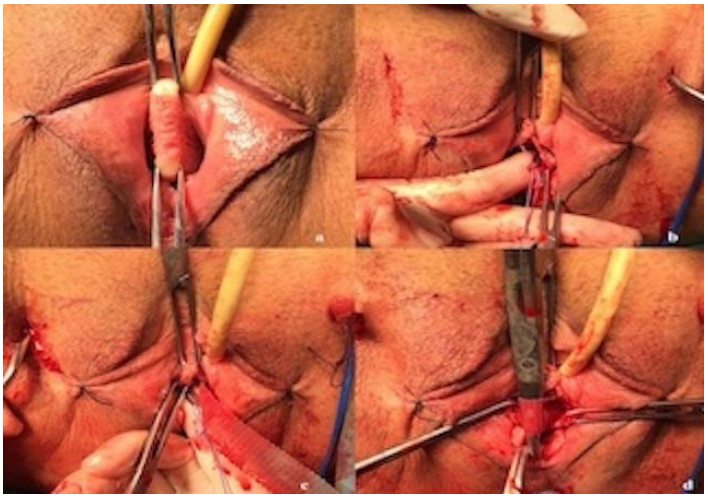

Figure 2. Surgical repair of mesh exposure, also known as erosion (our own operation images were shared with the consent of the patient).

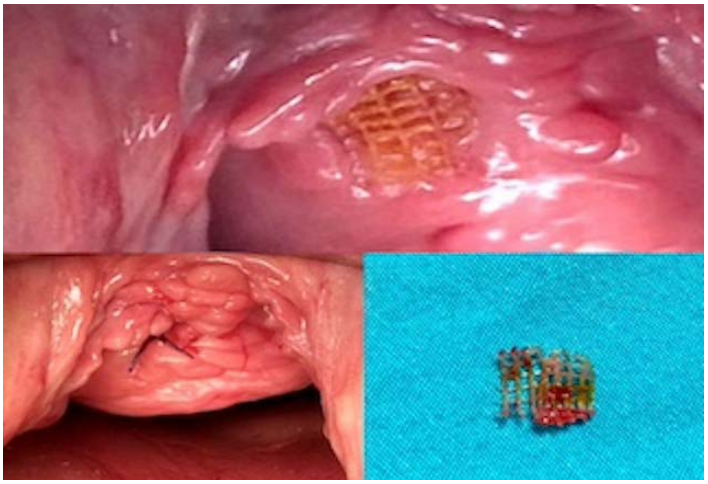

Figure 3. Surgical repair of another mesh exposure (our own operation images were shared with the consent of the patient).

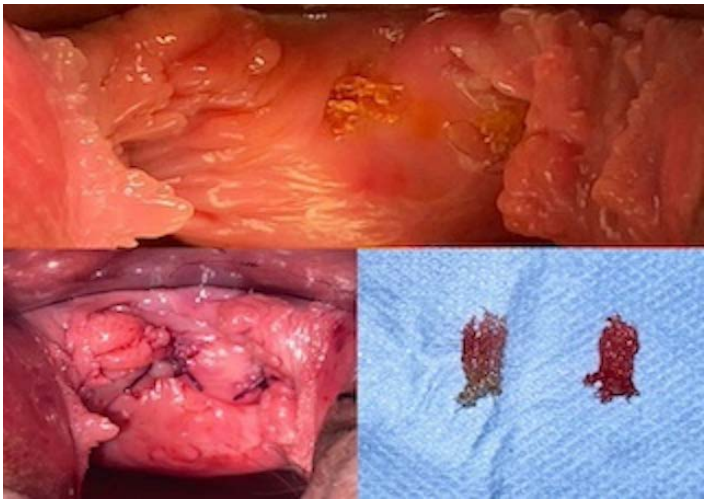

Table 1. Demographic and clinical characteristics of the groups.

Variables	Group 1 (n = 45)	Group 2 (n = 32)	P-value
Age (year) †	42.8 ± 4.5	58.7 ± 7.5	0.001*
BMI (kg/m2) †	28.3 ± 4.2	27.0 ± 3.5	0.140
Parity ‡	4 (2-9)	5 (3-12)	0.076
Comorbidity§ Diabetes mellitus Hypertension Hyperlipidaemia	10 (22.2) 4 (8.9) 5(11.1) 1 (2.2)	15 (46.9) 5 (15.6) 8 (25.0) 2 (6.3)	0.021*
Previous cesarean section§	17 (37.8)	7 (21.9)	0.108
Smoker§	12 (26.7)	11 (34.4)	0.316
Menopausal§	2 (4.4)	31 (96.9)	0.001*

*BMI, body mass index; Group 1, age ≤ 50 years; Group 2, age > 50 years. †Data are presented as mean ± standard deviation. ‡Data are presented as median (range). §Data are presented as number (percentage). *P ≤ 0.05 is statistically significant.*

Table 2. Surgical outcomes of TOT procedure.

Variables	Group 1 (n = 45)	Group 2 (n = 32)	P-value
Clinical outcome† Cured Improved Failed Cured + Improved	26 (57.8) 16 (35.6) 3 (6.7) 42 (93.3)	13 (40.6) 12 (37.5) 7 (21.9) 25 (78.1)	0.105
Patient satisfaction† Satisfied Moderately satisfied Dissatisfied	28 (62.2) 13 (28.9) 4 (8.9)	14 (43.8) 11 (34.4) 7 (21.9)	0.085
Hospital stay (days) ‡	1.3 ± 0.5	1.6 ± 0.7	0.031*
Operative time (min) ‡	54.2 ± 13.0	61.3 ± 18.9	0.076
Blood loss (cc) ‡	22.8 ± 6.5	22.7 ± 6.7	0.967
Post-operative ICIQ-SF score§	1 (0-16)	7.5 (0-21)	0.003*

*ICIQ-SF, International Consultation on Incontinence Questionnaire—Short Form; Group 1, age ≤ 50 years; Group 2, age > 50 years. †Data are presented as number (percentage). ‡Data are presented as mean ± standard deviation. §Data are presented as median (range). *P ≤ 0.05 is statistically significant.*

Table 3. Post-operative morbidity of TOT procedure.

Variables	Total (n = 77)	Group 1 (n = 45)	Group 2 (n = 32)	P-value
Complication rate† Voiding difficulty Vaginal erosion Vaginal perforation De novo urgency Operative site bleeding Urinary retention Suprapubic/thigh pain Dyspareunia	33 (42.8) 4 (5.2) 3 (3.9) 1 (1.3) 11 (14.3) 2 (2.6) 1 (1.3) 9 (11.7) 2 (2.6)	17 (37.8) 2 (4.4) 1 (2.2) 1 (2.2) 7 (15.6) 1 (2.2) 0 (0) 5 (11.1) 1 (2.2)	16 (50) 2 (6.3) 2 (6.3) 0 (0.0) 4 (12.5) 1 (3.1) 1 (3.1) 4 (12.5) 1 (3.1)	0.286

*Group 1, age ≤ 50 years; Group 2, age > 50 years. †Data are presented as number (percentage). *P ≤ 0.05 is statistically significant.*

SS-22

Comparison of Punch Biopsy and Loop Biopsy in Patients with High-Grade Squamous Intraepithelial Lesion

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OBJECTIVE: The aim of this study was to conduct a comparative assessment of the effectiveness of cervical punch biopsy and loop biopsy procedures.

METHOD: The research focused on patients diagnosed with high-grade squamous intraepithelial lesions (HGSIL) between 2019 and 2020, who underwent colposcopy and biopsy. Retrospective file analysis was used to examine the clinical data and demographic characteristics of the patients.

RESULTS: The study included 56 patients who had punch biopsy (PB) and 51 patients who had loop cervical biopsies. The average age of the PB and Loop biopsy groups was 35.3 ± 8.2 and 37.6 ± 10.5, respectively, with no statistically significant difference between the two groups (P= 0.208). In addition, 21.4% of patients in the PB group were nulliparous, while 21.6% of patients in the Loop group were also nulliparous (P= 0.571). The mean width of the specimen was 4.9 ± 1.2 mm for the PB group and 11.0 ± 1.7 mm for the Loop group, with a statistically significant difference (P< 0.001). The depth of the specimen was lower in the punch biopsy group (3.9 ± 0.7 for PB, 6.6 ± 1.0 for Loop; P< 0.001). Minimal hemorrhages occurred at similar rates in both groups (8.9% for PB, 9.8% for Loop). In terms of pain experienced during the procedure, patients in both groups reported similar levels of discomfort (5.8 ± 1.3 for PB, 6.2 ± 1.8 for Loop; P= 0.206). The overall tissue score, comprising three parameters, showed no difference between the groups in terms of tissue adequacy (including epithelium + stroma).

CONCLUSION: Despite the greater specimen depth and width in the Loop biopsy group and evidence of cautery artifact, tissue adequacy, bleeding, and pain scores were similar for both PB and Loop biopsies. This study did not determine the superiority of one biopsy method over the other.

Keywords: High grade squamous intraepithelial lesion, cervical punch biopsy, cervical loop biopsy

SS-23

Prevalence of Bleeding Disorders in Adolescents Presenting with Heavy Menstrual Bleeding and Anemia

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OBJECTIVE: Heavy menstrual bleeding (HMB) is one of the most common gynecologic disorders among adolescents. While anovulatory bleeding (AB) is usually the underlying cause, a previously undiagnosed bleeding disorder (BD) can also may also lead to such bleeding. It has been reported that approximately 20% of adolescents with HMB and up to 33% of girls hospitalized for HMB may have BD1,2. The aim of our study was to investigate the prevalence of BD in a population of adolescents who were evaluated for HMB and whose hemoglobin values were 12 and below.

METHODS: We retrospectively reviewed medical records of 137 adolescents aged 10 to 18 years who were presented with HMB to a tertiary Pediatric and Adolescent Gynecology Service between July 2017 and September 2023 and had hemoglobin values of 12 g/dL and below. Data on medical history, menstrual history, bleeding symptoms, gynecologic evaluation, hospitalization, blood transfusion, treatments, and screening for BD were evaluated.

RESULTS: A total of 137 adolescents with HMB met the inclusion criteria. The mean age at the onset of symptoms and at menarche 14±1.9 years and 12.1±1.3 years, respectively. A history of previously diagnosed BD or a medical condition that could cause BD was identified in 14 patients. The mean hemoglobin value on presentation was 8.1±2.2 g/dL. The rate of hospitalization for management was 51% (70/137) and 44 patients (32.1%) received packed red blood cell transfusions. Evaluation for the presence of a bleeding disorder was performed in 106/123 (%86.1) of the patients. Overall, 9 adolescents were diagnosed with some underlying BD, giving a prevalence of 9/106 (8.4%) in those screened for BD (Table 1). Among these 9 patients, von Willebrand disease was the most common BD (55%). When all patients are divided into two groups as those with an initial Hb value of 8 or less (Group 1) and those with a Hb value between 8 and 12 (Group 2), 5.5% of patients in Group 1 (3/55) and 11.7% in Group 2 (6/51) had a coagulation disorders, with no statistically significant difference (Table 2).

CONCLUSION: In this age group, anovulatory bleeding alone may cause severe anemia required inpatient hospital stays and blood transfusion needs. Timely initiation of hormonal suppression in these cases is important to reduce these negative consequences. According to our findings, the rate of detection of BD was 8.4% in the adolescents presented with HMB. The fact that the detection rate of BD was found to be higher in adolescents who presented with a more chronic bleeding complaint and mild anemia suggested that BD screening should be performed with the same care in this group.

Keywords: adolescent gynecology, bleeding disorders, heavy menstrual bleeding

SS-24

Abscess Comparison of clinical data of patients diagnosed with TOA (Tuboovarian Abscess) according to localization differences, Tertiary Center Experiences

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AIM: Tubaovarian abscess (TOA) is an inflammatory mass formed by the fallopian tube, ovary and, less commonly, adjacent pelvic organs. Initial treatment of TOA is intravenous antibiotic therapy followed by oral antibiotics. If medical treatment fails, the next step is laparoscopic or laparotomy abscess drainage, adnexectomy or hysterectomy. Another approach may be image-guided catheter needle aspiration and antibiotic treatment. The findings showed that bilateral abscesses were more likely to require surgical intervention compared to unilateral abscesses. Our aim in this study is to examine the results of TOA (Tuboovarian Abscess) management according to Abscess Localization differences.

METHOD: The data of the patient who was hospitalized with the diagnosis of TOA at the Etlik City Hospital Gynecology Service between January 2023 and January 2024 were examined retrospectively. Demographic and clinical data of the patients were examined. Patients were divided into Unilateral and Bilateral groups according to the USG imaging performed when TOA was diagnosed.

RESULTS: Of the 70 patients included in the study, 47 (61.4%) were in Unilateral Group 1 and 23 (32.7%) were in Bilateral Group 2. Among the groups, Gravida (p = 0.78), Parity (p = 0.65), BMI (p = 0.81), Type of Birth (x2.0.44), Contraception Method (x2.0.85), Smoking (x2.0.88), Additional Comorbid Disease (x2.0.73), Previous surgical history (x2.0.14), Body temperature on admission to the hospital (x2.0.78), Type of operation performed (x2.0, 34), Maximum size of abscess (p=0.15), Presence of pyosalpinx (x2.0.37), Abscess pattern (x2.0.17), Duration of hospital stay (p=0.81), Duration of drain stay (p =0.59), No significant difference was observed between the groups in terms of antibiotic regimen used in treatment (x2.0.26), CRP (p=0.12) and WBC (p=0.94) values. (p>0.05) A significant difference was observed between the groups in terms of total antibiotic therapy duration (p=0.04) and age (p=0.02). (p<0.05) In patients diagnosed with bilateral abscess, the duration of antibiotic therapy was longer and the average age of the patients was higher.

CONCLUSION: As a result of the study, a difference was observed between the groups in terms of age and antibiotic duration in terms of TOA with unilateral and bilateral localization. It suggests that bilaterally located abscesses have higher treatment resistance. We think that our study should be supported by more multicenter studies with a larger number of patients.

Keywords: Tuboovarian abscess, Pelvic inflammatory disease, Unilateral and bilateral localization,

SS-25

Premenstrual Syndrome Prevalence and Factors Playing a Role in Etiology

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OBJECTIVE: Premenstrual syndrome is considered to be one of the most frequently encountered diseases in women in the reproductive period and is frequently encountered in gynecology outpatient clinic applications. Our study aimed to determine the prevalence of premenstrual syndrome, which we think is extremely common, and to provide a guiding road map to patients.

MATERIALS-METHODS: In our study, 600 patients in the 18-40 age group who applied to our outpatient clinic with different complaints during the period January 2018-May 2022 were evaluated with a survey form prepared according to DSM-IV criteria. Patients with a known psychiatric disease diagnosis, patients using antipsychotic or antiepileptic drugs, patients using combined oral contraceptives, patients using levongestrel IUD, patients with a previous history of malignancy, and patients with a known diagnosis of diabetes mellitus were excluded from the study.

RESULTS: When the patients included in the study were evaluated, there were 520 (86.6%) patients who described mild or severe dysmenorrhea in the premenstrual period. Considering the premenstrual syndrome (PMS) diagnostic criteria of the women in the study group, PMS was detected in 245 (40.8%) patients. Among the group with PMS, 102 (41.6%) patients were nulliparous, 98 (40%) of the patients with a birth history had a cesarean delivery history, and 45 (18.4%) patients had a normal birth history. The prevalence of PMS was found to be low in patients who gave birth normally in the study group. The most common symptoms during this period were breast tenderness (55%), headache (35%), lower back pain (41.6%), fatigue (48.3%), edema (51.6%) and diarrhea (6.6%). It was revealed that 55 (22.4%) patients in the PMS group had a known diagnosis of migraine, and 40 (72.7%) patients in this patient group had a migraine attack during this period. It was determined that 200 (81.6%) of the patients diagnosed with PMS were university students or working women, and 45 (18.4%) patients were not working.

CONCLUSION: The prevalence of PMS in women is much higher than thought. This situation can affect the whole society. Its higher frequency in working and studying women reveals that it may be related to sociocultural level. In order to reduce the prevalence of PMS, improve the quality of life and integrate women into business and education life, necessary precautions should be taken to give more importance to this issue and especially to identify risk factors.

Keywords: Dysmenorrhea, Etiology, Premenstrual syndrome,

SS-26

Comparison of laparoscopic surgery with direct trocar entry versus Veress needle technique: a retrospective analysis

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OBJECTIVE: Laparoscopy is a commonly performed procedure in various surgical disciplines. Complications associated with laparoscopy usually arise from the initial entry into the abdominal cavity. The objective of this study was to assess the safety of direct trocar insertion compared to the Veress needle entry technique during gynecologic laparoscopic procedures.

METHODS: This study retrospectively analyzed patient data obtained from electronic medical records of those who underwent laparoscopic surgery at the Obstetrics and Gynecology Clinic of Bursa City Hospital between January 2022 and January 2024. The study protocol was approved by the Bursa City Hospital Ethics Committee at the beginning of the study period. The study included patients aged between 18 and 65 years who underwent surgery for benign reasons with umbilical trocar entry, operated by the same four surgeons. Patients who underwent emergency surgery, pregnant patients, patients with umbilical hernia, and patients who did not have the primary trocar entry through the umbilicus were excluded from the study. The patients were divided into two groups: The direct trocar insertion group (DIR) and Veress needle group (VER). The analysis included age, body mass index (BMI), history of previous surgeries, and the performed operation. The primary outcome of the study was complications occurring during abdominal entry and the presence of two or more entry attempts into the abdomen. The data were analyzed using SPSS V26, with a significance level of $p<0.05$.

RESULTS: In this study, 78 patients were included, 23 in the DIR group and 55 in the VER group. There were no significant differences between the two groups in terms of age, body mass index (BMI), and history of previous surgeries (Table 1). During abdominal entry, 2 patients (8.7%) in the DIR group and 9 patients (16.4%) in the VER group experienced two or more entry attempts, with no statistically significant difference between the groups ($p=0.375$) (Table 1). Furthermore, during abdominal entry, one patient in the VER group suffered a full-thickness ileum injury, and one patient underwent laparotomy conversion due to abdominal entry failure. No major vascular complications occurred in either group. The DIR group had a total of 2 complications (8.6%), while the VER group had 6 complications (9.1%), with no significant difference between the two groups (Table 2). In conclusion, the study found no significant difference in complication rates between the two groups.

