TAJEV
TÜRK ALMAN JİNEKOLOJİ
EĞİTİM, ARAŞTIRMA ve HİZMET VAKFI

XV. TÜRK ALMAN JİNEKOLOJİ KONGRESİ

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23-27 Nisan 2025 / Rixos Sungate, Antalya

Bildiri Özetleri Kitabı

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İÇİNDEKİLER

Değerli Meslektaşlarım,

1995 yılından beri süre gelen uluslararası katılımlı **Türk-Alman Jinekoloji Kongresi**'nin on beşincisi **23 Nisan-27 Nisan 2025** tarihleri arasında Antalya'da gerçekleştirilecektir. Katılımcı sayısı ve yüksek kalitedeki bilimsel içeriği ile ulusal ve uluslararası düzeyde ön planda yer alan kongremizin zengin içeriğini tüm katılımcılarımıza doyurucu bir bilimsel program halinde sunmayı amaçlıyoruz. Gerçekte bir fuar olan kongremizde herkes o yılki çalışmalarını ortaya koyacak ve meslektaşları ile tartışma fırsatı bulacaktır. Güncel gelişmeleri takip edip, birlikte sorgulayıp, birlikte en iyi çözümleri bulacağımız buluşmamızda yine önceki kongrelerimizde olduğu gibi alanında konularının en iyilerinin sunumlarına şahitlik edeceğiz.

Vakfımızın diğer ayağını oluşturan Almanya'daki meslektaşlarımızın yanı sıra dünyanın dört bir yanından katılım sağlayacak meslektaşlarımız ile birbirinden özel oturumlar, canlı cerrahi sunumlar, uluslararası derneklerle düzenleyeceğimiz ortak oturumlar ile oldukça zengin bir bilimsel şölen hazırlamayı planlamaktayız. Kongrenin akışında, her konuda aktif rol alarak fikirlerinizi özgürce paylaşmanız bizi çok mutlu edecektir. Kimse kimseden daha çok bilgi sahibi değildir. Bilge insan, bilim yolunda giden, doğru bilgi birikimini paylaşan, alçak gönüllü ve eğitici olandır! Kongre programımızda yer alan ve geçen yıllardaki yoğun ilgi nedeniyle devam ettirdiğimiz, sertifiye edilen "Spesifik Kurslar" ile bilgilerimizin yanı sıra becerilerimizi de geliştireceğiz. Genç meslektaşlarımız için önem arz eden uluslararası bir toplantıda sözel sunum yapma imkanı yaratarak onları bir adım ileriye taşıyacağımıza inanıyoruz. Katılımcılarımızın, kongremize ev sahipliği yapacak olan Rixos Sungate Otel'inden memnun ayrılacaklarını umut ediyoruz. Bu otel hem bilimsel fasilitelerinin yeterliliği hem de sosyal alanlarının benzersiz oluşu ile 2025'de, 30. senemizde, sizlere yakışan ayrıcalıklı bir kongre merkezi olacaktır. 23 Nisan-27 Nisan 2025 tarihlerinde XV. Türk-Alman Jinekoloji Kongresi'nde buluşmak dileğiyle...

Prof. Dr. Cihat Ünlü
TAJEV Başkanı

Prof. Dr. Jalid Sehouli
DTGG Başkanı
ESGO President Elect

15. TÜRK ALMAN JİNEKOLOJİ KONGRESİ
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Kongre Düzenleme Kurulu Figür Kongre Organizasyonları ve Tic. A.Ş.'yi, kongrenin resmi acentası olarak belirlemiştir. Kongre hakkında herhangi bir talebinizde Figür Kongre Organizasyonları ve Tic. A.Ş.'ye başvurmanızı rica ederiz.

FİGÜR
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19 Mayıs Mah. 19 Mayıs Cad. Nova Baran Center No: 4, 34360, Şişli / İstanbul - Türkiye
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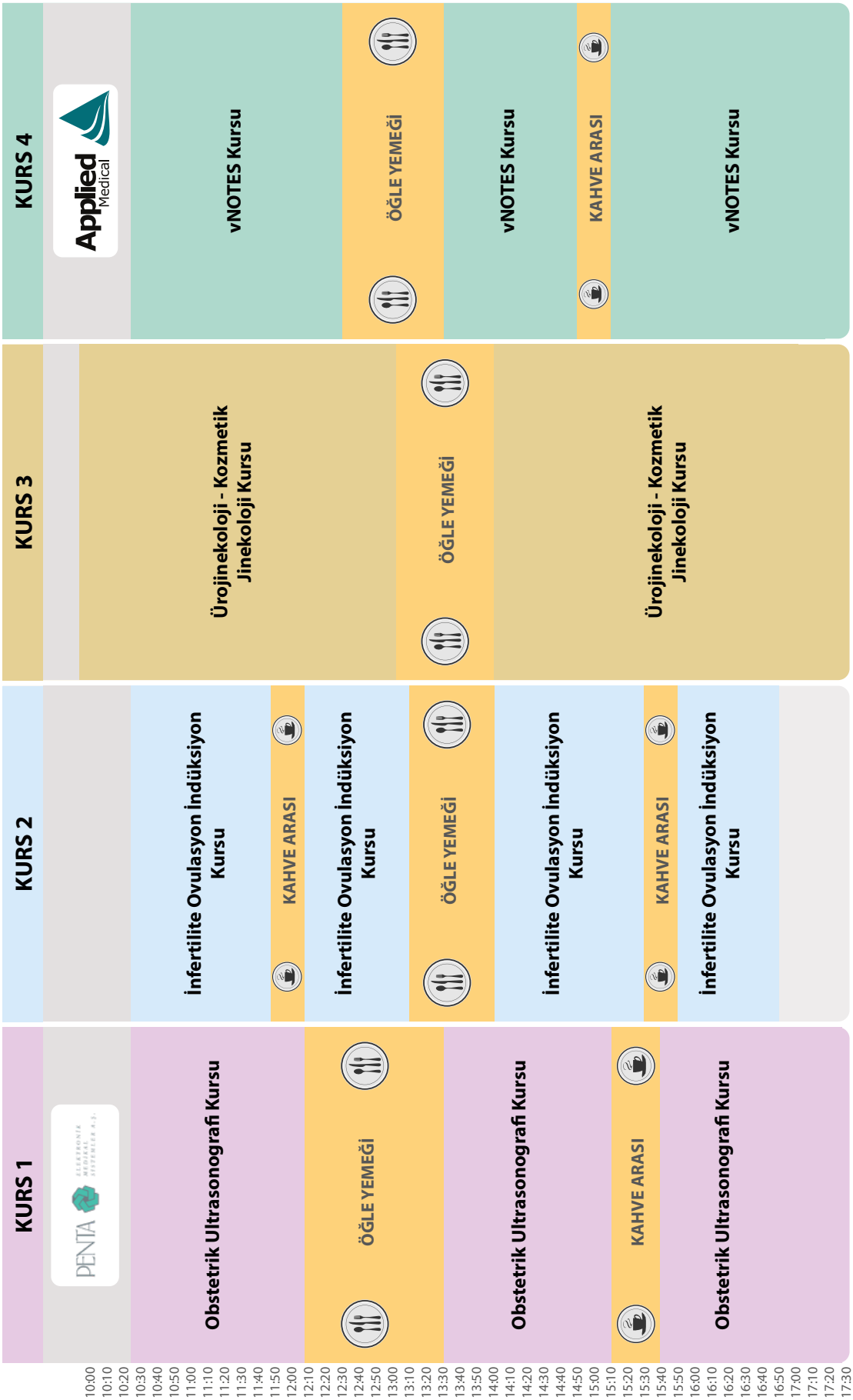
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Obstetrik Ultrasonografi Kursu
İnfertilite Ovulasyon İndüksiyon Kursu
Ürojinekoloji - Kozmetik Jinekoloji Kursu
vNOTES Kursu
ÖĞLE YEMEĞİ
KAHVE ARASI
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24 Nisan 2025, Perşembe

	SALON A	SALON B	SALON C	SALON D
09:00–09:30	KEYNOTE KONUŞMA			
09:40–10:20	Perinatoloji - İlk Trimester Tarama	Ultrasonografi	Sözel Sunumlar - 1	Sözel Sunumlar - 2
10:30–10:50	KAHVE ARASI			
11:00–11:30	UYDU SEMPOZYUMU 1 (Exeltis)			
11:40–12:50	Perinatoloji	Minimal İnvaziv Jinekoloji	Sözel Sunumlar - 3	Video Sunumlar - 1
13:00–13:50	ÖĞLE YEMEĞİ			
14:00–15:40	Polikistik Over Sendromu	Ürojinekoloji	NOGGO/DTGG Ortak Sempozyumu: Jinekolojik Onkolojide Güncelleme	Sözel Sunumlar - 4
15:30–15:40	KAHVE ARASI			KAHVE ARASI
15:50–16:30	UYDU SEMPOZYUMU 2 (ORGANON)			
16:40–17:50	Onkoloji	İnfertilite	Sözel Sunumlar - 5	Sözel Sunumlar - 6
18:00				

25 Nisan 2025, Cuma

	SALON A	SALON B	SALON C	SALON D
09:00–10:20	Jinekolojik Endoskopi	Obstetrik	Kadın Sağlığı ve İnfertilite	Sözel Sunumlar - 7
10:30–10:50		KAHVE ARASI		
11:00–11:30		UYDU SEMPOZYUMU 3 (BAYER)		
11:40–12:50	İnfertilite	Endometriozis	Almanya'da Kadın Hastalıkları ve Doğum Fellowship Programları	Video Sunumlar - 2
13:00–13:50		ÖĞLE YEMEĞİ		
14:00–15:20	Perinatoloji	Pelvik Kozmetoloji	İnfertilite	Sözel Sunumlar - 8
15:30–16:00		UYDU SEMPOZYUMU 4 (MEALIS her yaşta sağlıklı yaşam)		
16:10–16:30		KAHVE ARASI		
16:40–17:50	LIVE	CANLI CERRAHİ (Medtronic)		LIVE

26 Nisan 2025, Cumartesi

	SALON A	SALON B	SALON C	SALON D
09:00 – 09:50	Perinatoloji - Fetal Değerlendirme	Menopoz	Sözel Sunumlar - 9	Sözel Sunumlar - 10
10:00 – 10:50	KAHVE ARASI			KAHVE ARASI
11:00 – 11:40	UYDU SEMPOZYUMU 5			MSD
11:30 – 12:50	Reprodüktif Endokrinoloji	Onkoloji	İnfertilite	Video Sunumlar - 3
13:00 – 13:40	ÖĞLE YEMEĞİ			ÖĞLE YEMEĞİ
14:00 – 15:20	Perinatoloji	İnfertilite	Jinekoloji	Sözel Sunumlar - 11
15:30 – 15:40	KAHVE ARASI			KAHVE ARASI
15:50 – 16:30	UYDU SEMPOZYUMU 6			NBL PREGNA OMEGA
16:40 – 17:40	Yardımcı Üreme Teknikleri	Onkoloji	Akut Pelvik Ağrı Ayırıcı Tanı Paneli	Sözel Sunumlar - 12

27 Nisan 2025, Pazar

	SALON C	SALON D
09:00	Akılcı ilaç Kullanımı	Sözel Sunumlar - 13
09:10		
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SÖZEL BİLDİRİLER

SS-001 [Onkoloji]

A Novel Technique for Transdiaphragmatic Latero-Pericardial Cardiophrenic Lymph Node Excision Using the Minimally Invasive Surgical Access Procedure in Patient with Advanced Stage Ovarian Cancer

Candost Hanedan, Hande Nur Öncü, Tuba Zengin, Vakkas Korkmaz
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OBJECTIVE: This study reports the first case of transdiaphragmatic lateropericardial cardiophrenic lymph node excision using the GelPOINT™ mini access platform in a patient with advanced-stage ovarian cancer.

Patient: A 69-year-old woman with high-grade serous epithelial ovarian cancer.

METHODS: Cardiophrenic lymph node dissection is vital in advanced ovarian cancer surgery, as enlarged nodes are linked to poor prognosis. No clear guidelines exist for operating on patients with enlarged cardiophrenic lymph nodes.1,2 These nodes are categorized by location relative to the heart: anterior, median (lateropericardial), and posterior.3 Cardiophrenic lymph node resection can be performed using transdiaphragmatic, transxiphoid, or transthoracic approaches with VATS.4 In cases with suspicious nodes on imaging, removing them is essential for optimal cytoreduction and accurate staging. In this case, preoperative CT revealed suspicious cardiophrenic lymph nodes measuring 16x13 mm and 10x8 mm, located near the xiphoid process and lateral pericardium. A 30 mm diaphragm incision was made 60 mm from the xiphoid process. An Alexis O-wound retractor was used, and the GelPOINT™ mini platform was introduced with three ports, including one for the camera. A 30-degree optic scope was used to excise the node with LigaSure. When we needed smoke management, we used an aspirator. With this method, we were able to access distally located cardiophrenic lymph nodes with a small incision.

CONCLUSION: Transdiaphragmatic excision of the cardiophrenic lymph node using the mini access platform can be performed effectively with a smaller incision, demonstrating the feasibility and safety of this minimally invasive technique in managing such cases.

REFERENCES

1.National Comprehensive Cancer Network (NCCN). Cervical cancer (version 2.2023). Available: https://www.nccn.org/professionals/physician_gls/pdf/ ovarian.pdf [accessed 6 Sep 2023].

2.Colombo N, Sessa C, du Bois A, et al. ESMO-ESGO consensus conference recommendations on ovarian cancer: pathology and molecular biology, early and advanced stages, borderline tumours and recurrent disease. Ann Oncol 2019;30:672–705.

3.Agusti N, Bonaldo G, Kahn RM, Rosati A, Nachira D, Pan TL, Mburu A, Kochiashvili G, Paredes P, Hsu HC, Davies-Oliveira J, Ramirez PT. Cardiophrenic lymph nodes in advanced ovarian cancer. Int J Gynecol Cancer. 2024 Jan 5;34(1):150-158. doi: 10.1136/ijgc-2023-004963. PMID: 38097346

4. Martínez-Gómez C, Angeles MA, Leray H, et al. Transdiaphragmatic and transxiphoid cardiophrenic lymph node resection step-by-step in advanced ovarian cancer. Int J Gynecol Cancer

Keywords: Cardiophrenic lymph node, minimally invasive surgery, natural orifice transluminal endoscopic surgery (NOTES)

SS-002 [İnfertilite]

Autologous Intraovarian Hematopoietic Stem Cell Transplantation in IVF Patients with Diminished Ovarian Reserve or Embryo Arrest

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OBJECTIVE: Diminished ovarian reserve(DOR) and embryo developmental arrest(EDA) are significant challenges in assisted reproductive technologies(ART). This study aims to investigate the effects of intraovarian autologous hematopoietic stem cell transplantation(IOA-HSCT) on ovarian reserve parameters and embryo development in patients with DOR or EDA.

METHODS: This prospective clinical study was conducted at Ankara University Hospitals. The study protocol was approved by the university's clinical research ethics committee and the Ministry of Health's Stem Cell Research Unit. Patients with at least two previous IVF failures were included. The DOR group consisted of patients with an AMH level ≤ 0.5 ng/mL, while the EDA group included patients who had obtained at least 5 MII oocytes in previous cycles but experienced embryo arrest(no cleavage or mitotic division for ≥24 hours). Exclusion criteria included male factor, stage 3-4 endometriosis, uterine factors, hydrosalpinx, or a history of chemotherapy/radiotherapy. Autologous hematopoietic stem cells were collected from peripheral blood after mobilization with granulocyte colony-stimulating factor using the Spectra Optia apheresis device. CD34+ and CD133+ cells were isolated and injected into one ovary under laparoscopy(4.6ml per patient)(Figure 1). Ovarian reserve parameters were evaluated at baseline, 1 month, and 6 months post-procedure.

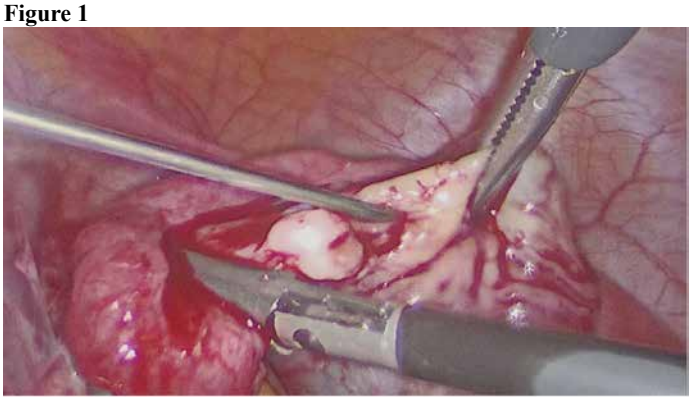
RESULTS: Fifteen patients with DOR(N=10) or EDA(N=5) were enrolled. In the DOR group, despite no change occurred in AMH levels following IOA-HSCT(baseline, 0.3±0.2 ng/mL vs. 6 month, 0.3±0.1 ng/mL, P:N.S.), an improvement in pregnancy rates was observed. Patient 5 achieved a live birth following fresh transfer of a grade A blastocyst, while patients 8 and 15 ovary delivered healthy live births following frozen embryo transfer. In patient 4 one grade A blastocyst were frozen but the patient did not request the embryo transfer yet. Patient number 4 had a spontaneous pregnancy thereafter ending up with missed abortion. Patient 13 conceived but miscarried at 7 weeks following transfer of a

grade A cleavage-stage embryo. However, three DOR patients (patients 1-3) experienced complete fertilization failure (Table 2). All but one embryo(patient 15) was generated from the IOA-HSCT treated ovary. Despite euploid embryo transfer, patients 1 and 6 did not conceive following frozen thawed embryo transfer In the EDA group, patient 7 conceived spontaneously two months post-IOA-HSCT, delivering a healthy live birth. Patient 16 generated a grade A blastocyst from the IOA-HSCT-treated ovary, though the subsequent FET failed. Two EDA patients(Patients 11-12) had adequate oocyte retrieval but complete fertilization failure (Table 3). The procedure was safe, with two minor surgical complications. The clinical pregnancy rate was 6/15(40%), the live birth rate was 4/14(26.7) following IOA-HSTC. Among the clinical pregnancies 4 conceived using ART, 2 were spontaneous. The clinical pregnancy rate using IVF in patients with DOR was 4/9(44.4%), despite no change in AMH levels.

CONCLUSION: IOA-HSCT improved clinical outcomes in study population. Notably, 2 patients failed to achieve pregnancy despite euploid embryo transfer and required further evaluation. Furthermore, 1 EDA patient achieved spontaneous pregnancy, suggesting systemic effects. However, fertilization failure persisted in some cases, indicating unresolved oocyte quality issues. Future larger studies should confirm the results of this study.

Keywords: Hematopoietic Stem Cell Transplantation, Ovarian Reserve, Infertility, in Vitro Fertilization, Embryo Development Arrest

Figure 1



Laparoscopic injection of stem cells into the ovary

Table 1

Parameters	DOR Patients (n=10)	EDA Patients (n=5)	Overall (n=15)
Age (years)	35.2 ± 4.1	33.8 ± 3.7	34.6 ± 3.9
BMI (kg/m²)	24.5 ± 3.2	23.8 ± 2.9	24.2 ± 3.1
AMH (ng/mL) - Baseline	0.3± 0.2	2.0± 1.2	0.9± 1.1
AMH (ng/mL) - 1. Mo	0.3 ± 0.2	1.5± 0.6	0.6± 0.7
AMH (ng/mL) - 6. Mo	0.3 ± 0.1	1.6± 0.2	0.7 ± 0.7
Weight (kg)	63.6 ±19.8	63.5 ± 13.8	63.6±17.2
CD34+ Cell count (x10⁶/kg)	28.8±23.3	30.7 ± 19.0	29.5 ± 21.1
Overall Cell Count (x10⁸)	17865.9± 25463.9	54986.8± 39468.6	32714.3± 35793.8

Demographic, Hematological, and Ovarian Reserve Characteristics of Patients

Table 2

Patient No	Diagnosis	No Oocyte retrieved	No of MII Oocyte	No Oocyte retrieved from Tx ovary	Notes
1	DOR	1	1	1	1 PGT-A Euploid ET (negative)
2	DOR	3	1	2	No Fertilization
3	DOR	1	1	1	No Fertilization
4*	DOR	3	3	1	1 Grade A Blast from Tx Ovary Cryo
5	DOR	1	1	1	1 Grade A Blast ET, Live Birth
6	DOR	1	1	1	1 Grade B FET, negative
8	DOR	4	2	NA**	1 FET, Live Birth
10	DOR	-	-	-	1 COS cycle canceled
13	DOR	7	1	3	1 Grade A Cleavage from HSCT ovary ET, Abortus(7 w)
15	DOR	4	2	1	1 Grade A FET From Contralateral Ovary, Live Birth

*Individual patient outcomes of DOR patients after IOA-HSCT *One spontaneous pregnancy resulted in a missed abortion during follow-up. **IVF cycle from another center*

Table 3

Patients No	Diagnosis	No Oocyte retrieved	No of MII Oocyte	No Oocyte retrieved from Tx ovary	Notes
7	EDA	NA	NA	NA	2 Mo after HSCT spontaneous pregnancy, live birth
9	EDA	DROP	DROP	DROP	DROP
11	EDA	3	1	1	No Fertilization
12	EDA	9	5	4	No Fertilization
14	EDA	10	2	6	1 Cleavage emb. From HSCT ovary Tx, negative

Individual patient outcomes of EDA patients after IOA-HSCT

SS-003 [Jinekoloji Genel]

Investigating the Protective Effects of Alprostadil Against Tissue Damage Caused by Ovarian Torsion in Rats

Irem Özge Uzunoğlu Mehrasa[1], Çağlayan Ateş[3], Funda Akpınar[2], Berna Dilbaz[2], Yaprak Üstün[4]
[1]Gölbaşı Şehit Ahmet Özsoy Devlet Hastanesi
[2]Ankara Etlik Şehir Hastanesi
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[4]Ankara Etlik Zübeyde Hanım Kadın Hastalıkları ve Doğum Hastanesi

AIM: Ovarian torsion is one of the most common gynecological emergencies.

It occurs due to the twisting of the ovary around its ligamentous attachments, resulting in tissue ischemia and increased reactive oxygen species (ROS) and oxidative stress.

Restoration of blood flow after detorsion can lead to adverse effects on the tissues.

This study investigates the role of Alprostadil in ovarian ischemia/reperfusion (I/R) injury.

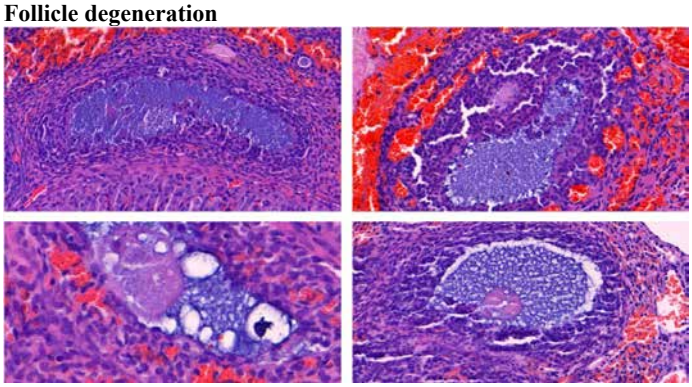
MATERIALS METHODS: Ovarian torsion was induced in female Wistar albino rats by clamping the vascular pedicle of the right adnexal area, including the ovary and uterine tube, 1 cm proximal and distal to the ovary. The rats were divided into six groups: Sham (n=7), Torsion (n=7), Torsion Detorsion (T/D, n=7), Torsion Detorsion + Saline (T/D+Saline, n=7), Torsion Detorsion + Alprostadil (T/D+Alprostadil, n=7), Torsion Detorsion + High-Dose Alprostadil (T/D+High-Dose Alprostadil, n=7).

Alprostadil was administered intraperitoneally at a dose of 10µg/kg (1 ml) and 20µg/kg (2 ml) for the high-dose group. Tissue samples were examined using hematoxylin and eosin staining. Vascular congestion, hemorrhage, leukocyte infiltration, follicular degeneration, and edema were scored from 0 to 3 for each group. The total score was recorded by summing up all the data. Residual ovary was scored from 0 to 100. The presence of hemorrhagic necrosis was evaluated. Serum samples were assessed for total antioxidant level (TAC) and total oxidant level (TOS). All data were statistically analyzed within and between groups, and significance was set at $p<0.05$. RESULTS: Compared to the Sham group, the Torsion, T/D+Alprostadil, and T/D+High-Dose Alprostadil groups showed significantly higher scores for vascular congestion ($p<0.001$, $p=0.004$, and $p=0.020$, respectively). Compared to the Sham group, the Torsion and T/D+Alprostadil groups had higher scores for hemorrhage, edema, and total histopathology ($p=0.004$, $p=0.024$, $p=0.022$, $p=0.002$, respectively, $p<0.001$). The Torsion group had higher scores for leukocyte infiltration compared to the Sham group ($p=0.010$). The Torsion, T/D, and T/D+Alprostadil groups had significantly lower residual ovarian tissue compared to the Sham group ($p<0.001$, $p=0.019$, $p=0.039$, respectively). Hemorrhagic necrosis was more frequently observed in the Torsion, T/D, T/D+Saline, and T/D+Alprostadil groups compared to the Sham group ($p=0.005$, $p=0.005$, $p=0.029$, $p=0.029$, respectively). There were no statistically significant differences in TAC levels between the groups ($p=0.127$). The T/D+High-Dose Alprostadil group had higher levels of TOS and oxidative stress index (OSI) compared to the Sham group ($p<0.001$).

CONCLUSIONS: Further comprehensive studies are needed to explore treatment options that can restore the oxidative-antioxidant

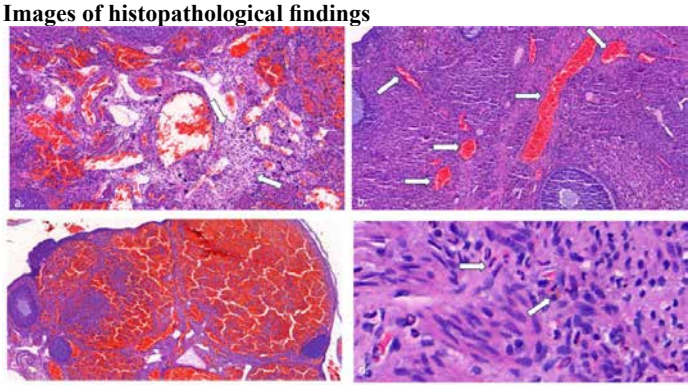
Keywords: Alprostadil, PGE1, Ovary, Torsion, TAC, TOS

Follicle degeneration



Visual showing follicular degeneration in the T/D + Alprostadil group, with signs of degeneration characterized by loss of follicular polarization, luminal basophilia, and apoptotic debris.

Images of histopathological findings



a. Stromal edema image evaluated as moderate damage in the T/D+Saline group (score 2) b. Vascular congestion image evaluated as severe damage in the T/D+Alprostadil (dose increased) group (score 3) c. Hemorrhage image evaluated as severe damage in the T/D + Alprostadil (dose increased) group (score 3) d. Leukocyte infiltration image evaluated as moderate damage in the torsion group (score 2)

Histopathology Results by Groups

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	P-value
Vascular congestion	1 (1-1)a, b, c	3 (3-3)a	2 (2-3)	2 (1,5-2,5)	3 (2-3) b	3 (2-3)c	<0,001†
Hemorrhage	1 (0-1)a, b	3 (3-3)a	2 (1-3)	1 (1-2,5)	3 (2-3) b	3 (0-3)	0,005†
Leukocyte infiltration	0 (0-0)a	2 (1-2)a	1 (0-2)	1 (0,5-1)	1 (1-1)	1 (0-1)	0,013†
Follicle degeneration	1 (0-1)	1 (1-1)	1 (0-1)	1 (0,5-1)	1 (1-2)	1 (1-1)	0,180†
Edema	0 (0-1)a, b	1 (1-2)a	1 (1-1)	1 (1-1)	1 (1-2) b	1 (1-1)	0,005†
Total score	4 (2-4)a, b	10 (8-10)a	8 (6-8)	6 (5,5-7)	9 (9-9) b	8 (4-9)	<0,001†
Residual ovary	100 (95-100)a, b, d	15 (10-20)a	25 (15-80)d	80 (30-90)	30 (20-60) b	30 (15-90)	<0,001†
Hemorrhagic necrosis	1 (%14,3)a, b, d, e	7 (%100,0) a	7 (%100,0) d	5 (%83,3) e	6 (%85,7) b	5 (%71,4)	<0,001‡

549 / 5.000 Descriptive statistics for rankable variables are shown as median (25th percentile-75th percentile). † Kruskal Wallis test, ‡ Fisher Freeman Halton test. a: Difference between Group 1 and Group 2 is statistically significant (p<0.01), b: Difference between Group 1 and Group 5 is statistically significant (p<0.05), c: Difference between Group 1 and Group 6 is statistically significant (p=0.020), d: Difference between Group 1 and Group 3 is statistically significant (p<0.05), e: Difference between Group 1 and Group 4 is statistically significant (p=0.029).