CONCLUSION: This retrospective analysis compares the use of Veress needle entry with direct trocar entry in gynecologic surgery. The data shows that the Veress needle group had a higher number of two or more entry attempts compared to the direct trocar group, Additionally, the Veress needle approach shows a higher incidence of complications, including omental injury, and

the necessity to convert to laparotomy due to access difficulties, although not reaching statistical significance. According to current meta-analyses, there is still no definitive consensus on the most effective approach for the initial entry into the peritoneal cavity.

Keywords: Laparoscopy, Veress needle entry technique, Direct trocar insertion

Table 1: Characteristics of patients in the groups

Variables	Direct trocar insertion (DIR) (n=23)	Veress needle (VER)(n=55)	p
Age (years) median(min-max)	40(29-59)	38(25-61)	0.521a
mean±std. deviation	40.73±8.11	39.58±7.38	
BMI (kg/m2) median (min-max)	27(22-32)	27(22-44)	0.72a
mean±std. deviation	27.52±3.01	27.51±3.55	
Previous abdominal surgery n (%)			
Pfannenstiel incision	7(30.4)	17(30.9)	
Laparoscopy	3(13)	2(3.6)	
Vertical incision	0	1(1.8)	
Total	10 (43.4)	20(36.4)	0.292b
Type of surgery			
Operative L/S for adnexal pathology	2(8.7)	10(18.2)	
Diagnostic laparoscopy	0	1(1.8)	
Bilateral tubal ligation	13(56.5)	40(72.7)	
Laparoscopic hysterectomy	8(34.8)	4(7.3)	
Patients with two or more access attempts	2(8.7)	9(16.4)	0.375b

a: Mann-Whitney U Test; b: Pearson's Chi-square Test

Table 2: Complications secondary to access into the abdominal cavity

Complications	Direct trocar insertion (DIR)(n=23)	Veress needle (VER) (n=55)	
Intestinal	0	1(1.8)	
Major vascular	0	0	
Subcutaneous emphysema	0	2(3.6)	
Vascular lesions of the abdominal wall	1(4.3)	1(1.8)	
Omental injury	1(4.3)	1(1.8)	
Conversion to laparotomy due to inability of access	0	1(1.8)	
Total	2(8.6)	6(9.1)	0.83 a

a: Pearson's Chi-square Test

SS-27

To compare the data of laparoscopic and abdominal hysterectomy cases performed with benign indications

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OBJECTIVE: The type of hysterectomy is affected by many factors such as the patient's indication, age, body mass index and comorbid diseases. Although vaginal hysterectomy is the gold standard, total or laparoscopic hysterectomy is also preferred in inappropriate cases (1). In the literature, laparoscopic hysterectomy has less hospitalisation, less bleeding risk, less infection risk compared to abdominal hysterectomy (2). However, it has more urinary system injuries and longer operation times (3).

The aim of this study into compare data of the laparoscopic and abdominal hysterectomies performed for benign causes at Atatürk University Traning and Reserch Hospital retrospectively and decide which hysterectomy technique will be applied for patients.

MATERIALS-METHODS: Demographic characteristics of patients who underwent benign laparoscopic and abdominal hysterectomy in our clinic between 2009 and 2019 are compared based on operation time, length of hospital stay, hemoglobin values at entry and exit from the operation, preoperative and postoperative complications, need for blood transfusion, outcome pathology of hysterectomy materials and uterine weights.

RESULTS: Our study included 524 patients who underwent laparoscopic hysterectomy and 1305 patients who underwent abdominal hysterectomy. The mean age of the patients who underwent laparoscopic hysterectomy was 47 (p=0.052), and the mean age of the patients who underwent abdominal hysterectomy was 48 (p=0.052). The operation time was found to be statistically significant (p<0.001). Uterine weight and hospitalization time were found to be higher in abdominal hysterectomy (p<0.001). As in the total frequency of complications, when the perioperative and postoperative complications were evaluated separately, the data of both groups were found to be close to each other. In postoperative complications, wound infection and vaginal hematoma-bleeding were observed more frequently in abdominal hysterectomy compared to laparoscopic hysterectomy, while rectovaginal fistula and bladder fistula were observed more frequently in laparoscopic hysterectomy.

CONCLUSION: There are points where both hysterectomy methods are superior to each other. This study shows that the hysterectomy method should be chosen and individualized according to the patient's characteristics and the surgeon's clinical experience, in a way that will be most beneficial for the patient.

Keywords: Laparoscopic Hysterectomy, Abdominal Hysterectomy, preoperative complications, postoperative complications.

SS-28

Induction Agents and the Active Phase of Stage 1 in Childbirth: A Retrospective Study at Hacettepe University Hospital

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Introduction/Background: Childbirth comprises three distinct stages. Stage 1, the cervix dilates, marks the termination of the first stage when full cervical dilation is achieved. Stage 2 spans the period between full cervical dilation and the birth of the baby, while Stage 3 encompasses the interval from the baby's birth to the expulsion of the placenta. Stage 1 of childbirth consists of two phases: the latent and active phases. The latent phase denotes cervical dilation between 0 cm and 6 cm, whereas the active phase delineates the process from 6 cm to complete dilation.

The objectives of induction in childbirth may vary from patient to patient, but its general aims are to facilitate cervical ripening, regularize contractions, enhance the amplitude and frequency of contractions, and shorten the duration of childbirth. One of the primary agents used in induction is misoprostol (Cytotec), an analog of prostaglandin E1, which exerts uterotonic effects primarily by promoting cervical ripening. Another agent, oxytocin (Synpitan), also manifests its effects through uterotonicity. In certain childbirth scenarios, the simultaneous use of multiple agents may also be warranted.

Methodology: This study retrospectively evaluates childbirths that occurred at Hacettepe University Hospital between 2022 December and 2023 May. The examinations of patients undergoing childbirth and the administration of any induction agents during childbirth were scrutinized by reviewing patient charts. The Kruskal-Wallis Test was employed to ascertain the statistical significance of the results. Additionally, One-way ANOVA was utilized for intragroup comparisons. A p-value less than 0.05 was deemed statistically significant.

RESULTS: In total, 200 patients were enrolled in the study, but data from 2 patients were excluded due to insufficient information. Among the study participants, 102 had not undergone any induction treatment. 17 patients received solely misoprostol, 32 received a combination of misoprostol and oxytocin, and 47 received oxytocin treatment exclusively. The time required to achieve complete dilation for the untreated group was 2.47 ± 1.41 hours, for the misoprostol group was 1.37 ± 0.84 hours, for the misoprostol and oxytocin group was 1.95 ± 1.3 hours, and for the oxytocin-only group was 2.76 ± 2.37 hours. In the Kruskal-Wallis test conducted for intergroup comparison, a p-value of 0.017 was obtained.

Discussion: The study findings indicate that induction agents exert a statistically significant impact on the active phase of Stage 1 of childbirth. Post hoc analysis with One-way ANOVA revealed that the administration of misoprostol alone significantly shortened the active phase compared to both untreated individuals and those receiving oxytocin, with respective p-values of 0.017 and 0.018. No statistically significant difference was observed in the comparison of other groups with each other. The strengths of this study include the statistical similarity of parity numbers and other independent variables across groups, as well as the balanced distribution of groups concerning other independent variables. However, a limitation of the study is the lower patient count compared to studies in the literature. Further studies with increased sample sizes are warranted to bolster the current findings.

Keywords: Active Phase, İnduction, Labor, Misoprostol, Oxytocin

SS-29

Can Immature Granulocyte Count Predict Malignancy in Patients Undergoing Endometrial Biopsy for Postmenopausal Uterine Bleeding?

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OBJECTIVE: Endometrial cancer is the most common gynecologic cancer in developed countries and the second most common in developing countries, and its incidence is increasing worldwide. The most common clinical symptom is postmenopausal bleeding (PMB) and abnormal uterine bleeding in perimenopausal women. Malignancies and inflammation are the primary causes of bone marrow activation. Tumor-related inflammation has gained importance at every stage of tumor formation. With technological advances, IG count among complete blood count parameters can be evaluated automatically in automated systems. Previous studies have investigated its association with breast, thyroid, and pancreatic cancers. In this study, we aimed to evaluate the relationship between pathology results and IG count in patients who underwent endometrial biopsy due to PMB in our clinic.

MATERIALS-METHODS: Patients who underwent endometrial biopsy by endometrial curettage (F/C) or hysteroscopy (H/S) methods due to PMB at Mersin University Hospital Gynecology and Obstetrics Clinic in 2023 were included in the study. Demographic and clinical characteristics were obtained from medical records. Chronic diseases and other characteristics were excluded from our study.

RESULTS: The study included 115 patients. 40 patients underwent H/S, and 75 patients underwent F/C. The pathology results of 35 patients who underwent HS were benign, and five were malignant. The pathology results of 60 patients who underwent F/C were benign, and 15 were malignant. Benign results included one hyperplasia with atypia and one hyperplasia without atypia. Of the patients with malignant pathology results, 16 were grade 1, 1 was grade 2, 1 was grade 3 endometrioid carcinoma, and 2 were clear cell carcinoma. The mean age of the patients was 56.6 ± 10.2 years, the mean gravidas were 3.4 ± 2.2, and the mean parity was 2.7 ± 1.8. Our study found that the number of IGs was statistically significantly higher in patients with malignant sampling results (p = 0.006). No significant result was found in the comparison between H/S and F/C (p = 0.312)

CONCLUSION: In studies conducted with cancer patients, it has been found that IG count can be used to predict lymph node metastasis, survival, and diagnosis. In our study, immature granulocyte count was found to be statistically significantly higher in patients who underwent endometrial biopsy due to postmenopausal bleeding and whose pathology result was endometrial cancer (p = 0.006). Age is known to be a risk factor for endometrial cancer. In our study, the mean age of patients with malignant pathology results (65.6 ± 9.3) was significantly higher than that of patients with benign pathology results (54.7 ± 9.4)

Keywords: pmb, immature granulocyte, endometrial cancer

Comparison of patients with benign and malignant pathology results

Table 1: Comparison of patients with benign and malignant pathology results

	Pathology Result Benign (n = 95)	Pathology Result Malign (n = 20)	p
Age	54,7 ± 9,4	65,6 ± 9,3	0,000*
Gravida	3,5 ± 2,2	2,8 ± 2,5	0,260
Parite	2,8 ± 1,8	2,1 ± 1,7	0,254
Immatur Granulocyte Count	0,0254 ± 0,0277	0,0360 ± 0,0201	0,006*

SS-30

An Evaluation of Serum Blood Parameters and Amyloid-A Levels in Women with Hyperemesis Gravidarum

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OBJECTIVE: Hyperemesis gravidarum (HEG) is an obstetric emergency encountered in the first trimester of pregnancy and defined as a complication accompanied by persistent nausea and vomiting. Prognosis in HEG is generally good, as a result of advances in medical treatment options. However, the condition can cause maternal and fetal problems such as spontaneous abortion, prematurity, congenital malformation, fetal growth restriction, preeclampsia, and low birth weight. Amyloid A (AA) is a molecule synthesized by the liver in acute inflammatory events. Its levels can rise up to 1000 times above the normal serum value, and serum levels remain higher than normal in chronic inflammatory diseases, although it is unclear whether it plays a role in the etiopathogenesis of these diseases. Increased serum levels are a poor prognostic criterion in atherosclerotic and cardiovascular diseases, as well as cancer. The great majority (95%) of AA is associated with high-density lipoprotein (HDL), and in severe acute inflammatory events it becomes the main apolipoprotein on HDL and induces cytokine production through immune mechanisms Serum AA levels rise in diseases such as colorectal carcinoma, ovarian cancer, uterine carcinoma, glioblastoma multiforme, pancreatic adenocarcinoma, and neonatal encephalopathy. This study aimed to investigate whether serum amyloid A (AA) levels can be used as a biomarker in women with hyperemesis gravidarum (HEG).

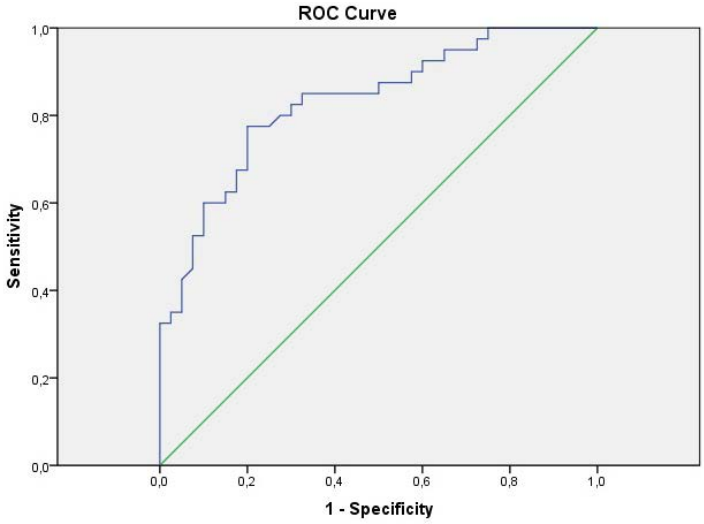
MATERIALS-METHODS: This prospective cohort study was conducted at the Antalya Training and Research Hospital Gynecology and Obstetrics Clinic, Türkiye, between July and December 2023. Forty women diagnosed with HEG and 40 healthy women were included.

RESULTS: No statistically significant differences were observed between the groups in terms of sociodemographic data such as age, body mass index, family history, educational status, economic level, place of residence, occupation, smoking and alcohol use, or drug habits. However, obstetric characteristics such as number of miscarriages, number of dilatation curettages, and gestational age and laboratory values including complete blood count, hematocrit, leukocyte, neutrophil, lymphocyte, platelet, free T4, albumin, alanine aminotransferase, aspartate aminotransferase, urea, creatinine, hs-C-reactive protein, and sodium ($p>0.05$) all differed significantly. In addition, significant differences were observed between the HEG and healthy groups in terms of numbers of gravidities [2 (1-3) vs 1 (0-1), respectively, $p<0.001$], numbers of parities [1 (0-1) vs 1 (0-1), $p<0.001$], numbers of living children [1 (0-2)) vs 1 (0-1), $p<0.001$], presenting complaints [nausea 0 (0%), nausea + vomiting 0 (0%), none 40 (100.0%) vs nausea 27 (67.5%), nausea + vomiting 13 (32.5%) %), none 0 (0%), $p<0.001$], serum thyroid-stimulating hormone (1.16±0.56 vs 1.81±0.624, $p=0.004$), potassium (4.1±0.7 vs 3.8±0.2, $p=0.001$), and AA values (7.29±2.61 vs 10.74±3.04, $p<0.001$). At receiver operating characteristic analysis, the area under the curve (AUC: 0.881) was statistically significant for serum AA (p: <0.001), with a cut-off value of ≥8.79 [95% confidence interval) 0.743-0.919, sensitivity 87.4%, specificity 80.2%]. The positive predictive value of serum AA was 81.1% and the negative predictive value was 80.4%.

CONCLUSION: The study results showed that serum AA can be used as a diagnostic biomarker in HEG. Prospective studies involving more participants are now required to confirm our results.

Keywords: Biomarker, hyperemesis gravidarum, serum amyloid A

ROC Curve for Serum Amyloid A.



Sensitivity, Specificity, Positive Predictive Value, and Negative Predictive Values for Amyloid A

	AUC	p	Lower limit	Upper limit	Sensitivity	Specificity	PPV	PPV
Amyloid A	0.881	<0.001	0.743	0.919	87.4%	80.2%	81.1%	80.4%

The Participants' Laboratory Values

	Control (Group 1) (n=40)	Study (Group 2) (n=40)	p
Hb (g/dl)	12.2±0.8	12.3±0.9	0.607
Htc (%)	36.6±2.9	36.1±4.9	0.491
WBC (10^3/mm^3)	10.04±3.74	9.37±2.73	0.359
Neutrophil (10^3/mm^3)	7.01±3.32	6.69±2.51	0.638
Lymphocyte (10^3/mm^3)	2.27±0.62	2.05±0.90	0.211
Platelet (10^3/mm^3)	277.27±57.30	260.58±54.85	0.187
NLR	3.27±1.80	3.99±1.91	0.188
PLR	128.29±34.75	157.38±29.33	0.173
TSH (uIU/ml)	1.81±0.62	1.16±0.56	0.004*
Free T4 (ng/dl)	0.93±0.25	0.87±0.29	0.578
Albumin (g/L)	41.69±3.65	41.65±2.49	0.948
ALT (U/L)	21.2±9.9	17.2±8.6	0.568
AST (U/L)	19.4±5.1	18.7±6.1	0.860
BUN (mg/dl)	8.05±2.57	8.70±3.38	0.336
Creatinine (mg/dl)	0.61±0.09	0.65±0.13	0.143
hs-CRP (mg/L)	6.80±2.90	8.27±2.52	0.346
Sodium (mmol/L)	138.05±3.15	138.70±4.47	0.411
Potassium (mmol/L)	4.1±0.7	3.8±0.2	0.001*
Amyloid-A (ng/ml)	7.29±2.61	10.74±3.04	<0.001*

The Participants' Sociodemographic Characteristics

	Control (n=40)	Study (n=40)	p
Age (years)	28.75±5.95	28.18±4.98	0.641
BMI (Body mass index, kg/m^2)	25.33±4.57	24.40±4.23	0.334
Smoking (n, %)	7 (17.5%)	10 (25.0%)	0.586
Alcohol consumption (n, %)	2 (5.0%)	4 (10.0%)	0.675
Drug abuse (n, %)	1 (2.5%)	3 (7.5%)	0.615
Gravity	2 (1-3)	1 (0-1)	<0.001*
Parity	1 (0-2)	1 (0-1)	<0.001*
Living child	1 (0-2)	1 (0-1)	<0.001*
Miscarriage	0 (0-0)	0 (0-0)	0.133
Dilatation- Curettage	0 (0-0)	0 (0-0)	0.317
Gestational age at admission (week)	10.6±2.5	11.1±2.1	0.418

SS-31

Evaluation of products of pregnancy (POCs) in cases of recurrent pregnancy loss (RPL) by cytogenetic analysis

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AIM: Pregnancy loss refers to the spontaneous demise of a pregnancy prior to 24 weeks of gestation, which occurs in approximately 15%-25% of pregnancies, and two or more pregnancy losses are defined as recurrent pregnancy loss (RPL). Chromosomal abnormalities can be confirmed by cytogenetic analysis of products of conception (POCs) in RPL cases. This study aims to evaluate the chromosomal results detected in the POCs of RPL cases by cytogenetic analysis.

METHOD: RPL cases with cytogenetic analysis of POCs between January 2021 and June 2022 were included in this retrospective study. Cases without two or more pregnancy losses, cases with pregnancy termination due to structural anomaly, cases with a gestational age higher than 24 weeks, RPL cases without cytogenetic analysis, cases with the result of prenatal cytogenetic analyses, and cases with missing data were excluded from the study. Data were obtained retrospectively from records of early pregnancy service (EPS) and the hospital registry system. Age, obstetric and demographic characteristics, gestational age, and cytogenetic results of POCs in RPL cases were evaluated.

RESULTS: Between January 2021 and June 2022, 3965 POCs from EPS were examined in the pathology department, 231 of them were subjected to cytogenetic analysis in the genetics department, and a total of 119 RPL cases were included in the study according to the eligibility criteria. The mean (standard deviation) age of the cases was 30.29 (6.97), gravida was 4.30 (2.06), parity was 1.60 (1.66) and the number of previous abortions was 2.70 (1.41). The mean gestational age was found to be 13.24 (5.97) weeks. Chromosome analysis reports could not be provided for 26 (21.8%) cases due to no progress in cell development was achieved. The cytogenetic analysis results of POCs are presented in Table 1. The cytogenetic report stated that in 4 (3.4%) cases, cells with 46 xx structures were detected as a result of maternal contamination. Although 77 (64.7%) cases were detected with normal karyotype, chromosomal abnormalities were detected in 13 (10.9%) cases. All chromosomal abnormalities in this study were numerical abnormalities and no structural abnormalities were detected. In this study, trisomies (5.8%) were found to be the most common chromosomal abnormalities in all RPL cases. In all cases, 55.5% (66) had female (xx) and 22.7% (27) male (xy) sex chromosomes, but chromosomal sex determination could not be achieved in 26 (21.8%) cases due to no progress in cell development.

DISCUSSION: The pathophysiology of RPL, particularly the prevalence of chromosomal abnormalities detected in POCs of RPL cases, is still not fully clarified. Although the majority of RPL cases had a normal karyotype and female sex chromosome in this

study, numerical chromosomal abnormalities, mostly trisomy 21 and monosomy x, were the most common cytogenetic abnormalities.

Keywords: Cytogenetic analysis, Chromosomal abnormalities, Recurrent pregnancy loss (RPL), Products of conception (POCs), Trisomy

Table 1

Results of cytogenetic analysis	Number (%)
Total cases	**119 (100)**
Normal karyotype	**77 (64.7)**
No progress in cell development was achieved	**26 (21.8)**
Maternal contamination	**4 (3.4)**
46,xy(12)/46,xx(2)	
46,xy(17)/46,xx(2)	
46,xy(2)/46,xx(18)	
46,xy,inv(9)(p12q13)(6)/46,xx,inv(9)(p12q13)(14)	
Chromosomal abnormality	**12 (10.1)**
Trisomy	***7 (5.8)***
Trisomy 21 (47,xx,+21 or 47,xy,+21)	3 (2.5)
Trisomy 18 (47,xy,+18)	1(0.8)
Trisomy 8 (47,xy,+9))	1(0.8)
Trisomy 9 (47,xx,+9)	1(0.8)
Trisomy 22 (47,xy,+22)	1(0.8)
Monosomy	***3 (2.5)***
Turner syndrome (45,x)	2 (1.7)
Turner mosaicism (45,x(1)/46,xx(19) level 1)	1(0.8)
Tetrasomy	***1(0.8)***
Tetrasomy 9p (47,xx,+idic(9)(q12))	1(0.8)
Triploidy	***1(0.8)***
Triploidy (69,xxy)	1(0.8)

Table 1: The cytogenetic analysis results of products of conception (POCs) in recurrent pregnancy loss (RPL) cases

SS-32

What is the best practice for salpingo-ooferectomy? Is single-port laparoscopy the preferred option, or could vaginal natural orifice transluminal endoscopic surgery (vNOTES) be a more appropriate alternative?

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AIM: To compare single-port laparoscopic surgery (SPLS) with vaginal natural orifice transluminal endoscopic surgery (vNOTES) to underwent salpingo oophorectomy.

METHODOLOGY: Retrospective assessment of patients who underwent salpingo-oophorectomy between 2016 and 2023 was conducted. Patients who underwent unilateral or bilateral salpingo-oophorectomy were included, while cases involving additional surgeries were excluded. Patients underwent surgery due to adnexal mass or BRCA mutation. SPLS was performed in 34 cases, whereas vNOTES was conducted in 21 cases. The primary outcome measures included postoperative recovery assessed by the Quality of Recovery (QoR)-40 survey score, visual analog scale (VAS). VAS scores were recorded at 2, 6, 12, and 24 hours post-surgery.

RESULTS: A total of 55 salpingo oophorectomy cases were analyzed. There was no significant difference in mean age between the SPLS (52.4 ± 11.4) and vNOTES (47.4 ± 4.9) groups (P = 0.106). Similarly, no significant differences were observed in body mass index (P = 0.911) or mass size (P = 0.096) between the two groups. Unilateral salpingo-oophorectomy was carried out in 76.5% of SPLS cases and 57.1% of vNOTES cases (P = 0.114). The operative time was shorter in the SPLS group compared to the vNOTES group (43.5 ± 7.6 vs. 53.1 ± 10.2; P <0.001). However, the mean removal time was found to be longer in the SPLS group (7.5 ± 3.2 vs. 7.0 ± 2.4; P= 0.587). QoR-40 scores were significantly higher in the vNOTES group compared to the SPLS group (148 ± 11 vs. 156 ± 14; P= 0.030). Additionally, VAS scores were found to be significantly lower in the vNOTES group at 2, 6, 12, and 24 hours.

CONCLUSION: Patients undergoing vNOTES for salpingo oophorectomy exhibited better postoperative pain management and recovery times compared to those undergoing SPLS.

Keywords: Single-port laparoscopic surgery, Vaginal natural orifice transluminal endoscopic surgery, Adnexal mass

SS-33

Evaluation of reproductive expectations and outcomes in patients diagnosed with breast cancer at a tertiary oncology center

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AIM: To determine the fertility status of breast cancer patients who were diagnosed and/or treated at our tertiary oncology center and who were in their reproductive period at the time of diagnosis, and to evaluate fertility expectations and pregnancy status of these patients after breast cancer diagnosis.

METHOD: Data of patients who were diagnosed and/or treated in Başkent University Adana Dr Turgut Noyan Application and Research Center, Department of Medical Oncology were scanned retrospectively. Among the patients diagnosed with breast cancer in between January 2012 and December 2023, women at 42 years of age or younger at the time of diagnosis were enrolled. Provided the contact information of these patients was obtained, a 10-question survey via the internet-based messaging program (WhatsApp), which is widely used in our country, was performed. Necessary approval for the study was obtained from the institutional board.

RESULTS: During the study period, a total of 1178 woman were found to be diagnosed with breast cancer at or before 42 years of age, during their reproductive period. Completing the survey, 161 (9%) of these patients were included in the study. The age at diagnosis of breast cancer in this group was 35.6±4.84 years. Recurrence of the disease was detected in 38 (23.6%) women. It was observed that 83.2% of the patients were married, 8.1% were single and 8.7% were seperated from their spouses. The rate of patients who desired to have a child after completion of breast cancer treatment was 32.9%. It was observed that 11 of these patients applied to the gynecologist to get assistance regarding reproduction, 3 of them tried assisted reproductive techniques, and 5 of them had their oocytes and/or embryos frozen. It was observed that 15 patients achieved pregnancy and 12 patients gave birth after diagnosis.

CONCLUSION: A significant portion of patients diagnosed with breast cancer in their reproductive age (32.9% in our study) reported that they desired pregnancy after the disease. However, it is understood that very few of these patients received treatment to preserve and maintain fertility. Providing access of patients to adequate and effective counceling and treatment opportunities to preserve and maintain fertility may play an important role in helping this patient group to complete their fertility.

Keywords: assisted reproduction, breast cancer, fertility preservation, oocyte cryopreservation

SS-34

Evaluation of Erythrocyte and Hemoglobin Concentrations in Adolescents with Polycystic Ovary Syndrome

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OBJECTIVE: Polycystic ovary syndrome (PCOS) is a disease characterized by increased androgen levels and impaired ovulation. Insulin resistance and the resulting excess insulin secretion cause increased androgen production, and excess androgens cause menstrual disorders, the development of ovarian cysts and hirsutism. However, the erythropoiesis-enhancing effect of androgens is known. Androgens stimulate erythropoiesis in the bone marrow, increase erythrocyte production and increase hematocrit. This study aimed to evaluate the relationship between increased androgen levels and erythrocyte and hemoglobin concentrations in adolescents with PCOS.

METHOD: Our study included 60 patients who applied to our outpatient clinic between January 2019 and March 2022 and were diagnosed with PCOS according to the Rotterdam criteria, and 60 adolescent healthy individuals with similar demographic characteristics. Demographic data and laboratory findings of the patients were obtained retrospectively from the hospital database. In our study, complete blood count parameters of patients in the PCOS group and healthy individuals were compared. The relationship between androgen levels and erythrocyte count and hemoglobin concentrations of patients with PCOS was evaluated.

RESULTS: In the PCOS group, hirsutism was detected in 26 (43.3%) patients, oligomenorrhea was detected in 48 (80%) patients, and polycystic ovaries were detected on ultrasonography in 45 (75%) patients. When androgen levels are evaluated in patients with PCOS; total testosterone level: 0.86±0.18 ng/mL, free testosterone level: 3.45±0.92 pg/ml and DHEAS level: 342.2±146.9 µg/dL. When the erythrocyte count, hemoglobin and hematocrit values of both groups were compared, the values of all parameters in the PCOS group were found to be higher than the control group. The erythrocyte count in the PCOS group was 5.0±0.6 10^6/µL and the hemoglobin level was 14.0±0.8 g/dl. In the control group, the erythrocyte count was 4.8±0.3 10^6/µL and the hemoglobin level was 13.6±1.0 g/dl, and it was found to be significantly lower in the control group compared to the PCOS group (p: 0.040, p: 0.022). The hematocrit level in the PCOS group was 42.0±2.1%, and the hematocrit level in the control group was 40.6±2.7%. The hematocrit level in the control group was found to be significantly lower than the PCOS group (p:0.008). No significant correlation was found between total testosterone level and hemoglobin level (r = 0.16; p: 0.97). No significant correlation was detected between DHEAS level and hemoglobin level (r = 0.18; p: 0.40). No significant correlation was detected between the Free Androgen Index and hemoglobin level (r = 0.13; p: 0.88).

CONCLUSION: Although the parameters indicating erythropoiesis in patients diagnosed with PCOS were found to be higher than in the control group, no correlation was found that high androgen levels affected erythropoiesis in patients with PCOS. Prospective studies with larger samples comparing erythropoietic activity in patient groups with high androgen levels will help elucidate the etiology.

Keywords: Erythrocyte, Hemoglobin, Polycystic Ovary Syndrome

SS-35

Surgery for ovarian dermoid cyst in the pediatric and adolescent patients, is size related to pain?

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INTRODUCTION: Dermoid cyst (DC) represents the most frequently diagnosed ovarian neoplasm in the pediatric and adolescent population. Although the definitive indications and timing of surgery have yet to be determined, cysts that are larger than 5cm, grow rapidly and/or symptomatic usually treated with an surgical management. Aims of the study: To evaluate indications, approach, and outcomes of the surgeries performed for DC.

METHODS: We retrospectively reviewed the records of patients aged under 21 who underwent surgical treatment of DC between 2017-2023. Data was collected on demographics, clinical presentation, surgical findings, and follow-up. We also analyzed presenting symptoms among patients with cyst size ≤5cm (Group-1) and >5cm (Group-2).

RESULTS: Among a total of 92 cases underwent surgical management of adnexal masses, 32 (34%) were performed for DC. The mean age of the patients was 16.6±3.6 (range,7-21) years. The mean cyst size was 6.1±2.5cm, two paitent had bilateral tumours. All but three patient (91%) underwent laparoscopic cystectomy (Table1). Patients in Group-2 (n=25) was more likely to present with torsion. While only one patients in Group-1 (n=7) presented with torsion, the other patients required surgical treatment due to chronic pain (Table 2). Among the cases presenting with torsion, while cystectomy was performed at the time of detorsion in 67%, other patients underwent interval ovarian cystectomy.

DISCUSSION: Although the timing of surgical treatment of DCs remains controversial, laparoscopic cystectomy is considered a safe and effective approach. Our findings suggest that regardless of size, DCs may present with chronic pelvic/abdominal pain that affects quality of life and may require surgical treatment.

Keywords: adolescent gynecology, dermoid cyst, ovarian cystectomy

Presentation of the patients in both groups

	Group 1 (n=7)	Group 2 (n=25)	P value
Incidentally found on imaging (n)	-	12	<0.001
Chronic abdominal/pelvic pain (n)	6	5	<0.001
Torsion (n)	1	8	<0.001

Surgical findings and follow-up

The patient's characteristics	
The mean age (y), mean±SD	16.6±3.6 (range, 7-21)
The mean cyst size (cm), mean±SD	6.1±2.5 (range, 3-15)
Bilateral, n (%)	2 (6%)
Laparoscopic cystectomy, n (%)	29 (91%)
Open cystectomy (laparotomy) n (%)	2 (6%)
Laparoscopic oophorectomy n (%)	1 (3%)
The median follow up time (months), mean±SEM	35.3±4.3 (range, 4-70)
The patients received at least 1 postoperative imaging n (%)	26 (81%)
ODC recurrence followed expectantly n (%)	1 (3%)
ODC recurrence followed with surgery n (%)	1 (3%) (on contralateral ovary)

SS-36

The role of SII value in treatment selection for ectopic pregnancy

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OBJECTIVE: The aim of this study was to predict the selection of treatment for ectopic pregnancy(EP) using the values of systemic immune inflammation index(SII), C-reactive protein(CRP) and β-hCG obtained from labarotory parameters routinely used in clinical practice.

MATERIALS-METHODS: This retrospective, cross-sectional study was conducted in the Department of Obstetrics and Gynecology of Bursa Yüksek İhtisas education and research hospital, between January 2021 and September 2023. Pregnant women hospitalized with the diagnosis of EP were included in the study. The demographic and clinical characteristics of all patients were collected from the hospital's electronic medical system using the appropriate International Classification of Disease codes for EP. The following data were recorded for each patient: age, body mass index (BMI), gestational age, gravidity, and parity. The patients were separated as those who received medical treatment with methotrexate (MTX)(Group I) and those who underwent surgical procedures (Group II). The two groups were compared with respect to pre-treatment demographic characteristics and laboratory parameters.

RESULTS: Of the 102 patients diagnosed with EP, 65 were in Group I, treated with MTX, and 37 were in Group II, treated with surgery. No significant difference was determined between the groups with respect to age, gravida-parity and BMI of the patients. BhCG, NLR and PLR values in Group II were significantly higher than in Group I ($p<0.05$). The CRP value did not differ significantly between the groups (p:0.062). The SII value was significantly higher in Group II than in Group I ($p<0.05$). ROC analysis was performed to evaluate the accuracy of serum SII estimation in treatment selection of EP. Ultimately, an SII score of 621.2 or higher can predict treatment selection for EP with 62.7% sensitivity and 56% specificity.

CONCLUSION: There was no significant difference in CRP value between the groups, but SII was found to be significantly higher in patients requiring surgery. These findings suggest that the SII index may be a useful, cost-effective and easily accessible objective biomarker in treatment selection for EP.

Keywords: C-reactive protein, ectopic pregnancy, methotrexate, systemic immune inflammation index, surgery

Table 1- Comparations of demographic characteristics between MTX and surgery groups.

Variables	MTX (n=65) Mean±SD	Surgery (n=37) Mean±SD	P
Age (years)	31.6±6.2	30.2±6.1	0.196
BMI (kg/m2)	25.8±3.7	25.1±3.3	0.142
Gravida	2.97±1.55	3.46±2.34	0.163
Parity	1.43±1.38	1.78±1.23	0.054
Gestational date (week)	6.64±1.38	7.91±1.41	0.061

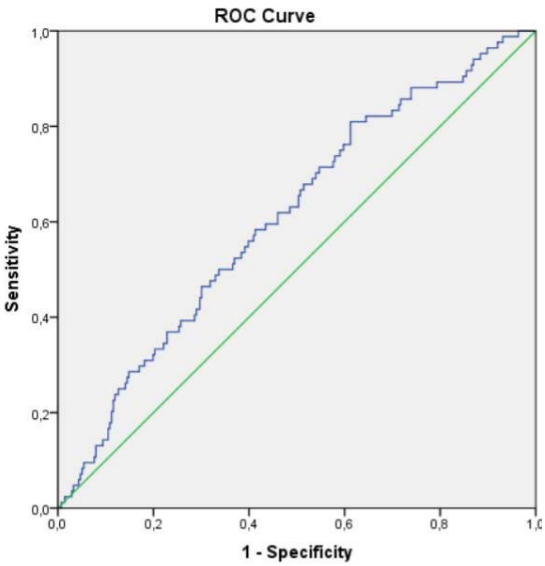
Note: MTX: Methotrexate, BMI: Body mass index Descriptive analyzes were performed using the mean and standard deviation (X±SD) for normally distributed data, minimum-maximum values (median (min-max)) for non-normally distributed data P<0.05 was considered significant.

Table 2- Descriptive and comparative analysis of laboratory data between MTX and surgery groups.