SS-004 [Obstetri Genel]

Machine Learning-Based Prediction of Delivery Mode: A Prospective Case-Control Study Using a Hybrid Approach

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AIM: Predicting the mode of delivery is critical to improving maternal and neonatal outcomes and avoiding unnecessary interventions. While traditional methods are based on more subjective judgments,they can lead to unnecessary interventions,increasing risks for the mother and the baby.The emergence of artificial intelligence has revolutionized various fields, including healthcare.Machine learning(ML) methods are increasingly preferred methods for analyzing and evaluating medical data.The integration of artificial intelligence into obstetric care is thought to have the potential to improve maternal and fetal outcomes.In recent years, ML techniques have been used to create predictive models for conditions such as preeclampsia,gestational diabetes mellitus and shoulder dystocia.This study aims to examine the effects of parameters such as maternal height,OGTT(oral glucose tolerance test) and cervical dilatation on predicting the mode of delivery using ML algorithms.

METHODS: Our study is a prospectively designed case-control study.842 pregnant women aged 18-44 years who were hospitalized in the Delivery Room of Ankara Bilkent City Hospital were included. The patients age,gravida,parity,abortion history,height,weight,week of delivery,dilatation and effacement at the time of admission,duration of the 1st and 2nd stages of labor,need and indication for cervical ripening,indication and duration of induction,delivery method,fetal weight,fetal length,apgar score,cesarean indication and OGTT parameters were recorded.The obtained records were evaluated separately with ML methods. All analyses regarding ML were performed using the R programming language,using the RWeka and e1071 packages.Variable importance was examined with Info Gain and Gain Ratio Attribute Eval tests.Machine Learning classification methods Naive Bayes,Multilayer Perceptron,AdaBoost,Decision Table,OneR and Hybrid Model(HM) were used.The data set was tested using 10-fold cross-validation and all analyzes were repeated 1000 times and the results were given.Accuracy,F-measure,Matthews Correlation Coefficient(MCC),ROC-Area and Precision-Recall Curve(PRC) Area were used as performance criteria.

RESULTS: When patients were classified according to the type of delivery,a significant difference was found in terms of weight, gravida, parity, gestational week, effacement(%), dilatation, duration of labor and second stage duration, cervical ripening, PGE2, induction time and 5th minute Apgar score ($p<0.05$). When the results were evaluated,it was seen that the created models were able to predict individuals who had vaginal delivery with high accuracy and individuals who had cesarean delivery with low accuracy.In order to increase the model accuracy,the HM approach,which has recently started to be used in the literature and consists of combining multiple methods,was used. The HM used in the study consisted of Naive Bayes, Multilayer Perceptron and AdaBoost methods.When the correct classification rate was evaluated according to F-measure and MCC values,the best result was achieved with the HM.According to the model created with the HM method, the correct classification rate was found to be 90.4%.In addition,with this model,the predicted results will be correct for 94.0% of the women we predict will have a vaginal birth and 82.2% of the women we predict will have a cesarean birth.

CONCLUSION: As a result of various ML analyses,the highest performing HM found the correct classification rate to be 0.904.In other words, 90.4% of patients whose delivery method is predicted using this method will have the correct prediction result.

Keywords: artificial intelligence, machine learing, prediction of the mode of delivery

SS-005 [Obstetri Genel]

New Second Trimester Ultrasound Scoring System In The Prediction of Preterm Birth

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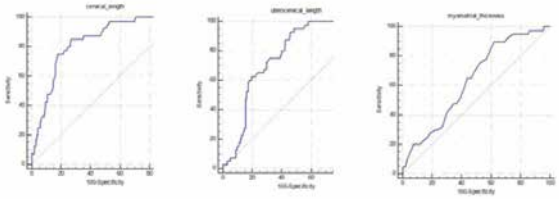
AIM: Preterm birth, defined as births occurring before 37th gestational weeks, is the leading cause of neonatal morbidity and mortality. Strategies to predict preterm birth include multifactorial risk scoring, fetal fibronectin and sonographic assessment of the cervix. Here, we aimed to develop a new scoring system by using second trimester sonographic measurements in addition to cervical dilatation. MATERIAL-METHODS: A total of 252 pregnant women who admitted to University of Health Sciences, Bursa Yuksek Ihtisas Research and Training Hospital, Department of Obstetrics Outpatients Clinic in the second trimester of pregnancy between August 2022 and September 2022 were included in this prospective study. The inclusion criteria were composed of being 18-45 years old, having singleton pregnancy, applied for routine antenatal follow-up at 16-24 weeks of gestation and gave birth in our clinic. Patients were followed and grouped as preterm birth group (n=40) and term birth group (n=212). Age, body mass index, parity, sonography week, cervical dilatation, birth weight and week, cesarean section rate, Apgar scores were recorded. Cervical length, uterocervical angle and myometrial thickness were measured and compared between groups. The predictive role of cervical length, uterocervical angle and myometrial thickness for preterm birth was evaluated with ROC analysis and a new scoring system was developed due to these cut-off values. Then, the predictive role of new scoring system for preterm birth was evaluated by ROC curve. RESULTS: There was no difference between two groups in terms of age, body mass index, parity, sonography week and cesarean section rate. In the preterm birth group, birth week, birth weight and Apgar scores were statistically significantly lower. Cervical dilatation was more common, cervical length was shorter, lower uterine segment myometrial thickness was thinner and uterocervical angle was larger in the preterm birth group as compared to term group (Table 1). Cervical length predicted preterm birth with a cut-off value of 36.3 mm with 85% sensitivity and 73.1% specificity (p<0.001, AUC=0.831) while uterocervical angle with a cut-off value of 102.1 degree predicted preterm birth with 92.5% sensitivity and 54,3% specificity (p<0.001, AUC=0.767). Additionally, myometrial thickness with a cut-off value of 5.7 mm predicted preterm birth with 90% sensitivity and 37.4% specificity (p=0.002, AUC=0.634) (Figure 1). A scoring system was created by taking into account the cut-off values of cervical dilatation, cervical length, lower uterine segment myometrial thickness and uterocervical angle (Table 2). Total score 2 and above predicted preterm birth with 75% sensitivity and 89.6% specificity (p<0.001, AUC=0.871) (Figure 2). DISCUSSION: This scoring system, which includes cervical length, uterocervical angle, lower segment myometrial thickness and cervical dilatation parameters can be used as an alternative tool to digital examination of the cervix, which is a subjective method for predicting preterm birth.

Keywords: cervical length, myometrial thickness, preterm birth, sonographic scoring system, uterocervical angle

Figure 1

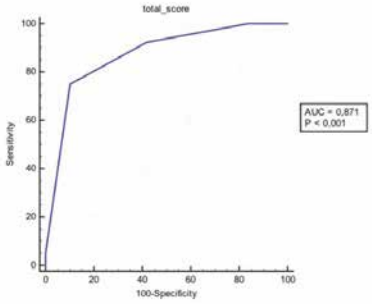
Figure 1. The ROC analysis evaluating the predictive role of (a) cervical length, (b) uterocervical angle and (c) myometrial thickness for preterm birth



The ROC analysis evaluating the predictive role of (a) cervical length, (b) uterocervical angle and (c) myometrial thickness for preterm birth

Figure 2

Figure 2. The ROC analysis evaluating the predictive role of total score for preterm birth



The ROC analysis evaluating the predictive role of total score for preterm birth

Table 1

	Preterm Birth (n=40)	Term Birth (n=212)	p
Age (year)	30 (18-41)	28 (18-42)	0.120
Body mass index (kg/m2)	26.37 (18.31-38.95)	26.1 (15.81-45.44)	0.859
Parity (n)	1 (0-6)	1 (0-5)	0.167
Sonography week (week)	20 (16-24)	20 (16-24)	0.978
Birth week (week)	35 (26-36)	38 (37-42)	<0.001
Birth weight (gram)	2407.5 ± 786.14	3274.2 ± 424.8	<0.001
Cesarean section rate (n,%)	26 (65%)	101 (47.6%)	0.066
Apgar score of first minutes	9 (0-9)	9 (6-9)	<0.001
Apgar score of fifth minutes	10 (0-10)	10 (9-10)	<0.001
Cervical dilatation (n,%)	2 (5%)	0 (0%)	0.025
Cervical length (mm)	32.79 ± 3.89	39.56 ± 5.65	<0.001
Myometrial thickness (mm)	4.7 (2.7-8.9)	5.2 (2.8-9.9)	0.007
Uterocervical angle (degree)	113.3 (97.7-146.2)	99.8 (78.8-142.8)	<0.001

Characteristics of all study group

Table 2

	Score
Cervical dilatation -Present -Absent	1 0
Cervical length (mm) - ≤36.3 mm - >36.3 mm	1 0
Myometrial thickness (mm) - ≤5.7 mm - >5.7 mm	1 0
Uterocervical angle (degree) - ≤102.1 - >102.1	0 1

The new scoring system by using sonographic measurements

SS-006 [İnfertilite]

Ovarian Hyperstimulation Syndrome Preventive Effect of Nifedipine As An Old Drug For New Target In: An Experimental Study

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Ovarian hyperstimulation syndrome (OHSS) is a life-threatening complication that usually develops as a result of triggering ovulation with human chorionic gonadotropin (hCG) after gonadotropin treatment, and in whose pathophysiology vascular endothelial growth factor (VEGF) and inflammatory mediators play a role. Nifedipine, used especially in the treatment of hypertension, is a calcium channel blocker. Nifedipine also has anti-inflammatory effects via transient receptor potential canonical (TRPC1) ion channel inhibition. VEGF also regulates the angiogenic process through TRPC channels. In our study, we investigated the potential of nifedipine to prevent OHSS due to its TRPC1 blocking effect and anti-inflammatory effects. A total of 28 rats were randomly divided into four equal groups. Group (G) 1 control group (n=7). Rats in G2 (n=7) were administered 30 IU pregnant mare serum gonadotropin for 4 days and OHSS was induced by administering 30 IU hCG on the fifth day. Rats in G3 (n=7) were induced to have OHSS and were given 100 µg/kg oral cabergoline, while rats in G4 (n=7) were induced to have OHSS and were given 20 mg/kg intraperitoneal nifedipine. On the fifth day, all rats were decapitated and VEGF, interleukin (IL)-1β, IL-6, tumor necrosis factor (TNF)-α, and hypoxia-inducible factor (HIF)-1α levels were measured in their serum and tissues. TRPC1 gene expression and immunohistochemical analysis were performed in ovarian tissue. We showed that nifedipine inhibited VEGF and some inflammatory factor levels more than cabergoline. We showed that nifedipine may achieve these effects through TRPC1 blockade and suppression of inflammatory factors.

Keywords: OHSS, rat, nifedipine, TRPC1, VEGF

SS-007 [Jinekoloji Genel]

The Role Taurine and Taurine Transporter on Aromatase Gene Expression in Endometriotic Stromal Cells

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OBJECTIVE: Endometriosis is an estrogen-dependent disorder that can result in substantial morbidity, including pelvic pain, multiple operations, and infertility. Approximately half of the patients with endometriosis are refractory to currently available treatments that create a hypoestrogenic state. In the past 20 years local aromatase gene expression and enzyme activity were demonstrated and aromatase enzyme inhibitors began to be used in treatment of endometriosis, successfully. But the problem is that, these non-spesific aromatase inhibitors also interfere with aromatase activity in cells other than endometriotic tissue. In our previous studies we showed that a histone deacetylase inhibitor, sodium butyrate (NaBu) has a promotor-specific inhibitory effect on aromatase activity in endometriotic cells and decreased the Taurine Transporter (TauT) gene expression (Figure1). In this study, we aim to understand the role of Taurine and TauT antibody on aromatase expression in endometriotic stromal cells.

MATERIAL-METHOD: Endometriotic tissues were obtained from women with confirmed histopathological diagnosis of endometriosis who admitted to Yeditepe University Hospitals. Endometrial stromal stem cells are isolated and cultured until they reach confluency. Cells are treated with Taurine (5,10,15, 20 nM and anti-TauT antibody (5 µg/mL) in time and dose dependendent manner for 12 and 24 hours. Aromatese gene expression was determined by a semi-cantitative reverse transcription-PCR method. Before doing PCR analyse, primer design was performed for the target gene Aromatase (CYP19A1) and the reference gene Beta-actin (ACTB) using gene-specific primers. PCR products were electrophoresed in 2% agarose gel, stained with Ethidium Bromide (EtBr). A 100 bp DNA ladder was used for each sample. Gels were visualized under UV transilluminator and bands were recorded digitally. In semi-quantitative analysis, band intensities of the target gene, Aromatase gene, were evaluated by comparing them to the reference gene, Beta-actin band. Only samples with positive Beta-actin bands were included in the analysis; band intensities were calculated comparatively using ImageJ software.

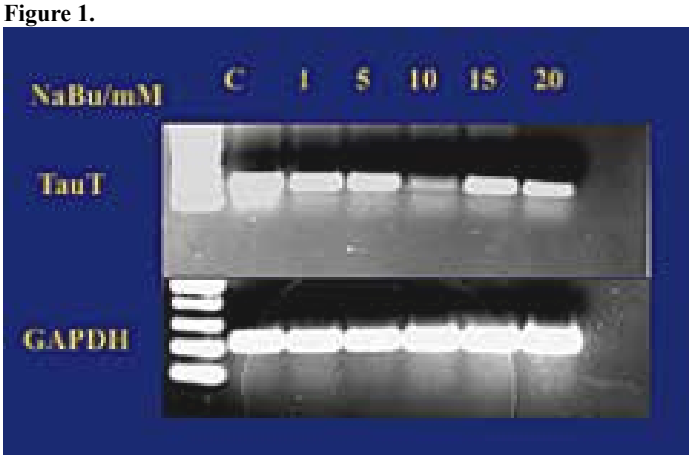
RESULTS: In this study, we showed that Taurine induces aromatase

expression in a dose and time dependent manner. This effect was significant at both 12 and 24 hours. We determined the optimal dose range as 10-15 nM. On the other hand, the use of anti-TauT antibody suppressed aromatase expression in the presence of Taurine (except for the 5nM Taurine dose) at all doses.

CONCLUSION: To date, no research has been conducted to demonstrate the role of Taurine and Taurine transporter in the etiopathogenesis of endometriosis. In this study, we have shown that Taurine and TauT induce aromatase expression. When we evaluate this finding together with our previous study in which we investigated the effect of NaBu on TauT, we presume that this effect is promoter specific via P38 and JNK pathways. Accordingly, the obtained data illuminates the mechanism of action of NaBu which is a histone deacetylation inhibitor, and anti-Taurine and Taurine Transporter antibodies may be effective in the treatment of endometriosis when its promoter specific effect is taken into account. In future studies, confirming this effect with animal experiments may offer a new treatment opportunity without suppressing estrogen synthesis in all body sites.

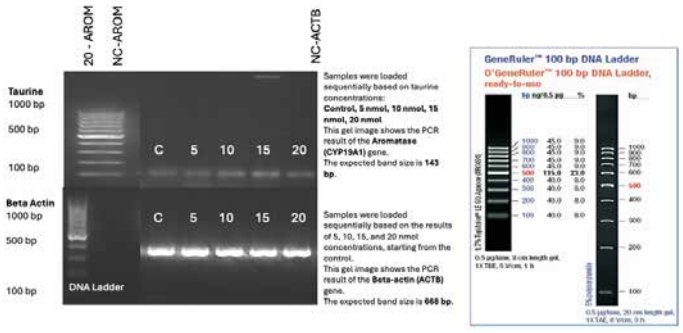
Keywords: Endometriosis, Taurine, Aromatase

Figure 1.



The effect of NaBu on TauT

Figure 2.



The effect of Taurin on aromatase expression at 12h treatment

SS-008 [Jinekoloji Genel]

A Comparative Analysis of Satisfaction, Acceptability, and Safety of Menstrual Cups Versus Sanitary Pads Among Women in Turkey: A Cross-Sectional Study

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INTRODUCTION: Menstrual hygiene products have undergone significant advancements, with menstrual cups emerging as an eco-friendly and cost-effective alternative to sanitary pads. While menstrual cups offer advantages such as longer wear time, reduced waste, and cost savings, their adoption remains limited due to discomfort, hygiene concerns, and cultural perceptions. This study aims to compare the satisfaction, acceptability, and safety of menstrual cups versus sanitary pads among women in Turkey, contributing to the growing body of research on menstrual health and sustainable product choices.

Materials and METHODS: A cross-sectional study was conducted among 667 women aged 18–49 years with regular menstrual cycles. Participants were categorized into two groups: menstrual cup users (n=331, 49.6%) and sanitary pad users (n=336, 50.4%). Inclusion criteria required menstrual cup users to have at least six months of experience. Exclusion criteria included pregnancy, breastfeeding, urogenital infections, or medical conditions preventing the use of menstrual products.

Data were collected through an online survey between June and October 2023. The survey included three sections. The first section covered demographic and menstrual characteristics, including age, BMI, menarche age, cycle duration, parity, and gravida. The second section focused on satisfaction and acceptability metrics, evaluating factors such as comfort, leakage, insertion, hygiene, and overall satisfaction using a 7-point Likert scale. The final section assessed safety metrics, including vaginal irritation, pain, vaginitis, and toxic shock syndrome. Statistical analyses were performed using IBM SPSS 25.0, with significance set at $p<0.05$.

RESULTS: In terms of demographics, menstrual cup users had a significantly lower gravida (3.05 ± 2.01) compared to sanitary pad users (3.35 ± 2.08, p = 0.047). Additionally, a higher percentage of menstrual cup users reported having "light" menstrual flow (24.8%) compared to sanitary pad users (15.8%, p = 0.013). However, there were no significant differences between the groups in terms of age, BMI, menarche age, or cycle duration.

Regarding satisfaction and acceptability, no statistically significant differences were observed between menstrual cup and sanitary pad users in terms of leakage, comfort, insertion, hygiene, or overall satisfaction. Both groups reported similar mean scores across these parameters, suggesting that user experiences with these menstrual products were comparable.

Safety analysis revealed that among menstrual cup users, 8.4% reported

vaginal irritation, 15.7% experienced pain during removal, 14.2% reported pelvic pain, and 0.3% had toxic shock syndrome. The incidence of these adverse effects was consistent with global findings on menstrual cup safety.

The survey demonstrated high internal consistency, with a Cronbach's alpha of 0.952, indicating strong reliability in measuring satisfaction and acceptability metrics.

DİSCUSSİON and CONCLUSION: Menstrual cups and sanitary pads provide comparable satisfaction levels, with menstrual cups offering environmental and cost benefits. Despite minor safety concerns, the overall acceptance rate suggests that menstrual cups are a viable alternative for menstrual hygiene management. However, cultural and educational barriers influence adoption rates in Turkey. Public health initiatives should focus on awareness campaigns to promote menstrual cup use and address misconceptions. Future research should explore longitudinal data on safety, usability, and long-term acceptability of menstrual cups in different populations.

Keywords: Menstrual cup, sanitary pad, satisfaction, safety, acceptability

SS-009 [Ürojinekoloji - Rekonstrüktif cerrahi]

The Psychosexual and Psychosocial Impacts of Female Genital Mutilation: A Cross-Sectional Study among Somali Women

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BACKGROUND: Female genital mutilation (FGM), also known as female circumcision or cutting, is the partial or total removal of the external female genitalia for non-medical reasons, which is common in many African countries. This study aimed to document the psychosexual and psychosocial problems of Somali women engaged in FCM. METHODS: This cross-sectional study included 753 consecutive women who had presented between September 1 and November 31, 2023, to the Department of Gynaecology of Mogadishu Somali Turkey Training and Research Hospital in Mogadishu, the capital city of Somalia. Data included maternal age, age of marriage, age of FGM, type of FCM (I, II, III, and IV), education, family income, residence area (rural or urban), the person who decides on FGM, where FGM is performed, and a person who this FCM operation. The participants were asked to complete two questionnaires: the Female Sexual Function Index (FSFI) and the Brief Symptom Inventory-18 (BSI-18). RESULTS: Of 753 women, 707 (93.8%) had FGM varying severity, and 46 (28.3%) had without FCM. Most FCM patients (47.1%, 332/707) had type II, followed by type III (28.1%, 199/707), type I (18.9%, 134/707), and type IV (5.9%, 42/707) forms. The age of FCM was 8.0±1.8 years (2-21). The mean age was 29.2±7.1 years (range 14-56). The two groups were similar with respect to family income and area of residency (p > 0.05). The overall incidences of sexual dysfunction were 62.8%. Women with FCM differed from those without FCM with significantly higher rates of illiterateness (35.2% vs 21.7%, p = p=0.047) and primary school (14.3% vs 8.7%, p = 0.047). Women with FCM had significantly lower scores in the desire, arousal, lubrication, orgasm, and satisfaction sub-domains; a significantly higher pain score; and sexual dysfunction, as defined by a total score of less than 26.55, was prevalent in both groups (64.8% for FCM vs 34.8% for no-FCM), with a significantly increased rate among women in FCM (p = 0.0001). Women with FCM had significantly higher scores of anxiety, depression, and somatization. Women with FCM were associated with significantly higher levels of anxiety, depression, and somatization (p<0.05) In regression analysis, FCM was in significant inverse associations with all FSFI subdomain scores and sexual dysfunction and in significant associations with the BSI all subdomain scores of anxiety, depression, and somatization (p<0.05). Increased Sexual dysfunction gradually increases with Female genital mutilation types. CONCLUSION: Our findings suggest that women in FCM experience considerably higher psychosexual and psychosocial adverse effects as compared with their non-FCM counterparts. Our findings exemplify how difficult life is for women living in an underdeveloped and resource-limited country like Somalia. Apart from providing the necessary education and training to all parties concerned, i.e., patients and health policymakers, it should be noted that a great majority of problems encountered in underdeveloped countries are of international nature and thus cannot be solved without international cooperation and collaboration.

Keywords: FCM, Somalia, psychosocial, psychosexual

Regression analysis showing associations between FGM and no-FGM and FSFI, and BSI

Table. Regression analysis showing associations between FGM and no-FGM and FSFI, and BSI

Multivariate analysis		OR	95% CI		p
Education status					
Illiterate		2.62	1.54	4.46	**0.001**
Primary school		1.28	0.99	1.65	0.060
Secondary and/or high school		1.50	0.86	2.61	0.154
Binary analysis					
Area of residency		0.88	0.50	1.55	0.660
Arranged marriage		1.08	0.75	1.57	0.678
RSE: low self-esteem		0.93	0.60	1.43	0.725
Sexual dysfunction		3.0	1.6	5.5	**0.0001**
Univariate analysis	**Estimate**	**SE**	**95% CI**		
FSFI					
Desire	-0.355	0.1138	-0.578	-0.131	**0.002**
Arousal	-0.428	0.1099	-0.644	-0.213	**0.0001**
Lubrication	-0.139	0.0987	-0.332	0.0553	**0.001**
Orgasm	-0.267	0.0969	-0.458	-0.0772	**0.006**
Satisfaction	-0.393	0.1122	-0.613	-0.172	**0.0001**
Pain	0.0574	0.0787	-0.0972	0.212	**0.001**
BSI					
Anxiety	1.02	0.392	0.25	1.79	**0.01**
Somatization	2.34	1.00	0.372	4.30	**0.02**
Depression	1.00	0.346	0.322	1.68	**0.004**

Reference: Monogamous marriage for sexual function, university education for education level, <$500 for income. FSFI: Female Sexual Function Index; BSI: Brief Symptom Inventory. OR: Odds ratio; SE: Standard error, CI: Confidence interval

Table Comparison of FGM and no FGM with respect to education status, area of residency, husband income, scores on FSFI and BSI

Table Comparison of FGM and no FGM with respect to education status, area of residency, husband income, scores on FSFI and BSI			
Parameters	**No FGM (n=46), n (%)**	**FGM (n=707), n (%)**	**p***
Age (years), mean±SD	26.8±5.3	29.4±7.2	**0.029***
Education status n (%)			**0.047****
Illiterate	10 (21.7)	249 (35.2)	
Primary school	4 (8.7)	101 (14.3)	
Secondary and/or high school	16 (34.8)	215 (30.4)	
University	16 (34.8)	142 (20.1)	
Area of residency			0.820**
Rural	5 (11.7)	74 (10.5)	
Urban	41 (88.3)	633 (89.5)	
Husband income ($ USA) n (%)			0.081**
<500	24 (52.0)	263 (37.2)	
,,500-1000	21 (45.5)	403 (57.0)	
>1000	1 (2.5)	41 (5.8)	
FSFI mean±SD			
Desire	4.4±1.3	4.0±1.3	**0.002***
,Arousal	4.5±1.2	4.0±1.2	**0.0001***
Lubrication	4.1±1.1	3.8±1.1	**0.002***
Orgasm	4.4±1.1	4.1±1.1	**0.006***
Satisfaction	4.6±1.2	4.3±1.3	**0.0001***
Pain	3.3±0.9	3.9±0.8	**0.002***
Sexual dysfunction n (%)	16 (34.8)	457 (64.6)	**0.0001***
BSI mean±SD			
Depression	4.06±4.1	4.8±3.9	**0.020***
Anxiety	4.04±4.4	5.1±4.2	**0.010***
Somatization	4.23±4.1	4.9±4.0	**0.015***
**Chi-squared test; *Independent-Samples T Test; SD: standard deviation; FSFI: Female Sexual Function Index; BSI: Brief Symptom Inventory.			

SS-010 [Jinekoloji Genel]

Bilateral Pleural Effusion as a severe complication of Tubo Ovarian Abscess

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OBJECTIVE: This case report presents a rare complication of tubo-ovarian abscess (TOA) leading to systemic infection, respiratory distress, and bilateral pleural effusion, requiring surgical intervention.

METHOD: A 48-year-old female was admitted with abdominal pain, distention, fever, and vaginal discharge. Imaging revealed a 6 cm TOA and uterine calcifications. Despite hospitalisation and administration of intravenous (IV) antibiotics, the patient's condition deteriorated with worsening inflammatory markers and new-onset respiratory symptoms. Computed tomography (CT) angiography confirmed bilateral pleural effusion. Anticoagulation, respiratory support, and diuretic therapy were initiated, but clinical improvement was insufficient. Due to persistent infection, an open hysterectomy was performed. Postoperatively, the patient required intensive care management, blood transfusion, and ultrasound-guided pleural drainage.

RESULTS: Despite broad-spectrum IV antibiotic therapy, the infection progressed, necessitating surgical intervention. Following hysterectomy and multidisciplinary management, including respiratory support and pleural drainage, oxygen saturation improved, and the patient was discharged with stable vital signs.

CONCLUSION: This case highlights the potential for severe systemic complications of TOA, including pleural involvement. Early recognition, aggressive medical therapy, and timely surgical intervention are essential for managing complex cases and preventing further deterioration.

Keywords: tubo-ovarian abscess (TOA), pleural effusion, systemic infection

Figure 1

Left Sided CXR image taken on 02/02/2025 shows normal findings Right Sided CXR image taken on 04/02/2025 shows findings consistent with Bilateral Pleural Effusion

Figure 2

Left Sided CXR image taken on 07/02/2025 shows partial recovery Right Sided CXR image taken on 12/02/2025 shows complete resolution of Pleural Effusion

SS-011 [Endoskopi]

A Rare Case of Endometriosis: Vaginal and Rectal Involvement Without Ovarian Involvement

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OBJECTIVE: Endometriosis is a chronic inflammatory disease characterized by ectopic endometrial tissue implantation outside the uterus. Deep infiltrative endometriosis (DIE) involving the rectovaginal space without ovarian involvement is an uncommon presentation. This case report aims to describe the diagnosis and surgical management of a rare case of DIE affecting the posterior vaginal fornix and rectum without ovarian lesions.

METHODS: A 39-year-old female, gravida 2 para 2, presented with chronic pelvic pain persisting for several years. Physical examination revealed tenderness during vaginal examination and fibrotic changes in the posterior vaginal fornix. Transvaginal ultrasound showed a normal-appearing uterus with fibrotic alterations in the posterior fornix and normal ovaries. Colonoscopy, performed due to the suspicion of rectal involvement, identified a mass causing luminal narrowing of the rectum. The patient was preoperatively evaluated by a multidisciplinary team, including general surgery, and was scheduled for surgical intervention with a preliminary diagnosis of deep infiltrative endometriosis.

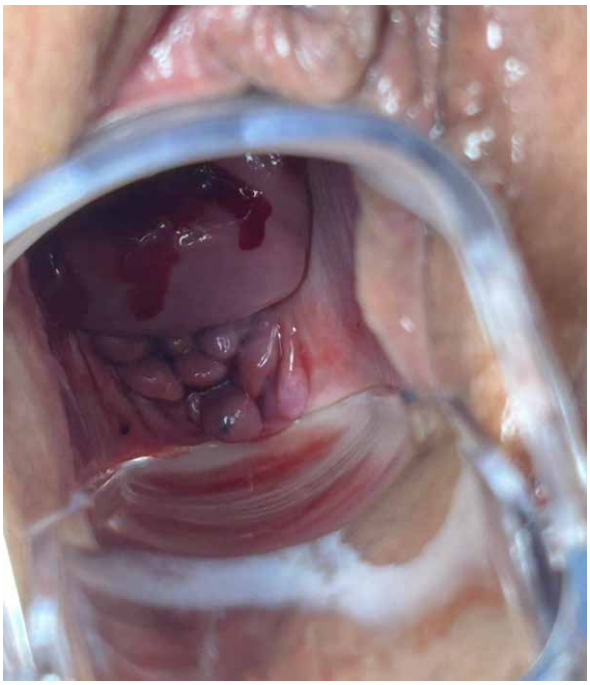
RESULTS: During laparoscopic exploration, the uterus and bilateral adnexa appeared normal. However, bilateral uterosacral ligaments

were thickened and fibrotic, and the Douglas pouch and rectovaginal space were obliterated. The posterior uterus was densely adhered to the rectum. Dissection was initiated with bilateral ureterolysis to preserve the ureters and autonomic nerves. The uterosacral ligaments were transected to release the rectovaginal space and Douglas pouch. A 7 cm endometriotic nodule involving the posterior vaginal fornix, uterosacral ligaments, and rectovaginal septum was excised. Additionally, a 4 cm rectal nodule was identified. To ensure optimal preservation of pelvic function, a nerve-sparing technique was employed while excising the lesions, and ureterolysis was performed to protect the ureters. The general surgery team performed a segmental rectal resection to ensure complete disease removal. Postoperatively, the patient had an uneventful recovery and reported significant symptom relief.