Parameters	MTX (n=65) X±SD/Median (min-max)	Surgery (n=37) X±SD/Median (min-max)	P
Hemoglobin (g/dl)*	11.8±0.7	10.2±1.4	<0.05
Neutrophil (10^9/L)*	5.9±1.6	6.7±1.9	0.078
Lymphocyte (10^9/L)*	2.1±0.4	1.8±0.4	0.12
Thrombocyte (10^9/L)	204 (136-367)	278 (102-483)	<0.05
NLR	2.8 (1.2-5.2)	3.3 (1.2-17)	<0.05
PLR	104.3 (52.6-275)	129.7 (50.8-386.6)	<0.05
SII*	601±195.3	923.16.1±491	<0.05
CRP (mg/L)	5.3±1.2	6.0±0.4	0.062
BhCG	2260±1655	5850±10760	<0.05

Note: MTX: Methotrexate, NLR: Neutrophil/LymphocyteRatio; PLR:Platelet/LymphocyteRatio, SII:Systemic Immune-inflammation Index; CRP: C Reactive Protein Descriptive analyzes were performed using the mean and standard deviation (X±SD) for normally distributed data, minimum-maximum values (median (min-max)) for non-normally distributed data P<0.05 was considered significant. (:One Way ANOVA, #: Kruskal Wallis).*

Figure-1.ROC curve analysis for assessing the cut-off value of SII to predict the surgery was demonstrated in Figure-1.



SS-37

Does High BMI negatively affect the outcomes of assisted reproductive treatments in patients with Polycystic Ovary Syndrome?

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BACKGROUND: Obesity commonly occurs in women diagnosed with polycystic ovary syndrome (PCOS) and is linked to various negative reproductive outcomes. However, the impact of excess weight and obesity on the reproductive outcomes of PCOS women undergoing in vitro fertilization-embryo transfer (IVF-ET) remains a topic of debate, especially considering variations in appropriate body mass index (BMI) levels among populations.

METHODS: In this retrospective cohort study, we examined 106 women diagnosed with PCOS who matched the criteria and underwent IVF treatment at our institution between 2019 and 2023, specifically focusing on their fresh embryo transfer cycles. Participants were classified based on BMI cutoff values suggested by the World Health Organization (BMI < 25 and BMI ≥ 25), and we analyzed the IVF cycle outcomes such as basal hormone levels, antral follicle counts, the number of retrieved oocytes, total gonadotropin doses, total stimulation days and pregnancy outcomes.

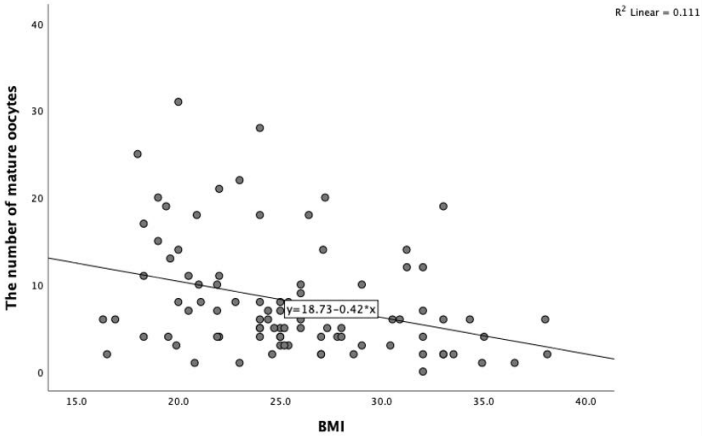
RESULTS: Similar basal FSH(follicle stimulating hormone), AMH(anti-mullerian hormone) levels and antral follicle count were observed prior to the treatments. Elevated BMI was associated with a decrease in the total number of retrieved oocytes, albeit not significantly(12.6±7.4 vs. 10.3±6.2, p=282). However, the number of mature oocytes were significantly lower in the high BMI group (10.3±7.6 vs. 6.1± 4.6, p=0.001). Additionally, PCOS patients with a BMI ≥ 25 kg/m² required a significantly higher total gonadotropin doses (1683±422 IU vs. 1443±398, p=0.001), and also elevated BMI showed lower estradiol levels on trigger day (mean 2738±2419 vs. 4570±1156, p=0.001). Moreover, total stimulation days were also higher in the elevated BMI group but it did not reach any significance(9.6±2.2 vs. 9.1±1.3, p=0.389). The pregnancy outcomes for the study groups did not different significantly. However, the clinical pregnancy rate of the high BMI group was lower compared to the low BMI levels(41.5% vs 48.6%, p=0.527). Additionally, we performed a correlation analysis between BMI levels and the number of mature oocytes. We revealed significant correlation between number of mature oocytes and BMI levels(p=0.001) (Figure).

CONCLUSIONS: PCOS patients with a BMI ≥ 25 kg/m² experience poorer clinical pregnancy outcomes, likely attributed to lower oocyte counts, reduced estradiol levels on the trigger day, and higher gonadotropin consumption compared to patients with a lower BMI. Although we did not find any significant differences for pregnancy outcomes, the clinical outcomes of the IVF cycles were significantly different especially for the number of retrieved oocytes and the gonadotropin consumption. We think that these

differences may be important for cost-effectivity analyses particularly in developing countries.

Keywords: bmi, ivf, oocyte number, pcos, pregnancy

Correlation analysis between the number of mature oocytes and BMI



SS-38

The effect of vagınal dysbıosıs on hpv ınfectıon and preınvasıve cervıcal epıthelıal lessıons

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ABSTRACT

OBJECTIVE

Although studies in the literature have shown that increased diversity of vaginal microbiota plays a role in the development of persistent HPV infection, there is still a lack of studies evaluating its effect on women with preinvasive cervical epithelial lesions. We observed the evaluation of the effect of vaginal microbiota on HPV infection and preinvasive cervical epithelial lesions.

STUDY DESIGN

In this retrospective study (GO 22/488 registration number. Decision No: 2022/08-57), we evaluated the records of 80 patients who were HPV positive and/or had cervicovaginal cytologic abnormalities and whose vaginal microbiota homeostasis was maintained with pre-probiotic vaginal capsules (Treatment capsules (Vagiflora®), (Motiflor®)) and 82 patients who did not receive vaginal microbiota treatment but presented for routine gynecologic examination.

RESULTS

Pre- and post-treatment smear results of 80 patients in the treatment group were analyzed in terms of ASCUS. While 48.8% of the patients had abnormal (≥ASCUS) smear results before treatment, this rate decreased to 33.8% after treatment and this difference was statistically significant. In the control group, 37.8% of 82 patients who did not receive treatment had abnormal smear results in terms of ASCUS (≥ASCUS). Then, after 6 months, 24.4% had an abnormal result. This difference was not statistically significant. These data revealed the positive effect of our treatment on smear results. However, when the other findings of our study were analyzed, the treatment did not lead to a statistically significant change in LSIL and HSIL smear results.

CONCLUSION

In this study, the positive effect of treatment with probiotics on smear results was revealed. However, when the other findings of our study were analyzed, the treatment did not lead to a statistically significant change in LSIL and HSIL smear results.

Keywords: cervical cancer, cervical cancer screening, papsmear, hpv, vaginal microbiota, cervical state types

SS-39

Prospective evaluation of the role of vaginal antiseptic solution application prior to cesarean section in preventing postoperative infections

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OBJECTIVE: Postoperative infections following cesarean section (CS) contribute to increased hospitalizations and healthcare costs. Preoperative vaginal antisepsis is not routinely recommended in guidelines to reduce postoperative infectious morbidity. This study aims to investigate the role of preoperative vaginal antisepsis in preventing post-CS infectious morbidity and to assess whether specific agents used for this purpose demonstrate superiority in reducing infectious morbidity.

MATERIALS-METHODS: The study included women undergoing CS after term pregnancy at Bursa Yuksek Ihtisas Training and Research Hospital Obstetrics and Gynecology Clinic between September 2022 and June 2023. A total of 309 patients, comprising those who underwent vaginal antisepsis (n=209) and those who did not (n=100), were enrolled. All patients received routine antibiotic prophylaxis and standard 4% chlorhexidine (CH) for abdominal skin preparation before CS. The study group received either 4% CH (n=108) or 10% povidone iodine (PI) (n=101) solution for vaginal antisepsis, while the control group did not undergo any vaginal wash. Demographic characteristics, gestational age, CS type, CS indication, duration of surgery, presence and duration of membrane rupture, vaginal examinations, intraoperative blood loss, need for transfusion, preoperative and postoperative 10th-day laboratory values, postoperative 10th-day and 1-month physical examination findings were recorded and compared. The primary outcome was endometritis. Secondary outcomes included postoperative fever, surgical site infection (SSI), and neonatal outcomes.

RESULTS: Sociodemographic and obstetric characteristics, preoperative, and postoperative laboratory results of the groups receiving and not receiving vaginal antisepsis were similar. Endometritis was not detected in the group receiving vaginal antisepsis, while the rate of endometritis in the non-antisepsis group was 1% ($p>0.05$). Additionally, the need for neonatal intensive care was lower in the group receiving vaginal antisepsis compared to those who did not (1.9% vs 8%, $p=0.022$). Within the vaginal antisepsis group, the total infection rate was significantly lower in the CH subgroup compared to the PI subgroup (0.9% vs 6.9%, $p=0.031$). (0.9% vs 6.9%, $p=0.031$).

CONCLUSION: The application of vaginal antisepsis before CS is considered advantageous in terms of maternal and neonatal outcomes. A reduction in maternal infectious conditions such as endometritis and SSI may be observed with the application of vaginal antiseptic solutions. Notably, washing with 4% CH solution demonstrates superiority over 10% PI solution, particularly in patients with CH-prepared abdominal skin. Further multicenter randomized controlled trials are warranted to provide additional insights and facilitate the development of standardized preparation protocols.

Keywords: Cesarean section, Vaginal antisepsis, Chlorhexidine, Povidone iodine, Postoperative infection

SS-40

Fetal Renal Artery Doppler Evaluation In Monochorionic Diamniotic Pregnancies Complicated By Twin to Twin Transfusion Syndrome and Treated By Fetoscopic Lazer Coagulation

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OBJECTIVE: The widespread use of fetoscopic laser coagulation has enabled treating twin to twin syndrome (TTTS) efficiently. However, pre and post-operative parameters to predict the success of the procedure is limited. This study is designed to evaluate the difference in fetal renal artery Doppler (RAD) parameters before and after fetoscopic laser coagulation and to investigate the possible role of RAD to predict fetoscopic laser coagulation procedure success.

MATERİAL AND METHODS: A single center, prospective before and after (quasi-experimental) study is designed at Istanbul University Istanbul Medical Faculty Obstetrics and Gynecology Department Perinatology unit. Patients were recruited between September 2022 and April 2023. 31 monochorionic diamniotic pregnancies between 16-26 gestation week which were complicated by twin to twin transfusion syndrome (TTTS) and treated successfully with fetoscopic laser coagulation were included. Success in fetoscopic laser coagulation procedure is defined as the disappearance of TTTS criteria in the following 4 weeks after the procedure without any recurrence. Renal artery Doppler values were measured in both twins before and after the procedure and the change in renal arter Doppler values were calculated. The change in donor fetus renal artery pulsatility index (PI) was investigated as the primary outcome. Secondary outcomes were: changes in recipient fetus renal artery Doppler PI, donor fetus renal artery peak sistolic (PSV) and recipient fetus renal artery PSV.

RESULTS: Donor fetus renal artery Doppler (RAD) PI values at two occasions after the laser coagulation procedure (24-48 hours and 10-15 days) were found to be statistically lower than pre-procedure values (Table 1). Although a similar change was observed for the RAD PI values of the recipient twin immediately after the operation, there was no difference between the post-operative 24-48 hours and 10-15 day values (Table 2). Renal artery PSV values of the donor fetus were higher 24-48 hours and 10-15 days after the procedure (Table 3) and no statistically significant change between the pre and post-operative (24-48 hours) PSV values of the recipient was observed (Table 4).

CONCLUSIONS: Renal artery Doppler PI and PSV, especially donor twin values, were found to be significantly changed after successful fetoscopic laser coagulation due to the possible systemic circulatory changes. The value of fetal renal artery Doppler assessment to diagnose TTTS and to predict fetoscopic laser coagulation success should be investigated in further studies.

Keywords: twin to twin transfusion syndrome, monochorionic diamniotic twin pregnancies, fetoscopic laser coagulation, renal artery Doppler

Tables

Table 1

Donor Fetus	Mean ± SD	P value
Renal artery PI before laser coagulation	1,8 ± 0,26	<0.001
Renal artery PI 24-48 hours after laser coagulation	1,69 ± 0,22	
Renal artery PI before laser coagulation	1,8 ± 0,26	<0.001
Renal artery PI 10-15 days after laser coagulation	1,44 ± 0,26	
Renal artery PI 24-48 hours after laser coagulation	1,69 ± 0,22	<0.05
Renal artery PI 10-15 days after laser coagulation	1,44 ± 0,26	

Table 2

Recipient Fetus	Mean ± SD	P value
Renal artery PI before laser coagulation	1,82 ± 0,34	<0.001
Renal artery PI 24-48 hours after laser coagulation	1,66 ± 0,26	
Renal artery PI before laser coagulation	1,82 ± 0,34	<0.001
Renal artery PI 10-15 days after laser coagulation	1,45 ± 0,19	
Renal artery PI 24-48 hours after laser coagulation	1,66 ± 0,26	>0.05
Renal artery PI 10-15 days after laser coagulation	1,45 ± 0,19	

Table 3

Donor Fetus	Mean ± SD	P value
Renal artery PSV before laser coagulation	15,8 ± 3,25	<0.001
Renal artery PSV 24-48 hours after laser coagulation	17,3 ± 3,19	
Renal artery PSV before laser coagulation	15,8 ± 3,25	<0.001
Renal artery PSV 10-15 days after laser coagulation	20,8 ± 3,47	
Renal artery PSV 24-48 hours after laser coagulation	17,3 ± 3,19	<0.001
Renal artery PSV 10-15 days after laser coagulation	20,8 ± 3,47	

Table 4

Recipient Fetus	Mean ± SD	P value
Renal artery PSV before laser coagulation	20,1 ± 4,09	>0.05
Renal artery PSV 24-48 hours after laser coagulation	19,3 ± 3,22	
Renal artery PSV before laser coagulation	20,1 ± 4,09	>0.05
Renal artery PSV 10-15 days after laser coagulation	21,1 ± 3,42	
Renal artery PSV 24-48 hours after laser coagulation	19,3 ± 3,22	<0.05
Renal artery PSV 10-15 days after laser coagulation	21,1 ± 3,42	

Table 1-4

SS-41

Comparison of endometrial thickness on the day of embriyo transfer with the thickness on oocyte pickup day in frozen embryo transfer cycles and assessment of pregnancy rates

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OBJECTIVE: The aim of the present study is to compare the endometrial thickness measurements taken on the day of oocyte pickup (OPU) with those observed during frozen embryo transfer cycles (FET) conducted with hormone replacement therapy in patients undergoing embryo freezing after IVF treatment. Additionally, we aimed to evaluate the correlation between the percentage difference in endometrial thickness across these cycles and the clinical pregnancy rates.

METHODS: This retrospective study was carried out at the University of Health Sciences, Ankara Etlik Zübeyde Hanım Women's Health Training and Research Hospital IVF Clinic between 2007 and 2024. A total of 498 patients with an endometrial thickness of >7 mm during their embryo transfer cycles were included in the study. Data on the patients' age, obstetric history, infertility reasons, IVF protocols, measurements of endometrial thickness, and clinical pregnancy outcomes were recorded. The endometrial thickness measurements taken on the day of oocyte pickup (OPU) were compared with those observed during frozen embryo transfer cycles conducted with hormone replacement therapy in patients undergoing embryo freezing after IVF treatment. The percentage change in endometrial thickness from the OPU day to the hormone replacement therapy-assisted frozen embryo transfer cycles was calculated and categorized into increasing and decreasing percentile ranges.

RESULTS: No significant difference was observed in age, body mass index(BMI), thickness measurements on OPU day and embryo transfer day between patients with and without positive b-hCG results (Table 1). Changes in endometrial thickness were evaluated as increasing and decreasing, with increments assessed in percentile ranges. A significant increase in b-hCG positivity was found in patients with an endometrial thickness increase of 10% or more, and 15% or more (Table 2).

CONCLUSION: Over the last decade, advancements in effective and safe embryo vitrification techniques, along with efforts to prevent OHSS and the increase in preimplantation genetic diagnosis, have led to a significant rise in the global adoption of "freeze all" approach and frozen embryo transfer (FET) cycles. Despite the increase in FET cycles, the optimal protocol for endometrial preparation remains a topic of debate. It is crucial to follow an individualized approach for each patient to enhance live birth rates after FET cycles. This study concludes that a minimum of 10% increase in endometrial thickness on the day of embryo transfer compared to the thickness on OPU day significantly enhances the likelihood of b-hCG positivity. The results regarding the rates of endometrial thickness aim to minimize the financial and emotional burden on patients by facilitating individualized FET cycle selection, making informed embryo transfer decisions, and determining the optimal endometrial thickness, thus preventing unnecessary FET cycle cancellations.

Keywords: endometrial thickness, frozen embryo transfer cycle, oocyte pickup, pregnancy rates

Table 1: Demographic and FET cycle characteristics of the patients

Characteristic Mean±SD (min-max)	BHCG (+)	BHCG (-)	p
Age (years)	29.35±4.10 (20-42)	29.29±4.02 (20-38)	0.973
BMI (kg/m2)	25.93 ± 4.50 (17.9-38.5)	25.86±4.99 (15.8-41.1)	0.544
E2 on ET day (pg/ml)	1966.45±1442 (134.1-8881.1)	2048.73±1685.1 (84.9-15229)	0.542
OPU day endometrial thickness (mm)	9.75±2.13 (4.3-16.1)	9.84±1.96 (3.6-16.2)	0.074
ET day endometrial thickness (mm)	10.56±2.17 (7-18.3)	10.7±2.56 (7-23.2)	0.995
Freezing Oosit Count	2.26±1.21 (1-8)	2,34±1.24 (1-9)	0.502

Comparisons were made by Mann Whitney U test where appropriate.

Table 2: BHCG Positive rates at different levels of difference of endometrial thickness from 0% to 15%.

Difference	BHCG(+) (n=279)	P value	Sensitivity	Specificity
<0% n=184 n(%)	95 (51.6)	0.130	58.6	48.4
>0 % n=314 n(%)	184 (58.6)			
<5 % n=211 n(%)	109 (51.7)	0.092	59.2	48.3
>5 % n=287 n(%)	170 (59.2)			
<10% n=258 n(%)	133 (51.6)	0.037	60.8	48.4
>10% n=240 n(%)	146 (60.8)			
<15% n=289 n(%)	149 (51.6)	0.018	62.2	48.4
>15% n=209 n(%)	130 (56)			

Comparisons were made by chi-square test where appropriate.