CONCLUSION: This case highlights an unusual presentation of deep infiltrative endometriosis affecting the rectovaginal space without ovarian involvement. A multidisciplinary approach, including gynecological and general surgical expertise, is crucial for optimal management. Complete excision of endometriotic lesions with nerve-sparing techniques and ureteral preservation may enhance symptom relief and improve patient outcomes. This report underscores the importance of considering DIE in patients with chronic pelvic pain and rectal symptoms, even in the absence of ovarian involvement. Clinicians should remain vigilant and tailor their examination approach accordingly, as endometriosis should still be suspected in patients with chronic pelvic pain, even when the ovaries appear normal.

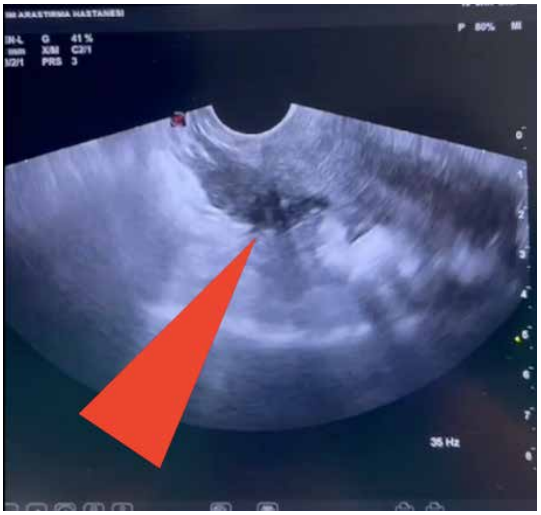
Keywords: Deep Infiltrative Endometriosis (DIE),Chronic Pelvic Pain,Multidisciplinary Surgical Approach

DIE 1



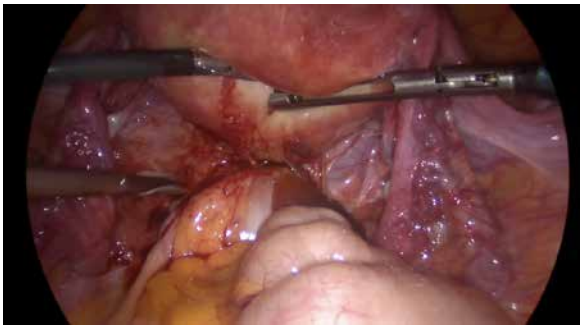
Endometriotic lesions observed in the posterior fornix during vaginal examination

DIE 2



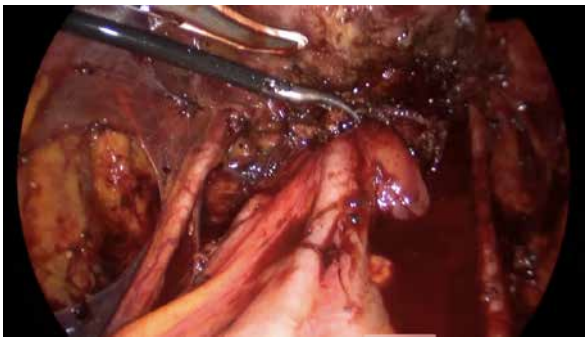
Endometriotic focus/nodule observed in the posterior fornix on ultrasound

DIE 3



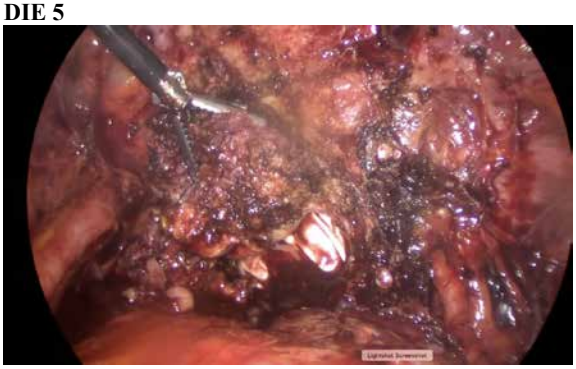
Obliterated appearance of the Douglas pouch with normal-appearing adnexa

DIE 4



Bilateral ureters

DIE 5

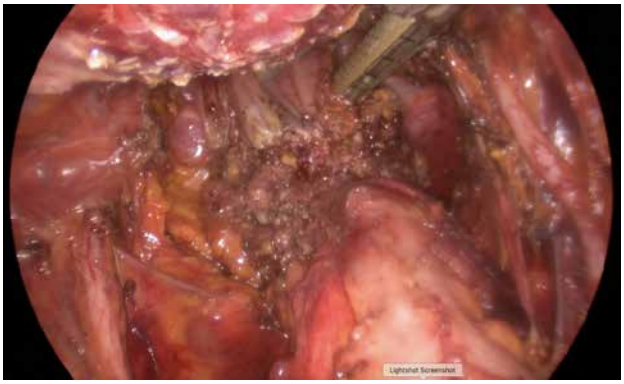


Excision of the nodule after the rectovaginal space was opened

DIE 6

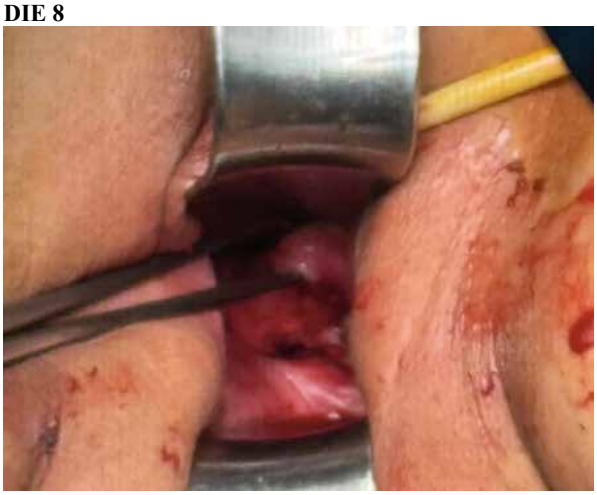
Vaginal cavity formed after excision of the focus from the rectovaginal space

DIE 7



Endometriotic focus on the anterior surface of the rectum

DIE 8



Postoperative vaginal examination

SS-012 [Jinekoloji Genel]

Case: Gastric Paresis After Total Abdominal Hysterectomy

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Uterine fibroids, polyps, or other gynecological diseases may require total abdominal hysterectomy (TAH) as a surgical option in cases of excessive bleeding. If the patient has a comorbid systemic disease, such as diabetes, caution should be exercised regarding early postoperative complications. In this case report, we aim to present a patient who developed gastric paresis (GP) after TAH. A 62-year-old diabetic patient, who underwent TAH due to a submucosal myoma, developed GP on the 3rd postoperative day and was treated with an appropriate multidisciplinary approach. GP after TAH is typically a temporary condition and can improve with proper treatment.

OBJECTIVE: Total abdominal hysterectomy (TAH) is a commonly preferred method for gynecological issues such as abnormal uterine bleeding. However, in diabetic patients, the risk of postoperative metabolic complications can increase. In this presentation, a case of gastric paresis (GP) caused by diabetic ketoacidosis (DKA) after TAH will be discussed.

METHOD: Case presentation.

FINDINGS: A 62-year-old patient presented to our clinic with abnormal uterine bleeding. The patient had a history of hypertension, diabetes, and hypercholesterolemia. A transvaginal ultrasound revealed a 12 cm wide-based submucosal myoma located at the fundus of the uterus. The patient underwent TAH. On the 3rd postoperative day, the patient developed nausea, vomiting, abdominal pain, and generalized body shaking. The patient's vital signs were as follows: Blood pressure: 148/96 mmHg, Temperature: 36.8°C, Pulse: 100 bpm, Respiratory rate: 38/min, Blood sugar: 351, Blood gas: pH 7.010, PO2: 187, PCO2: 10, HCO3: 6. A CT scan was performed, which revealed that the stomach was 12 cm in size (Image 1). The patient was diagnosed with gastric paresis secondary to DKA. The patient was quickly referred to endocrinology, and the treatment was planned as follows

1. The patient was intubated with a nasogastric tube, and 1000 cc saline (SF) was given as a bolus over 1 hour, followed by IV hydration at a rate of 150 cc/hour.

2. A 0.1 IU/kg IV bolus of insulin was administered, followed by a 0.1 IU/kg/hour infusion (the infusion rate was reduced to 0.05 IU/kg once glucose levels dropped to 200-250 mg/dL).

3. For each liter of saline, 1-2 ampules of KCl were added.

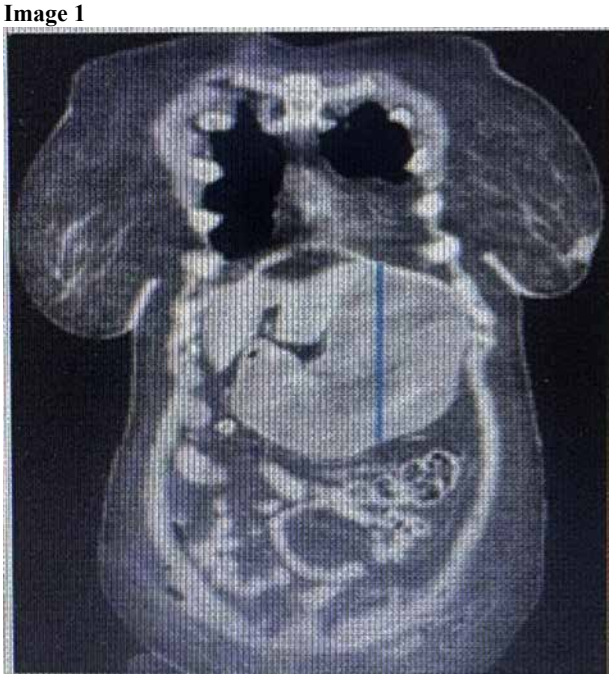
4. Once glucose levels fell below 250 mg/dL, a 5% dextrose solution (150-200 mL/hour) was started.

5. Arterial blood gases and biochemical parameters were monitored every 2-4 hours. The treatment was continued until acidosis was corrected. Additionally, due to the development of cellulitis at the IV insertion site on the left arm, cefepime (2x2 g IV) was started. The patient was discharged on postoperative day 17 in stable condition, with no complaints and normal vital signs.

CONCLUSION: Gastric paresis (GP) after hysterectomy is a rare but serious complication, particularly in diabetic patients, where surgical stress and poor glucose control may trigger its development. A multidisciplinary approach (gynecology, internal medicine, infectious diseases, endocrinology) is crucial for effective management. Early intervention and tight glucose monitoring are essential in reducing mortality and morbidity in these patients.

Keywords: gastric paresis, total abdominal hysterectomy, diabetic patient

Image 1



SS-013 [Jinekoloji Genel]

A rare case report- Sclerosing stromal tumor in a postmenopausal patient

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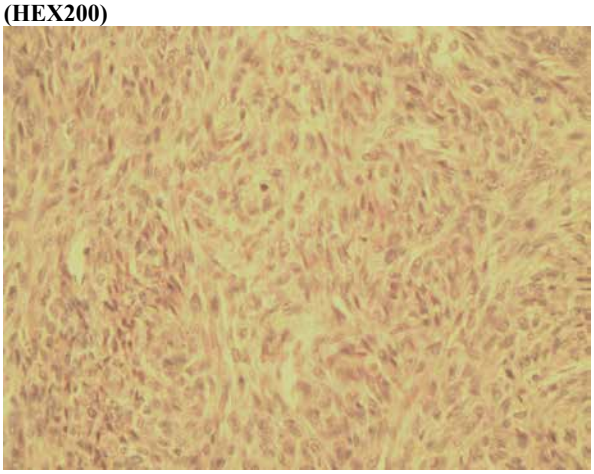
INTRODUCTION: Sclerosing stromal tumor (SST) is a rare benign sex cord-stromal tumor of the ovary and was first described in 1973. It is included in the World Health Organization (WHO) classification of sex cord stromal tumors and occurs in only 1-2% of all sex cord-stromal tumors. It is usually diagnosed in the premenopausal period, but there are rare cases in the postmenopausal period. SST may present with symptoms such as pelvic pain and menstrual irregularities and may be clinically and radiologically confused with malignancy. Definitive diagnosis is made by histopathologic examination.

CASE: A 69-year-old patient presented with postmenopausal bleeding. She had a history of hypertension, hypothyroidism, breast cancer (in remission since 2011) and chronic myelocytic leukemia (in remission). Routine gynecologic examinations revealed no pathology. Vaginal examination revealed postmenopausal bleeding and atrophic vagina and cervix. Ultrasonography and magnetic resonance imaging (MRI) revealed a 23*25 mm hypoechoic area in the right ovary. CA125: 62U/mL, other tumor markers were negative. Total laparoscopic hysterectomy and bilateral salpingoopherectomy were planned due to postmenopausal bleeding and elevated CA125. The operation was uncomplicated and pathological examination revealed sclerosing stromal tumor in the right ovary.

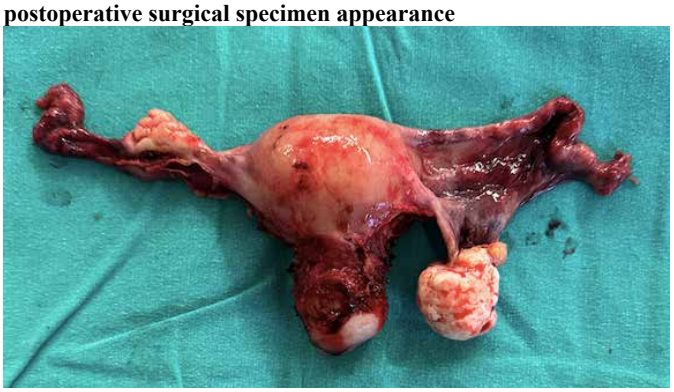
DISCUSSION: Sclerosing stromal tumor is usually seen in premenopausal women aged 20-30 years, while cases in the postmenopausal period are rare and the diagnostic process may be more challenging due to the risk of malignancy. Hormone production usually decreases during the postmenopausal period, which may affect clinical symptoms. Radiological images show that SST shows well-circumscribed and vascular features but may be confused with malignant tumors. Therefore, the definitive diagnosis should be made by histopathologic examination. The occurrence of SST in the postmenopausal period creates diagnostic difficulties and may be confused with malignancy. In such cases, preoperative evaluation and multidisciplinary approach are important. Surgical treatment is the main approach in the management of SST and complete excision is usually sufficient. Postmenopausal patients do not have fertility concerns, but malignancy concerns may affect treatment approaches. This case makes an important contribution to the literature by demonstrating that SST can also be seen in postmenopausal patients outside the young age group. Consideration of SST in the differential diagnosis will help prevent misdiagnosis of malignancy and unnecessary treatment approaches.

Keywords: adnexal mass, postmenopausal bleeding, sclerosing stromal tumor

Hypercellular area hemangioperistoma-like vascular structures (HEX200)



Laparoscopic hysterectomy and bilateral salpingo-oophorectomy - postoperative surgical specimen appearance



SS-014 [Jinekoloji Genel]

Sarcoidosis in endometrium causing dysmenorrhea: A case report and review of the literature

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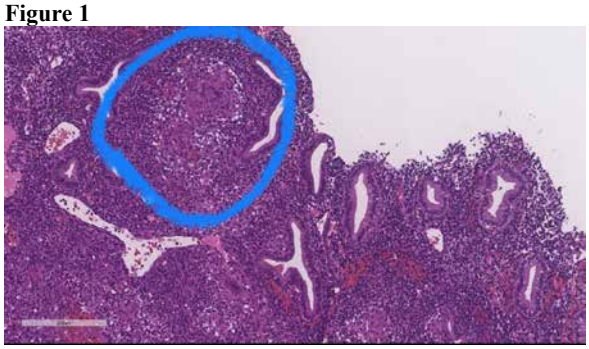
AIM: Sarcoidosis is a multisystem inflammatory disease which affects women of 20-40 years of age commonly (Zurkova M et al). The lungs are the primary organs involved. Extrapulmonary involvement of the disease includes skin, lymph nodes and eyes. Very rarely sarcoidosis is diagnosed in the the female reproductive system. Here, we wished to present an incidentally found case of uterine sarcoidosis causing dysmenorrhea. METHOD: A 46 years old woman G1 P1, admitted to the gynecology outpatient clinics for a checkup examination. The history revealed regular cycles with additional complaint of dysmenorrhea. There was no history of intrauterine devise use. The physical examination revealed normal sized uterus but an irregular thickness in the endometrium was seen in the transvaginal ultrasonography. The endometrium was 8 mm in thickness other than irregular parts. Adnexal region was natural. Because of that irregular echogenic lesion, hysteroscopy was decided. In the hysteroscopic view a, an approximately 1 cm irregular polypoid formation on the right side wall near the tubal orifice was seen. The specimen was sent to the pathology which showed discrete non-caseating granulomas (Figure 1). The serum levels of angiotensin-converting enzyme (sACE) was 18 U/L (range 8-52). Sarcoidosis was the definite diagnosis after ruling out the other infectious diseases. Because extrapulmonary sarcoidosis is usually seen with concomitant pulmonary involvement, she had sent to the chest diseases department but the patient refused the chest examination. She had no symptom like coughing or dyspnea. In the follow up at two months, she pointed out the cure of dysmenorrhea without any other treatment. The endometrium was seen as normal by transvaginal ultrasound. RESULTS: Sarcoidosis rarely affects female reproductive system including uterus, ovaries, fallopian tube and vulva (Rosenfeld SI). The uterus is the most common organ affected (Römer T). Menstrual irregularities, menorrhagia, metrorrhagia and postmenopausal bleeding can be seen with gynecological involvement. Also it can be asymptomatic. There are postmenopausal cases of sarcoidosis in the literature, suggesting a relationship between hormones and pathogenesis of the disease. In our case the patients' cycles were regular but she had dysmenorrhea which was not previously reported. It was observed that dysmenorrhea was cured after resection of sarcoidosis. Uterine sarcoidosis is diagnosed with endometrial biopsy and needs exclusion of other granulomatous diseases. CONCLUSION: In the routine gynecology practice sarcoidosis is a very rare disease depending on the diagnosis of exclusion. The pathological specimens of the endometrial samples should be well assessed due to the possibility of the sarcoidosis. Additionally, sarcoidosis may cause dysmenorhea as is in this case.

Keywords: Sarcoidosis, endometrium, dysmenorhhea, chronic pelvic pain

Figure 1



Histopathological view of granulomas in the endometrium

SS-015 [Endoskopi]

Unexpected findings in pelvic surgery: Tailgut Cyst initially diagnosed as endometrioma

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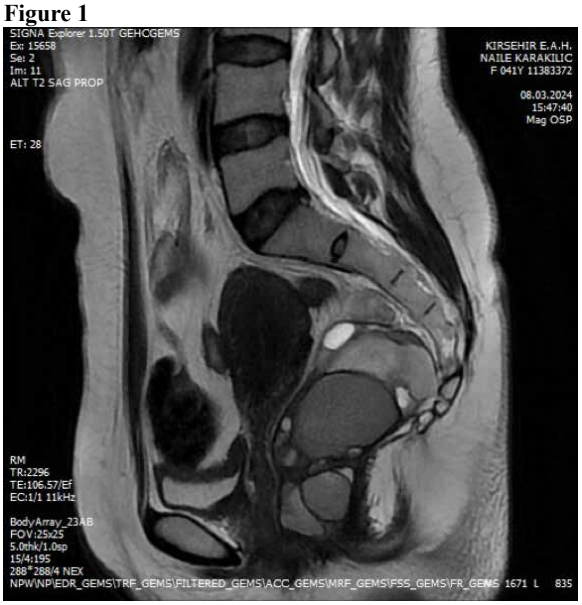
OBJECTIVE: Tailgut cysts, also known as retrorectal cystic hamartomas, are rare congenital lesions originating from embryonic hindgut remnants. These cysts are predominantly found in females and are typically located in the retrorectal or presacral region. Most cases remain asymptomatic and are incidentally discovered, though some patients experience pelvic pain, constipation, or urinary disturbances. Due to the risk of infection and malignant transformation, complete surgical excision is recommended. Laparoscopic approaches are increasingly utilized due to their advantages in visualization and reduced morbidity. However, in cases with suspected malignancy, laparoscopic excision is contraindicated due to the risk of cyst rupture and tumor dissemination. This case report presents a tailgut cyst initially misdiagnosed as an ovarian endometrioma, later identified and excised laparoscopically.

CASE: A 42-year-old female presented with intermittent abdominal pain and constipation. Initial ultrasound imaging suggested an ovarian cyst. The patient had no rectal bleeding, mucus discharge, or genitourinary symptoms. Physical examination was unremarkable. Transvaginal ultrasound identified a 73 × 42 mm heterogeneous, multilocular cystic mass posterior to the uterus. Biochemical and tumor marker tests (AFP, CEA, CA 19.9, CA 125, CA 15.3, β-hCG) were within normal limits. MRI revealed a 5 cm retrouterine lesion with T1 hypointensity and T2 hyperintensity, initially interpreted as endometriomas. The patient was referred to the gynecology clinic for further evaluation. Laparoscopy was performed based on the suspected diagnosis of endometrioma. Intraoperatively, the uterus and ovaries appeared normal. Upon accessing the retroperitoneal area, a cystic mass was identified posterior to the rectum. The lesion was completely excised without complications. Postoperative recovery was uneventful, with gas passage on the first day and drain removal on the second day. The patient was discharged on the sixth postoperative day and followed up for three months. Histopathological examination confirmed a benign tailgut cyst, revealing multiple cystic structures lined by stratified squamous epithelium (both keratinized and non-keratinized), as well as cuboidal and prismatic epithelium. Dense fibroconnective tissue was also observed within the cyst wall.

CONCLUSION: Tailgut cysts are rare congenital lesions of embryonic origin, often misdiagnosed due to their asymptomatic nature. MRI is a valuable diagnostic tool for distinguishing these cysts from other pelvic masses. Complete surgical excision remains the gold standard for treatment due to the potential for malignant transformation. Laparoscopic excision offers significant benefits, including shorter hospital stays, faster recovery, and reduced postoperative morbidity. However, the risk of intraoperative rupture and subsequent dissemination of dysplastic cells necessitates careful surgical planning. In suspected malignant cases, alternative surgical approaches should be considered. Given the cysts' proximity to vital anatomical structures, a multidisciplinary approach is essential for optimal patient management.

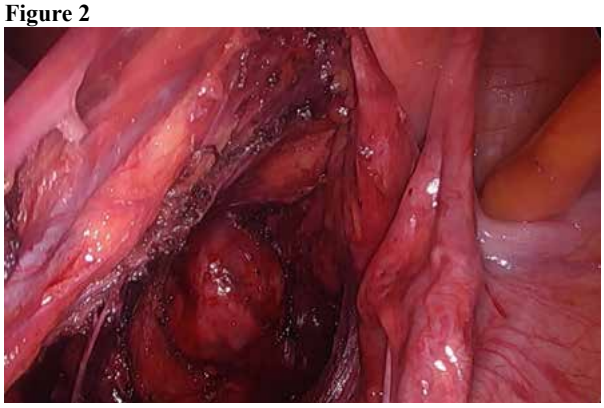
Keywords: endometrioma, pelvic mass, tailgut cyst

Figure 1



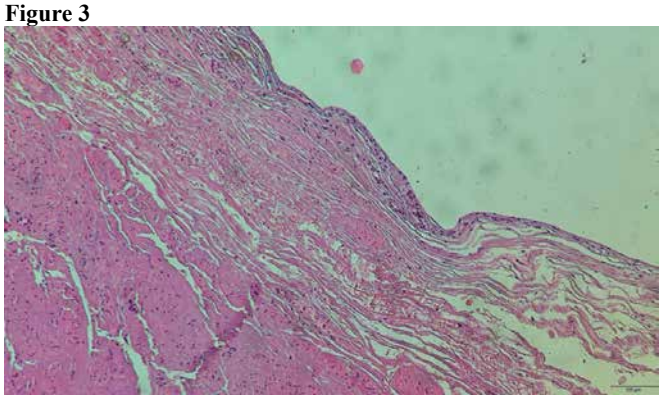
Sagital section MRI image shows the lesion

Figure 2



Intraoperative cyst appearance

Figure 3



Cyst Wall Lined with Flat Cuboidal Epithelium and Underlying Smooth Muscle Bundles (H&E, 100X)

SS-016 [Obstetri Genel]

Evaluation of endoplasmic reticulum stress in patients diagnosed with hyperemesis gravidarum

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OBJECTIVE: The aim of this study is to evaluate the levels of PERK (Human Phospho Extracellular Signal Regulated Kinase) and ATF4 (Human Activating Transcription Factor 4), which are key markers of endoplasmic reticulum stress, in pregnant women diagnosed with hyperemesis gravidarum (HEG) and to compare these levels with those of healthy pregnant women.

MATERIALS-METHODS: Our study is a prospective study conducted with patients aged 18-45 who applied to the Obstetrics and Gynecology Clinic of Konya City Hospital between July 1, 2024, and November 31,

2024. A total of 170 patients were included in the study, comprising 85 patients diagnosed with HEG during the first 16 weeks of pregnancy and 85 healthy pregnant women at the same gestational period. Laboratory data were obtained from residual blood samples left over from routine tests of the patients. From these samples, markers of endoplasmic reticulum stress, ATF4 and PERK, were analyzed. The findings obtained were statistically compared between the two groups. RESULTS: The demographic data of both groups were similar (p>0.05). No significant differences were observed between the groups in terms of gravida (p=0.132), parity (p=0.252), abortion count (p=0.443), or gestational age (p=0.360). The weight of patients in the HEG group was found to be significantly lower than that of the control group (p=0.025). The sodium (Na) levels of the patient group were significantly lower than those of the control group (p=0.001). The TSH levels in the patient group were significantly lower than those in the control group (p=0.001). Similarly, the ATF-4 levels in the patient group were significantly lower than those in the control group (p=0.002). However, no significant difference was observed between the groups in terms of PERK levels (p=0.965). The ability of ATF-4 and PERK levels to predict the presence of HEG was analyzed using ROC analysis, and their cut-off values were determined. For ATF-4, a cut-off value of 4.263 was identified, with a sensitivity of 45.9% and a specificity of 77.6%, indicating it as a good predictor. For PERK, a cut-off value of 1.98 was identified, with a sensitivity of 28.2% and a specificity of 85.9%, indicating it as a poor predictor.

CONCLUSION: Our study has contributed significantly to the literature by providing a better understanding of the molecular mechanisms of HEG and demonstrating that these markers should be considered potential therapeutic targets. We can state that monitoring ER stress markers clinically may be important in the diagnosis and treatment processes of HEG. In the future, studies conducted on larger populations and long-term outcome analyses could help validate these findings and contribute to the development of innovative approaches for HEG management. A detailed investigation of ER stress pathways may offer a deeper understanding of the pathophysiology of HEG, paving the way for personalized treatment approaches.

Keywords: Hyperemesis gravidarum, Endoplasmic reticulum stress, PERK, ATF4, Adaptive stress response, Apoptotic mechanisms

SS-018 [Obstetri Genel]

Assessment of positivity and true positivity rates of second and third trimester tests in patients admitted to trabzon kanuni education and research hospital between march 2018- march 2019 years

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AİM: Nowadays in prenatal screening, double and triple tests are performed.The Third Trimester Tests is based on the measurement of the baby's BPD (Biparietal Diameter) in USG also β HCG, AFP and E3 values in the mother's blood measured and recommended to be performed in the 16th-18th weeks of pregnancy.These tests are performed for screening purposes and their diagnostic value should be supported by detailed USG.For this reason, we aimed to investigate the screening test positivity and true positivity rate.

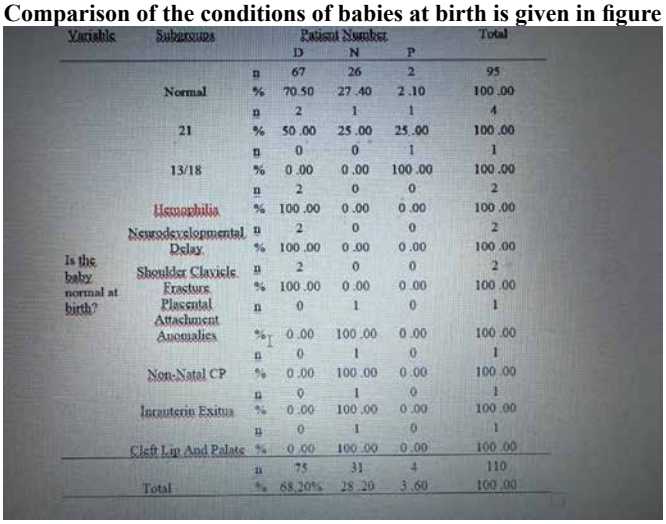
METHOD: In our study, 138 patients who tested positive and who applied to our hospital between March 2018 and March 2019, were called by phone by accessing their records from the hospital automation system in order to retrospectively examine them.This method was also advantageous during the Covid 19 outbreak. We acheive 138 patients. Among 75 of 92 patients who were found to be positive for trisomy 21 and 31 of 41 patients who were found to be at risk for NTD also 4 of 5 patients who were found to be at risk for trisomy 13/18.Total 110 patients were achieved and form was filled out for each patient also the verbal consent obtained and patients dermographic characteristics noted. Community prevalence rates higher than 1/1000 for NTD risk were considered risky. For Trisomy 21 and Trisomy 13.18, values higher than 1/250 were considered risky. For age, values higher than 1/250 were considered risky. For the scanning program: Prisca 5.1.0.17 was used. All statistical analyzes were analyzed in the IBM Statistics 25 program environment with an error level of $\alpha = 0.05$ and a confidence interval of 95%. With this form, patients at risk of trisomy 21, trisomy 13/18 and NTD were recorded separately.

FINDINGS: The dermographic findings of our patients are shown in table 1. Comparison of the conditions of babies at birth is given in resim: 1. Apart from that, Trisomy 21 disease in 4 babies (3.6%) 13/18 disease in 1 baby (0.9%) Hemophilia in 2 babies (1.8%) Neurodevelopmental delay in 2 babies (1.8%) Shoulder clavicle fracture in 2 babies (1.8%) Placenta adhesion anomalies in 1 baby (0.9%) Extranatal CP in 1 baby (0.9%) Intrauterın exitus in 1 baby (0.9%) Cleft palate-lip condition was reported in 1 baby (0.9%). Two of the 4 patients at risk of trisomy 13/18 were born healthy, and 1 died intrauterine. The other one died one day after birth due to multiple anomalies. Two of died patients had multiple anomalies: IUGR, cardiac anomaly and Bochdalac hernia. Among the 3 (2.7%) patients with

a previous history of trisomy 21, 1 patient had Down syndrome, 1 patient had a history of NTD, and 1 patient had Edward syndrome. RESULTS: Among the 110 babies evaluated in total, the normal birth rate appears to be quite high. When the conditions of the babies at birth were examined, it was found that 95 of them (86.4%) were normal. Interestingly, two of our patients were diagnosed with hemophilia A, which was diagnosed prenatally by chorionic villus biopsy.

Keywords: prenatal screening, hemophilia, triple test

Comparison of the conditions of babies at birth is given in figure 1



Variable	Subgroups		Patient Number D	N	P	Total
Is the baby normal at birth?	Normal	n	67	26	2	95
		%	70.50	27.40	2.10	100.00
	21	n	2	1	1	4
		%	50.00	25.00	25.00	100.00
	13/18	n	0	0	1	1
		%	0.00	0.00	100.00	100.00
	Hemophilia	n	2	0	0	2
		%	100.00	0.00	0.00	100.00
	Neurodevelopmental Delay	n	2	0	0	2
		%	100.00	0.00	0.00	100.00
	Shoulder Clavicle Fracture	n	2	0	0	2
		%	100.00	0.00	0.00	100.00
	Placental Attachment Anomalies	n	0	1	0	1
		%	0.00	100.00	0.00	100.00
	Non-Natal CP	n	0	1	0	1
		%	0.00	100.00	0.00	100.00
	Intrauterin Exitus	n	0	1	0	1
		%	0.00	100.00	0.00	100.00
	Cleft Lip And Palate	n	0	1	0	1
		%	0.00	100.00	0.00	100.00
	Total	n	75	31	4	110
		%	68.20%	28.20	3.60	100.00

The dermographic findings of our patients are shown in table 1

Variable	All Patients
Age (years)	34.00 ±6.48
Weight (kg)	69.59±12.92
Number of Follows	13.75 ± 2.42
Birth Week	37.69 ± 4.06
Baby Weight (gr)	3108.18 ± 886.31
Baby Height(cm)	49,22 ± 4,24
Month of Meeting	22.74 ± 4.45
Bpd (cm)	38.85 ± 2.64
Test Time Week of Pregnancy	17.58 ± 0.77

SS-019 [Perinatoloji]

Evaluation of Structural and Genetic Anomalies and Pregnancy Outcomes Associated with Single Umbilical Artery Cases Detected in Perinatology Outpatient Clinic of T.C. Ministry of Health Eskişehir City Hospital between December 2023 and January 2025

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OBJECTIVES: The Umblical cord normally contains two arteries and one vein. However, this condition is characterized by the absence of one of the umbilical arteries and is referred to as a singleumbilical artery (SUA). The incidence of this condition on second trimester prenatal ultrasonography is 0.5 %. SUA cases are significantly associated with fetal structural abnormalities, genetic abnormalities and poor pregnancy outcomes. In this study, we evaluated fetal structural and genetic abnormalities and pregnancy outcomes in cases of SUA detected during second trimester fetal ultrasound screening.

METHODS: This retrospective analysis include 21 pregnant women diagnosed with SUA at Eskişehir City Hospital between December 2023 and January 2025. Fetal malformations were detected during detailed ultrasonography screening performed in the perinatology outpatient clinic at 18-22 weeks of gestation. These patients were evaluated for additional structural anomalies, fetal genetic abnormalities and pregnancy outcomes.

RESULTS: Of the total 21 patients with SUA, 8 (38%) were diagnosed with fetal structural anomaly, 2 (9.5%) with genetic anomaly and 3 (14.2%) with severe fetal growth restriction (FGR) in the later gestational weeks. Associated structural fetal anomalies: Cardiac anomalies (VSD) in 4 cases, gastrointestinal anomalies (duodenal atresia, omphalocele, persistent right umbilical vein) in 3 cases, genitourinary anomaly (hypospadias) in 1 case, central nervous system anomaly (agenesis of corpus callosum) in 1 case. Associated genetic anomalies: In 1 case Turner syndrome (45XO) was detected in non-invasive prenatal test and confirmed by postpartum karyotype study, in 1 case Noonan syndrome was diagnosed in postpartum genetic examination. One of the 3 cases of severe FGR was a twin pregnancy and postpartum whole exome sequence investigation is ongoing, another case was diagnosed with postpartum biotinase enzyme defect, and no additional structural or genetic anomaly was detected in the other case. In 11 cases (52,3%), SUA was isolated and neither structural nor genetic abnormalities were detected and the pregnancy was uneventful. No fetal loss occurred in any of the cases with SUA.

CONCLUSION: Patients with SUA should be carefully evaluated for concomitant fetal structural and genetic anomalies and closely monitored for possible pregnancy complications.

Keywords: Noonan syndrome, Single umbilical artery, structural and genetic anomalies, Turner syndrome

SS-020 [Perinatoloji]

Evaluation of Indication and Perinatal Outcomes in Pregnancies Managed with Microwave Coagulation

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INTRODUCTION: Microwave coagulation is a technique used for thermal ablation. It is an advantageous method because it is minimally invasive and easy to use. In monochorionic pregnancies, complications such as twin-to-twin transfusion syndrome (TTTS), selective fetal growth retardation (sFGR) and Twin Reversed Arterial Perfusion (TRAP) syndrome carry a high risk for fetal and neonatal morbidity. In addition, placental invasion anomalies such as scar site pregnancy also carry serious maternal-fetal risks. Microwave coagulation is a minimally invasive procedure that can be used in selected cases. In our study, we aimed to investigate the effectiveness of microwave coagulation by classifying pregnancies according to indications and evaluating perinatal outcomes.

METHODS: In this retrospective study, pregnant women who underwent microwave coagulation in our center were examined. Cases were grouped according to the reasons for the procedure:

1. Monochorionic Diamniotic twin pregnancy- Patients who underwent microwave ablation after TTTS laser coagulation (n=3)

2. Monochorionic Diamniotic twin pregnancy-Selective FGR (n=5)

3. Monochorionic Diamniotic twin pregnancy - Twin twin hydrops fetalis (n=5)

4. Monochorionic Diamniotic twin pregnancy - Twin twin fetal anomaly (exencephaly, NTD) (n=2)

5. Twin Reversed Arterial Perfusion (TRAP) syndrome (n=1)

6. Dichorionic triamniotic triplet pregnancy- Fetal anomaly in one fetus (hydrops fetalis (n=2)

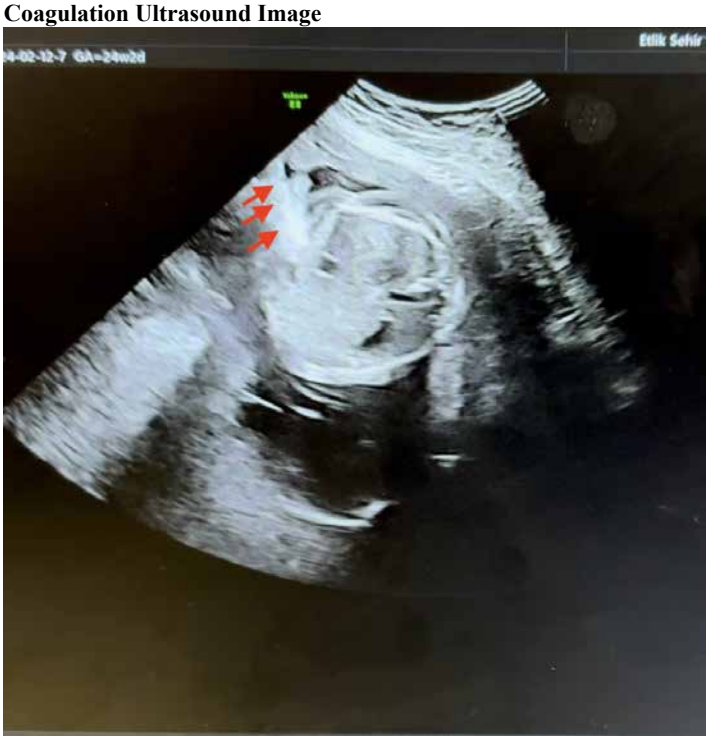
7. Scar site pregnancy (n=2) In addition, gestational weeks, birth outcomes and perinatal complications were analyzed.

RESULTS: A total of 20 patients underwent microwave coagulation procedure in our clinic between 2023 and 2025. 2 of these cases were scar site pregnancies. Among the patients with multiple pregnancies; the total number of live birth cases was 16 and the number of intrauterine ex-fetus cases was 2. The mean gestational age of these cases was 33+6 weeks, the earliest delivery was 25+0 weeks and the latest delivery was 39+0 weeks. Four of the cases were term deliveries and 12 were preterm deliveries. Four of the preterm deliveries developed after preterm premature rupture of membranes (PPROM). Distribution according to gestational week: Early preterm (<34 weeks): 38%, late preterm (>34 weeks): 37%, term (≥37 weeks): 25%. Mean Apgar scores were 7 at 1 minute and 8 at 5 minutes.

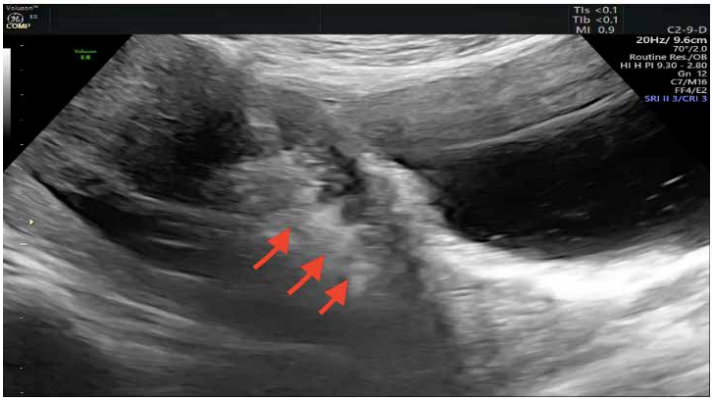
CONCLUSION: Microwave coagulation is an important prenatal intervention in monochorionic pregnancies associated with complications such as TTTS, selective IUGR and fetal anomaly. However, microwave coagulation is also used in cases of scar pregnancy. The success rate in scar pregnancies was high and cure was achieved in 2 of our cases without the need for additional procedure. It was determined that 88% of the pregnant cases resulted in live birth. However, larger scale studies are needed to evaluate the long-term effects of the procedure and its impact on neonatal outcomes.

Keywords: Microwave Coagulation, Monochorionic Pregnancies, Perinatal Outcomes

Monochorionic Diamniotic Twin Pregnancy - Microwave Coagulation Ultrasound Image



Scar Site Pregnancy - Microwave Coagulation Image



SS-021 [Perinatoloji]

Fetal intracranial hemorrhage: Prenatal diagnosis and management of four antenatally diagnosed cases

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OBJECTIVE: The goal of this study is to enhance the understanding of ultrasound (US) findings in prenatally diagnosed intracranial hemorrhage (ICH), assess the contribution of fetal magnetic resonance imaging (MRI) to the diagnosis, and discuss the management of a series of fetal ICH cases.

MATERIAL-METHODS: This retrospective, observational study included four fetuses diagnosed with ICH from January 2024 to February 2025. The data regarding patients medical records, prenatal US and MRI findings and prognosis of fetal ICH cases were collected from the hospital database and analyzed.

RESULTS: Fetal ICHs were grade 3 in two cases, germinal matrix hemorrhage in one case and one of the cases had previous hemorrhage-related findings. The mean gestational age at diagnosis was 32.7 weeks. Fetal cranial MRI was performed in all patients following ultrasonographic diagnosis. MRI confirmed fetal ICH diagnosis and previous US findings regarding location and grade in all cases. One patient diagnosed with previous ICH underwent pregnancy termination through fetocides. One of the remaining three cases, diagnosed with grade 3 ICH resulted in born alive at the 36th week of gestation. The pregnancy follow-ups of the remaining two cases are ongoing.

CONCLUSION: Fetal ICH is a rare diagnosis. It is mainly detected in the third trimester after a normal second-trimester ultrasound examination. The clinical manifestations of fetal ICH are diverse and have a wide spectrum of severity and prognostic implications. These cases can be safely diagnosed and graded by US examination, but the underlying etiology frequently cannot be determined. Fetal cranial MRI may aid in diagnosis confirmation if this is unclear from US in order to provide appropriate counseling to the parents.

Keywords: fetal, intracranial, haemorrhage, MRI, prenatal diagnosis, ultrasound

SS-022 [Perinatoloji]

The case of an interval delivery with emergent cerclage in a twin pregnancy

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INTRODUCTION: Studies on cervical cerclage for singletons and twins have employed various methodologies, resulting in diverse conclusions regarding its effectiveness. Retrospective analyses have consistently suggested a possible protective effect against premature labor. Although there is no consensus on the benefits of cerclage in twin pregnancies, we know that when cervical dilation reaches a critical threshold, emergent cerclage serves as a necessary rescue intervention when other conservative measures fail. Furthermore, recent systematic reviews and meta-analyses corroborate these findings, indicating significant improvements in mean gestational age at delivery and reductions in neonatal morbidity associated with cerclage placement in twins. The objective of this presentation is to describe a case of emergency cerclage accompanying interval labor in a dichorionic diamniotic (DCDA) twin pregnancy to contribute to the follow-up and management of these unique patients.

MATERIAL-METHOD: A 34-year-old patient who had previously experienced four pregnancy losses with no live births attended our perinatology outpatient clinic for a second-trimester anomaly screening. In the current pregnancy, Prophylactic cerclage was performed at an external center at 12 weeks of gestation. The ultrasound (USG) examination revealed a DCDA twin pregnancy, presenting with anatomically normal 20-week-old fetuses. Upon observation of cervical opening on transvaginal USG, the vaginal examination was performed, and it was observed that the cerclage suture had lost its tension, and there was a cervical opening of approximately 3 cm. The cerclage suture was removed, and the patient was hospitalized.

RESULTS: Antibiotherapy and tocolytics were initiated, and infection markers were requested. Following a 48-hour period during which the pregnancy persisted, there was no increase in patency, and the infection markers remained negative. Consequently, the risks were explained to the patient, and cerclage was recommended once more. However, two weeks after the cerclage, premature preterm rupture of the membranes occurred. The fetus with ruptured membranes was born spontaneously, while the placenta remained in the uterus as it did not detach on its own. The patient was observed for a 48-hour period, during which spontaneous recovery occurred. Antibiotherapy was administered throughout this period. Following the resolution of bleeding and contraction and the regression of cervical patency, cerclage was once again recommended and performed after the patient accepted it. The patient was discharged, and the infant was delivered at 38 weeks and 5 days of gestation without any complications.

CONCLUSION: Due to the complex nature of twin pregnancies, the role of cerclage—whether prophylactic or therapeutic—remains a subject of ongoing investigation. The dual challenges posed by increasing rates of cervical dilatation and the multifaceted pathophysiology of twin pregnancies pose difficulties in investigating the efficacy of cerclage. However, in cases of patients with a poor obstetric history, where live birth is highly desirable, radical solutions such as emergent cerclage after interval labor should considered. In light of our case, it can be concluded that in DCDA twin pregnancies, cervical cerclage insertion

after the extremely premature delivery of twin 1 may increase the gestational age and the birth weight of twin 2 and prolong the delivery interval.

Keywords: Cervical insufficiency, interval delivery, twin pregnancy

SS-023 [Obstetri Genel]

Evaluation Of Risk Factors for Surgical Site Infection After Cesarean Section: A Retrospective Study

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INTRODUCTION: Surgical site infections (SSIs), are common complications after cesarean sections, causing significant morbidity, prolonged hospital stays, disrupted mother-baby bonding, psychological stress, and higher treatment costs. Risk factors include diabetes, hypertension, obesity, prolonged labor, premature rupture of membranes, chorioamnionitis, emergency cesareans, extended operation time, blood transfusions, and smoking.

OBJECTIVE: This study aims to determine the SSI rate post-cesarean, identify risk factors, and develop preventive strategies to reduce infections.

Methodology: A retrospective study was conducted at İzmir City Hospital's Obstetrics and Gynecology Clinic, reviewing 4,606 cesarean cases from October 16, 2023, to January 31, 2025. Of these, 63 patients with SSIs (Group-1) and 130 without (Group-2) were compared based on BMI, operation duration, hospital stay, anesthesia type, smoking, prior abdominal surgery, blood transfusion, drain use, hemoglobin levels, labor presence, and emergency/elective status. RESULTS: The SSI rate was 1.36%. The SSI group had higher age, BMI (Body mass index), hospital stay, operation duration, and hemoglobin levels. Significant differences were observed for smoking, blood transfusion, and drain use. No differences were found for anesthesia type, prior surgery, emergency/elective status, or active labor presence. CONCLUSION: Obesity and smoking are independent SSI risk factors. Reducing hospital stays, operation time, and avoiding non-medically indicated cesareans, especially in obese women, can lower SSI risks. Restricting cesarean deliveries to cases with absolute medical indications is also crucial. Women with these risk factors should be closely monitored postpartum.

Keywords: surgical site infection, cesarean section, risk factors

Table 1. Demographic and clinical characteristics of case and control groups

	Group-1	Group-2	p
Number of patients(n)	63	130	
Body mass index (BMI)	30,2±4,8	27,7±3,2	<0,001
Age(years)	30,8±5,2	28,9±4,9	0,01
Hospital stays(hours)	75,6±47,6	57,2±18,3	0,01
Cesarean section duration (minutes)	79,1±25,3	61,6±16,9	<0,001
Postoperative hemoglobin level(g/dL)	10,42±1,15	10,19±1,3	<0,001

Table 2. Comparison of operative and clinical characteristics of case and control groups

	Category	Group-1(Number/%)	Group-2 (Number/%)	p
Anesthesia Type	Spinal	52 (82,5)	115 (88,5)	0,182
	General	11 (17,5)	15 (11,5)	
Smoking	Yes	10 (15,9)	8 (6,2)	0,031
	No	53 (84,1)	122 (93,8)	
Prior Surgery	Yes	40 (63,5)	74 (56,9)	0,238
	No	23 (36,5)	56 (43,1)	
Blood Transfusion	Yes	17 (27,0)	17 (13,1)	0,016
	No	46 (73,0)	113 (86,9)	
Drain	Yes	9 (14,3)	2 (1,5)	<0,001
	No	54 (85,7)	128 (98,5)	
Operation Plan	Elective	24 (38,1)	54 (41,5)	0,383
	Emergency	39 (61,9)	76 (58,5)	
Labor Presence	Yes	26 (41,3)	41 (31,5)	0,121
	No	37 (58,7)	89 (68,5)	

SS-024 [Obstetri Genel]

Factors Affecting the Management of Episiotomy Dehiscence

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AIM: Our study aims to investigate the impact of perineal infection on managing patients with episiotomy dehiscence.

MATERIALS-METHODS: In this retrospective study, patients admitted to our hospital with an episiotomy dehiscence in 2024 were included. Term, low-risk pregnancies without any complications were included. The patients were divided into two groups: those with episiotomy site infection at admission (Group 1) and those without signs of infection (Group 2). The groups were compared based on demographic data, the day of hospital admission, vaginal culture results and their microorganisms, antibiotic treatment, infection parameters, education level of those who

repaired episiotomy incision, the time of secondary episiotomy suturing, and the length of hospital stay. The medical records of 119 out of 121 patients who underwent secondary episiotomy repair were reviewed. In both groups, symptomatic treatment (analgesics for pain relief, wound dressing, and heating therapy) was provided during hospital stay. RESULTS: The sum of vaginal deliveries in our hospital for one year was 4870.Among these, 2532 (52%) patients underwent right mediolateral episiotomy (RME). The incidence of episiotomy dehiscence ±infection requiring hospitalization was 4.8% (121/2532). However, only the results of 119 patients with complete medical records, were analyzed. There were 61 patients (51%) (Group 1) with infection signs on examination and 58 patients (49%) (Group 2) with no signs of infection. The demographic and obstetric features at delivery (age, parity, BMI, smoking status, gestational weeks at delivery, birthweight of the newborns, Hb levels, and WBC count at delivery were comparable between the groups at delivery (p>0.05) (Table). Out of 119 cases with episiotomy dehiscence, 63.1% had spontaneous delivery, 36.9% experienced labor induction. No patients with episiotomy dehiscence had instrumental delivery. Rehospitalization duration for episiotomy dehiscence was significantly shorter in the infected episiotomy group than in the non-infected group (7 (IQR) (3-15) vs 8.5 (IQR) (4-18); p=0.002). Wound separation was most common in both groups, with the skin and subcutaneous tissues opening up to Fourchette together, and the size of episiotomies were not different between the groups (p>0.05) (Table). CRP values at rehospitalisation were again significantly higher in the infected group (median (IQR) 33 vs 15 (IQR) p=0.001). Wound swab cultures were obtained from all (infected and non-infected) cases but only 5 patients among the noninfective group with episiotomy dehiscence. Subsequently, 48 patients in the infected dehiscence group were started on parenteral antibiotic treatment (iv ampicillin-sulbactam 3x1 g or cefazolin 2x1 g as standard) at the first hospitalisation. In the infected dehiscence group, 13 patients with CRP >50 were started on ceftriaxone 1x1 g at first admission. All bacteria grown in cultures obtained from infected episiotomy wounds were aerobic or facultatively anaerobic (Table2). CONCLUSION: In our study, even in non-infected episiotomy group, wound cultures were obtained positive 56% of cases. However, although non-infected episiotomies were not treated with antibiotics due to their clinical findings, the results of the secondary suturing were similar to the infected group.Therefore, we do not recommend wound cultures prior to secondary suturing for episiotomy dehiscence unless there are clinical signs of infection.

Keywords: episiotomy, dehiscence, wound infection

Vulvar and vaginal examination photographs.

Group 2: Non-infected episiotomy dehiscence was found on vaginal examination photograph

Vulvar and vaginal examination photographs.

Group 1: Patiens with episiotomy site infection at admission

Infected and non-infected episiotomy

	nfected episiotomy	Non-infected episiotomy	p
Age	25.4 ±4.4 (18 – 41)	25.7 ±3.5 (19 – 37)	0.636
Parity (n, %) 1	57(93.4)	51 (87.9)	0.081
Parity (n, %) ≥2	4(6.6)	7(12.1)	
Smoking-Yes	52	49(84.5)	
Smoking -No	9	9(15.5)	0.908
BMI (kg/m2)	30.1 ±4.6 (19.0 – 42.3)	29.2 ±4.3 (21.2 – 45.4)	0.252
Gestational weeks at delivery	39.5 ±1.1 (37 - 41.6)	39.3 ±1.2 (35.6 - 41.2)	0.417
Duration of labor (hours) >12 Hours	39 (63.9)	37 (63.8)	0.987
Duration of labor (hours) <12 Hours	22 (36.1)	21 (36.2)	
Birth weight of newborn (gr)	3281 ±386 (2550 - 4250)	3200 ±380 (2470 -4480)	0.252
Hb levels at delivery (g/dL)	11.6 ±1.5 (8.6 - 16)	12.0 ±1.9 (8.2 -15,5)	0.183
Time for present to the hospital for episiotomy dehiscence (postpartum days)	7 (4) (3 - 15)	5 (4) (4 – 18)	0.002
Size of the dehiscence (n, %) Only skin (Up to Fourchette)	5 (8.2)	3 (5.3)	
Size of the dehiscence (n, %) Skin and subcutaneous (Up to Fourchette)	54 (88.5)	52 (91.2)	0.818
Size of the dehiscence (n, %) Skin and subcutaneous (Dehiscence along the episiotomy line)	2 (3.3)	2 (3.5)	
CRP levels at readmission (mg/L)	33 (36) (2 - 235)	15 (22) (1 - 83)	0.001
CRP level just before secondary suturation (mg/L	6.5 (11) (1 - 43)	4 (11) (0 - 24)	0.446
Secondary suturation time (days)	7 (3) (1 - 12)	3 (2) (1-6)	0.001
Total hospital stays (days)	8 (2) (6 - 13)	3 (2) (1 - 7)	0.001
Secondary saturation success rates	60 (98.4%)	58 (%100)	0.981

Wound swab culture comparison between infected and non-infected episiotomy dehiscence.

	Infected episiotomy dehiscence (n=61)	Non-infected episiotomy dehiscence (n=53)	p
Wound swab culture Positive	51 (%83.6)	30 (%56.6)	0.002
	Gr (-) bacteria (n=28; %54.9)	Gr (-) bacteria (n=12; %40)	
	Gr (+) bacteria (n=18; %35.3)	Gr (+)bacteria (n=16; %53.3)	
	Multiple types of bacteria (n=5)	Multiple types of bacteria (n=2)	

Comparing two groups according to wound swab culture results

SS-026 [Obstetri Genel]

Perspective Of Mothers Who Gave Birth In Secondary Centers On Birth And Delivery Types

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This study was conducted to evaluate the birth experiences and perspectives of mothers who gave birth in a secondary health center on birth methods. A survey was created via Google Workspace for patients. Patients who responded to the survey between September 1, 2024, and December 31, 2024, were included in the study. The study was conducted on 828 mothers from different occupational groups, aged between 30 and 67. While 86.96% of the participants had natural pregnancies, 13.04% became pregnant through in vitro fertilization. According to the results of the study, the most common choice for birth method was cesarean section with 54.35%. The most common reasons for cesarean section were non-progressive labor (21.62%), fear of normal vaginal birth (18.92%) and precious pregnancy (13.51%). On the other hand, the majority of the participants (86.96%) stated that they were satisfied with their current birth method. Regarding who should decide on the birth method, 69.57% stated that it was appropriate for the doctor or midwife to decide. Postpartum complications were reported by only 6.52%, half of which were defined as spinal headache and the other half as postoperative pain. 82.61% of mothers stayed in the same room with their babies after birth, while 17.39% stated that they needed support for their newborns. In conclusion, this study reveals the satisfaction levels and preferences of mothers who gave birth in secondary health centers regarding the delivery methods and processes. The study draws attention to the importance of guidance from health professionals in the selection of delivery methods and provides ideas on how practices can be shaped in practice based on mothers' experiences and preferences.

Keywords: Normal Vaginal Delivery, Caesarean Section, Secondary

SS-027 [İnfertilite]

Comparison of the efficacy of different ovulation induction agents in ovulation induction and intrauterine insemination therapy in polycystic ovary syndrome phenotypes

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OBJECTIVE: Polycystic ovary syndrome (PCOS) is the leading cause of anovulatory infertility and accounts for %70-80 of anovulatory cases. Clomiphene citrate (CC) is the drug of choice for ovulation induction in infertile anovulatory women. Letrozole (LT) has been used for ovulation induction since 2001 and several clinical trials have compared the efficacy of LT and CC in infertile women with PCOS. However, the success of CC and LT for ovulation induction has not been previously evaluated according to PCOS phenotypes and in patients with and without hyperandrogenism (HA). We designed this study to compare the success of CC and LT in terms of ovulation, clinical pregnancy and ongoing pregnancy rates in PCOS phenotypes and subgroups according to modified Ferriman-Gallwey (mFG) score and HA.