SS-42

An Evaluation of Serum Blood Parameters and Amyloid-A Levels in Pregnant Women with Threatened Miscarriage

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OBJECTIVE: Threatened miscarriage, is defined as vaginal bleeding without cervical dilatation before the 20th week of pregnancy and may be accompanied by pelvic pain. Fetal causes in the etiology of threatened abortion include chromosomal and congenital anomalies and trauma due to invasive interventions for prenatal diagnosis. Fetal growth restriction (FGR), preterm labor and birth, hypertensive diseases of pregnancy, and gestational diabetes mellitus are obstetric complications associated with threatened miscarriage. Bed rest is the initially recommended treatment, the aim being to prevent patients engaging in active and heavy exercise. Oral, vaginal, or intramuscular administration of progesterone is the most commonly used medical treatment, its use being especially significant in corpus luteum failure. Amyloid A (AA), the physiological mechanism of which is not yet fully understood, is thought to play an important role in host defense.. Immunologically, serum AA induces cytokines, increases the chemotaxis of leukocytes, and causes remodeling of the extracellular matrix by increasing matrix metalloproteinases. Studies have examined whether serum AA levels can represent a biomarker for numerous tumor types, but no definitive conclusion has been reached (10). However, important findings have been obtained concerning the measurement of serum AA levels during pregnancy. For example, studies have shown an increase in serum AA levels in pregnant women who give birth prematurely (11). They have also confirmed that serum AA levels in the newborn are associated with the severity of neonatal encephalopathy, and that elevation may be an indicator of mortality. This study investigated whether serum amyloid A (AA) levels can be used as a biomarker in patients with threatened abortion.

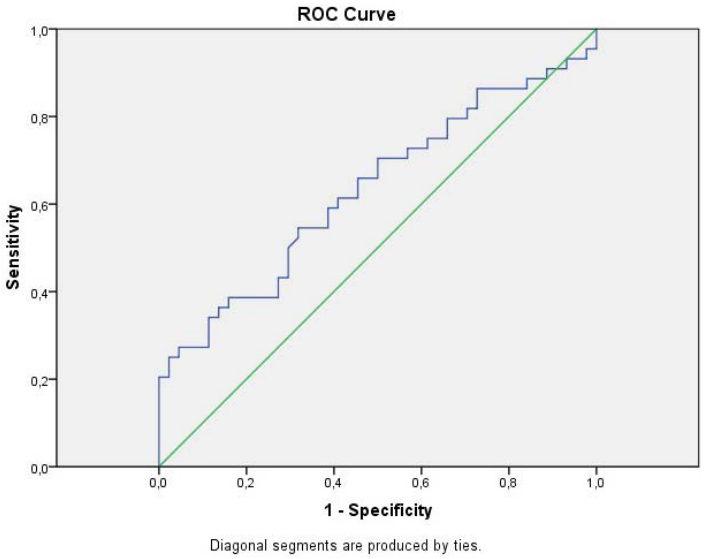
MATERIAL-METHODS: This prospective cohort study was conducted at the Antalya Training and Research Hospital, Department of Obstetrics and Gynecology, Türkiye, between April and October 2023. Eighty-eight pregnant women, 44 diagnosed with threatened miscarriage (Group 1) and 44 healthy individuals (Group 2), were included in the study. Sociodemographic, obstetric, and laboratory parameters were compared between the groups.

RESULTS: No statistically significant differences were observed between the groups in terms of sociodemographic data (age, body mass index, education level, economic status, occupation status, smoking, and alcohol consumption). However, obstetric characteristics (number of pregnancies, living children, miscarriages, dilatation and curettage, gestational age on admission, and fetal crown-rump length) and laboratory values including complete blood count, hematocrit, leukocyte, neutrophil, lymphocytes, platelet, hs-C-reactive protein, neutrophil-lymphocyte and platelet-lymphocyte ratio (p>0.05), and serum AA values (7.49±3.07 in Group 1 vs 9.46±4.80 in Group 2, p= 0.024) differed significantly. ROC analysis showed that the area under the curve (AUC: 0.662) was statistically significant for serum AA (p=0.032), with a cut-off value of ≥7.51 [95% confidence interval) 0.516-0.749, sensitivity 65%, specificity 51%]. The positive predictive value of serum AA for threatened miscarriage was 56.8%, and the negative predictive value 59.4%.

CONCLUSION: This study shows that serum AA can be used as a biomarker in the diagnosis of threatened miscarriage. Prospective studies involving more participants are now needed to confirm our results.

Keywords: Biomarker, serum Amyloid A, threatened miscarriage

ROC Curve for Serum Amyloid A.



Sensitivity, specificity, positive predictive, and negative predictive values for amyloid A

	AUC	p	Lower limit	Upper limit	Sensitivity	Specificity	PPV	NPV
Amyloid A	0.662	0.032	0.516	0.749	65%	51%	56.8%	59.4%

The participants' laboratory values.

	Control (Group 1) (n=44)	Study (Group 2) (n=44)	p
Hb (g/dl)	12.2±1.11	12.1±1.21	0.594
Hct (%)	36.5±4.68	36.1±5.2	0.590
WBC (10^3/mm^3)	9.24±1.72	9.69±2.94	0.379
Neutrophil (10^3/mm^3)	6.26±1.38	6.88±2.60	0.171
Lymphocyte (10^3/mm^3)	2.11±0.55	2.01±0.66	0.428
Platelet (10^3/mm^3)	254.16±61.45	263.91±69.95	0.489
NLR	3.17±1.19	4.14±1.29	0.146
PLR	129.73±50.57	143.62±61.55	0.236
TSH (uIU/ml)	1.48±0.84	1.58±0,97	0.639
Free T4 (ng/dl)	0.73±0.14	0.76±0.18	0.980
hs-CRP (mg/L)	5.41±4.68	5.53±4.74	0.907
hs-CRP (mg/L)	7.49±3.07	9.46±480	0.024*

The participants' sociodemographic characteristics.

	Control (Group 1) (n=44)	Study (Group 2) (n=44)	p
Age (years)	28.50±5.66	29.16±6.33	0.608
BMI (Body mass index, kg/m2)	24.60±4.57	26.79±6.21	0.071
Smoking (n, %)	9 (20.5%)	11 (25.0%)	0.611
Alcohol consumption (n, %)	2 (4.5%)	3 (6.8%)	0.644
Drug abuse (n, %)	1 (2.3%)	2 (4.5%)	0.553
Gravidity	3 (1-3)	2 (2-3)	0.823
Parity	1 (0-2)	1 (0-2)	0.152
Living children	1 (0-2)	1 (0-2)	0.103
Miscarriage	0 (0-1)	0 (0-1)	0.167
Dilatation- Curettage	0 (0-0)	0 (0-0)	0.112
Gestational age on admission (week)	12.1±3.5	11.6±4.3	0.663
CRL (mm)	11.7±3.6	11.3±4.4	0.662

SS-43

An investigation of the umbilical artery N-Terminal proBrain (NT-proBNP) of fetuses delivered by cesarean section due to fetal distress in term pregnancies

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OBJECTIVE: This study aimed to investigate umbilical artery N-Terminal proBrain (NT- proBNP) in fetuses delivered by cesarean section due to fetal distress in term pregnancies.

METHODS: This prospective case-control study was conducted at the Antalya Training and Research Hospital Obstetric Department, Türkiye. One hundred forty pregnant women were included, 70 who underwent elective cesarean sections between weeks 37 and 40 of gestation (Group 1, the control group) and 70 who underwent cesarean sections due to fetal distress (Group 2, the study group). The participants' sociodemographic and obstetric data and fetal umbilical blood NT- proBNP levels were recorded in a database.

RESULTS: While age, body mass index, gestational age, prenatal diagnostic tests, fetal anatomical scanning, and baby gender ratios were comparable between the groups (p>0.05), statistically significant differences were observed in terms of gravidity (3.0 vs 1.0 p= <0.001) and parity numbers (2 vs 0 p= <0.001), baby height (50.36±0.88 vs 49.80 ±0.86, p= <0.001) and weight (3422.43 ±409.16 vs 3239.86 ±293.74 p= 0.003), 1st minute Apgar (9.0 ±0.1 vs 8.5 ±1.3 vs p= <0.001) and 5th minute Apgar (10.0 ±0.1 vs 9.8 ±0.4 p= 0.026) scores, umbilical artery pH (7.32 ±0.05 vs 7.25 ±0.07 p= <0.001), umbilical artery base deficit (-2.48 ±1.23 vs -4.36 ±1,09 p= <0.001), and NT-proBNP levels [8.77 (7.72-9.39) vs 12.35 (9.69-12.92), p<0.001].

CONCLUSION: This study showed that NT-proBNP can be used as an important marker in the diagnosis of fetal distress. Prospective studies with more participants are now needed to confirm the accuracy of our results.

Keywords: Fetal distress, hypoxia, non-stress test, NT- proBNP, pregnancy

SS-44

Does Transfer of a Poor Quality Embryo with a Good Quality Embryo Affect Pregnancy Rates?

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The frequency of the use of assisted reproductive technology (ART) is increasing. Even though transferring good-quality embryos is preferable, for a fairly large number of patients without good quality embryos, the transfer of poor quality embryos is unavoidable. Transferring more than one embryos is usually considered in patients with unfavorable prognosis, such as poor ovarian reserve, multiple failed previous cycles or advanced age. There are very limited studies assessing the adverse effect of an additional poor quality embryo along with a good quality embryo on the pregnancy rates through fresh transfer of IVF-ICSI. Thus, the aim of the current study was to evaluate the effect of transferring one good quality plus one poor quality on clinical pregnancy and live birth rates in ART in fresh cycles. This information would be useful for clinicians to counsel patients for the management of residual poor quality embryos that are also not amenable for cryopreservation. This retrospective cohort study evaluated all women who underwent in vitro fertilization (IVF)-intracytoplasmic sperm injection (ICSI) at the IVF clinic over two years. The study was carried out with a total of 1631 cases aged between 20 and 40 years old.

Women between 20- 40 years submitted to controlled ovarian stimulation (COS) for ICSI who had an embryo formed and transferred were considered eligible. If the patient had been subjected to more than one COS cycle during this period, only data from the first cycle were included in the analysis. For controlled ovarian stimulation, we utilized a GnRH antagonist protocol. The GnRH-antagonist protocol was started on the third day of the menstrual cycle with either hMG or rFSH. Cetrorelix acetate was administered when the leading follicle reached 12 to 14mm in size. When the dominant follicle reached ≥ 18mm in the presence of at least two 16mm follicles, choriogonadotropin-alfa 250 was ordered to trigger ovulation. Oocyte retrieval was performed 35 to 36 hours after hCG injection. The mature oocytes were subjected to ICSI and cultured individually.

During the study, one embryo was transferred to patients <35 years of age in their first two IVF attempts; two embryos were transferred only after previous ≥2 failed IVF attempts. In patients who were aged ≥35 years, two embryos were transferred regardless of previous IVF attempts in accordance with the Turkish legislation of elective single embryo transfer. Clinical pregnancy per ET was named as clinical pregnancy rate (CPR) while live birth per embryo transfer was named as live birth rate (LBR) The following parameters were assessed: age, number of retrieved oocytes, number of captured metaphase II (MII) oocytes, number of formed embryos, of transferred embryos and of TQEs. Significance was evaluated at the p<0.05 level.

Our study indicated that the transfer of an additional poor quality embryo along with a top quality embryo doesn't have a favorable effect on clinical pregnancy and live birth rates. On the contrary, an additional poor quality negatively effects live birth rates. This study was a retrospective one and naturally a randomized controlled trial would be more persuasive.

Keywords: in vitro fertilization, intracytoplasmic sperm injection, embryo, pregnancy

Table-1

		Transferred Embryo Quality					p
		G1(1 TQE) (n=891)	G2 (2 TQE) (n=109)	G3 (1 TQE+ 1 PQE) (n=126)	G4 (1 PQE) (n=450)	G5 (2 PQE) (n=55)	
Age	*Mean±SD*	30.67±3.99	34.56±4.74	35.48±3.51	31.40±4.23	35.76±3.43	[1]*0.001***
Etiology	Unexplained *n;%*	309; %34.7	35; %32.1	49; %38.9	164; %36.4	20; %36.4	[2]*0.436*
	Male factor *n;%*	379; %42.5	48; %44	41; %32.5	196; %43.6	21; %38.2	
	Tubal factor *n;%*	203; %22.8	26; %23.9	36; %28.6	90; %20	14; %25.5	
Number of oocyte retrieved	*Min-Max; median*	1-25; 8	2-20; 8	2-25; 6	1-25; 6	1-19; 6	[3]*0.001***
EMB	*Min-Max; median*	1-17; 2	1-11; 3	1-20; 2.5	0-11; 1	1-7; 2	[3]*0.001***
M2	*Min-Max; median*	1-22; 6	2-17; 7	2-25; 5	1-20; 4	1-18; 4	[3]*0.001***
E2	*Mean±SD; median*	50.43±33.45; 43	51.28±22.93; 48	52.81±35.66; 44	52.06±34.6; 46	54.29±64.94; 44	[3]*0.136*
Prl	*Mean±SD; median*	1.68±0.48 ; 2	1.69±0.47; 2	1.67±0.49; 2	1.67±0.5; 2	1.73±0.49; 2	[3]*0.933*
Day	*Mean±SD; median*	8.65±1.6; 9	8.67±1.52; 9	8.62±1.43; 9	8.72±1.79; 9	8.4±1.9; 8	[3]*0.556*
Clinical Pregnancy rate	*n;%*	301; %33.8	53; %48.6	33; %26.2	76; %16.9	9; %16.4	[2]*0.001***
Live birth rate	*n;%*	235; %26.4	40; %36.7	21; %16.7	58; %12.9	7; %12.7	[2]*0.001***

Table-1 (only table)

Table-1 (results)

The study was carried out with a total of 1631 cases aged between 20 and 40 years old. The mean age is 31.67±4.39 years.

There was a statistically significant difference between the **ages** according to the transferred embryo quality (p<0.01). The mean age of Group 1 was significantly lower than Group 2 (p<0.01), Group 3 (p<0.01), Group 4 (p<0.05) and Group 5(p<0.01).

The mean age of the Group 2 was also found to be significantly lower than the Group 3 (p<0.01), Group 4 (p<0.05) and Group 5 (p<0.01).

There was no statistically significant difference between the mean ages of the other groups (p>0.05).

There was no statistically significant difference between the groups in terms of **infertility etiology** (p>0.05).

There was a statistically significant difference between the groups according to **number of oocyte retrieved** (p<0.01). The oocyte counts of the Group 3 (p<0.05), Group 4 (p<0.01) and Group 5 (p<0.05) were found to be significantly lower than the oocyte numbers of the Group 1.

The oocyte numbers of the Group 3 (p<0.01), Group 4 (p<0.01) and Group 5 (p<0.01) were significantly lower than the oocyte numbers of Group 2.

There was no statistically significant difference between the oocyte counts of the other groups (p>0.05).

There was a statistically significant difference between the groups according to **total number of embryo obtained** (p<0.01). The total number of embryo obtained of the Group 1 was lower than the embryo numbers of the Groups 2 (p<0.01) and Groups 3 (p<0.01).

The total number of embryo obtained of the Group 4 was lower than Group 1 (p<0.01), Group 2 (p<0.01), Group 3 (p<0.01) and Group 5 (p<0.01).

There was no statistically significant difference between the EMB numbers of the other groups (p>0.05).

There was a statistically significant difference between the groups according to the **M2 oocyte numbers** (p<0.01). M2 oocyte number Group 3 was lower than Group 2 (p<0.01).

The M2 oocyte number of Group 4 was lower than the M2 oocyte numbers of from Group 1 (p<0.01), Group 2 (p<0.01) and Group 3 (p<0.01).

The M2 oocyte number of Group 5 was also lower than the M2 number of Group 1 (p<0.01) and Group 2 (p<0.01). There was no statistically significant difference between the M2 oocyte numbers of the other groups (p>0.05).

There was no statistically significant difference between the groups in terms of **E2, prolactin levels and transfer days** (p>0.05).

There was a statistically significant difference between the groups according to the **clinical pregnancy rates** (p<0.01).

Pregnancy rate in the Group 1 (33.8%) was found to be significantly higher than the Group 4 (16.9%) and Group 5 (16.4%).

The clinical pregnancy rate in the Group 2 (48.6%) was found to be significantly higher than Group 1 (33.8%), Group 3 (26.2%), Group 4 (16.9%), and Group 5 (16.4%).

Clinical pregnancy rate of Group 3 (26.2%) was found to be significantly higher than Group 4 (16.9%) and Group 5 (16.4%).

There was no statistically significant difference between the clinical pregnancy rates of the other groups (p>0.05).

There is a statistically significant difference between the groups according to **live birth rates** (p<0.01).

Live birth rate of Group 1 (26.4%) was significantly higher than Group 3 (16.7%), Group 4 (12.9%) and Group 5 (12.7%).

The live birth rate in Group 2 (36.7%) was found to be significantly higher than Group 1 (26.4%), Group 3 (16.7%), Group 4 (12.9%) and Group 5 (12.7%).

There was no statistically significant difference between the live birth rates of the other groups (p>0.05)

Table-1 (results)

SS-45

Evaluation of the relationship between nausea and vomiting complaints and vitamin D levels in pregnant women

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OBJECTIVE: Hyperemesis gravidarum, also known as persistent nausea and vomiting of pregnancy, is a pregnancy complication that may progress with weight loss, electrolyte irregularity and renal dysfunction and may have serious effects on the fetus. Vitamin D is a fat-soluble vitamin that can be obtained through diet but can mainly be synthesized from the skin under the influence of ultraviolet rays. The role of vitamin D deficiency and receptor defect in common immune-mediated and inflammatory diseases has been shown. In this study, we aimed to evaluate the relationship between vitamin D levels and nausea-vomiting and hyperemesis gravidarum in pregnant women who applied to our clinic with nausea-vomiting symptoms in the first trimester.