MATERIALS-METHODS: Patients with a diagnosis of PCOS who were admitted to Ankara University Faculty of Medicine, Department of Obstetrics and Gynecology, Infertility Outpatient Clinic between November 2023 and April 2024 and underwent ovulation induction with CC or LT were included in the study. Patients treated for other infertility factors were excluded. Patients were compared in terms of response to ovulation induction, clinical pregnancy and ongoing pregnancy rates.

RESULTS: A total of 207 patients were included in the study. There were 159 patients with HA (phenotypes A, B and C) and 48 patients without HA (phenotype D). In total, 104 women underwent ovulation induction with CC and 103 with LT. There was a significant difference in ovulation between the CC and LT groups (77.9% and 93.2%, respectively; P=0.002). According to multivariate logistic regression analysis, age (Odds ratio: 0.843, 95% confidence interval 0.732-0.971, P=0.018) and free androgen index (FAI) (Odds ratio: 0.279, 95% confidence interval 0.091-0.860, P=0.026) were significantly associated with the chance of clinical pregnancy. In the phenotype A, B and C subgroup, there was a significant difference between CC and LT for ovulation (78.7% and 94.3%, respectively; P=0.005). In the mFG score>8 subgroup, there was a significant difference between CC and LT for ovulation (78.9% and 94.4%, respectively; P=0.005). Furthermore, in the group of patients with FAI□7, a significant difference was found between CC and LT for ovulatory response (50% and 100%, respectively; P=0.006), clinical pregnancy (0% and 66.7%, respectively; P=0.003) and ongoing pregnancy (0% and 58.3%, respectively; P=0.007). In patients with tT değeri□48, there was a significant difference between CC and LT for clinical pregnancy (0% and 24%, respectively; P=0.012) and ongoing pregnancy (0% and 20%, respectively; P=0.023).

CONCLUSION: There is no significant difference between CC and LT in ovulation induction of different PCOS phenotypes. However, LT was found to be a more effective option in terms of ovulation rates in

PCOS patients with clinical and/or biochemical HA. In addition, higher clinical and ongoing pregnancy rates are achieved with LT in patients with laboratory HA but not clinical HA.

Keywords: infertility, ovulation induction, polycystic ovary syndrome

SS-028 [İnfertilite]

Effect of weight loss on serum anti-müllerian hormone levels in overweight infertile women with polycystic ovary syndrome

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Effect of weight loss on serum anti-müllerian hormone levels in overweight infertile women with polycystic ovary syndrome

AIM: Polycystic ovary syndrome (PCOS) affects one-fifth of women of reproductive age and is anovulatory causes subfertility. Obesity negatively affects reproductive health, including ovarian function. Anti-Mullerian hormone (AMH) is widely used as an indicator of ovarian reserve because it is secreted by antral follicles. Women with PCOS are believed to have significantly higher AMH levels compared to healthy women; this is associated with an increased number of antral follicles. Some studies have suggested that an anti- Mullerian hormone (AMH) level of 3.8–5 ng/ mL can be used for the diagnosis of PCOS. The aim of this study was to evaluate the effects of body mass index and weight loss on AMH levels in overweight and obese women with polycystic ovary syndrome.

METHOD: For this study, patients who applied to the infertility clinic of the Gynecology and Obstetrics Clinic of Kayseri City Hospital between 05/10/2024 and 01/03/2025; aged between 18-40 years, diagnosed with PCOS including all three criteria according to the Rotterdam criteria (oligo- or anovulation on ultrasound, hyperandrogenism and polycystic ovaries), with a body mass index (BMI) >30 kg/m2, and started on metformin treatment and were referred to the obesity clinic for weight loss, were selected among those who lost weight after a 3-month diet. The basal hormone and AMH levels of 24 patients at first application were compared with the values after the diet.

FINDINGS: The ovarian reserve tests were evaluated before and after weight loss, no statistically significant difference was found in terms of basal FSH, LH, E2, AMH ($p>0.05$).

CONCLUSION: Weight loss is not associated with changes in circulating AMH levels in obese women with PCOS.

Keywords: AMH, Polycystic ovary syndrome, Obesity

Evaluation of FSH, LH, E2, AMH and their measurements before and after weight loss

	Before weight loss (n = 24)	After weight loss (n=24)	p
FSH (mIU/ml)	4.92±1.53	5.61±0.82	0.58
LH (mIU/ml)	6.40±3.08	4.83±1.05	0.71
Estradiol (pg /ml)	55.7±11.26	58±9.48	0.46
AMH (ng/ml)	5.11±1.12	4.68±0.79	0.64

SS-029 [Jinekoloji Genel]

Ovarian Reserve Variability Among PCOS Phenotypes in the Turkish Population

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OBJECTIVE: This study has aimed to investigate the differences in ovarian reserve among various PCOS phenotypes. By enhancing the understanding of the biological diversity among PCOS phenotypes, our research has sought to contribute to the development of diagnostic and therapeutic strategies in clinical practice. Design: Cross-sectional, observational study

METHODOLOGY:

•Participant Selection: Women aged 18–40 years diagnosed with PCOS were included in the study. Participants have been classified into different PCOS phenotypes based on the Rotterdam criteria.

• Data Collection: Ovarian reserve has been assessed using antral follicle count (AFC), anti-Müllerian hormone (AMH) levels, and other biochemical parameters.

• Analysis: Statistical comparisons have been performed to determine significant differences in ovarian reserve among PCOS phenotypes.

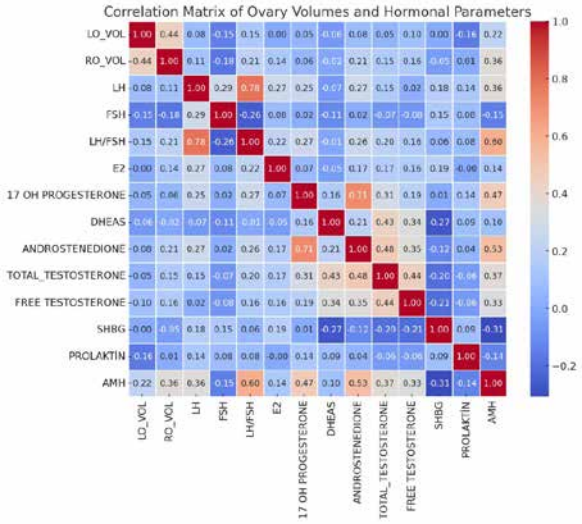
• Ethical Considerations: Participation was entirely voluntary, and informed consent was obtained from all participants. Data was anonymized and securely stored, accessible only to the research team

RESULT: Statistically significant differences were found in ovarian volume among PCOS phenotypes ($p < 0.05$). Post-hoc analysis showed significant differences in both left ovarian volume (LOV) and right ovarian volume (ROV) among specific phenotypic groups: Phenotype A vs. B, Phenotype B vs. C, and Phenotype B vs. D ($p < 0.05$). These findings indicate that Phenotype C tends to have the largest ovarian volumes, while Phenotype B had the lowest values and exhibits the most distinct variations compared to other phenotypes. No statistically significant differences were observed among the other phenotype groups.

CONCLUSION: This study confirms that ovarian volume significantly differs among PCOS phenotypes, with Phenotype C displaying the highest ovarian volumes and Phenotype B showing the lowest values. The findings suggest that ovarian volume is an important distinguishing factor among PCOS subtypes. These results highlight the need to consider ovarian volume in the phenotypic classification and clinical assessment of PCOS patients, as it may contribute to better diagnostic accuracy, personalized treatment planning, and optimized fertility management. Future large-scale, longitudinal studies are needed to further explore the biological mechanisms underlying these variations and their long-term clinical implications in PCOS management.

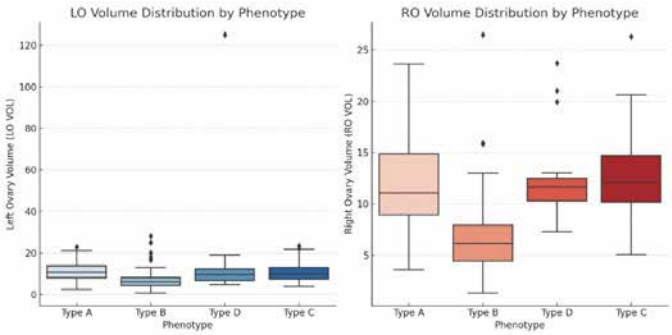
Keywords: Antral Follicle Count, Fertility Treatment, Ovarian Volume, Phenotypic Classification, Polycystic Ovary Syndrome (PCOS), Rotterdam Criteria

Correlation Matrix of Ovary Volumes and Hormonal Parameters in PCOS Phenotypes



The correlation matrix visualizes the relationships between ovary volumes (LO VOL & RO VOL) and key hormonal parameters in PCOS phenotypes. The color intensity and numerical values represent the strength and direction of these correlations.

LEFT OVARIAN AND RIGHT OVARIAN VOLUME DISTRIBUTION BY PCOS PHENOTYPES



1.Right Ovary Volume (RO VOL) shows more variation among phenotypes compared to Left Ovary Volume (LO VOL); 2.Type C tends to have the largest ovary volumes in both left and right ovaries, while Type B has the lowest RO VOL; 3.Outliers are observed in both graphs, particularly in Type A and Type C, indicating that some individuals have significantly larger ovary volumes than the rest of their group.

SS-030 [İnfertilite]

Evaluating the Reproductive Impact of Pembrolizumab in Mice: Ovarian Function and Hormonal Changes

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BACKGROUND: Immunotherapy, while effective in treating various cancers, is associated with numerous immune-related side effects. However, there are insufficient data concerning its impact on the female reproductive system. This study aimed to investigate the effects of pembrolizumab on ovarian function in a mouse model.

METHODS: A total of 24 mice were divided into acute and chronic groups to examine changes in hormone levels and follicular counts, with a focus on primordial, preantral, and secondary follicles. The mice received either pembrolizumab or saline and underwent superovulation, followed by evaluations of estradiol, follicle-stimulating hormone (FSH), luteinizing hormone (LH), and anti-Müllerian hormone (AMH) levels.

RESULTS: Hormonal analysis revealed significant reductions in estradiol levels in the pembrolizumab-treated groups compared with the control groups (p=0.007). FSH and LH levels remained stable across all groups, with no significant differences noted (p=0.461 and p=0.038, respectively). AMH levels also showed no significant change (p=0.460). Notably, primordial follicle counts were significantly greater in the control group than in the pembrolizumab-treated groups (p=0.009).

CONCLUSION: This study highlights the specific impact of pembrolizumab on estradiol levels and primordial follicle counts, suggesting potential reproductive side effects. These findings underscore the importance of monitoring reproductive health in women undergoing immunotherapy to balance oncological benefits against possible reproductive risks.

Keywords: Immune Checkpoint Inhibition, Ovarian Function, Pembrolizumab, Reproductive Toxicity, Reproductive Health

Histopathological Sections of Ovarian Excisional Biopsies

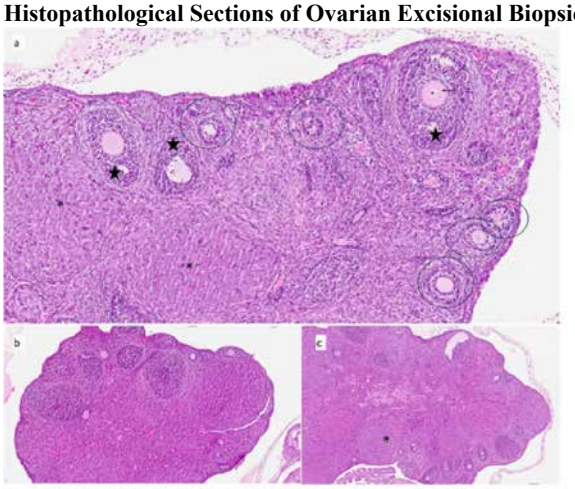

Figure 1: a, b, c. Histopathological sections of ovarian excisional biopsies. Representative ovarian tissue sections showing various stages of follicular development, including the oocyte (arrow), primordial and primary follicles (in black circles), and secondary follicles (stars).

Comparison of Serum Hormone Levels (E2, FSH, LH, and AMH) Between Control and Pembrolizumab-Treated Groups

	Acute Control Group 1	Acute Treatment Group 2	Chronic Control Group 3	Chronic Treatment Group 4	p-value ANOVA	p-value Group 1 vs Group 2	p-value Group 3 vs Group 4	p-value Group 2 vs Group 4
E2 (pmol/L)	93.18 ± 7.62	68.69 ± 17.38	78.80 ± 8.22	67.34 ± 14.36	0.007	0.015	0.413	0.998
FSH (IU/L)	161.02 ± 16.18	161.54 ± 10.30	153.47 ± 12.09	151.41 ± 14.28	0,461	0.989	0.993	0.609
LH (IU/L)	20.42 ± 1.32	19.68± 1.34	22.44 ± 4.41	17.62 ± 2.22	0.038	0.962	0.023	0.545
AMH (ng/mL)	49.30 ± 4.80	49.45 ± 3.06	47.05± 3.59	46.44± 4.24	0.460	0.998	0.993	0.567

Data are expressed as means ± SDs. Significant differences of measurement traits were analyzed using one-way ANOVA, followed by Tukey HSD post hoc analysis. A p value of <0.05 indicates a significant difference.

Counts of Follicular Stages in Control and Treatment Groups

	Acute Control Group 1	Acute Treatment Group 2	Chronic Control Group 3	Chronic Treatment Group 4	p-value ANOVA	p-value Group 1 vs Group 2	p-value Group 3 vs Group 4	p-value Group 2 vs Group 4
Primordial Follicle	6 ± 1	3 ± 2	6 ± 1	3 ± 2	0.001	0.007	0.002	0.997
Preantral Follicle	4 ± 2	5 ±5	4 ± 1	4 ± 3	0.761	0.723	0.997	0.870
Secondary Follicle	2 ± 2	3 ± 1	3 ± 2	3 ± 2	0.445	0.793	0.793	0.881
Total Follicles	11 ± 4	11 ± 2	13 ± 3	10 ± 3	0.384	0.998	0.366	0.991

Data are expressed as means ± SDs. Significant differences of measurement traits were analyzed using one-way ANOVA, followed by Tukey HSD post hoc analysis. A p value of <0.05 indicates a significant difference.

SS-031 [İnfertilite]

Quality of life and emotional problems in women with infertility

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BACKGROUND: The fertility quality of life (FertiQoL) measure specifically evaluates the impact of fertility problems in various life areas. The aim of this study was to examine sociodemographic characteristic of infertile female patients, the relationship between FertiQoL and the Screen IVF questionnaire.

METHOD: This study included two hundred of female patients who underwent various fertility examination and treatments in our infertility department from January to March 2018 in GAK ''Narodni front'', Belgrade.

RESULTS: Our results showed that the four core scales of the FertiQoL measure had a Cronbach's α value between 0.538-0.842. Our results showed the average FertiQoL score 62.23(±15.49), significantly associated with education (p=0.037). The quality of fertility was significantly influenced by age (p=0.035), incomes (p=0.035), length of relationship with partner (p=0.036), type of sterility (p=0.020), length of treatment (p=0.037). The quality of treatment is statistically significantly related to the incomes (p=0.016) and the cause of sterility (p=0.024). Treatments tolerance is statistically related to age (p=0.018), incomes (p=0.05), length of treatment (p= 0.043) and the cause of infertilities (p=0.001). Almost all subjects are at increased risk of developing deep emotional problems on ScreenIVF (98%).

CONCLUSION: It is necessary to introduce psychological expert assistance as gold standard in the process of testing and treating infertilities for the purpose of better quality of life and outcome of treatment.

Keywords: Quality of life, infertility,depression

SS-032 [İnfertilite]

Evaluation of the concordance between endo-myometrial junctional zone thickness determined by three-dimensional (3D) transvaginal ultrasound and histological findings of chronic endometritis

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OBJECTIVE: Chronic endometritis (CE) is a persistent inflammation of the endometrium characterized by endometrial stromal infiltration and the presence of plasma cells. The gold standard for diagnosing CE is the histopathological examination of endometrial biopsy specimens to demonstrate plasma cells within the endometrium. In this study, we aimed to investigate the feasibility of 3D TVUS in diagnosing CE by examining changes and loss areas in the endo-myometrial junctional zone (JZ).

METHODS: This prospective study included 66 patients diagnosed with recurrent pregnancy loss (RPL) and recurrent implantation failure (RIF) who presented to the Department of Obstetrics and Gynecology at Ankara University Medical School between November 2023 and August 2024 and underwent diagnostic or operative H/S. Preoperatively, patients were evaluated by 3D TVUS; the JZ was visualized in the coronal plane, and the length, presence of loss area, and regularity of the endo-myometrial junctional zone for the fundus, right lateral wall, and left lateral wall were recorded. During H/S, the uterine cavity was fully visualized, and macroscopic findings potentially indicative of CE, such as hyperemia, stromal edema, strawberry appearance, and micro polyps, were documented. Endometrial biopsy samples were collected at the end of the procedure and stained with hematoxylin and eosin (H&E) and CD38 immunohistochemistry (IHC). A CE diagnosis was confirmed upon observing at least one plasma cell in a single high-power field (HPF) under the microscope.

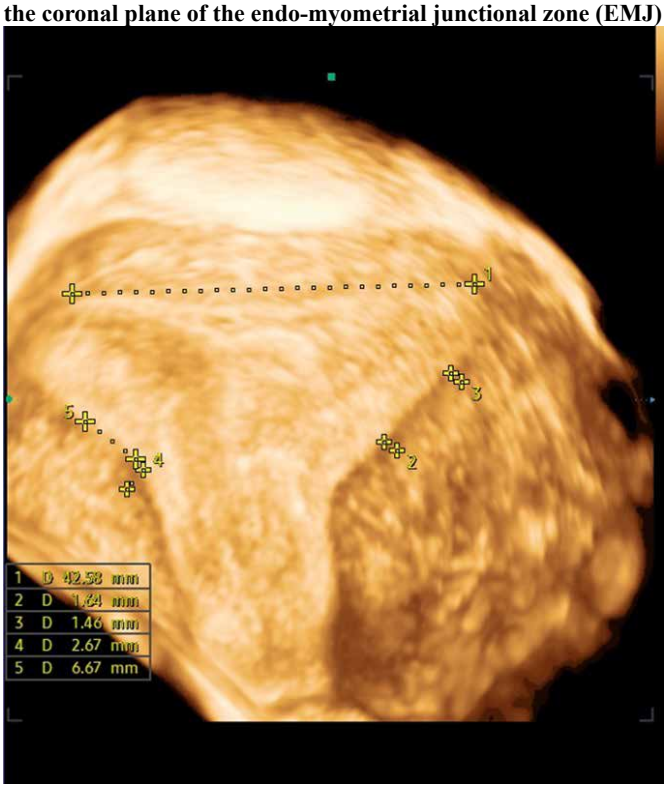
RESULTS: A total of 66 patients were included, with 26 diagnosed with RPL and 40 with RIF, of whom 39 were diagnosed with CE based on pathology results. The incidence of CE among RPL and RIF patients in our clinic was 53.8% and 62.5%, respectively. Significant differences were found between the two groups regarding the JZ loss length (mm) and JZ loss percentage (%) in the right and left lateral walls (p=0.032, p=0.014, p=0.018, and p=0.020, respectively).The proportion of cases with a JZ loss percentage of at least 50% in any wall was 64.1% in the CE group and 33.3% in the other pathology group, showing a significant difference (p=0.014). In the diagnosis of CE, when the presence of at least one macroscopic finding during H/S or a loss of at least 50% in any wall of the JZ on 3D transvaginal ultrasonography (TVUS) is considered as criteria, the sensitivity and specificity values for H/S were found to be 66.7% and 74.3%, respectively, with a positive predictive value (PPV) of 74.3% and a negative predictive value (NPV) of 58.1%. For 3D TVUS, the sensitivity was 64.1%, specificity was 66.7%, PPV was 73.5%, and NPV was 56.3%.

CONCLUSION: Our data indicate that an increased JZ loss length and JZ loss percentage are associated with histopathological CE diagnosis. These findings suggest that 3D TVUS may serve as a potential diagnostic tool for CE. Further prospective randomized studies with larger sample

sizes and heterogeneous patient populations are needed to support the feasibility and reliability of 3D TVUS as an adjunctive method in the diagnosis of CE.

Keywords: Chronic endometritis, Endomyometrial junctional zone, Hysteroscopy, Recurrent pregnancy loss, Recurrent implantation failure, Three dimensional ultrasonography

Three-dimensional (3D) transvaginal ultrasonography (TVUS) in the coronal plane of the endo-myometrial junctional zone (EMJ)



In 3D TVUSG, VCI imaging was used to obtain a coronal plane view of the uterus. In region 1, a complete loss of the endomyometrial junctional zone (EMJ) in the fundus is observed. In region 2, the thickest EMJ measurement is detected in the left lateral wall, while in region 3, the thinnest EMJ measurement is noted in the same area. In region 4, the thickest EMJ measurement is identified in the right lateral wall. Finally, in region 5, a focal loss of the EMJ in the right lateral wall is observed.

Sensitivity and Specificity of Hysteroscopy (H/S) and Three-Dimensional (3D) Transvaginal Ultrasonography (TVUS) in the Diagnosis of Chronic Endometritis (CE)

Results	H/S	3D TVUS
Sensitivity (95% CI)	%66,7 (49,8-80,9)	%64,1 (47,2-78,8)
Specificity (95% CI)	%66,7 (46,0-83,5)	%66,7 (46,0-83,5)
Positive Predictive Value (95% CI)	%74,3 (61,9-83,7)	%73,5 (60,8-83,3)
Negative Predictive Value (95% CI)	%58,1 (45,2-69,9)	%56,3 (43,9-67,9)

CI: Confidence Interval, H/S: Hysteroscopy, 3D TVUS: Three-Dimensional Transvaginal Ultrasonography

SS-033 [İnfertilite]

Pregnancy success with a reproductive health nutrition program in women diagnosed as infertile purpose

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PURPOSE: The World Health Organization defines infertility as a disorder of the male or female reproductive system characterized by the inability to achieve pregnancy despite regular unprotected intercourse over a period of 12 months or longer. It is assumed that 35-40% of cases of infertility have a female factor. The aim of this study was to investigate the effects of a reproductive health nutrition program on the success of natural or IVF (in vitro fertilization) pregnancy in women diagnosed with infertility.

METHODS: The study involved 110 women who had been diagnosed with infertility and enrolled in a special diet clinic. Age, weight, height, detailed dietary history, biochemical parameters (Tsh, b12, iron, ferritin, vitamin D, hba1c) and medications/supplements taken were recorded. Apart from the foods in the diet program, no medication or additional treatment techniques (such as infusion therapy, prp, exosome) were used during the diet, but personalized nutritional supplements were compiled. A nutritional model for reproductive health similar to the Mediterranean diet, low in red meat, rich in anti-inflammatory substances and omega-3 fatty acids, rich in orange and purple fruits and vegetables, and daily superfoods (e.g. wheatgrass powder, matcha powder, açai powder) was applied to our participants for at least three months. The quality of the eggs and embryos of those who became pregnant with the in vitro fertilization treatment was compared with previous treatments, or information on quality was obtained if it was the first treatment.

RESULTS: The age range of the 130 participants diagnosed with infertility ranged from 23 to 42 years. 56 participants who used the diet program between two and six months became pregnant naturally, while 54 achieved pregnancy through IVF (in vitro fertilization). In 20 participants, the IVF (in vitro fertilization). Treatment led to a negative result.

The graph above shows the effect of the nutrition program in the treatment of infertility. The graph shows that the nutrition program significantly increases the probability of pregnancy (85% success). Similar success rates were observed with natural pregnancy (43%) and IVF (in vitro fertilization) (42%).

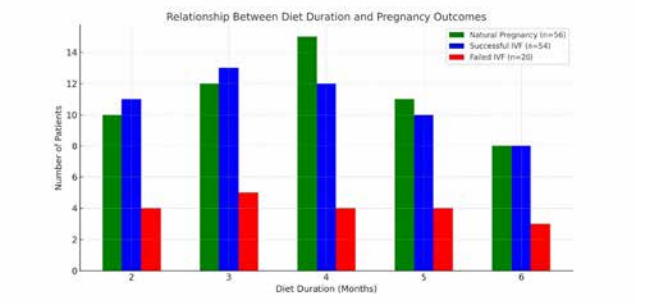
The most effective results were observed with a 3-4 month nutrition program. For IVF (in vitro fertilization). Treatment, 3 months proved to be the optimal duration. For natural conception, a 4-month program is recommended. The program is both natural and effective for IVF (in vitro fertilization) treatment.

CONCLUSIONS: This study demonstrates that a nutritional model for reproductive health similar to the Mediterranean diet, rich in orange and purple vegetables and fruits, containing both animal and plant sources of omega-3, consuming 4-5 servings of red meat per month, and supplemented with daily superfoods may help improve pregnancy outcomes and that further randomized controlled clinical trials are

needed

Keywords: Health nutrition, Infertility, Pregnancy

Relationship Between Diet Duration and Pregnancy Outcomes



SS-035 [Jinekoloji Genel]

Compared effects of surgical and natural menopause on osteoporosis and metabolic syndrome

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OBJECTIVE: To evaluate the impact of oophorectomy performed in addition to hysterectomy for benign reasons in premenopausal or perimenopausal women on the risk of developing osteoporosis and metabolic syndrome in subsequent years. The aim was to determine the risks of osteoporosis and metabolic syndrome by comparing the serum lipid profiles and bone mineral density of women who entered natural and surgical menopause.

METHODS: This study was conducted on 201 women aged between 45 and 65 years. Of the participants, 100 entered surgical menopause, and 101 entered natural menopause. All participants were evaluated for metabolic syndrome according to ATP III (Adult Treatment Panel III) criteria and for bone mineral density using DEXA (Dual-Energy X-ray Absorptiometry).

RESULTS: The prevalence of metabolic syndrome was found to be lower in women who entered surgical menopause compared to those in the natural menopause group, but no statistically significant difference was found ($p>0.05$). Regarding bone mineral density (BMD), the total femur T-score in the surgical menopause group was significantly lower than in the natural menopause group ($p<0.05$). Although the L1-L4 total T-scores were lower in the surgical menopause group, this difference was not statistically significant ($p>0.05$).

CONCLUSION: Although the ovaries do not produce estrogen after menopause, they maintain a significant portion of androgen levels. Studies have shown that androgens contribute to bone density in women after menopause. In our study, while no significant difference was found between the two groups in terms of the risk of metabolic syndrome, bone mineral density was found to be significantly lower in women who entered surgical menopause.

Keywords: Natural menopause, surgical menopause, osteoporosis, metabolic syndrome.

General average values of all participants

		Min-Mak	Medyan	Ort.±ss/n-%
Yaş		45.0 - 65.0	57.0	56.9 ± 4.7
Menopoza Girme Yaşı		33.0 - 56.0	48.0	47.5 ± 3.9
Menopoz Süresi Yıl		1.00 - 27.0	9.0	9.3 ± 4.6
Boy cm		145 - 176	157	158 ± 5.4
Kilo kg		49.0 - 126	75.0	75.9 ± 13.2
BMI		19.6 - 44.6	30.1	30.5 ± 5.0
Sigara Kullanımı	(-)			132 66.0%
	(+)			68 34.0%
Sigara Paket/Yıl		0.0 - 45.0	0.0	6.8 ± 11.5
Metabolik Sendrom Varlığı	(-)			94 47.0%
	(+)			106 53.0%
L1-L4 T Skor		-3.9 - 4.1	-1.3	-1.2 ± 1.4
Total Femur T Skor		-2.6 - 3.1	-0.2	-0.24 ± 1.0
Karın Çevresi cm		70.0 - 200	101	102 ± 16.3
TA Sistolik mm/Hg		98.0 - 185	130	132 ± 16.0
TA Diastolik mm/Hg		60.0 - 110	81.0	81.1 ± 10.0
AKŞ mg/dl		73.0 - 418	106	115 ± 36.7
LDL mg/dl		34.0 - 235	132	134 ± 36.2
HDL mg/dl		32.0 - 193	56.0	57.8 ± 17.4
TG mg/dl		44.0 - 472	138	157 ± 76.5
Kolesterol mg/dl		89.0 - 2077	223	233 ± 138

SS-036 [Jinekoloji Genel]

The Effect of Climateric Symptoms and Attıtudes Towards Menopause on Sleep Quality and Sexual Functıons In Postmenopausal Women

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Menopause is a period of life in which women transition from the reproductive age to the age of loss of reproductive capacity due to the decline in ovarian function. The climacteric period is the period between the years before the last menstrual period and the age limit (generally accepted as 65 years) after which reproductive capacity decreases and ends.). In the early period, vasomotor changes (night sweating, hot flashes and sleep problems, etc.), psychological changes (anxiety, depression, restlessness, decreased sexual interest, etc.) and atrophic changes (vaginal atrophy, stress incontinence, painful sexual intercourse, etc.) can be

observed due to estrogen deficiency, and in the late period, osteoporosis and cardiovascular diseases can be observed. In the menopausal period, sexual function is affected in almost every area to varying degrees. While health problems related to menopause are widely discussed in the literature, studies examining the relationship between the attitudes of women towards menopause in this period and their sexual lives and sleep quality are limited in our country.