METHOD: 140 pregnant women in the first trimester who applied to our clinic between April 2018 and March 2020 were included in the study. Demographic and clinical characteristics of the participants were recorded. Those diagnosed with gastrointestinal diseases, pregnant women with known endocrine diseases, multiple pregnancies, and pregnancies with assisted reproductive techniques were excluded from the study. Nausea and vomiting symptoms of pregnant women were scored according to the modified Pregnancy Unique Quantification of Emesis (PUQE) Scoring System. Those with a PUQE score of 6 and below constituted the normal/mild nausea and vomiting of pregnancy (NVP) group, and those with a PUQE score of 7 and above constituted the moderate and severe NVP/hyperemesis gravidarum group. In the study, moderate and severe NVP groups were considered as a single group due to the similarities in their patients' clinics and treatment modalities. Vitamin D levels; Those over 30 ng/ml were defined as adequate, those between 20-30 ng/ml as vitamin D insufficiency, those below 20 ng/ml as vitamin D deficiency, and pregnant women with levels below 10 ng/ml as severe vitamin D deficiency.RESULTS: Vitamin D levels were determined in the mild and moderate-severe NVP groups by distribution of the patients according to their Vitamin D levels. According to the PUQE scoring system, 38 (27.1%) pregnant women were found in the mild NVP group and 102 (72.9%) pregnant women were found in the moderate and severe NVP group. The median Vitamin D level was found to be statistically significantly lower in the moderate-severe NVP group compared to the mild NVP group (p:0.038).

The PUQE score of all patients in the severe vitamin D deficiency patient group was found to be compatible with the severe NVP group. Vitamin D levels of 20 patients were found to be within normal limits, and only 2 (10%) of these pregnant women were in the moderate NVP group. CONCLUSION: Vitamin D levels were found to be statistically significantly lower in patients with moderate and severe nausea and vomiting. Further studies are required for routine application of early replacement vitamin D therapy during pregnancy.

Keywords: Nausea, Vitamin D, Vomiting

SS-46

Routine Uterine Artery Ligation at Its Origin in Laparoscopic Hysterectomy: A Perspective from Resident Training

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OBJECTIVE: In conventional total laparoscopic hysterectomy (TLH), the closure of the uterine artery (UA) typically occurs towards the later stages of the surgery. An alternative approach to conventional TLH involves bilateral ligation of the UA at its origin from the internal iliac artery via a lateral approach prior to TLH. Although not yet widely practiced, this method has been shown in studies to offer advantages such as reducing blood loss compared to conventional TLH, particularly in cases involving a large uterus or presence of leiomyomas. The objective of this study is to investigate whether ligating the UA at its origin during TLH provides any benefits over conventional TLH in terms of resident training perspective.

MATERIALS-METHODS: Between January 2022 and February 2024, cases of benign TLHs performed by 2-year residents as the primary surgeon were retrospectively reviewed at the obstetrics and gynecology clinic of a training and research hospital. Sociodemographic, clinical characteristics, perioperative findings, and follow-up data of the patients were recorded from the electronic medical files. A total of 397 patients were included in the study. Patients were grouped into TLH with uterine artery ligation (UAL) performed via a lateral approach from the origin of the UA from the internal iliac artery and conventional TLH. The groups were compared in terms of age, BMI, pregnancy history, surgical indication, pre-postoperative hemoglobin values, operation time, intraoperative-postoperative complications, transfusion and intensive care need, hospitalization duration, and rehospitalization. Furthermore, residents who participated in the cases rated their overall comfort in UAL-TLH and conventional TLH using a scale ranging from 1 to 10. Additionally, subscores were generated and compared for comfort in cuff suturing and hemorrhage control. Statistical analysis was conducted using SPSS23.0 software. A significance level of $P < 0.05$ was considered statistically significant.

RESULTS: The UAL-TLH group comprised 75 patients, while the conventional TLH group included 322 patients. The groups were comparable in terms of age, BMI, gravida-parity, comorbidities, and history of prior abdominal surgery. The surgical indications were similar between the groups in terms of abnormal uterine bleeding, leiomyoma/adenomyosis, and endometrial polyp/hyperplasia. The overall complications rates were statistically similar between the UAL-TLH group (4.0%) and the conventional group (7.1%) (p=0.440). The duration of surgery was significantly shorter in the UAL-TLH group compared to the conventional group (95 min(55-150) vs. 110 min(60-250), p<0.001). There was no need for relaparotomy in the UAL-TLH group. In the other group, relaparotomy was required in 2 patients. When assessed on the resident comfort rating scale, the score in the UAL-TLH group was significantly higher than in the conventional group in terms of retroperitoneal visibility-hemorrhage control and total comfort score (8.5(5-10) vs. 7(6-8), p=0.04 and 8(7-10) vs. 7(6-8), p=0.04, respectively). The comfort score of the resident during cuff suturing was similar between the groups.

CONCLUSION: Given the short surgical duration and high comfort scores for residents in the UAL-TLH group, in the presence of an experienced second surgeon, ligating the UA at its origin during TLH can be deemed a safe method for resident training.

Keywords: Laparoscopic, Hysterectomy, Uterine Artery, Ligation

Table 1. Sociodemographic and clinical characteristics of the groups.

	UAL-TLH (n=75)	Conventional TLH (n=322)	p
Age, years	52.0 (38.0-75.0)	51.0 (39.0-78.0)	0.253
BMI, kg/m2	29.0 (20.7-41.6)	28.7 (17.8-40.4)	0.599
Gravida	3 (0-10)	3 (0-17)	0.451
Parity	3 (0-10)	3 (0-11)	0.624
Total Comorbidities, n (%) Hypertension Pulmonary Diabetes mellitus Thyroid disease Cardiovasculary Autoimmune disease Inflammatory bowel disease Malignancy	43 (57.3) 21 (28.0) 4 (5.3) 13 (17.3) 2 (2.7) 1 (1.3) 2 (2.7) 0 (0) 0 (0)	183 (56.8) 83 (25.8) 24 (7.5) 24 (7.5) 16 (5.0) 8 (2.5) 12 (3.7) 2 (0.6) 14 (4.3)	0.157
Previous abdominal surgery, n (%)	33 (44.0)	114 (35.4)	0.165
Indications, n (%) AUB Leiomyoma/adenomyosis Endometrial Polip /Hyperplasia Benign adnexial mass	14 (18.7) 19 (25.3) 24 (32.0) 18 (24.0)a	124 (38.5) 65 (20.2) 103 (32.0) 30 (9.3)	<0.001

UAL: uterin artery ligation, TLH: Total laparoscopic hysterectomy, BMI: body mas index, AUB: abnormal uterine bleeding. Values are given as medain (min-max) unless otherwise specified. Mann- Whitney U test and Chi- square test were performed. p<0.05 is considered as statistically significant. a The difference originates from this group.

Table 2. Perioperative characteristics and Resident comfort rating scale scores of the groups.

	UAL-TLH (n=75)	Conventionel TLH (n=322)	p
Preoperative Hb level, mg/dL	12.2 (6.3-15.1)	12.4 (7.5-16.0)	0.822
Postoperative Hb level, mg/dL	11.1 (7.9-14.5)	11.0 (7.2-15.4)	0.991
Duration of surgery, min	95 (55-150)	110 (60-250)	<0.001
Presence of USO/BSO, n (%)	68 (90.6)	257 (79.8)	0.089
Presence of drain catheter, n (%)	51 (68.0)	249 (77.3)	0.090
Overall Complications, n (%) Intraoperative Postoperative	3(4.0) 2 (2.7) 3(4.0)	23 (7.1) 15 (4.7) 10 (3.1)	0.440 0.751 0.718
Need for transfusion, n (%)	1 (1.3)	9 (2.8)	0.695
Relaparotomy, n (%)	0 (0)	2 (0.6)	1.000
Need for Extensive care unit, n (%)	6(8.0)	18 (5.6)	0.423
Duration of hospitalization, days	2 (1-11)	2 (1-11)	0.062
Resident comfort total rating score Cuff suturation score Retroperitoneal visibility and hemorrhage control score	8 (7-10) 8 (6-10) 8.5 (5-10)	7 (6-8) 7 (5-9) 7 (6-8)	0.044 0.135 0.041

UAL: uterin artery ligation TLH: Total laparoscopic hysterectomy, hb: hemoglobine, USO: unilateral salphingooophorectomy, BSO: bilateral salphingooophorectomy. Values are given as medain (min-max) unless otherwise specified. Mann- Whitney U test and Chi- square test were performed. p<0.05 is considered as statistically significant.

SS-47

Investigation of the effect of body mass index and physical activity level on the formation of preeclampsia

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OBJECTIVE: Preeclampsia is considered an obstetric disease characterized by hypertension and high amounts of protein in the urine. Preeclampsia risk factors;These can be listed as obesity, primary hypertension, advanced maternal age and diabetes mellitus. It is generally more common in multiple pregnancies and in women with a history of primigravida. In our study, we aimed to investigate the effect of body mass index(BMI) and physical activity level on the development of preeclampsia.

METHOD: In our study, 40 patients who underwent routine pregnancy follow-up in our hospital between 2018-2023 and were diagnosed with preeclampsia, and 40 patients whose demographic characteristics were matched, were included in the control group and the patients were evaluated retrospectively. The presence of primary-chronic hypertension, diabetes, renal disease were accepted as exclusion criteria. Demographic characteristics, anthropometric measurements, physical activity status of all pregnant women included in the study were collected from the hospital database. Height, weight measurement and BMI were evaluated. BMI values are classified according to WHO.RESULTS: When the distribution of pre-eclamptic pregnant women and healthy pregnant women according to their pre-pregnancy BMI values was examined, the value of 2(5%) pre-eclamptic pregnant patients was <20kg/m2, the value of 24(60%) patients was 20-25kg/m2, and the value of 8(20%) patients was 25-30kg/m2, 6(15%) patients had a value >30kg/m2.Among healthy pregnant women, the value of 3(7.5%) patients is <20kg/m2, the value of 27(67.5%) patients is 20-25 kg/m2, the value of 6(15%) patients is 25-30 kg/m2, 4 (10%) the patient's value was determined to be >30kg/m2.The BMI average of preeclamptic pregnant women(25.23±4.18) was found to be significantly higher than the average of healthy pregnant women(22.88±1.85)(p:0.042).Individuals were grouped according to their light, moderate and heavy physical activity values. Preeclamptic pregnant women;It was determined that 70% of pregnant women were at a light activity level before pregnancy and 10% during pregnancy, while 65% of normal pregnant women were at a light activity level before pregnancy and 10% during pregnancy.It was determined that 30% of preeclamptic pregnant women were at a medium activity level before pregnancy and 5% during pregnancy, while 35% of normal pregnant women were at a medium activity level before pregnancy and 5% during pregnancy. There were no pregnant women with high physical activity levels in either group. When the physical activity levels(PAL) of pre-eclamptic and normal pregnant women before and during pregnancy were compared, no statistically significant difference was found in PAL values before pregnancy(p:0.465), while significant decreases in PAL levels were detected during pregnancy,

especially in the pre-eclamptic group, and this difference between the groups was found to be statistically significant(p:0.045)

CONCLUSION: In our study, pre-pregnancy BMI values of pre-eclamptic pregnant women were found to be higher than normal pregnant women.In our study, it was observed that the PAL score of preeclamptic pregnant women was lower than that of healthy pregnant women. The important benefits of keeping the physical activity level at a moderate-active level should not be forgotten in preventing complications that may arise for all pregnant women, especially those who are obese.

Keywords: Body mass index, Physical activity, Preeclampsia

SS-48

Evaluation of pregnant follow-ups in the near term after the earthquake, Hatay tertiary center experiences

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PURPOSE: On February 6, 2023, a 7.8 magnitude earthquake occurred in Turkey, followed by numerous aftershocks and another 7.6 magnitude earthquake that devastated the affected areas. Among earthquake victims, more than 226,000 pregnant women in Turkey currently require medical access, according to the United Nations Population Fund (UNFPA). Earthquakes made it difficult for pregnant women to access prenatal care, including check-ups, ultrasound scans and other critical services. The destruction of hospitals and medical centers made it difficult for these women to get the care they needed. In our study, we examined the follow-up processes and results of pregnant women who applied to Hatay Mustafa Kemal University emergency department in the recent period (in April and May) after the February 6 earthquake.

METHOD: The data of pregnant women who applied to Hatay Mustafa Kemal University Emergency Department between April 2023 and May 2023 and whose data could be accessed retrospectively were examined. Demographic and clinical data of the patients were examined.

RESULTS: The average gestational week of the 75 pregnant women included in the study was 20.52 ±10.91. Gravida mean was 2.16 ±1.10. The parity average was 0.94 ± 0.87. 16 of the pregnant women (21.3%) had active complaints. The examinations of 38 pregnant women (50.6%) could be examined. The average Hb level of the pregnant women whose examinations were examined was 10.97 ± 1.25. The average number of follow-up visits of pregnant women was 2.77 ± 2.43. It was observed that 17 (22.6%) of the pregnant women included in the study had given birth, 30 (40%) were planned to be referred, and 28 (37.4%) were lost from pregnancy follow-up.

CONCLUSION: The fact that the patients were at an early gestational age suggests that those at an advanced gestational age migrated for birth. Although the number of pregnancy follow-ups decreased and they were lost to follow-up, 17 births were delivered safely, thanks to the high dedication and motivation of the healthcare team. the earthquakes in Turkey had a devastating impact on pregnant women in the affected areas. Lack of access to basic healthcare, risk of complications during childbirth, and psychological trauma and stress experienced by pregnant women are significant challenges that need to be addressed.

Keywords: Earthquake, Hatay, Pregnancy,

SS-49

A retrospective study in patients with high response blastocyte transfer comparison of frozen embryo transfer versus fresh embryo transfer results of pregnancies in Tepecik Education and Research Hospital invitro fertilization clinic

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OBJECTIVE: There has been an increasing trend in the use of frozen embryo transfer (FET) all around the world in recent years. There are medical and non-medical indications for frozen embryo transfer. In the current study, we aimed to evaluate the pregnancy results of the frozen embryo transfers retrospectively and confront them with fresh blast transfers.

METHOD: All patients undergoing FET cycle because of medical indications and all patients who were applied fresh blast transfers were scrutinized in In-Vitro Fertilization Center, Department of Obstetrics and Gynecology, Tepecik Education and Research Hospital between January 2017 and January 2019. Only patients diagnosed with PCO, unexplained infertility and male infertility were included. Single embryo transfer performed 50 FET patients and single embryo transfers performed 30 fresh blast transfer patients are included. In all cycles GnRH antagonist protocol was performed.

RESULTS: Clinical pregnancy rate in the FET patients is 62% and in the fresh blast transfers it is 33,3%. Live birth rate in the FET patients is 40,42% and in the fresh blast transfer group it is 21,42%. Although there is no statistically significant difference but in cryopreservation cycle has more clinical pregnancy rate is a remarkable finding.

CONCLUSION: It is shown that live birth rate is much more in the patients which we perform frozen embryo transfers.

Keywords: blastocyst, cryopreservation, fifth day fresh blast transfer, fresh cycle, infertility

SS-50

Comparison of blood loss and blood transfusion need in Laparoscopic and Laparotomic Myomectomy Procedures, preliminary data from a single-center study

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INTRODUCTION: In this study, we aimed to compare the outcomes of laparoscopic (L/S) myomectomy and laparotomic (L/T) myomectomy in terms of blood loss, the necessity for blood transfusion, and other relevant clinical parameters. Myomectomy, a surgical procedure for the removal of uterine fibroids, can be performed through various surgical approaches, each with its own set of advantages and challenges. The choice of technique is influenced by factors such as the size, number, and location of fibroids, as well as patient-specific considerations like fertility preservation.

METHODS: A retrospective study was conducted on 171 patients who underwent laparoscopic and laparotomic myomectomy at our institution between June 2022 and February 2024. This study aimed to determine the relationship between the chosen surgical method for myomectomy and the observed decrease in hemoglobin values, as well as the necessity for blood product replacement post-surgery. Hemoglobin levels measured in the peripheral blood during the early postoperative period (first 12 hours) were compared with those taken during routine preoperative preparation. Additionally, the study examined the relationship between the surgical procedures and various patient demographics and clinical characteristics, including age, number of myomas removed, diameter of the largest myoma in the specimens, and parity. Data for this analysis were meticulously gathered from patient medical records and archived files through the institutional computer database. Our inclusion criteria were to be older than 18 years and to have undergone laparoscopic or laparatomic myomectomy. Patients younger than 18 years of age, patients with the use of blood thinning agents, and patients with missing parameters in their medical records required for the study were excluded.

RESULTS: The analysis included 171 patients who underwent laparoscopic myomectomy (L/S) and laparotomic myomectomy (L/T) between June 2022 and February 2024. The median age of patients in the L/S group was 39 years (range: 22-50), while in the L/T group, it was 41 years (range: 23-52), with no statistically significant difference observed (p=0.344). The median number of fibroids removed was 5 (range: 1-20) for L/S and 3 (range: 1-32) for L/T, with no significant difference between the groups (p=0.324). Similarly, the median diameter of the largest fibroid was 8.75 cm (range: 1.5-20) for L/S and 8 cm (range: 1.6-30) for L/T, with no significant difference observed (p=0.303). Regarding parity, the median was 0 (range: 0-3) for L/S and 0.5 (range: 0-4) for L/T, showing a statistically significant difference (p=0.042). Preoperative hemoglobin levels were comparable between the groups, with mean values of 12.9±1.52 g/dl for L/S and 12.5±1.59 g/dl for L/T (p=0.101). The median postoperative hemoglobin drop was 2 g/dL (0.5-73) for L/S and 1.8g/dL (0-7.2) for L/T group (p=0.431). Rate of the need for postoperative blood transfusion was 4.8%

for L/S and 14% for L/T group, showing no significant difference between the groups (p=0.165).

Discussion/CONCLUSION: According to our results suggest comparable outcomes between laparoscopic and laparotomic myomectomy in terms of blood loss, transfusion requirements, and perioperative parameters.

Keywords: fibroids, myomectomy, intraoperative blood loss, haemoglobin drop, laparoscopy, laparotomy

Analysis values of laparoscopy vs.laparatomic myomectomi according to criteria

Variables	Laparoscopy	Laparotomy	p value
Age, median (min - maks)	39 (22-50)	41 (23-52)	0.344
Number of fibroids, median (min - maks)	5 (1-20)	3 (1-32)	0.324
Biggest diameter of the biggest fibroid, median (min - maks)	8.75 (1.5-20)	8 (1.6-30)	0.303
Parity, median (min - maks)	0 (0-3)	0.5 (0-4)	0.042
Preop Hb mean (±SD)	12.9 (±1.52)	12.5 (±1.59)	0.101
Hb drop, median (min - maks)	2 (0.5-7.3)	1.8 (0-7.2)	0.431
Postoperatif blood product replacement	2/42 (4.8%)	18/129 (14%)	0.165

SS-51

Results Of The Use Of Dinoprostone For Labor İnduction İn Pregnancies Complicated By İntrauterine Growth Restriction

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Aim

The suitability of the cervix is important for labor induction. A quantitative method used to predict successful labor induction is the Bishop score. Dinoprostone is a frequently used prostaglandin derivative for labor induction in pregnant women with inappropriate Bishop scores. In our study, we aimed to evaluate the effect of dinoprostone use on obstetric outcomes in pregnant women with intrauterine growth retardation (IUGR).

Method

In our study, we conducted to compare of pregnant women who were diagnosed with IUGR and planned to induce labor with pregnant women who had premature rupture of membranes (PROM) or post-term pregnancy and were planned to induce labor. For this aim, information was collected by scanning the hospital data recording system and patient files to retrospectively evaluate the results of dinoprostone use for labor induction. In our study, while the number of pregnant women with IUGR was 100, the number of PROM and post-term pregnancies that constituted the control group was taken as 219.

RESULTS: The age of the patients, gravida number, parity number, and number of abortions did not differ significantly ($p>0.05$) between the control and case groups. Bishop score, time from the beginning of induction to birth, type of delivery, 1st minute and 5th minute Apgar scores did not differ significantly ($p>0.05$) between the control and case groups. The need for a neonatal intensive care unit in the case group was significantly ($p<0.05$) higher than in the control group. In the IUGR group, the normal birth rate was found to be 88%, and the cesarean section rate was 12%. These rates are similar to the control group. In addition, the need for oxytocin after induction with dinoprostone was similar between groups.

Discussion

We showed in our study that dinoprostone used for labor induction in pregnancies complicated with IUGR when the Bishop score is not appropriate does not have a negative effect on obstetric outcomes. Using dinoprostone for induction did not increase the cesarean section rate in pregnant women diagnosed with IUGR, and the vaginal birth rate was found to be 88%.

Keywords: Dinoprostone, Intrauterine growth retardation, Labor induction

SS-52

A Retrospective Evaluation of the Sociodemographic and Clinical Characteristics of Placenta Previa and Placenta Accreta Spectrum Cases Between 2021 and 2023

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OBJECTIVE: Postpartum hemorrhage (PPH) is still one of the most important causes of maternal mortality despite advances in technology, improvements in medical care, the use of effective and powerful uterotonic agents, improved blood transfusion facilities, modernization of intensive care units, enhanced radiological intervention techniques, and surgical procedure innovations.

The most important risk factor for PPH is a previous history of uterine surgery, and the most common cause is C/S deliveries (4). The risk of placenta previa and placenta accreta spectrum (PAS) increases with each C/S delivery, and the risk of peripartum C/S hysterectomy therefore also rises. There is no doubt that when truly indicated, C/S protects the life of both the baby and the mother, and also reduces pelvic organ prolapse and lower urinary tract symptoms. While the management of placenta previa and PAS depends on the diagnosis of the case (whether adjacent organ invasion, such as accreta, increta, or percreta is present or not), the experience of the surgery and anesthesia team, the facilities available in the hospital (blood transfusion facility, the possibility of interventional procedures, etc.), and the individual's desire for fertility, PAS has been identified as an important risk factor that may require emergency peripartum hysterectomy. Focal resection and leaving the placenta in the uterus are alternative approaches for PAS, which is usually managed by means of peripartum cesarean hysterectomy, and management of PAS with a multidisciplinary team in tertiary centers can reduce morbidity and mortality. This study aimed to evaluate the demographic characteristics and maternal and perinatal outcomes of placenta previa and placenta accreta spectrum (PAS) cases in our clinic over a three period.

METHODS: The sociodemographic characteristics and laboratory results of 94 participants (control = group 1; n=30, placenta previa = group 2; n=44, and PAS = group 3; n=20) were documented and compared between the groups.

RESULTS: No difference was observed between the groups in terms of age, body mass index, number of miscarriages, educational level, economic status, area of residence, re-laparotomy, and thromboembolism rates (p>0.05). However, gravity, parity, previous cesarean sections, symptoms on admission, signs of invasion at ultrasonography, gestational age at delivery, birthweight, neonatal intensive care unit admission rate, hysterectomy rate, length of hospital stay, blood transfusion, and atony differed significantly between the groups (p<0.05).

Additionally, while preoperative the levels of hemoglobin (Hb), hemotocrit (Htc), and leukocyte count, and postoperative leukocyte count were comparable between the groups (p>0.05), postoperative hemoglobin (groups 1 vs 2, 10.96+1.78 vs 9.66+1.22; p<0.001 and groups 1 vs 3, 10.96+1.78 vs 9.37+1.20; p<0.001) and Htc (groups 1 vs 2, 32.23±2.84 vs 28.83±3.97; p=0.001 and groups 1 vs 3, 32.23±2.84 vs 28.36±3.49; p<0.001) levels differed between them.

Conclusion(s): Invasion status and timing of delivery should be determined by means of ultrasonography in cases of placenta previa and PAS. A multidisciplinary approach to pregnant women with PAS in tertiary centers and involving an experienced team is very important in reducing maternal morbidity and mortality rates.

Keywords: peripartum hysterectomy, placenta accreta spectrum, placenta previa, pregnancy

Laboratory outcomes of the participants.

	Control (Group 1) (n=30)	Placenta previa (Group 2) (n=44)	Placenta accreta spectrum (Group 3) (n=20)	1 vs 2	1 vs 3	2 vs 3
Preoperative Hb level (g/dl)	11.23±1.47	10.50±2.18	10.33±1.94	0.133	0.133	0.133
Postperative Hb level (g/dl)	10.96±1.78	9.66±1.22	9.37±1.20	<0.001*	<0.001*	0.543
p	0.076	0.010*	0.034*			
Preoperative Htc level (%)	33.01±4.57	31.39±5.75	31.57±6.10	0.560	0.560	0.560
Postoperative Htc level (%)	32.23±2.84	28.84±3.97	28.36±3.49	<0.001*	<0.001*	0.476
p	0.071	0.006*	0.028*			
Preoperative leukocyte count (103) (mcl)	11.11±2.54	12.11±5.01	12.62±4.61	0.451	0.451	0.451
Postoperative leukocyte count (103) (mcl)	12.15±2.33	13.34±4.30	13.54±3.96	0.263	0.263	0.263
p	<0.001*	<0.001*	<0.001*			

SS-53

Has the Covid - 19 pandemic changed the biochemical and clinical data of our IVF patients? Tertiary Center Experiences

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PURPOSE: Advances in treatment options along with technological and scientific developments resulting from research in the field of infertility enable new treatment approaches in cases that were previously unsolvable. COVID-19 disease (SARS-CoV-2 Disease) spread rapidly from China to the whole world in December 2019, and as of March 2020, it started to be seen in our country. The disease exhibited clinical results resulting in mortality due to asymptomatic carriage, and all elective surgical interventions had to be postponed. Our aim in this study is to investigate the differences in the biochemical and clinical data of our IVF patients before and after the pandemic.

METHOD: For our cross-sectional retrospective observational study, data of 1067 patients between 2018 and 2021 (two years before and after the pandemic), whose clinical pregnancy results were planned for diagnosis, follow-up and treatment, were obtained in our ART/IVF unit of Health Sciences University Etlik Zübeyde Hanım Gynecology Training and Research Hospital, It was scanned retrospectively from the patient registry system. Two groups were created from the patients who met the inclusion criteria in the study: 664 between March 2018 and 2020 (the date when the first case was reported in our country), and 371 between March 2020 and October 2021 (the date when the pandemic restrictions ended in our country). Demographic and clinical data of the included patients were recorded.

RESULTS: Among the groups, age (p=0.41), BMI (p=0.27), Gravida (p=0.40), Parity (p=0.10) AMH (p=0.24) values and pregnancy clinical rates.(x2,0.95) No difference was observed (p>0.05) Mens Day 3 FSH (p=0.02) LH (p=0.00) E2 (p=0.00) AFC (Antral Follicle Count) (p=0.25) IVF indications (x2.0.007) and Embryo Transfer day (x2.0.005) A statistically significant difference was observed, Mens 3rd day FSH and Mens 3rd day E2 values were lower in the post-pandemic period. Mens 3rd day LH and AFC (Antral Follicle Count) values were higher in the post-pandemic period. Among the IVF indications in the post-pandemic period, it was observed that the Male Factor increase and the 5th Day transfer rate as the Embryo Transfer day increased.

RESULT: No significant difference was observed between many parameters in the biochemical and clinical data of our IVF patients before and after the pandemic. We think that our study should be supported by more multicenter studies in order to examine the indication changes in hormone profile changes epidemiologically and to guide the fight against possible epidemics in the future.

Keywords: IVF, COVID-19, IVF indications,

VİDEO BİLDİRİLER

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

VS-01

Ruptured ectopic pregnancy after conventional microsurgical tubal reanastomosis: A Case Report:

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Objective: Some women who have undergone tubal ligation regret their decision. The alternative to regain fertility for these women is either in vitro fertilization or tubal reanastomosis. One of the adverse outcomes of tubal reanastomosis is ectopic pregnancy. Our patient in this video case report is 35 years old. The last menstrual period was 15/01/2024, and there was a history of irregular bleeding. After 3 vaginal deliveries, she underwent laparoscopic bilateral tubal ligation followed by laparotomic conventional microsurgical tubal reanastomosis surgery. The patient has been a prisoner in a closed prison for approximately 1.5 months. She was brought to the emergency departmant with a complaint of widespread abdominal pain in the morning.

Method: The patient's vital values were normal. There was widespread tenderness in the abdomen on examination, there was voluntary defense, no rebounding. White blood cell(Wbc):8500, c-reactive protein(crp):7, hemogram(hb):11.6. The differential diagnosis between plastron appendicitis and pelvic mass could not be made in the radiological ultrasound and CT tomography examinations, so I was consulted at the afternoon. During vaginal examination, the vulva and vagina appeared natural, a multiparous cervix and minimal leukorrhea discharge was observed, and colum movements were easy. On transvaginal ultrasound, the endometrium was thin and regular, the left ovary was normal and its blood supply was normal, but the right ovary could not be evaluated clearly. 75*43 mm complex pelvik mass? in the right adnexial area. Minimal fluid was observed in douglas. No free fluid was observed in the abdomen, under the liver and spleen. Tuba-ovarian abscess was not considered. Beta hCG test, tumor markers, pelvic contrast MRI, and hemogram follow-up every 6 hours were requested.

Results: Beta hcg: 172, tumor markers were negative, hb: 11.7-->10.7. Pelvic MRI was reported "A multiseptated, 50 mm diameter, dense lesion with contrasting walls is observed in the right ovarian region. The appearance may be compatible with a tubo-ovarian abscess". The patient was pre-diagnosed with right tubal ectopic pregnancy. The radiologist was contacted again and it was learned that the pre-diagnosis of appendicitis could not be excluded. The patient was taken to emergency laparoscopic surgery. In the patient, diffuse coagulation and adhesion were observed in the abdomen. Ruptured ectopic pregnancy material located in the right tubal isthmic region was removed by right salpingo-oophorectomy. The appendix was observed to be inflamed. The general surgeon on duty was invited to the surgery, and an appendectomy was performed laparoscopically.

Conclusion: In literature, rates of ectopic pregnancy after tubal reconstructive surgery range widely, from 3 to 30 percent. The patient who want to reconstructive surgery after tubal ligation should be discussed in detail for success rates, unhealthy pregnancy rates and risk factors. Assisted reproductive techniques should be explain to the patient as an option if she wishes to become pregnant. When choosing contraceptive methods at an early age, surgery may perhaps be last option and regrets may be prevented. The possibility of pregnancy should be considered under all conditions in women of reproductive age.

Keywords: case report, ectopic pregnancy, laparoscopy, tubal reanastomosis

VS-02

Laparoscopic sclerotherapy for an endometrioma

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Endometriosis affects approximately 6-10% of women in their reproductive years. It usually comprises endometrial tissues and stroma found in the peritoneum and ovary, beyond the uterine cavity. Ovarian cysts that contain fluid with remnants of menstrual tissue are known as ovarian endometriomas. Between 17% and 44% of patients with endometriosis develop these conditions. Endometriosis, a condition that affects 35-50% of women, presents as pelvic pain and infertility. The typical treatment for ovarian endometrioma involves surgical removal through laparoscopic cystectomy. It reduces endometrioma recurrence and pain. Surgical removal of the endometrioma provides a higher rate of successful pregnancy and improved overall results compared to drainage alone, with or without ablation of the pseudocapsule. Ovarian cystectomy decreases ovarian reserve. If there is no clear separation between the endometrioma and the ovarian tissue, the healthy tissue next to the cyst wall is taken out. Overcoagulation to the ovary for hemostasis is another reason. These findings have influenced endometrioma treatment to be more conservative. It is important for clinicians to inform patients about the potential loss of ovarian function following surgery. Ovarian endometrioma can be managed without surgery by using expectant management, aspiration, or sclerotherapy to protect the ovarian reserve. Sclerotherapy can decrease the elevated recurrence rate of aspiration. Either the process of "washing" or the process of "in situ retention" is performed to introduce a sclerosing agent into the cyst cavity. It disturbs the protective layer of cells in the cyst, leading to inflammation and the formation of scar tissue that will completely destroy the cyst. Sclerotherapy is beneficial for patients with ovarian endometrioma and benign ovarian cysts.

Keywords: Laparoscopic sclerotherapy, endometriosis, infertility, endometrioma

VS-03

Laparoscopic Burch Colposuspension: A video presentation

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INTRODUCTION: The incidence of stress urinary incontinence (SUI) varies between 4-35%. With increasing life expectancy, it is estimated that one in five women will undergo at least one surgical procedure for SUI and pelvic organ prolapse (POP) in their lifetime. The April 2019 NICE (National Institute for Health and Care Excellence) guideline recommends that patients scheduled for SUI surgery should be offered open or laparoscopic Burch colposuspension as a priority. In our clinic, laparoscopic Burch operation is widely used in the treatment of SUI due to the advantages of not using vaginal synthetic mesh and being a minimally invasive approach.

OBJECTIVES: We aimed to make a video presentation of a Burch colposuspension operation performed in our clinic.

CASE: A 65-year-old G3P3 patient was operated on for abnormal uterine bleeding and stress urinary incontinence refractory to medical treatment. She underwent laparoscopic hysterectomy and simultaneous laparoscopic Burch colposuspension. The patient was discharged with no postoperative complications and the post-mictional residual urine amount was 75cc. Postoperative follow-up showed that the patient's incontinence complaints regressed.

CONCLUSION: Urinary incontinence is a common symptom that adversely affects the quality of life of millions of people worldwide. Many procedures have been described for the treatment of urinary incontinence in women. Burch colposuspension is a proven method among retropubic interventions.

Keywords: Burch, laparoscopy, suspension

VS-04

Surgical treatment of a rare case of 46,XY disorder of sexual treatment

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INTRODUCTION: 46,XY partial gonadal dysgenesis (PGD) is a rare cause of disorder of sexual development (DSD) and characterized by a range of testicular dysgenesis, ambiguous genitalia, and absent/rudimentary Müllerian structures.We present the surgical management of a 21-year-old patient with 46,XY PGD,who has predominantly female external genitalia with clitoral enlargement and complete vaginal agenesis.

CASE: Our patient presented with primary amenorrhea and lack of breast development. Clitoral enlargement was present with a single urethral opening and absence of an external vaginal opening (Fig.1)Laboratory evaluation revealed low testosterone concentrations (0.3 ng/ml) with elevated FSH and LH leves.Total testosterone/dihydrotestosterone and androstenedione ratios were normal. While pelvic imaging showed no uterus and vagina, bilateral streak gonadal tissue were observed within the distal part of inguinal canals.The genetic evaluation showed a 46, XY karyotype with FISH analyses positive for the SRY gene.Detailed genetic analysis performed for a 46,XY DSD panel with targeted next generation sequencing (NGS) failed to reveal any identified mutation.Our patient was raised a female and expressed no gender identity confusion. Bilateral gonadectomy with open inguinal incisions, reduction clitoroplasy and McIndoe vaginoplasty were performed during the same session.The small dysgenetic gonads in the inguinal canals were determined preoperatively.Two full-thickness skin grafts were harvested from the bilateral inguinal incision. Reduction clitoroplasty was performed by reducing the corpus cavernosum while preserving the glans clitoris and neurovascular structures3.In the presence of a wide urethral opening without a vaginal introitus, creating the appropriate vaginal opening with a perineal approach was meticulously performed.The operation was completed by placing skin grafts into the created vaginal cavity.Pathological findings was significant for seminoma in the right testicle.A vaginal mold was left in place all day for the first 3 months and only at night for an additional 3 months. She was started on estrogen replacement for pubertal induction.Significant reduction in size of the glans and no vaginal stenosis were observed 3 months after the procedure (Fig.2). Intended Objectives

CONCLUSION: 46,XY DSD patients, especially those with genital ambiguity, are complex cases in terms of both clinical and surgical management. 46,XY PGD should be considered as a rare cause in these cases where other possible causes have been excluded. Achieving a good cosmetic result without functional loss requires a well-planned and meticulous surgical intervention. Creating a neovaginal space requires great care, especially in cases where there is no vaginal introitus.

Keywords: amenorrhea, gonadal dysgenesis, vaginoplasty

VS-05

Autologous fat grafting: video presentation

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It is important to understand that women desire vulvovaginal surgery to address both functional and aesthetic concerns. They may desire improved sexual function, improved vulvovaginal cosmesis, or improved sexual self-esteem. Soft tissue augmentation with autologous fat grafting after liposuction is an established method within plastic surgery. Following the standardization of the procedure by Coleman, the method has been effectively employed for soft tissue augmentation in various disorders.