The research data were collected using the "Personal Information Form", 21-question "Greene Climacteric Scale", 20-question "Attitude Scale Towards Menopause", 24-question "Pittsburg Sleep Quality Index (PSQI)" and 19-question "Female Sexual Function Inventory Questionnaire (FSFI)" developed by the researchers.

The aim of this study was to examine the effects of climacteric symptoms and attitudes towards menopause in women during menopause on sleep quality and sexual functions.

In this study, it was observed that the symptoms seen in women during the climacteric period had a significant effect on sleep quality, but it did not have a significant effect on sexual functions. We believe that early diagnosis of the symptoms of this period, planning of education and consultancy services to be provided for them, and thus providing health awareness to women, will be beneficial in terms of enabling them to cope with the problems that may be experienced during this period. We see that the attitudes of the women participating in the study towards menopause had a significant effect on their sexual functions. With a one-unit increase in the attitude scale towards menopause, FSFI decreased by 0.207 times. No relationship was found between the way they entered menopause and their attitudes towards menopause, climacteric symptoms and sexual functions. However, the scores related to sleep quality were found to be higher in women who entered menopause naturally. According to the results of our study, health education should be provided to reduce the severity and negative effects of menopausal symptoms and to cope with them, and women should be supported in these issues. At the same time, it is important to take into account the individual and sociocultural characteristics of women in the education and consultancy services to be provided. Clinics that women in menopause can easily access and that provide continuous education and counseling services should be opened, the facilities of existing clinics should be improved and their functions should be increased.

Keywords: menopause, sleep quality, sexuality, climacteric period

Table-1: Descriptive statistics of demographic data and all parameters of the participants in the study

Table-1: Descriptive statistics of demographic data and all parameters of the participants in the study

Demographic Data n=400	Ort.±SS (Min-Maks) veya n (%)
Age	51,92±5 (45-65)
Educational status	
Illiterate	24 (6)
Secondary school	159 (39,8)
High scholl	170 (42,5)
University	47 (11,8)
Marital status	
Married	256 (64)
Single	144 (36)
Employment status	
Employed	252 (63)
Unemployed	148 (37)
Number of children	2±1,3 (0-5)
Smoking	
Non-smoking	189 (47,3)
Smoking	211 (52,8)
Chronic disease	
Non	207 (51,8)
HT	127 (31,8)
DM	66 (16,4)
Operation related to reproductive organs	
No	298 (74,5)
Yes	102 (25,5)
Menopause type	
Natural	310 (77,5)
Surgical	90 (22,5)
SAT	4,46±3,8 (1-22)
HRT	
No	345 (86,3)
Yes	55 (13,8)
Attitude scale towards menopause	46,21±3,4 (40-51)
Green climacteric scale	30,45±3,2 (26-35)
PUKI	8,42±1 (7-10)
FSFI	26,78±3 (20,5-29,55)

Table-2: Effect of Greene climacteric scale and attitude scale towards menopause on PSQI

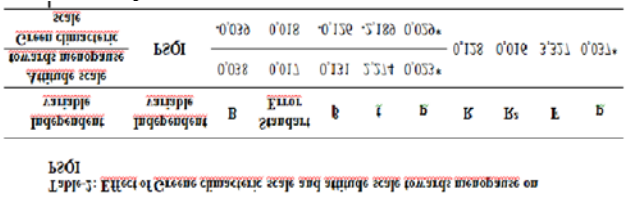

Table-3: Effect of Greene climacteric scale and attitude scale towards menopause on FSFI

Table-3: Effect of Greene climacteric scale and attitude scale towards menopause on FSFI

Independent variable	Independent variable	B	Standart Error	β	t	p	R	R²	F	p
Attitude scale towards menopause	FSFI	-0,178	0,049	-0,207	-3,638	0,0001**	0,181	0,033	6,725	0,001**
Green climacteric scale		0,074	0,052	0,080	1,414	0,158				

Table-4: Comparison of scales according to the type of menopause

Table-4: Comparison of scales according to the type of menopause

	Natural (n=310)			Surgical (n=90)			p
	Median (IQR)	Min-Maks	Ort.±SS	Median (IQR)	Min-Maks	Ort.±SS	
Attitude scale towards menopause	46 (6)	40-51	46,16±3,5	47 (6)	41-51	46,4±3,1	0,646
Green climacteric scale	30,5 (6)	26-35	30,46±3,2	33 (6)	26-34	30,4±3,3	0,356
PSQI	9 (1)	7-10	8,52±0,98	8 (2)	7-10	8,07±0,93	0,0001**
FSFI	28,05 (3)	20,5-29,55	26,78±2,9	28,05 (6,85)	20,5-29,55	26,78±3,1	0,497

SS-037 [Obstetri Genel]

Evaluation of dinoprostone use in primiparous post-term pregnancies: a retrospective analysis

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[2]Etlik Zubeyde Hanim Women's Health Education and Research Hospital

AIM: The current study aims to evaluate the outcomes of the dinoprostone vaginal insert used for cervical ripening for primiparous post-term pregnancies.

METHODS: This retrospective study examined the cases of primiparous pregnant women diagnosed with post-term who were hospitalized for labor induction between 2018 and 2024. The study excluded cases with other obstetric indications (mild preeclampsia, fetal growth restriction, oligohydramnios), pregnancies with contraindications for vaginal labor inductions, multiparous pregnancies, and cases without an available dataset. Dinoprostone vaginal insert (PROPESS® 10 mg) was administered as a cervical ripening agent in these cases. The vaginal dinoprostone was removed in the presence of uterine hyperstimulation (>5 contractions in 10 min), non-reassuring fetal heart rate (NRFHR), successful ripening (Bishop score >8-10), or 24 h after insertion regardless of the Bishop score. The cases were divided into two groups according to successful cervical ripening with Dinoprostone. The main outcome was the cesarean section rate. Obstetric and neonatl outcomes were also compared.

RESULTS: The study encompassed a total of 125 cases, which were categorized into two distinct groups based on the outcomes of labor induction with cervical ripening using dinoprostone: Group I (N=97, 77.6%), comprising cases that resulted in successful labor induction, and Group II (N=28, 22.4%), encompassing cases that did not achieve the desired outcome. The mean maternal ages of both groups were found to be similar (23.79 ± 4.14 vs 24.71 ± 4.85 years, p=0.367). The body mass index of the groups was found to be similar (p=0.620), and all cases were of primiparous women. Bishop scores of both groups were similar (1.60 ± 1.35 vs 1.82 ± 0.86, p=299). The results of umbilical artery Doppler ultrasonography and the pre-and post-partum haemogram values are presented in Table 1. The duration of dinoprostone application was comparable across the groups (13.53 ± 6.16 vs. 15.43 ± 8.59 hours, p = 0.292). As demonstrated in Table 2, the time interval from the administration of dinoprostone to the birth and hospital stay was found to be significantly prolonged in Group II (p = 0.009 and 0.036, respectively). The rate of additional methods used for labor induction was higher in Group II (p=0.014, Table 2). The rate of cesarean sections was found to be significantly higher in Group II (p<0.001). The indications for cesarean sections are outlined in Table 3. A comparison of the birth weight, Apgar scores, newborn intensive care unit (NICU) admission rates, and postpartum hemorrhage rates between the groups yielded no statistically significant differences (p>0.05, Table 2).

DISCUSSION: Despite the labor induction for primiparous post-term women using dinoprostone showing no impact on neonatal outcomes in cases of failure, the rates of cesarean section were higher, and the duration of both labor induction and hospital stay was longer in this group.

Keywords: Cervical ripening, Dinoprostone, Primiparous, Post-term, Cesarean Section

Table 1

Table 1: Comparison of demographic, obstetric, and laboratory characteristics of the groups

	Total cases N=125 (100 %)	Cervical ripening with Dinoprostone: Succesesful (Group I) N=97 (77.6%)	Failure (Group II) N=28 (22.4%)	p value
Age, years, mean ± SD	24.0 ± 4.3	23.79 ± 4.14	24.71 ± 4.85	0.367
BMI, kg/m², mean ± SD	29.14 ± 4.07	29.24 ± 4.0	28.78 ± 4.38	0.620
Gravida, n, mean ± SD	1.1 ± 0.39	1.12 ± 0.43	1.0 ± 0	0.140
Miscarriage, mean ± SD	0.1 ± 0.39	0.12 ± 0.43	0 ± 0	0.070
Gestational Age, week, mean ± SD	41.06 ± 0.34	41.02 ± 0.14	41.18 ± 0.67	0.225
Bishop score, mean ± SD	1.65 ± 1.26	1.60 ± 1.35	1.82 ± 0.86	0.299
Umbilical Artery, S/D, mean ± SD	2.07 ± 0.33	2.07 ± 0.34	2.08 ± 0.33	0.916
Umbilical Artery, PI, mean ± SD	0.47 ± 0.11	0.47 ± 0.11	0.45 ± 0.10	0.495
Pre-partum WBC, (x10⁹/L), mean ±SD	10.11 ± 2.33	10.15 ± 2.47	9.94 ± 1.81	0.608
Pre-partum HB (gr/dl), mean ±SD	11.9 ± 1.32	12.03 ± 1.33	11.76 ± 1.25	0.332
Pre-partum PLT (x10⁹/L), mean ±SD	240.24 ± 65.78	239.10 ± 67.15	244.21 ± 61.80	0.719
Post-partum WBC, (x10⁹/L), mean ±SD	18.37 ± 5.89	19.45 ± 5.78	14.65 ± 4.70	**<0.001**
Post-partum HB (gr/dl), mean ±SD	11.03 ± 1.49	11.12 ± 1.55	10.73 ± 1.25	0.185
Post-partum PLT (x10⁹/L), mean ±SD	242.49 ± 60.95	245.15 ± 59.27	233.28 ± 66.75	0.366

Independent t-test, p values < 0.05 is statistically significant

BMI;Body mass index, HB; Hemoglobin, HCT; Hematocrit, n; Number, PLT;Platelets, PI;Pulsatility Index, SD; Standart Deviation, S/D;systole / diastole, WBC; White blood cells

Comparison of demographic, obstetric, and laboratory characteristics of the groups

Table 2

Table 2: Comparison of obstetric and neonatal characteristics of the groups

		Total Case N=125 (100 %)	Cervical Ripening With Dinoprostone: Succesesful (Group I) N=97 (77.6%)	Failure (Group II) N=28 (22.4%)	p Value
Duration of dinoprostone, h, mean ±SD		13.95 ± 6.7	13.53 ± 6.16	15.43 ± 8.59	0.292[a]
Time from dinoprostone administration to birth, h, mean ±SD		21.91 ± 15.12	20.03 ± 11.78	28.43 ± 22.34	**0.009**[a]
An additional method	No	92 (73.6%)	75 (77.3%)	17 (60.7%)	**0.014**[b]
	Oxytocin	31 (24.8%)	22 (22.7%)	9 (32.1%)	
	Balloon + oxytocin	2 (1.6%)	0 (0.0%)	2 (7.1%)	
Hospital stay, day, mean ±SD		3.59 ± 1.55	3.44 ± 1.57	4.11 ± 1.39	**0.036**[a]
Birth Type	Vaginal Birth	76 (60.8%)	75 (77.3%)	1 (3.6%)	**<0.001**[b]
	Caesarean Section	49 (39.2%)	22 (22.7%)	27 (96.4%)	
Birth Weight, g, mean ±SD		3351.87 ± 342.73	3381.88 ± 339.66	3247.93 ± 338.87	0.072[a]
APGAR Score (1st-minute), mean ±SD		8.91 ± 0.56	8.92 ± 0.57	8.89 ± 0.56	0.840[a]
APGAR Score (5th-minute), mean ±SD		9.92 ± 0.46	9.93 ± 0.43	9.89 ± 0.56	0.720[a]
Admission on NICU	No	117 (93.6%)	91 (93.8%)	26 (92.9%)	0.855[b]
	Yes	8 (6.4%)	6 (6.2%)	2 (7.1%)	
Postpartum Hemorahge	No	122 (97.6%)	95 (97.9%)	27 (96.4)	0.132[b]
	Uterine atony	1 (0.8%)	0 (0.0%)	1 (3.6%)	
	Severe vaginal laceration	2 (1.6%)	2 (2.1%)	0 (0.0%)	
Postpartum infection	No	122 (97.6%)	96 (99.0%)	26 (92.9%)	**0.026**[b]
	In episiotomy	1 (0.8%)	1 (1.0%)	0 (0.0%)	
	In abdominal incision	2 (1.6%)	0 (0.0%)	2 (7.1%)	

*= Independent t-test **=Chi Square test, p values < 0.05 is statistically significant
h;hour, n; Number, NICU; Newborn intensive care unit, SD; Standart Deviation

Comparison of obstetric and neonatal characteristics of the groups

Table 3

Table 3: Comparison of cesarean section indications between groups

	Total Case	Cervical Ripening With Dinoprostone: Succesesful (Group I)	Failure (Group II)	p value
Caesarean Indications	N=49 (39.2%)	N=22 (22.7%)	N=27 (96.4%)	
Failed Induction Of Labor	8 (16.3%)	0 (0.0%)	8 (29.6%)	
Fetal Distress	27 (55.1%)	13 (59.1%)	14 (51.9%)	**0.026**
Cephalopelvic Discordance	3 (6.1%)	3 (13.6%)	0 (0.0%)	
Prolonged Phase	9 (18.4%)	5 (22.7%)	4 (14.8%)	
Maternal Intolerance	1 (2.0%)	0 (0.0%)	1 (3.7%)	
Prolapsed umbilical chord	1(2.0%)	1 (4.5%)	0 (0.0%)	

Chi Square test, p values < 0.05 is statistically significant

Comparison of cesarean section indications between groups

SS-038 [Obstetri Genel]

The Association Between Maternal Hematological Indices and Neonatal Intensive Care Unit Admission in Cases of Premature Rupture of Membranes

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OBJECTIVE: This study aims to evaluate the association between maternal hematological indices and neonatal intensive care unit (NICU) admission in pregnancies diagnosed with preterm premature rupture of membranes (PPROM). The study seeks to determine whether hematological parameters can predict fetal well-being and investigate the impact of maternal inflammatory markers on neonatal prognosis.

METHODS-MATERIALS: This retrospective cohort study includes clinical data of 32 pregnant women diagnosed with PPROM and delivered at our hospital. Neonates were divided into two groups: 19 not admitted to the NICU and 13 requiring NICU admission. The demographic characteristics of the mothers (age, gestational week, gravida, parity, etc.) and hematological parameters and indices were analyzed retrospectively. Differences between the groups were assessed using the Mann-Whitney U test, with statistical significance set at $p<0.05$. Patients with underlying chronic inflammatory diseases, rheumatologic conditions, or a history of upper respiratory tract infections were excluded from the study.

RESULTS: Upon analyzing maternal hematological parameters, SII values in the NICU-admitted group were 973.1 (311.36 - 5696.4), compared to 1037.06 (334.76 - 1885.32) in the non-admitted group (p=0.818). PIV, NLR, and MLR values were higher in the NICU-admitted group; however, no statistically significant differences were observed ($p > 0.05$). PIV values were 861.0 (186.82 - 7405.32) in the NICU-admitted group and 705.6 (268.8 - 1885.32) in the non-admitted group (p=0.848); NLR values were 3.88 (1.90 - 28.20) and 3.77 (1.76 - 8.83), respectively (p=0.645); MLR values were 0.47 (0.14 - 1.70) and 0.46 (0.12 - 1.33), respectively (p=0.367).

CONCLUSION: Maternal hematological parameters were not found to be significant predictors of NICU admission in pregnancies diagnosed with PPROM. Despite a more pronounced maternal inflammatory response, SII, PIV, NLR, and MLR values did not demonstrate statistical significance in predicting NICU admission. Further large-scale and prospective studies are needed to explore the role of these biomarkers in predicting neonatal morbidity and determining the optimal delivery timing.

Keywords: Preterm Premature Rupture of Membranes, Neonatal Intensive Care Unit, Maternal Hematological Indices, Inflammatory Biomarkers

Comparison of Maternal Hematological Indices Between Neonates with and without NICU Admission

INDICES	NICU Admission (Median, Min-Max)	No NICU Admission (Median, Min-Max)	p-value
SII (Systemic Immune-Inflammation Index)	973.1 (311.36 - 5696.4)	1037.06 (334.76 - 1885.32)	0.818
PIV (Pan-Immune-Inflammatory Value)	861.0 (186.82 - 7405.32)	705.6 (268.8 - 1885.32)	0.848
NLR (Neutrophil-to-Lymphocyte Ratio)	3.88 (1.90 - 28.20)	3.77 (1.76 - 8.83)	0.645
MLR (Monocyte-to-Lymphocyte Ratio)	0.47 (0.14 - 1.70)	0.46 (0.12 - 1.33)	0.367

SII, PIV, NLR, and MLR are hematological indices used to assess systemic inflammation and immune response. This table compares their values between neonates who required NICU admission and those who did not. No statistically significant differences were observed ($p > 0.05$).

SS-039 [Obstetri Genel]

A Prospective Study Of The Association Of Maternal Serum Netrin-1 Levels With The Diagnosis Of Gestational Diabetes Mellitus And Pregnancy Complications

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OBJECTIVE: This study aims to investigate whether maternal netrin-1 levels are associated with gestational diabetes mellitus (GDM) and to evaluate Netrin-1's usefulness in predicting GDM complications.

MATERIAL-METHOD: This single-center prospective case-control study was conducted between 1st of September 2023 and 1st of May 2024 in an obstetric clinic of a tertiary center by including 141 pregnant women (51 diagnosed with GDM and 90 control group) who gave birth in that clinic after single or two-step GDM screening and met the study criteria. Both groups' oral glucose tolerance test (OGTT) results and maternal serum netrin-1 levels were compared. SPSS 22.0 and MedCalc 18 programmes were used for statistical data analysis.

RESULTS: When comparing the demographics of the patient groups, only age and OGTT weeks were similar. Netrin-1 levels were 0.11 (0.01-0.49) in the gestational diabetes mellitus group and 0.12 (0.07-1.4) in the control group and were statistically significantly lower in the gestational diabetes mellitus group (p=0.013). Polyhydramnios, macrosomia, fetal and maternal complications, and the need for maternal intensive care were more common in the gestational diabetes mellitus group. The gestational week of labour was statistically significantly earlier in the gestational diabetes mellitus group. According to the ROC analysis evaluating the role of netrin-1 in predicting the development of ketoacidosis in gestational diabetes mellitus, netrin-1 level of 0.06 and below predicted the development of ketoacidosis in gestational diabetes mellitus with 100% sensitivity and 91.84% specificity ($p<0.001$, AUC=0.923). Netrin-1 level ≤0.09 increased the risk approximately

four times (p<0.001), and multivariate analysis was applied. One unit increase in BMI increased the risk approximately one point two times, and Netrin-1 level ≤0.09 increased the risk approximately three point five times compared to those without (Hosmer-Lemeshow p=0.288, model p=0.001). One unit increase in BMI increased the risk one point two times. When the multivariate analysis was applied, one unit increase in BMI increased the risk approximately one point two times, and Netrin-1 level≤0.09 increased the risk approximately three point five times compared to those without (Hosmer-Lemeshow p=0.288, model p=0.001).

CONCLUSION: Netrin-1 levels can be used to predict gestational diabetes mellitus, but prospective studies with larger study groups are needed to evaluate.

Keywords: Gestational diabetes mellitus, inflammation, netrin-1, oral glucose tolerance test

SS-041 [Obstetri Genel]

Evaluation of Pica Symptoms in Pregnant Women with Iron Deficiency Anemia and the Effect of Iron Therapy

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OBJECTIVE: Iron deficiency anemia (IDA) is a common public health issue, especially among pregnant women. Anemia affects not only hematological parameters but also cognitive functions, mood, and nutritional behaviors. In this context, pica is an eating disorder characterized by the compulsive consumption of non-nutritive substances (such as ice, soil, chalk, starch, etc.), which is strongly associated with iron deficiency. The aim of this study is to evaluate the pre- and post-treatment status of pica symptoms in pregnant individuals diagnosed with iron deficiency anemia and to investigate the effect of iron therapy on pica behaviors.

Materials and METHODS: This prospective observational study was conducted at Etlik Zübeyde Hanım Women's Health and Research Hospital between November 2023 and December 2024. A total of 272 women were screened, and 41 patients who met the inclusion criteria (aged 18-45, Hb <10 g/dL) were included in the study. Patients with obsessive-compulsive disorder (OCD) or any other psychiatric diagnoses were excluded.

Demographic characteristics, obstetric history, and hematological parameters (hemoglobin, serum ferritin, serum iron, and total iron-binding capacity levels) of the patients were recorded. Pica symptoms were assessed using a structured questionnaire both before treatment and six weeks after iron therapy.

Patients received oral iron preparations containing 100-200 mg of elemental iron or intravenous iron treatment according to clinical indications. Descriptive statistical methods were used for statistical analysis, and a p-value of <0.05 was considered statistically significant.

RESULTS: Of the 41 patients, 9 (21.9%) exhibited pica symptoms before treatment. The average age of patients with pica symptoms was 30.22, the median gravida value was 2, the median parity value was 1, and the average gestational week was 24.8. The average hemoglobin level before treatment was 9.26 g/dL, and the average ferritin level was 18.49 ng/mL. The most frequently consumed non-nutritive substances were ice, soil, and starch.

After iron therapy, the average hemoglobin level of the patients increased to 12.22 g/dL, and a significant correlation was found between the increase in hemoglobin levels and the reduction in pica symptoms (p<0.05).

Three patients received intravenous iron treatment, and one patient received erythropoiesis-stimulating (ES) replacement therapy. Additionally, one patient also received psychotherapy. After treatment, the majority of patients with pica symptoms experienced complete resolution of their symptoms.

CONCLUSION: This study highlights the strong relationship between iron deficiency anemia and pica behaviors, demonstrating that iron therapy significantly reduces pica symptoms. The findings suggest that pica may not only be a psychological phenomenon but also a biochemical response to nutritional deficiencies. Therefore, screening for pica symptoms should be included in the clinical evaluation process for anemic pregnant women, and early iron supplementation should be integrated into treatment algorithms to prevent potential complications related to pica. Future studies with larger sample sizes and long-term follow-up are needed to better understand the long-term effects of iron therapy on pica.

Keywords: Iron deficiency anemia, Pica, Pregnancy, Iron therapy, Nutritional deficiency

SS-042 [Obstetri Genel]

Evaluation of endoplasmic reticulum stress levels in patients diagnosed with missed abortion

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OBJECTIVE: The aim of this study is to evaluate the relationship between endoplasmic reticulum stress and the development of missed abortion and to assess the potential role of endoplasmic reticulum stress in predicting missed abortion.

MATERIALS-METHODS: This prospective study was conducted with patients aged 18–45 years who applied to the Obstetrics and

Gynecology Clinic of Konya City Hospital between July 1, 2024, and November 31, 2024. The study aimed to compare demographic, hematological, and endoplasmic reticulum stress parameters between patients with missed abortion and healthy pregnant women. A total of 170 participants, including 85 patients with missed abortion and 85 healthy pregnant women, were included in the study. Laboratory data were obtained from residual blood samples collected during routine examinations. Markers of endoplasmic reticulum stress, including Activating Transcription Factor 6 (ATF-6), inositol-requiring enzyme 1 (IRE-1), and phospho extracellular signal-regulated kinase (PERK), were analyzed in the blood samples. Additionally, hematological parameters routinely assessed during initial evaluations were used to calculate neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), monocyte-to-lymphocyte ratio (MLR), derived neutrophil-to-lymphocyte ratio (dNLR), neutrophil-(lymphocyte × platelet) ratio (NLPR), systemic immune inflammation index (SII), and systemic inflammation response index (SIRI). The findings were statistically compared between the two groups.

RESULTS: The groups were similar in terms of sociodemographic characteristics ($p > 0.05$). Age, height, weight, and BMI values did not differ significantly between the groups ($p > 0.05$). The average number of pregnancies and births was significantly higher in the missed abortion group compared to the control group ($p < 0.05$). The mean gestational age was significantly lower in the missed abortion group compared to the control group ($p < 0.05$). Hematocrit and lymphocyte levels were significantly higher in the missed abortion group than in the control group ($p < 0.05$). In contrast, PLR, MLR, and SII were significantly higher in the control group compared to the missed abortion group ($p < 0.05$). ATF-6 and IRE-1 levels were similar between the two groups ($p > 0.05$). However, PERK levels were significantly higher in the missed abortion group compared to the control group ($p < 0.05$). No significant differences in ATF-6, IRE-1, or PERK levels were observed based on gestational age ($p > 0.05$).

CONCLUSION: This study found significant differences in hematological and endoplasmic reticulum stress parameters between patients with missed abortion and healthy pregnant women. Notably, elevated PERK levels in the missed abortion group suggest a potential association with stress response in these cases. Our findings highlight the potential diagnostic and follow-up roles of these biomarkers. Further comprehensive studies are warranted to develop preventive clinical strategies.

Keywords: Missed abortion, endoplasmic reticulum stress, PERK, IRE-1, ATF-6

SS-043 [Perinatoloji]

Perioperative indomethacin and antibiotic use in cases undergoing cerclage based on physical examination: a case series

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OBJECTIVE: In this study, we present three cases from our clinic in which asymptomatic cervical shortening was detected, and cerclage was performed based on physical examination findings.

METHODS: The study included cases referred to the Etlik Zübeyde Hanım Women's Health Care, Training and Research Hospital perinatology outpatient clinic for detailed ultrasonography from october 2023-october 2024. These cases, which were asymptomatic during the ultrasound examination, had cervical shortening, subsequently undergoing emergency cerclage with perioperative indomethacin and antibiotic therapy. All cerclages were performed transvaginally using the McDonald technique with 5 mm Mersilene sutures (Ethicon).

RESULTS and DISCUSSION: Cervical cerclage, a treatment method for preterm birth, is recommended by the American College of Obstetricians and Gynecologists (ACOG) guidelines. Cerclage indications are classified based on patient history, physical examination findings, and ultrasound findings, with specific protocols guiding its application (1). In this case series, we evaluated the outcomes of cerclage performed with perioperative indomethacin and antibiotic therapy based on physical examination findings. Cervical insufficiency is a significant condition that increases the risk of pregnancy loss and preterm birth. Although the use of cerclage in such patients is widespread in the literature, data also exist on the efficacy of perioperative indomethacin and antibiotic use. Perioperative indomethacin is frequently utilized in surgical procedures due to its potential to reduce inflammation and control pain (2). Part of the rationale for perioperative indomethacin use is related to inflammation associated with cerclage placement (2). Prostaglandins F1α and E2 have been shown to transiently increase immediately after transvaginal cerclage procedures (3). Because inflammation is believed to be the primary mechanisms responsible for preterm birth, it is hypothesized that indomethacin use could enhance cerclage efficacy (2,4). Perioperative use of antibiotics in combination with perioperative use of indomethacin has been shown to increase the rate of delivery after cerclage (5,6). Cervical dilation may increase the risk of ascending colonization of vaginal bacteria into the cervix and uterus, and perioperative antibiotics may reduce the risk of bacterial seeding into the uterine cavity (6). In our cases, perioperative indomethacin (100 mg rectal suppository) and antibiotic therapy (2 g intravenous cefazolin) were administered. In Case 1, due to fetal membranes protruding into three-fourths of the vaginal canal, an amniodrainage procedure was also performed at before cerclage procedure (Figure 1). According to ACOG, cases undergoing amniocentesis before cerclage have been reported to exhibit higher rates of chorioamnionitis, preterm premature rupture of membranes (PPROM), and preterm birth (1). The occurrence of PPROM in Case 1 aligns with these findings in the literature. The perinatal outcomes observed in Cases 2 and 3 suggest that perioperative indomethacin and antibiotic use could be effective methods (Figures 2 and 3; Table 1).

CONCLUSION: In cases undergoing cerclage based on physical examination findings in the second trimester, perioperative indomethacin and antibiotic therapy have been shown to prolong the duration of pregnancy (6). The perinatal outcomes observed in two cases in our study are promising. However, larger studies are needed to confirm the improvement in perinatal outcomes.

Keywords: Cervical cerclage, indomethacin, antibiotic, amniodrainage

Figure 1: Case 1 (a) Before cerclage P: Poch M: Bladder F: fetus

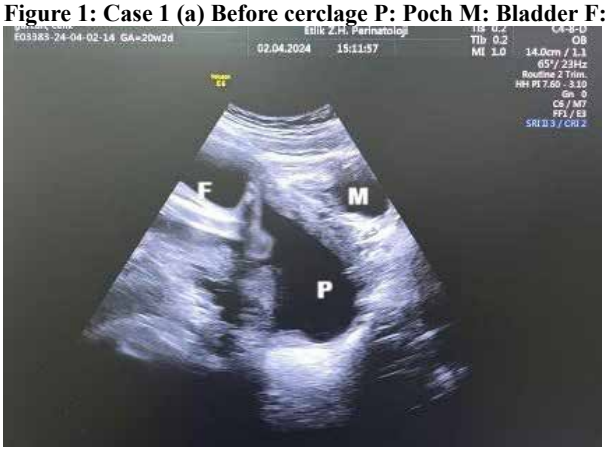


Figure 1: Case 1 (b) After cerclage S:Cervix

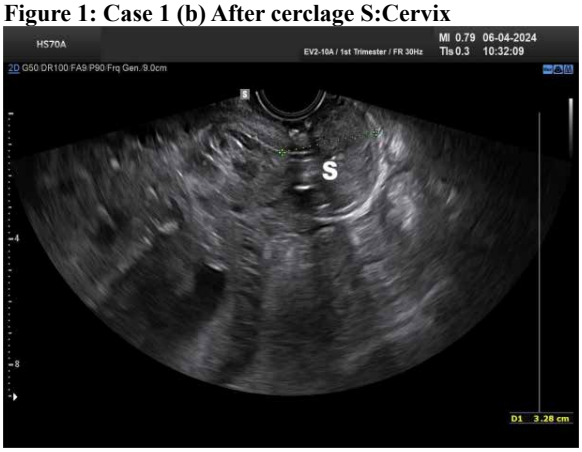


Figure 2: Case 2 (a) Before cerclage S: Cervix F: Fetus

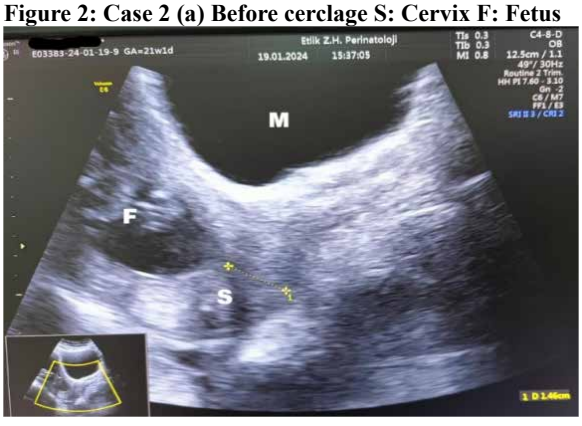


Figure 2: Case 2 (b) After cerclage S: Cervix F: Fetus

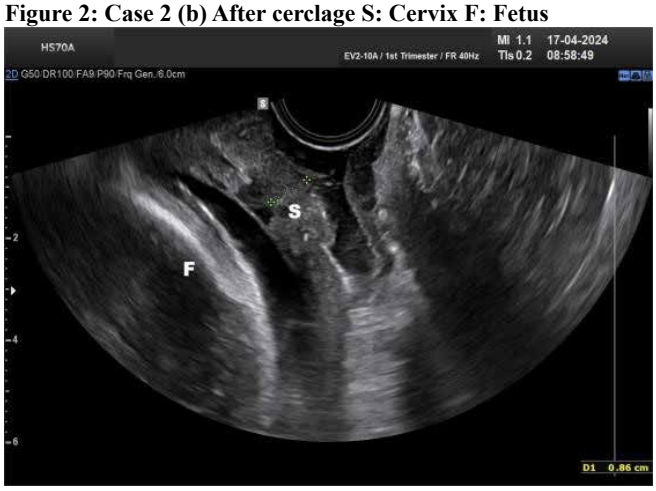


Figure 3: Case 3 (a) Before cerclage S: Cervix M:Bladder F:Fetus

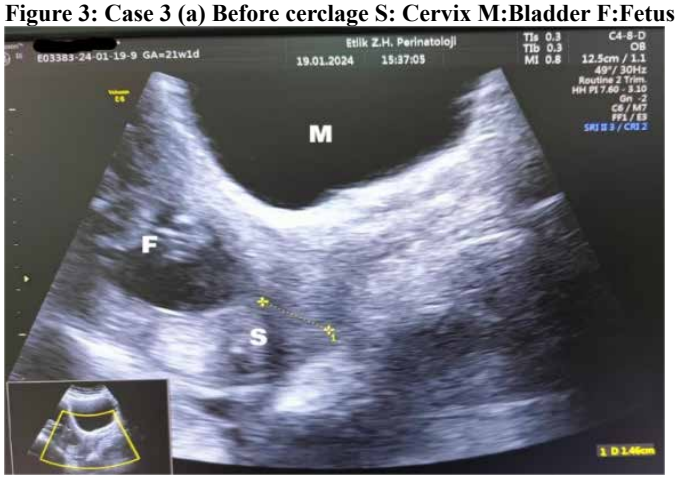
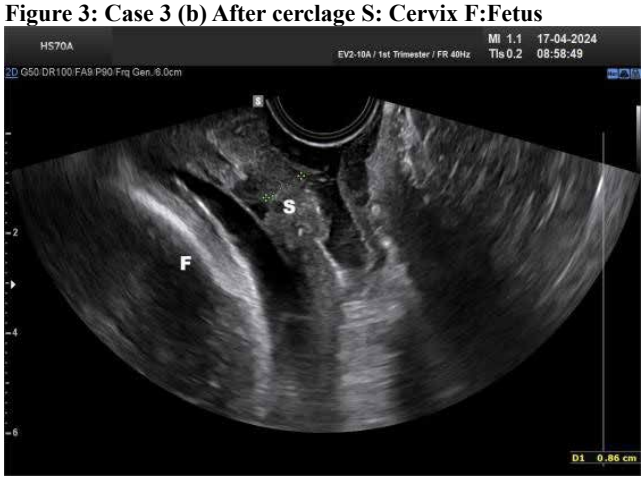


Figure 3: Case 3 (b) After cerclage S: Cervix F:Fetus



Characteristics and perinatal outcomes of cases undergoing cerclage

Case	History	Ultrasound examination	Physical examination	Laboratory findings	Before cerclage	Perioperative intervention	Perinatal outcome
Case 1							
32-years-old; G1P0 21w 3d	No history of painless miscarriage, preterm birth, or cerclage	Abdominal ultrasound: Fetal membranes in the vagina	Cervix: 3 cm, 40% effacement, fetal membranes intact in the vagina on speculum examination	Vaginal culture: Candida	Amniodrainage procedure	Indomethacin 100 mg rectal suppository 1 × 1, Cefazolin 2 g, iv 1 × 1	Abortion at 22 w, 1 d 490 g
Case 2							
34-years-old; G2P1 22w3d	No history of painless miscarriage, preterm birth, or cerclage	TVUSG: Cervix: 9.6 mm	Cervix: 2 cm, 30% effacement, fetal membranes intact, visible from the cervical os	Vaginal culture: No growth	TVUSG: Fetal membranes in the vagina; cervix: 9.6 mm	Indomethacin 100 mg rectal suppository 1 × 1, Cefazolin 2 g, iv 1 × 1	37w Vaginal delivery 3000 g
Case 3							
24-years-old; G2P1A1 16 w	History of one painless miscarriage, no history of preterm birth, or cerclage	TVUSG: Cervix: 14 mm	Cervix: 1–2 cm, effacement 30% fetal membranes intact, visible from the cervical os	Vaginal culture: No growth	TVUSG: Fetal membranes in the vagina; cervix: 14 mm	Indomethacin 100 mg rectal suppository 1 × 1, Cefazolin 2 g, iv 1 × 1	33w 5d Vaginal delivery 2302 g

Abbreviations: G: Gravida, P: Parity, A: Abortion, w: week, d: day, TVUSG: Transvaginal ultrasound, iv: intravenous, g: gram, mg: milligram, mm: millimeter

SS-044 [Perinatoloji]

Hepatic Artery Doppler As An Indicator In Assessing Vascular Dysfunction In Intrauterine Growth Restrictıon (IUGR) Pregnancies

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Object: The aim of this study is to compare the Doppler measurements of pregnant women with late-onset intrauterine growth restriction and those without fetal growth restriction and to investigate the relationship between Doppler measurements and pregnancy outcomes. Hepatic artery doppler is distinguished by its buffer mechanism known as hepatic arterial buffer response (HABR). It is thought that the decrease in portal blood flow causes an increase in blood flow in the hepatic artery by increasing the adenosine mediator, an endogenous vasodilator It is postulated that in the event of fetal hypoxia, the blood flow to the liver decreases, leading

to local adenosine accumulation, which acts directly on the hepatic artery and causes vasodilation, resulting in a compensatory increase in blood flow to the liver. We designed our study based on this assumption.

MATERIALS-METHODS: This prospective cross-sectional study was conducted with pregnant women who applied to the Perinatology and Obstetrics Polyclinics of Dr. Sami Ulus Women's Diseases, Child Health and Diseases Training and Research Hospital between 01 April 2022 and 01 October 2022. With 30 patients in each group, a total of 90 patients, those with fetal AC (abdominal circumference) or EFW (estimated fetal weight) < 3% percentile formed the 1st Group, those with fetal AC or EFW 3-10% percentile formed the 2nd Group, and those without IUGR formed the 3rd Group. Pregnant women were evaluated once between 32-37 weeks of gestation, and UA PSV (umbilical artery peak systolic velocity), UA S/D (umbilical artery systolic/diastolic), UA PI (umbilical artery pulsatility index), MCA PSV (middle cerebral artery peak systolic velocity), MCA PI (middle cerebral artery pulsatility index), DV PSV (ductus venosus peak systolic velocity), DV PI (ductus venosus pulsatility index), HA PSV (hepatic artery peak systolic velocity), HA PI (hepatic artery pulsatilla index), CPR (cerebroplacental ratio) values were measured with Doppler ultrasound. Demographic characteristics of the pregnant women and neonatal outcomes were recorded.

RESULTS: No statistically significant difference was found between the groups in terms of sociodemographic and obstetric characteristics ($p>0.05$). It was determined that the UA S/D values of both the 1st group and the 2nd group were significantly higher than the control group ($F=35.485$; $p<0.001$). It was determined that the HA PI and CPR values of the 1st group were significantly lower than the 2nd group and the control group ($\chi2=9.531$; $p=0.009$), ($F=3.600$; $p=0.031$). There was no relationship between Apgar scores and HA PSV, HA PI and CPR values in all groups ($p>0.05$). In Group 1, a negative correlation was found between HA PI and UA PI, and a positive correlation with MCA PI and CPR. ($r=-0.204$, $p=0.001$; $r=0.211$, $p=0.001$; $r=0.233$, $p=0.002$)

CONCLUSION: Our study paves the way for the hepatic artery to be used as a marker in fetuses with growth retardation in the near future. It may be an early marker for detecting IUGR. We believe that our study is important because it draws attention to hepatic artery results that have not yet found sufficient space in the literature compared to UA, MCA, and CPR measurements.

Keywords: doppler, fetal growth restriction, hepatic artery, intrauterine growth restriction, ultrasonic examination

SS-045 [Perinatoloji]

Comparison of Serum Neutrophil Percentage-Albumin Ratio and Inflammatory Markers Between Preeclamptic Pregnant Women and Healthy Pregnant Women

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AIM: Hypertensive disorders of pregnancy represent 5-11% of all pregnancies, while preeclampsia affects 3-5% of all pregnancies. Preeclampsia is associated with an elevated risk of preterm birth, perinatal mortality, neurodevelopmental delay in offspring, an increased likelihood of maternal cardiovascular and metabolic disorders, maternal cerebrovascular incidents, and long-term development of diabetes mellitus and cardiovascular diseases. Consequently, preeclampsia represents a significant burden on maternal and fetal mortality and morbidity. The objective of this study is to ascertain whether there is a distinction in the serum neutrophil percentage-albumin ratio (NPAR) and inflammatory markers between patients diagnosed with preeclampsia and healthy pregnant women, and to determine whether these ratios have a role in predicting preeclampsia.

MATERIALS-METHODS: In the present study, pregnant women diagnosed with preeclampsia and healthy pregnant women who were followed, treated, and delivered at the University of Health Sciences Konya City Hospital, Women's Health Education and Research Hospital between May 1, 2021, and May 1, 2024, were retrospectively reviewed. The patients included in the study were evaluated in a retrospective manner. A total of 200 patients were included in the study, with 100 in the control group (50%) and 100 in the preeclampsia group (50%). The medical records were obtained from the patient files and the hospital's patient record systems. The obstetric history, delivery time in patients with preeclampsia, complete blood count, spot urine, and serum albumin values were examined, and non-parametric and inflammatory markers were recorded.

RESULTS: A comparison of the two groups revealed that the incidence of preterm births was higher in the preeclampsia group than in the control group. With regard to the hematological parameters, the neutrophil percentage was higher and the lymphocyte count was lower in the preeclampsia group. The inflammatory parameters, including the Systemic Inflammatory Index (SII) and the neutrophil-to-lymphocyte ratio (NLR), were found to be statistically significantly higher in the preeclampsia group. The NPAR was observed to be higher in the preeclampsia group compared to the control group, and higher in the severe preeclampsia group compared to the mild preeclampsia group. When the NPAR cut-off value was set at 2.18, it demonstrated a sensitivity of 89% and a specificity of 95%, indicating a high diagnostic performance in comparison to other markers.

CONCLUSION: The findings of our study indicate that the NPAR and inflammatory markers examined have the potential to be valuable in the diagnosis of preeclampsia and in differentiating between severe and mild forms of the condition. Nevertheless, further and larger-scale prospective studies are required to ascertain the diagnostic value of these markers and their role as predictive markers. The data obtained from our study contribute significantly to the existing literature on the subject, indicating that NPAR could be used in the diagnosis of preeclampsia.

Keywords: Serum Neutrophil Percentage-Albumin Ratio, NPAR, preeclampsia, chronic hypertension, HELLP syndrome

SS-047 [Jinekoloji Genel]

Uterine Leiomyomas Showing Loss of Fumarate Hydratase: Metabolic Reprogramming and Clinical Outcomes

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OBJECTIVE: This study aims to investigate the metabolic reprogramming mechanisms of uterine leiomyomas with fumarate hydratase (FH) deficiency and the impact of these changes on clinical outcomes. It also aims to provide insight into the clinical management of patients diagnosed with FH-deficient leiomyoma following surgery for multiple uterine myomas.

MATERİAL & METHODS: Our patient is a 33-year-old woman who presented to the Gynecology and Obstetrics Clinic of Ankara Etlik City Hospital with complaints of pelvic and abdominal pain, menometrorrhagia, and postcoital bleeding. She has a history of five pregnancies, including two abortions and three spontaneous vaginal deliveries. Two years ago, due to severe bleeding, a levonorgestrel-releasing intrauterine device (IUD) was placed. A transvaginal ultrasound revealed multiple intramural fibroids: one measuring 48×46 mm in the uterine fundus, another measuring 39×32 mm at the uterine fundus-corpus junction, and a third measuring 45×40 mm in the posterior uterine corpus. The intrauterine device was visualized within the endometrial cavity. After discussing treatment options with the patient, a decision was made to proceed with laparoscopic myomectomy.

Findings: The patient's final pathology report confirmed a diagnosis of uterine leiomyoma with fumarate hydratase (FH) deficiency. The largest lesion measured 5.2 cm, with no necrosis observed. Mitotic activity was reported as 2/3 per 10 high-power fields. Cytological atypia was multifocal and ranged from moderate to severe. A total of seven leiomyoma specimens were sent for pathological evaluation. Follow-up for hereditary leiomyomatosis and renal cell carcinoma (HLRCC) was recommended, along with a urology consultation. Genetic testing revealed a heterozygous pathogenic variant in exon 5 of the FH gene. As a result, during the gynecologic oncology board meeting, a decision was made to proceed with a hysterectomy and regular urology follow-up.

CONCLUSION: Mutations in the FH gene lead to enzyme dysfunction in the Krebs cycle, resulting in Hereditary Leiomyomatosis and Renal Cell Carcinoma (HLRCC) syndrome. This autosomal dominant disorder is characterized by cutaneous and uterine leiomyomas, as well as aggressive papillary renal cell carcinoma (RCC). In HLRCC, cutaneous lesions serve as key diagnostic markers, while RCC is often metastatic at diagnosis and affects women more frequently than men. Some studies suggest an increased risk of uterine sarcoma in perimenopausal women with HLRCC. FH mutations are also observed in Multiple Cutaneous and Uterine Leiomyomatosis (MCUL1/Reed's Syndrome) and may contribute to the loss of tumor suppressor mechanisms. Therefore, women with leiomyomas and their families should be screened for a history of cutaneous myomas or papillary RCC, and further evaluation for renal cancer risk should be conducted.

Keywords: Fumarate Hydratase Deficiency, Leiomyomatosis, Renal Cell Carcinoma

SS-048 [Jinekoloji Genel]

Management of Apoplectic Leiomyoma in Pregnancy

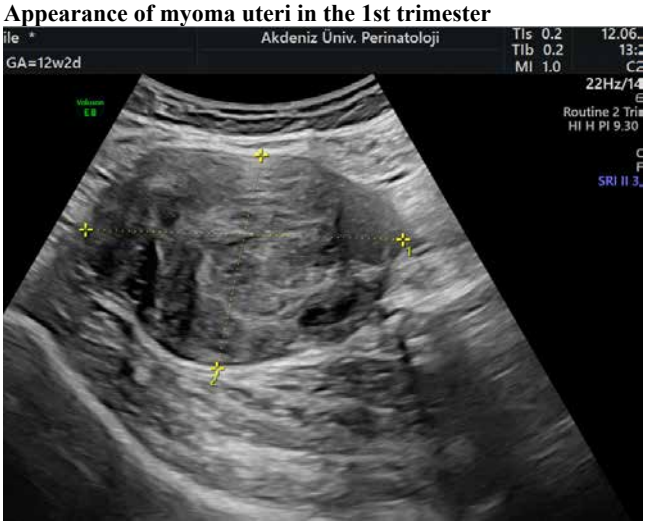
Ömer Faruk Öz, Can Dinç, Cem Dağdelen, Tuğçe Tunç Acar, Gizem Pınar, Selin Er
Akdeniz University, Faculty of Medicine

Myoma uteri, the most common solid tumor of the female reproductive system, affects approximately 20–40% of women. Its growth is estrogen-dependent, as evidenced by its tendency to regress during menopause and enlarge during pregnancy. Although myomas are generally asymptomatic, their presence during pregnancy has been associated with complications such as spontaneous abortion, preterm birth, placental abruption, and increased risk of cesarean delivery. Apoplectic leiomyoma, a rare pathological subtype, is characterized by hemorrhage, hypercellularity, mitotic activity, nuclear atypia, and necrosis, making it difficult to differentiate from leiomyosarcoma. It has been linked to hormonal therapy and occurs in women of reproductive age, particularly those using oral contraceptives, pregnant, or postpartum. A 36-year-old primiparous woman at 12 weeks and 3 days of gestation presented for a routine pregnancy check-up. Ultrasound revealed a 6 × 4 cm uterine myoma in the anterior corpus. During follow-up, she reported severe recurrent pelvic pain. Despite recommendations for hospitalization and observation, she declined inpatient care. Non-invasive prenatal testing (NIPT) results were normal, with a fetal fraction rate of 3%. At 22 weeks and 4 days, ultrasound showed normal fetal development and no increase in myoma size. However, the patient's pain had intensified. An MRI revealed a solid uterine lesion with red degeneration or torsion, measuring 70 × 36 mm, with heterogeneous T2 hypo- and hyperintense areas. The patient was hospitalized for pain management, receiving intravenous and intramuscular analgesics. No contractions were detected on cardiotocography (CTG), and fetal heart rate tracings were variable. She was discharged after one week at her request. At 33 weeks and 6 days, she was admitted to the emergency department with severe pelvic pain. She was hospitalized and treated with analgesics. No uterine contractions or obstetric anomalies were detected on ultrasound, and her transvaginal cervical length was 24 mm. Due to the risk of preterm birth, antenatal corticosteroids were administered. The myoma persisted without size changes but showed further degeneration. After 10 days, the patient was discharged following pain relief and counseling on potential obstetric complications. Subsequent weekly check-ups showed no changes in myoma size or pain intensity. At 38 weeks and 1 day, the patient was again referred to the emergency department for severe pain. CTG showed minimal irregular contractions, and vaginal examination revealed no cervical dilatation. Ultrasound confirmed normal fetal well-being and adequate amniotic fluid levels. She was admitted for observation and pain management, with no further complications beyond persistent pelvic pain. At 39 weeks and 4 days, the patient experienced spontaneous rupture of membranes. She declined vaginal delivery and insisted on a cesarean section to avoid labor pain. She and her husband were counseled on the risks of cesarean delivery. In preparation for a possible intraoperative myomectomy, erythrocyte suspension was arranged. A healthy 3,150-gram infant was delivered via cesarean section. Following placental removal and hemostasis, a

myomectomy was performed without complications. Histopathological examination confirmed the diagnosis of apoptotic leiomyoma. This case highlights the significance of close monitoring and individualized management of myomas in pregnancy to optimize maternal and fetal outcomes.

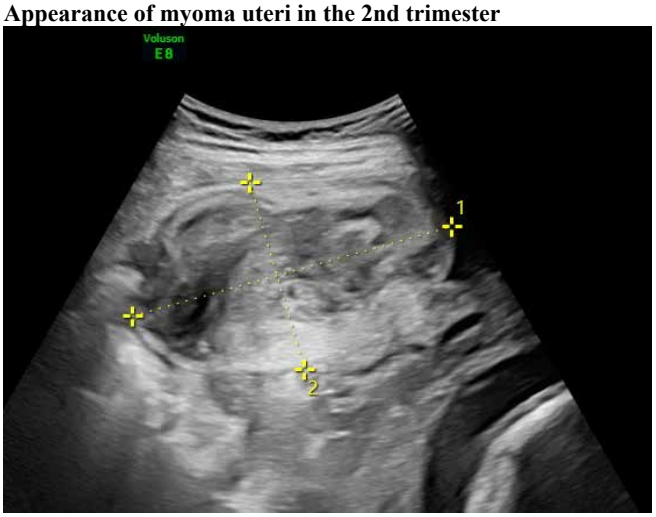
Keywords: Apoplectic myoma, pregnancy, hemorrhagic degeneration, fibroma

Appearance of myoma uteri in the 1st trimester



Appearance of myoma uteri in the 1st trimester

Appearance of myoma uteri in the 2nd trimester

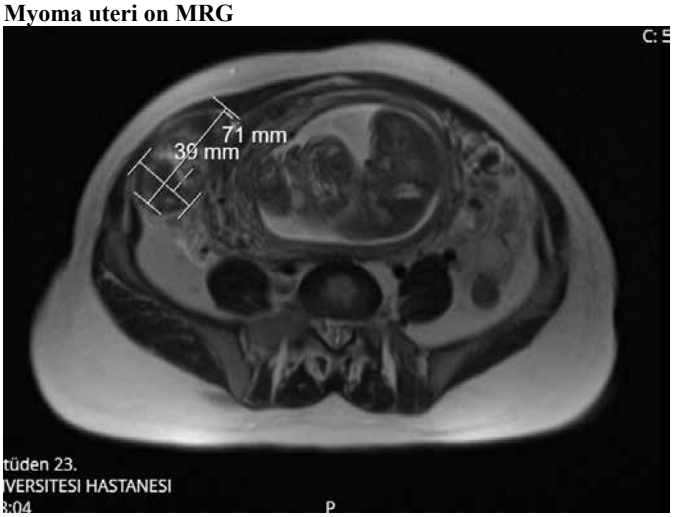


Appearance of myoma uteri in the 2nd trimester

Appearance of myoma uteri in the 3rd trimester

Appearance of myoma uteri in the 3rd trimester

Myoma uteri on MRG



Myoma uteri on MRG

Pathology result

T.C.
AKDENİZ ÜNİVERSİTESİ REKTÖRLÜĞÜ
AKDENİZ ÜNİVERSİTESİ HASTANESİ
PATOLOJİ RAPORU

Sayfa : 1 / 1

Adı Soyadı :		Dosya No :	
TC Kimlik No :		Başvuru No :	
Baba Adı		Müracaat Tarihi :	
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Hizmet Adı :	910420 Myom (lar), myomektomi, uterus hariç X 1	Onay Tarihi :	30.12.2024 09:30:43
Tanı :	O26-Gebelikle ilgili diğer durumlarda anne bakımı - O82-Tek doğum, sezeryan ile - D25-Uterusun leiomiyoması - O24-Diyabetes mellitüs, gebelikte		
Açıklaması:	MYOMEKTOMİ		

MAKROSKOPİ
tek parça halinde gönderilmiş 6x 4,5x 3 cm boyutlarında biyopsi materyali.
Kesilerek incelendiğinde kesit yüzü yer yer yer yer girdapsı beyaz ve sarı alanlar barındırdığı izlendi.. çeşitli alanlardan örneklendi. 6k.
Dr İy 25.12.2024

PATOLOJİK TANI
Apoplektik leiomyom, myomektomi materyali

Pathology result

Postoperative appearance - leiomyoma

Postoperative appearance - leiomyoma

SS-049 [Jinekoloji Genel]

Benign Metastasizing Leiomyoma And Intravenous Leiomyomatosis: A Case Report

Özhan Özdemir, Gizem Işık Solmaz, Vildan Altahhan, Mustafa Mesut Topdemir, Sezin Alparslan Çetin
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INTRODUCTION: Uterine leiomyomas are the most common benign tumors in women of reproductive age. Benign metastasizing leiomyoma (BML) and intravenous leiomyomatosis (IVL) are rare entities that represent potentially aggressive variants of uterine leiomyomas. IVL is characterized by the intravascular proliferation of smooth muscle cells, which can extend through the uterine veins into the inferior vena cava (IVC) and, in rare cases, the right atrium. Although IVL is often asymptomatic, it may result in serious clinical complications, particularly of a cardiac nature. BML typically metastasizes to the lungs and retroperitoneum while retaining histologically benign features. Here, we report a rare co-occurrence of IVL and BML involving both pelvic and cardiac manifestations. This report aims to highlight the clinical course and management strategies in such rare cases.

CASE PRESENTATION: A 43-year-old woman with a medical history of two spontaneous vaginal deliveries, hypertension, type 2 diabetes mellitus, and epilepsy underwent a myomectomy in 2018. Due to recurrence of uterine fibroids, she underwent a total abdominal hysterectomy with unilateral salpingo-oophorectomy in 2022. In November 2022, she presented with syncope, and imaging revealed a right atrial mass. Surgical resection of the intracardiac mass was performed, and histopathology confirmed a benign smooth muscle tumor consistent with intravenous leiomyomatosis. In October 2023, she presented again with a recurrent pelvic mass, and medical management was initiated. Despite receiving two doses of a subcutaneous GnRH analog administered at three-month intervals, imaging with CT and MR venography in February 2024 demonstrated persistent pelvic disease and a smooth muscle tumor extending into the IVC and right atrium. Given the involvement of major vascular structures, the cardiovascular surgery team performed excision of the intracardiac mass, followed by resection of retroperitoneal masses by the gynecology team (Figures 1–2). Pathology identified a spindle cell mesenchymal tumor consistent with leiomyoma. In July 2024, she underwent an additional unilateral salpingo-oophorectomy and resection of retroperitoneal masses due to recurrent pelvic disease. Histopathological analysis confirmed that both the cardiac and retroperitoneal lesions were consistent with benign metastasizing leiomyoma.

DISCUSSION: IVL can extend from uterine leiomyomas through the venous system to reach the right atrium in advanced stages. BML commonly involves the lungs and retroperitoneum, despite its histologically benign behavior. In this case, involvement of the IVC and cardiac chambers underscores the potentially aggressive behavior of the disease. Surgical excision remains the cornerstone of treatment; however, adjunctive hormonal therapy may be considered depending on disease progression. Advanced imaging and histopathological analysis are critical for accurate diagnosis and treatment planning. The literature supports complete surgical resection as providing the best prognosis. Long-term follow-up with serial imaging is essential to monitor for recurrence.

CONCLUSION: This case highlights the unusual co-occurrence of IVL and BML, which may result in life-threatening cardiac complications. In particular, cardiac involvement in IVL requires urgent attention. Multidisciplinary management involving cardiothoracic surgery, gynecology, radiology, and pathology is essential. Early diagnosis and aggressive surgical intervention, combined with appropriate follow-up, are key to optimizing outcomes.

Keywords: Intravenous Leiomyomatosis (IVL), Benign Metastasizing Leiomyoma (BML), Surgical Excision, Multidisciplinary Management

Fig 1. Cardiac Mass

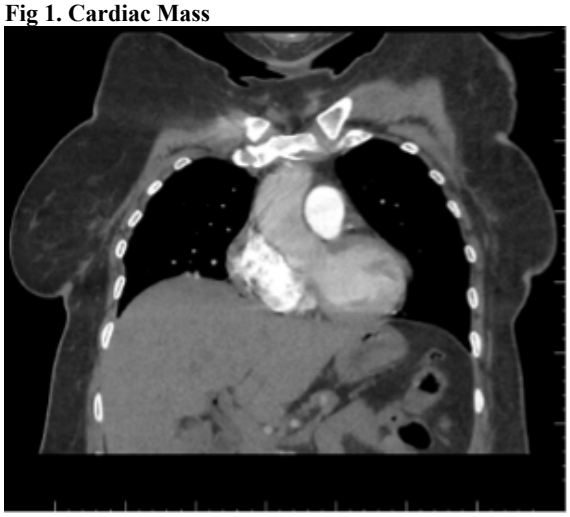
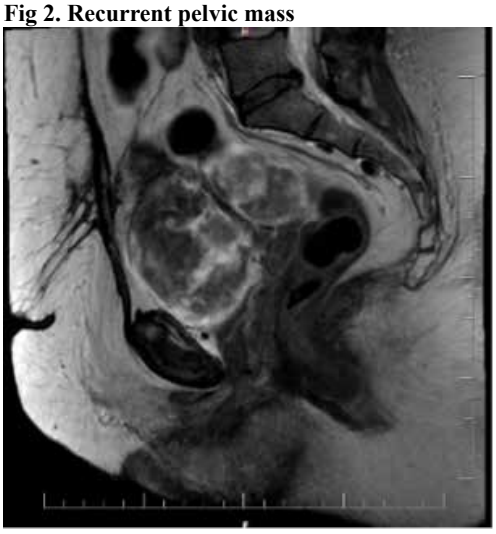


Fig 2. Recurrent pelvic mass



SS-050 [Jinekoloji Genel]

Fumarate Hydratase-Deficient Uterine Fibroids: A Retrospective Case Series and Clinical Implications

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AIM: Fumarate Hydratase (FH) -deficient fibroids, a rare subtype of uterine fibroids, arise from somatic or germline mutations, with germline cases linked to HLRCC. This autosomal dominant disorder increases the risk of renal carcinoma and often first manifests as multiple, recurrent fibroids in the third decade, causing heavy bleeding, irregular menstruation, and pelvic pain. FH-deficient fibroids develop earlier, recur more often, and may require a hysterectomy before age 40. This study examines their clinical, histopathological, and genetic features, recurrence rates, and renal associations.