Video presentation of an autologous fat grafting surgery performed in our clinic.

The procedure was performed with the patient in the lithotomy position under general anaesthesia. Prophylactic antibiotics, 1.5 g Cefalotin and 1.5 g metronidazole, were administered intravenously. Thereafter, approximately 150 ml of fat suspension was harvested by manual liposuction. The suspension was centrifuged for 2 minutes at 3000 rpm before the infranatant was removed. The spinning was reduced to 1000 rpm, as more cautious spinning might improve the viability of the fat graft. The fat material was then injected into the vulva.

Keywords: liposuction, vulvar fat grefting, cosmetic gynecology

VS-06

Laparoscopic hysterectomy case report: uterus totally adherent to the anterior abdominal wall

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A 54-year-old patient who had 2 cesarean sections and had no additional features in her history. She applied to the outpatient clinic because of menometrorrhagia. In the vaginal examination cervix appeared usual. In the transvaginal ultrasound, the uterus was larger than normal, heterogeneous, and an approximately 4 cm myoma was observed in the fundus. The uterine myometrium layer had an adenomatous appearance. Endometrial thickness was linear and 5 mm. A 3.5 cm anechoic cyst was observed in the right adnexial area. TLH and bilateral salpingoopherectomy was planned after the patient was informed and a written consent was obtained. The patient was placed in the lithotomy position under general anesthesia. V-Care uterine manipulator was inserted into the uterus. An incision was made from the umbilicus and a 10 mm trocar was inserted into the abdominal cavity using the open technique. Following the pneumoperitoneum, two 5 mm trocars were entered into the abdomen from the left inguinal region and the left upper abdominal quadrant. Multiple adhesions were observed during intraperitoneal observation and bridectomy was performed. The uterus was observed to be completely adherent to the anterior abdominal wall from the fundus. Bilateral tubas were observed adhered to the lateral abdominal wall. All adhesions were separated with the help of bipolar and monopolar energy modality. Afterwards, bilateral ligamentum suspansoriumovarii and cardinal ligaments were cauterized and cut with bipolar energy modality. Anterior and posterior colpotomy was performed over the sacrouterine ligaments with a ultrasonic dissection device. With a uterine manipulator, the uterus was pulled out of the vagina by holding the cervix with a single-tooth clamp, and the uterus was removed through the vaginal route. The cuff was closed with an barbed suture. The operation was terminated after bleeding control and abdominal control.

Keywords: Laparoscopic hysterectomy, menometrorrhagia, adhesiyolisis, fibroids

VS-07

Vaginally assisted laparoscopic radical hysterectomy: Vaginal manchette technique to cover the tumor

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Serviks kanseri cerrahisi için LACC çalışması sonrasında laparoskopik cerrahi konusunda güvenlik endişesi ortaya çıkmıştır. Laparoskopik cerrahinin Onkolojik sonuçları açık cerrahiye göre daha kötüdür. Vajinal manşetin oluşturulup tümörün kapatıldığı durumlarda, manipülatör de kullanılmadığı serilerde sonuçlar açık cerrahiye benzerdir. Bu video prezantasyonunda 2 cm servikal tümörü olan hasta LEEP sonrası vajinal asiste laparoskopik radikal histerektomi tekniği özellikle vajinal manşet oluşturma tekniği de prezente edilerek sunulacaktır.

Keywords: Cervical cancer, vaginally assisted laparoscopic radical hysterectomy, vaginal mancehtte formation

VS-08

Vaginally Assisted Laparoscopic Lateral Suspension VALLS

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Laparoscopic lateral suspension of uterus or vagina is a mesh-using suspension procedure for prolapsed pelvic organs. Not requiring presacral dissection, it is reported to have high objective success and lower major complication rate than laparoscopic sacrohystero/colpopexy. Only time consuming part of the procedure is the suturation of the mesh. Vaginal vesicouterine dissection and suturation of the mesh was proposed to make this part easier and quicker. We want to present our first experience of vaginally assisted laparoscopic lateral Suspension (VALLS).

Keywords: lateral suspension, vaginally assisted, pelvic organ prolapse, mesh

VS-09

Laparoscopic hysterectomy and concomitant Burch colposuspension

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AIM: This video aims to demonstrate concomitant laparoscopic hysterectomy and Burch colposuspension in a patient who was operated due to uterine fibroid and stress urinary incontinence.

METHODS: A 10 mm trocar and three 5 mm accessory trocars were placed in the umbilicus and on lateral sides respectively. Following adhesiolysis, laparoscopic hysterectomy was performed, and the vaginal cuff was sutured. The bladder was backfilled by using an indwelling catheter with 200 milliliters. Access to the prevesical space was obtained with a bipolar electrosurgical device. Cooper's ligament was visualized. The bladder neck and anterolateral vaginal fascia were identified. Two nonabsorbable sutures were placed on each side of the bladder neck and attached to the ipsilateral Cooper's ligament without tension.

FINDINGS: A 45-year-old patient with a history of three cesarean section deliveries complained of pelvis pain, pelvic pressure, and involuntary urine leakage while coughing. On pelvic examination, an enlarged, mobile uterus was palpated. The stress test was positive, and no sign of prolapsus was seen. Transvaginal ultrasound revealed a Type 5 uterine fibroid with a diameter of 6. centimeters in the posterior uterine wall at the isthmic level. Laparoscopic hysterectomy with bilateral salpingectomy and concomitant Burch Colposuspension surgery were planned.

RESULT: A well-recognized method for surgical treatment of stress urine incontinence (SUI) is Burch colposuspension. Although minimally invasive techniques such as retropubic and transobturator mid-urethral sling procedures are regarded as the "gold standard" today; a debate over the safety profile of synthetic mesh has come to attention. Such scrutiny may lead surgeons to practice and master older surgical methods for urinary incontinence such as Burch colposuspension. In light of this, Burch colposuspension can be considered as an option in patients with SUI where concomitant abdominal surgery is planned or when a non-mesh surgical procedure is chosen.

Keywords: Stress urinary incontinence, hysterectomy, minimally invasive surgery, Burch colposuspension, non-mesh surgery

VS-10

Pelvic retroperitoneal anatomy; video presentation

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Keywords: retroperiton, pelvic, anatomy

VS-11

Deep Pelvic Endometriosis Case Presentation

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Title: Case Presentation of Deep Pelvic Endometriosis: A 36-Year-Old Female Patient Presenting with Chronic Pelvic Pain and Infertility

INTRODUCTION: Deep pelvic endometriosis is a significant gynecological condition associated with clinical symptoms such as infertility and chronic pelvic pain. In this case presentation, the evaluation and treatment of a 36-year-old female patient presenting with chronic pelvic pain, dysmenorrhea, and infertility will be discussed.

Case Presentation: The patient is a 36-year-old female presenting with chronic pelvic pain, dysmenorrhea, and a desire for pregnancy for the past 3 years. She has no known medical history. Laboratory testing revealed an anti-Müllerian hormone (AMH) level of 1.8 ng/mL. Hysterosalpingography (HSG) showed bilateral tubal patency. Pelvic magnetic resonance imaging (MRI) revealed endometriomas in both ovaries and endometriosis lesions on the serosal surface of the uterus. Ultrasonography demonstrated endometriomas measuring 68x55 mm in the right ovary and 59x50 mm in the left ovary, along with a kissing ovary sign.

Diagnostic METHODS: Pelvic MRI and ultrasonography were used in the patient's diagnostic process. She underwent diagnostic laparoscopy and hysteroscopy (L/S+H/S) procedures.

Surgical Approach: The patient was advised to undergo surgical excision of endometriomas and lesions associated with pelvic endometriosis.

Surgical FINDINGS: During surgery, endometriomas in both ovaries were identified and excised. Additionally, endometriosis lesions observed on the serosal surface of the uterus and between the ovaries were removed.

Outcomes: Postoperatively, the patient was followed up, and a significant improvement in symptoms was observed. The causes of her infertility are being evaluated, and fertility treatment will be planned as needed.

DISCUSSION: This case underscores the importance of a multidisciplinary approach in the diagnosis and treatment of deep pelvic endometriosis. Surgical intervention proves to be an effective treatment option for controlling symptoms and addressing the patient's desire for fertility.

CONCLUSION: Deep pelvic endometriosis in patients presenting with infertility and chronic pelvic pain can be effectively managed with thorough evaluation and appropriate surgical treatment.

Keywords: Deep endometriosis, Pelvic pain, Quality of life

VS-12

Cornual ectopic pregnancy

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Entry: Ectopic pregnancy; is the implantation of the blastocyst outside the embryo. Its incidence is 1-2%. It is the most common cause of maternal death in the first half of pregnancy. The main cause of mortality is hemorrhage.The most important risk factor is a history of previous ectopic pregnancy, while the primary etiological factor is the distortion of tubal anatomy. In recent years, due to an increase in assisted reproductive techniques and sexually transmitted diseases, as well as earlier and more definite diagnosis, there has been an increase in the number of ectopic pregnancies. In patients presenting with pain, vaginal bleeding

CASE: Our patient, with no significant medical history, presented to our center due to thickening of the voice, especially in the jaw area, increased hair growth, thickening, and darkening of hair on the face, genital area, arms, and legs, along with amenorrhea for three months, approximately 10 years ago. During laparoscopic examination, when it was understood that the majority of the 6-7 cm cyst was a solid mass with small cystic areas, the patient underwent laparotomy, and the pathology result revealed a sex cord stromal tumor, for which right salpingo-oophorectomy was performed. The patient underwent postoperative follow-up.

On February 16, 2024, the patient presented to an external center with nausea, groin pain, and dizziness, with a beta-hCG level of 651, and was scheduled for a follow-up appointment one week later. On February 22, 2024, the patient returned to the external center with a beta-hCG level of 3984, and a 7.5 mm ectopic focus near the right cornual region was observed, with no gestational sac or yolk sac visible. The patient was referred to our center on the same day and received Rh immunoglobulin and 84 mg of methotrexate due to blood incompatibility. On February 24, 2024, the beta-hCG level was 3871, and on February 25, 2024, it was 5776. Another 84 mg dose of methotrexate was administered on February 26, 2024. On February 28, 2024, the patient's beta-hCG level was 9300, and an ultrasound showed a 11.7 mm gestational sac in the right cornual region, with a 5.6 mm yolk sac and a 2.1 mm crown-rump length (fetal heart rate absent). On February 29, 2024, a laparoscopic right cornual excision and curettage of the cavity with a Karman cannula were performed. On the first postoperative day, the patient's beta-hCG level was 4129, and she was discharged with a follow-up appointment scheduled for one week later.

Conclusıon: In this case, we want to emphasize that the ectopic pregnancy occurred again in the same region due to the distortion of tubal anatomy. A history of ipsilateral salpingectomy is a specific risk factor. Cornual pregnancies, due to their location within the myometrial part of the uterus, do not immediately produce symptoms, making diagnosis difficult. Due to the high vascularity and challenging diagnosis, they account for a significant percentage of ectopic pregnancy-related deaths. If there is no rupture, methotrexate can be administered, or laparoscopic cornuostomy or cornual excision can be performed.

Keywords: Cornual,ectopic pregnancy,resection

VS-13

Laparoscopic management of retroperitoneal angioleiolipoma

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Laparoscopy is a useful tool to evaluate and treat intraabdominal pathologies. In this video, we present a 65 years old woman with a lower abdominal pain. Pelvic MRI revealed a large (115 mm measuring) retroperitoneal mass, angioleiolipoma as a provisional diagnosis. A laparoscopy was planned. During laparoscopy 12 cm measuring mass obstructing obturators fossa was observed. Retroperitoneal dissection, ureteral dissection were carried out with the total excision of the mass. As the woman had uterine prolapse symptoms, after excision of lesion and hysterectomy (+ BSO), culdoplasty and uterosacral ligament placation was carried out. Mass was taken out vaginally in endobag. Pathology report revealed benign angioleiolipoma.

Keywords: Angioleilipoma, laparoscopy, retroperitonal mass

VS-14

The excision of giant mass with Notes surgery

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20 year old virgin women was admitted to the gynecologic oncology unit with abdominal pain.

Patient had not a surgery history.

Transabdominal ultrasound showed a 200 mm diameter, round shaped, anechoic adnexial mass at right ovarian fossa.

The tumour markers were normal.

Single port laparoscopy was planned.

The abdomen was entered through a 5 cm incision from the side of the umblicus. The gel point was placed, our exploration showed no Peritoneal involvement and that the cyst originated from the right ovary.Then, a no 10 trocar was inserted into the cyst capsule and the contents were aspirated without spilling into the abdomen. The cyst capsule was separated from the ovarian tissue. Afterwards the ovarian tissue was repaired.A partial omentectomy was performed. Lastly, after hemostasis the surgery was completed. The pathological result came out as borderline serous papillary cyst adenoma.

Keywords: Adnexial mass, Single port, laparoscopy

VS-15

A rare complication of ovarian torsion: Spontaneous oophorectomy resulting in parasitic pelvic mass

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Amerikan Hastanesi

INTRODUCTION: Ovarian torsion is defined as complete or partial rotation of ovary around its ligaments. It can affect women of any age and is a common gynecologic cause of acute pelvic pain. In its pathophysiology; excessive mobility of infindibulopelvic ligament or rotation of the ovarian tissue around infindibulopelvic ligament and the utero ovarian ligament due to adnexal mass have been held responsible. As a result of interruption of arterial, venous and lymphatic flow, edema and hemorrhage and eventually necrosis may develop. Prompt diagnosis is important for preservation of ovarian and tubal functions. When diagnosis is delayed spontaneous oophorectomy or salpingooophorectomy may result further complicating the management. In this case report we report on a patient with bilateral dermoid cysts and left spontaneous salpingooophorectomy possibly due to missed diagnosis of ovarian torsion.

Case Report

A 35-year-old woman presented with long standing abdominal-pelvic pain. 7 weeks ago, she was hospitalized twice due pain, nausea and vomiting. An ovarian cyst was seen and patient was recommended to undergo ovarian cystectomy. Analgesics were prescribed as patient declined surgery. Patient presented to our outpatient clinic with persistent abdominal pain. She reported taking analgesics regularly for pain but without relief. Her medical history was unremarkable except for a previous cesarean section 2 years ago. Transvaginal US revealed 3 ovarian cysts compatible with a dermoid. The cyst sizes were 72x40 mm in the right ovary, 40x49 mm and 28x32 mm in the left ovary. A laparoscopy was performed that showed a normal uterus with an obliterated culdesac. Left ovary and tube were not visualized in their normal anatomic location. An approximately 70 mm cyst was observed in the right ovary. Adherent to the right ovary and located in the culdesac there were two additional cysts of 3o and 40 mm in size. The mass composed of these cysts was adherent to the posterior part of the uterus and the sigmoid colon. The left ureter was retracted medially and was densely adherent to the mass in the culdesac. The mass in the culdesac was carefully dissected and liberated from the left ureter, sigmoid colon and the posterior wall of the uterus. The cysts were compatible with a dermoid. Since there was no ovarian tissue attached to this cyst and there was no blood supply, this structure was thought to be a spontaneously oophorectomized left ovary. A cystectomy was performed by stripping the 7 cm cyst in the right ovary. Postoperative course of the patient was uneventful and she was discharged the next day. She has been pain-free since then. Pathological examination of the specimens was consistent with a benign dermoid cyst.

Discussion

Women presenting with an adnexal mass and abdominal pain should be carefully evaluated for a possible diagnosis of adnexal torsion. When the diagnosis is delayed there is a possibility of

spontaneous salpingo-oophorectomy that will compromise future fertility and cause difficulty in differential diagnosis. Laparoscopy is the treatment of choice in patients with early and late diagnosis of the condition.

Keywords: torsion, spontaneus oophorectomy, ovarian reserve, pelvic mass

VS-16

Laparoscopic ureteral dissection and excision of bilateral ovarian masses

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INTRODUCTION: Ovarian metastasis associated with breast cancer is reported in the literature at a rate of 23.9-39.4%. Breast cancer that metastasizes to the ovaries is often of ductal or lobular type, and in most cases, there is a tendency for involvement of both ovaries.

CASE: A 59 years old patient (G2P2) with breast cancer,BRCA mutation is negative.Underwent mastectomy 7 years ago and hysterectomy 10 years ago.The patient was referred based on the detection of bilateral ovarian involvement on PET-CT.

FINDINGS: The ultrasound showed 6 cm solid mass in the left ovary and 3 cm solid mass in the right ovary with pathological doppler findings.The tumor markers were CA 125:17.20 U/ml(0-35), CA 15-3:16.50 U/ml(0-25), CA19-9:7.62 U/ml(0-39) At this video presentation laparascopic findings showed a close relationship between the left adnexal mass and the left ureter Peritoneum was explored, and no implants were detected in the abdominal and upper peritoneal regions. One implant was observed in the rectum and excised.

RESULTS: The pathology results indicate that the origin of the mass is invasive ductal carcinoma.

Keywords: ovarian mass,metastatic cancer,ureteral dissection

VS-17

Hydatidiform mole management and the hysteroscopic approach; a case report

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AIM: To demonstrate hysteroscopic resection of a hydatidiform mole with a surgical video and the management of molar pregnancy.

METHODS-MATERIALS: Physical examination records, blood tests, video record and other medical records of a 46-year-old woman with mole hydatidiform

RESULTS: The operation time was 20 minutes. The bleeding was 50 cc. No intraoperative and postoperative complications were observed. The patient was discharged on operation day. Pathology results were complete hydatidiform mole.

CONCLUSION: A hydatidiform mole, also known as a molar pregnancy, is a rare complication of early pregnancy that results from the incorrect fusion of reproductive cells. Patients may experience nausea, vomiting, abnormally enlarged uterine sizes, abnormal vaginal bleeding, and elevated serum beta-hCG levels. In ultrasound imaging, a molar pregnancy may appear as a cluster of grapes or show a “snowstorm” pattern. Treatment aims to remove the abnormal tissue from the endometrial cavity through dilation and curettage (D&C) or hysteroscopic resection. This is crucial to prevent complications such as persistent gestational trophoblastic disease (GTD) or, more rarely, choriocarcinoma.

Keywords: hysteroscopy, hydatidiform mole, molar pregnancy

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