METHODOLOGY: This retrospective case series included 25 patients who underwent surgical intervention for uterine fibroids at the Cerrahpaşa Medical Faculty, Department of Gynecoldogy and Obstetrics, between 2020 and 2024. All cases were confirmed to have FH deficiency through histopathological evaluation. Patient data were retrospectively collected, including demographic characteristics, clinical presentation, surgical procedures, histopathological findings, genetic analyses, and renal follow-up results. Patients were recalled for a follow-up evaluation to assess for recurrence and any associated renal pathology. Immunohistochemical analysis was performed on all pathological specimens to evaluate the expression of the FH enzyme. Genetic testing was also conducted to identify any potential germline FH mutations. Renal imaging, including ultrasound and/or CT, was performed in a subset of patients to assess for renal pathologies.

RESULTS: The most frequent presenting symptom was heavy menstrual bleeding, reported by all patients. The patient ages ranged from 23 to 54 years, with a median age of 36. Gynecological examination revealed multiple uterine fibroids in 70% of cases. Of the 25 patients, eight had multiple myomas, with a median fibroid size of 10 cm (2–16 cm). Surgical interventions included hysterectomy in 11 patients (44%) and myomectomy in 14 (56%). Histopathological examination identified bizarre nuclei in four cases. Immunohistochemical analysis confirmed loss of FH enzyme expression in all specimens. Atypical leiomyoma was diagnosed in four patients, while one patient was diagnosed with cellular leiomyoma. The remaining cases demonstrated low mitotic indices (0–3/10 high-power fields), mild atypia, and no evidence of necrosis. During follow-up, 63% (7/11) of patients who underwent myomectomy experienced recurrence of fibroids, with four patients developing multiple myomas. Renal imaging conducted in 12 of the 25 patients revealed benign renal pathologies in four cases, with no evidence of renal cell carcinoma.

CONCLUSION: The diagnosis of hereditary leiomyomatosis and renal cell carcinoma (HLRCC) syndrome is clinically significant due to the aggressive nature of FH-deficient uterine leiomyomatosis and its association with an increased risk of renal cell carcinoma. This study highlights the high recurrence rate of FH-deficient fibroids, particularly following myomectomy, and underscores the importance of genetic testing for early detection of HLRCC syndrome. Early identification allows for timely surveillance and intervention, improving patient outcomes, particularly by facilitating early detection of renal cell carcinoma. Given the rarity of this condition, further large-scale, prospective studies are necessary to confirm these findings and refine management strategies for patients with FH deficiency.

Keywords: case series, fumarate hydratase deficiency, hereditary leiomyomatosis and renal cell carcinoma, uterin fibroid

SS-051 [Jinekoloji Genel]

Pulmonary Embolism in the Early Postoperative Period Following Laparotomic Myomectomy: Case Series and Review of the Literature

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OBJECTIVE: This study investigates the early postoperative development of pulmonary embolism (PE) following laparotomic myomectomy, aiming to identify etiological factors and potential risk factors associated with this life-threatening complication.

Additionally, the study evaluates the possible contribution of intraoperative tourniquet application to the risk of PE.

Myomectomy is a commonly performed surgical procedure for the treatment of uterine leiomyomas. However, it carries a risk of venous thromboembolism (VTE), including deep vein thrombosis (DVT) and PE, as postoperative complications. PE is a severe and potentially fatal event, significantly contributing to postoperative morbidity and mortality. Despite the implementation of prophylactic measures, current evidence suggests that PE remains a persistent postoperative risk, highlighting the need for further investigation into its prevention.

A tourniquet is often applied to the isthmic region to temporarily occlude

uterine artery blood flow, aiming to reduce intraoperative blood loss, shorten operative time, and decrease hospital stay. While this technique is widely used, no major complications directly attributed to tourniquet application have been reported in the literature.

METHODS: This retrospective study evaluates four female patients who developed pulmonary embolism (PE) within 48 hours following laparotomic myomectomy at the Department of Obstetrics and Gynecology, Istanbul University-Cerrahpasa, Cerrahpasa Faculty of Medicine. The early postoperative impact of this complication was analyzed in detail. Data collection included patients' sociodemographic characteristics, anthropometric measurements, comorbidities, predisposing risk factors for PE, preoperative gynecological findings, intraoperative details, and postoperative follow-up records.

RESULTS: The ages of the patients were 28, 45, 47, and 49 with two patients having autoimmune diseases. None of the patients received preoperative prophylactic low-molecular-weight heparin (LMWH), and no preoperative blood transfusions were administered. PE symptoms appeared within the first 24 hours postoperatively, with computed tomography (CT) scans confirming the diagnosis in all cases. In two patients, a tourniquet was applied intraoperatively for approximately 30 minutes. A closer examination of these cases revealed that one patient developed PE symptoms at the initiation of surgery, while the other presented symptoms at the sixth postoperative hour. Importantly, these patients underwent only myomectomy, with no additional abdominal surgical procedures. The average operative duration was two hours, and no intraoperative blood transfusions were required.

CONCLUSION: This study highlights the potential risk of PE in the early postoperative period following laparotomic myomectomy. While the application of an intraoperative tourniquet may increase the risk of venous thromboembolism, further prospective, case-control studies are needed to better understand this association and to refine preventive strategies.

Keywords: Myomectomy, Pulmonary Embolism, Tourniquet

SS-052 [Jinekoloji Genel]

Effects on Hemoglobin Change and Bleeding Profile in Laparoscopic and Laparotomy Myomectomy Operations: Tertiary Center Experiences

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OBJECTIVE: : The aim of this study is to evaluate the effects on hemoglobin changes and bleeding profile in laparoscopic and laparotomy myomectomy operations. In line with our tertiary center experience, the effects of both surgical methods on the amount of bleeding by analyzing preoperative and postoperative hemoglobin changes are aimed to provide information on the optimal surgical approach.

MATERIAL & METHOD: In this retrospective cohort study, hemoglobin change and bleeding profile of patients undergoing laparoscopic (L/S) and laparotomic (LPT) myomectomy were evaluated. Our study included 37 L/S myomectomy and 45 LPT myomectomy patients who underwent myomectomy operation with type 2-5 single fibroids between 6-10 cm between January 2024 and January 2025 at Ankara Etlik City Hospital Gynecology and Obstetrics Clinic. Demographic data, preoperative and postoperative hemoglobin (Hb) and white blood cell (WBC) values were analyzed. Preoperative and postoperative hemoglobin and WBC values were obtained from patient files. Independent t-test was used for intergroup differences and dependent t-test was used for intra-group preoperative and postoperative changes. Statistical significance level was accepted as $p < 0.05$.

RESULT: There was no significant difference between the age, preoperative hemoglobin, postoperative hemoglobin and preoperative WBC values of the groups (p values 0.900, 0.874, 0.181, 0.983, respectively) (Table-1). Postoperative WBC values of the groups were 13.31 ± 4.65 in L/S myomectomy group and 9.14 ± 2.30 in LPT myomectomy group and there was a significant difference between them (p <.001) (Table-1). Postoperative - preoperative WBC difference values of the groups were -5.41 ± 4.53 in L/S myomectomy group and -1.23 ± 2.98 in LPT myomectomy group and there was a significant difference between them (p <.001) (Table-1). There was no significant difference between the postoperative and preoperative hemoglobin difference values of the groups (p=0.073) (Table-1).

When the preoperative and postoperative changes of the hemoglobin values of the groups were examined, the preoperative Hb value of the L/S myomectomy group was 11.95 ± 1.88 and the postoperative Hb value was 10.75 ± 1.84, the preoperative Hb value of the LPT myomectomy group was 11.89 ± 1.78 and the postoperative Hb value was 10.25 ± 1.50. The difference between the preoperative and postoperative Hb values of both groups was significant (p<.001) (Table-2).

When the preoperative and postoperative changes of the WBC values of the groups were examined, the preoperative WBC value of the L/S myomectomy group was 7.90 ± 2.58 and the postoperative WBC value was 13.31 ± 4.65, the preoperative WBC value of the LPT myomectomy group was 7.91 ± 2.73 and the postoperative WBC value was 9.14 ± 2.30. The difference between the preoperative and postoperative Hb values of both groups was significant (p<.001) (Table-3).

CONCLUSION: This study found no significant difference in hemoglobin decline between laparoscopic and laparotomic myomectomy, though WBC increase was more pronounced in the laparoscopic group. Both methods showed similar effects on blood loss, highlighting the importance of patient characteristics and surgical experience in choosing the optimal approach.

Keywords: Bleeding profile, Hemoglobin change, Laparoscopic myomectomy, Laparotomy myomectomy

Analysis of Variables between Groups

	L/S Myomectomy (n=37)	LPT Myomectomy (n=45)	p Value
Age	41.51 ± 8.01	41.73 ± 7.66	0.900
Preoperative Hemoglobin (g/dl)	11.95 ± 1.88	11.89 ± 1.78	0.874
Postoperative Hemoglobin (g/dl)	10.75 ± 1.84	10.25 ± 1.50	0.181
Preoperative WBC (*103)	7.90 ± 2.58	7.91 ±2.73	0.983
Postoperative WBC (*103)	13.31 ± 4.65	9.14 ± 2.30	<.001
Postoperative – preoperative Hemoglobin Difference	1.21 ± 0.793	1.64 ± 1.27	0.073
Postoperative – preoperative WBC Difference	-5.41 ± 4.53	-1.23 ± 2.98	<.001

*= *Analyzed with Independent T Test*

Preoperative and Postoperative Analysis of Hemoglobin Value in Group

	Preoperative Hemoglobin (g/dl)	Postoperative Hemoglobin (g/dl)	p Value*
L/S Myomectomy	11.95 ± 1.88	10.75 ± 1.84	<.001
LPT Myomectomy	11.89 ± 1.78	10.25 ± 1.50	<.001

=* *Analyzed with Dependent T Test*

Preoperative and Postoperative Analysis of WBC Value in Group

	Preoperative WBC (*103)	Postoperative WBC (*103)	p Value*
L/S Myomectomy	7.90 ± 2.58	13.31 ± 4.65	<.001
LPT Myomectomy	7.91 ±2.73	9.14 ± 2.30	<.001

*= *Analyzed with Dependent T Test*

SS-053 [Jinekoloji Genel]

Opportunistic Bilateral Salpingoo-Oophorectomy During Vaginal Hysterectomy: A Missed Opportunity for Ovarian Cancer Risk Reduction - A Case Report

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OBJECTIVE: The aim of this article is to emphasize the importance of performing bilateral salpingo-oophorectomy (BSO) during vaginal hysterectomy as a strategy for detecting existing ovarian malignancy and reducing the risk of future ovarian cancer.

INFORMATION AND BACKGROUND: Vaginal hysterectomy (VH) has long been regarded as a minimally invasive and effective approach for the treatment of pelvic organ prolapse. VH offers advantages such as reduced operative time, faster recovery and fewer urinary tract injuries compared to abdominal or laparoscopic routes.[1] However, the global prevalence of vaginal surgery has declined over the past two decades due to technical and training limitations. As a result, pool of surgeons proficient in vaginal techniques like as adnexectomy has diminished. Currently, retrograde salpingo-oophorectomy is rarely performed during VH -despite growing evidence supporting its role in ovarian cancer prevention. Consequently, many patients miss a critical opportunity for ovarian cancer prevention. There has been a growing emphasis on integrating opportunistic salpingo-oophorectomy into benign gynecologic surgeries, particularly for women who have completed childbearing. Numerous guidelines now recommend adnexal removal during hysterectomy, even in women without elevated cancer risk.[2] This case report illustrates the diagnostic potential of opportunistic salpingo-oophorectomy performed during VH, even in asymptomatic patients, and supports the growing calls to expand surgical training and awareness in this domain.

CASE DESCRIPTION: We report the case of a 74-year-old woman presented to our outpatient gynecology clinic with complaints of chronic constipation and a bulging sensation in the vaginal area. She denied abdominal pain, weight loss, or any history suggestive of malignancy. Her medical and family history were unremarkable. On examination, the patient had Stage IV uterine prolapse and a Grade 3 rectocele, with no palpable adnexal masses. Transvaginal ultrasonography revealed atrophic ovaries and no abnormal adnexal structures. Preoperative laboratory results, including tumor markers, were within normal limits:

• CA-125: 17.5 U/mL (0–35)

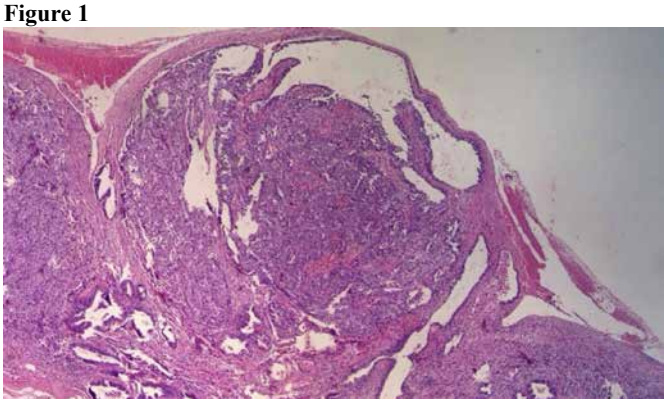
• CEA: 2.13 ng/mL (0–10)

Given her postmenopausal status and completed childbearing,we planned a vaginal hysterectomy with BSO, using a retrograde approach to the adnexa.[3] Additional procedures included colpocleisis and posterior colporrhaphy under general anesthesia. The surgery was uneventful. Surprisingly, the final histopathological examination revealed 3 cm dimension high-grade serous carcinoma of the left ovary, with involvement of the ovarian surface but no capsular rupture *Figures*. The contralateral adnexa and uterus showed no malignancy. The patient was referred to the gynecologic oncology team, and in a second surgical session, she underwent primary debulking surgery and pelvic and para-aortic lymph node dissection. Pathology confirmed Stage IC disease with no lymph node metastasis. She was initiated on adjuvant chemotherapy with a platinum-based regimen and is currently in follow-up with no signs of recurrence at six months postoperatively.

CONCLUSION: This case highlights the diagnostic and prophylactic value of opportunistic BSO during VH. Given current evidence and updated guidelines, the integration of retrograde adnexectomy techniques into standard gynecologic training and practice is imperative. Enhancing surgeon competency in this area may help bridge the gap between evidence-based recommendations and real-world surgical practice, ensuring that more patients benefit from this life-saving intervention.

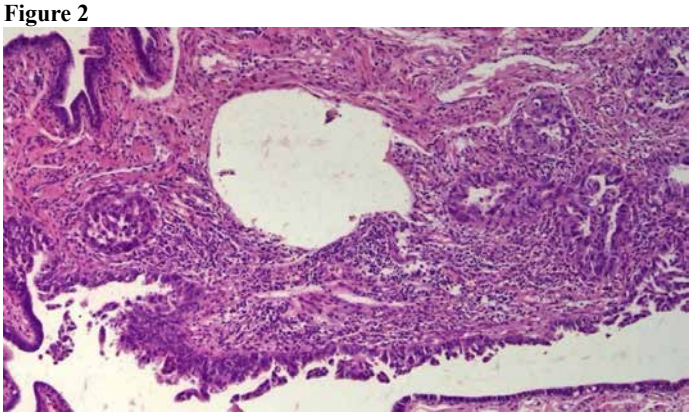
Keywords: gynecologic surgical procedures, ovarian cancer, salpingo-oophorectomy, vaginal hysterectomy

Figure 1



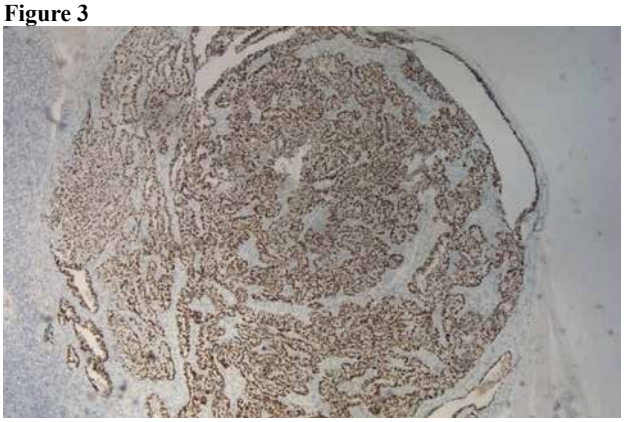
Histopathological architecture of high-grade serous cancer.(H&E, ×4)

Figure 2



Representative photomicrographs of STICs. (H&E, x10)

Figure 3



Immunological marker p53, typically seen in high-grade serous ovarian cancer. (x4)

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SS-055 [Jinekoloji Genel]

The Adverse Reaction To Hemoostatic Powder In Gynecologic Surgeries and Blood Type Relation

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The need for this research arises from our observation of patients who experienced severe intraperitoneal fluid accumulation within the first three days of the postoperative recovery period following Haemocer™ usage.

**AIM: ** Our objective is to identify potential causes of this reaction and determine underlying predisposing factors. We conducted a PubMed literature search using the keywords “hemostatic powder” and “intraperitoneal complication” but found no articles discussing intraperitoneal complications associated with these powders. We observed that 6 out of 94 patients developed similar fluid collections at the surgical site by the second postoperative day.

**METHOD: ** We recorded demographic, medical, and surgical details of patients who received this hemostatic powder at the end of their procedure and analyzed the data for relevant variables.

**RESULTS: ** We obtained data from 94 patients who underwent laparoscopic gynecologic surgery and received Haemocer™, a hemostatic and adhesion-preventive powder, at the surgical site. Among them, 6 patients developed excessive fluid accumulation postoperatively. Of these, 4 were managed by the interventional radiology team, who placed extracorporeal catheters in the pelvic area to drain the fluid. One hysterectomy patient required transvaginal drainage on three separate occasions in an outpatient setting, while another patient required reoperation. Each patient had approximately 300 mL of gray-colored fluid drained. Notably, 3 of these 6 patients had B Rh+ blood type, while the other 3 had A Rh+. Statistical analysis using SPSS 27 indicated that 33% of patients with B+ blood type experienced this unexplained reaction, which was statistically significant ($p < 0.05$).

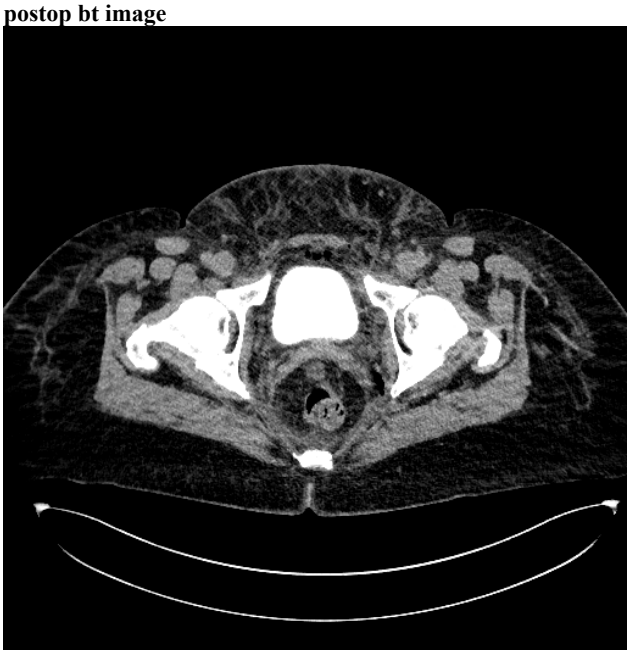
**CONCLUSION: ** While this reaction has not been previously documented in the literature, all fluid cultures were negative, ruling out infection. Drainage of the fluid proved to be the definitive and successful treatment in all cases. The reaction generally subsided as the drainage fluid color changed from gray to bright yellow, typically resolving within two weeks. Four of six patients required hospitalization for more than three days, with one patient staying for 17 days. Ultimately, all patients fully recovered. Our findings suggest that patients with B Rh+ blood type may be at a higher risk of developing this reaction to starch-based polysaccharide hemostatic powder. Further studies with larger sample sizes are needed to confirm these findings.

DISCUSSION Several safety trials have evaluated hemostatic powders. For instance, a Korean animal study demonstrated no adverse effects in rats; however, this study did not assess intra-abdominal safety, limiting its applicability to gynecological surgeries [1]. Although hemostatic powders are marketed for various types of surgeries, including orthopedics, neurosurgery, and gastrointestinal bleeding management [2,3], their safety profile in gynecologic procedures remains unclear.

A case of type 1 hypersensitivity reaction was reported in a 44-year-old orthopedic patient with alpha-gal syndrome following exposure to a hemostatic agent [4]. Additionally, one study suggested that polysaccharide-based hemostatic powders may be safer than alternative products for gynecologic procedures, though the available data were limited [5].

Keywords: gynecology, hemostatic, powder, intraperitoneal, adverse, reaction

postop bt image



patient postop BT image

spss analysis results

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
complication management * Blood Type	92	97,9%	2	2,1%	94	100,0%

complication management * Blood Type Crosstabulation

			Blood Type						
			a +	a -	b+	ab+	0+	0-	Total
complication management	0	Count	38a	3a, b	6b	5a, b	27a	7a, b	86
		% within Blood Type	97,4%	100,0%	66,7%	100,0%	93,1%	100,0%	93,5%
	1	Count	1a	0a, b	3b	0a, b	2a	0a, b	6
		% within Blood Type	2,6%	0,0%	33,3%	0,0%	6,9%	0,0%	6,5%
Total		Count	39	3	9	5	29	7	92
		% within Blood Type	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%

Each subscript letter denotes a subset of Blood Type categories whose column proportions do not differ significantly from each other at the ,05 level.

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)
Pearson Chi-Square	12,668a	5	,027	,039
Likelihood Ratio	9,046	5	,107	,084
Fisher-Freeman-Halton Exact Test	8,006			,088
N of Valid Cases	92			

a. 8 cells (66,7%) have expected count less than 5. The minimum expected count is ,20.

SS-056 [Jinekoloji Genel]

The effect of postoperative Cicatris® management on wound healing and body image in gynecological and obstetric surgeries

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Introduction: The aim of this study was to evaluate the effect of a topical gel called Cicatris® on wound healing in women who underwent cesarean section or gynecological surgery via a Pfannenstiel incision. Cicatris® is a topical preparation containing Hyaluronic Acid, Centella Asiatica, Aloe Vera, St. John's Wort, Provitamin B5, Vitamin E, Squalene, Sea Buckthorn, Calendula Officinalis, Melaleuca Alternifolia, and Camellia Sinensis—components that have been shown to promote wound healing. Previous studies have reported that the individual ingredients in this formulation contribute positively to the wound healing process [1–3].

Materials and Methods: This case-control study included women over 18 years of age who underwent gynecological surgery or cesarean section using a Pfannenstiel incision at our clinic. 50 patients received Cicatris® for postoperative wound care after being discharged from the hospital, while another 50 did not use any topical preparation and were assigned to the control group. Ethical approval was obtained from our university's ethics committee. Patients with comorbidities that may impair wound healing—such as uncontrolled diabetes, anemia (Hb < 8 g/dL), a history of chemotherapy or radiotherapy, steroid use, psoriasis, congenital collagen synthesis disorders, immune deficiencies, sepsis, liver failure, and renal failure/uremia—were excluded from the study. In all cases, the subcutaneous tissue and Pfannenstiel incision were closed using a standard technique with selected suture materials, in individual and subcuticular layers, respectively. Patients in the intervention group applied the gel topically once daily for one month. At the one-month follow-up, patients were asked to complete the Patient and Observer Scar Assessment Scale (POSAS), rating parameters such as satisfaction with scar appearance, pain, burning, and itching on a scale from 0 to 10. In addition, physician-evaluated complications such as wound infection, hypertrophic scar formation, or keloid were recorded. In the statistical analysis, the Fisher's exact test was applied to compare categorical variables between the two groups, while the Student's t-test and Mann–Whitney U test were used for the comparison of means and medians, respectively. A p-value < 0.05 was considered statistically significant.

Results: There were no significant differences between the case and control groups in terms of age, body mass index, hemoglobin, or albumin levels. Hypertrophic scar formation was significantly more common in the control group than in the Cicatris® group (n = 11 vs. n = 0, p = 0.01). Wound infection and keloid were not observed in either group. According to the POSAS, scores for vascularity, pigmentation, thickness, irregularity, pliability, surface area, and overall assessment were significantly lower in the Cicatris® group (Table 1). The appearance-related parameter rated by patients was significantly higher in the Cicatris® group (8.18 vs. 7.30, p = 0.017). Although the parameters of pain, burning, and itching were lower in the Cicatris® group, these differences were not statistically significant.

Conclusion: Evaluation of outcomes at one month postoperatively revealed that women treated with Cicatris® exhibited reduced hypertrophic scar formation compared to those in the control group. Additionally, patient satisfaction with the cosmetic appearance of the scar was significantly higher in the Cicatris® group.

Keywords: Body Image, Cesarean Section, Gynecology, Scar, Wound, Wound Healing

Table 1

Parameters	Control (n=50) (mean/min-max)	Case (n=50) (mean/min-max)	p value
Image	7.30 (min 2-max 10)	8.18 (min 4-max 10)	0.02*
Pain	1.86 (min 0-max 8)	2.12 (min 0-max 8)	0.38
Burning	0.58 (min 0-max 7)	0.52 (min 0-max 4)	0.87
Itching	0.78 (min 0-max 7)	0.44 (min 0-max 3)	0.34
Vascularity	2.94 (min 1-max 7)	1.84 (min 1-max 4)	0.01*
Pigmentation	3.06 (min 1-max 6)	1.98 (min 1-max 5)	0.01*
Thickness	3.36 (min 1-max 6)	1.88 (min 1-max 5)	0.01*
Relief	3.22 (min 1-max 7)	1.72 (min 1-max 5)	0.01*
Pliability	3.46 (min 1-max 8)	1.98 (min 1-max 5)	0.01*
Surface Area	3.16 (min 1-max 6)	1.80 (min 1-max 5)	0.01*
Overall Opinion	3.62 (min 1-max 7)	2.00 (min 1-max 5)	0.01*

*Comparative analysis of parameters between control and case groups. * $p<0.05$, statistically significant.*

SS-057 [Jinekoloji Genel]

Case series: laparoscopic Vecchietti procedure

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Ankara University School of Medicine Department of Obstetrics and Gynecology

AIM: To share our clinical experience with the laparoscopic Vecchietti procedure for neovagina creation in six patients, highlighting the safety, efficacy, and patient satisfaction with this technique. METHODS: This retrospective case series includes five patients diagnosed with MRKH syndrome and one patient with 5 alpha reductase deficiency, all of whom underwent the laparoscopic Vecchietti procedure at our institution. Patients had primary amenorrhea and vaginal agenesis, diagnosed clinically and radiologically. The procedure involved laparoscopic placement of a traction device connected to the vaginal dimple via an olive-shaped bead. Gradual tension was applied over 5-7 days to create a neovagina of adequate length and caliber. Postoperative follow-up included clinical assessment of vaginal length and patient-reported satisfaction regarding sexual function. FINDINGS: All six procedures were successfully completed without intraoperative complications. The average operative time was approximately 60 minutes, and the hospital stay ranged from 5-7 days. Progressive traction was well tolerated, and satisfactory neovaginal length was achieved in all cases. No significant postoperative complications, such as infection, bladder injury, or rectal injury, were observed. However, in one case, the Vecchietti needle perforated the bladder. This was promptly detected intraoperatively using cystoscopy, and the patient was managed with a Foley catheter. The bladder healed completely without further intervention, and the patient recovered uneventfully. Follow-up assessments indicated that 5 out of 6 patients achieved functional neovaginas of adequate length, with the majority reporting positive sexual function outcomes. However, one patient, who has not engaged in intercourse and was unable to perform vaginal dilation exercises effectively, experienced vaginal shortening. A re-operation is planned for this case. Detailed follow-up information is presented in Table 1. CONCLUSION: The laparoscopic Vecchietti procedure is a highly effective and minimally invasive option for neovagina creation. Compared to other surgical techniques, it avoids graft harvesting and extensive dissection, resulting in faster recovery and lower complication rates. In our series, all patients achieved functional neovaginas of adequate length with excellent postoperative outcomes and high patient satisfaction. Our findings support the laparoscopic Vecchietti procedure as a first-line surgical option in creating neovagina, with minimal complications and favorable long-term results.

Keywords: neovagina, Vecchietti, laparoscopic, MRKHS

Traction Device

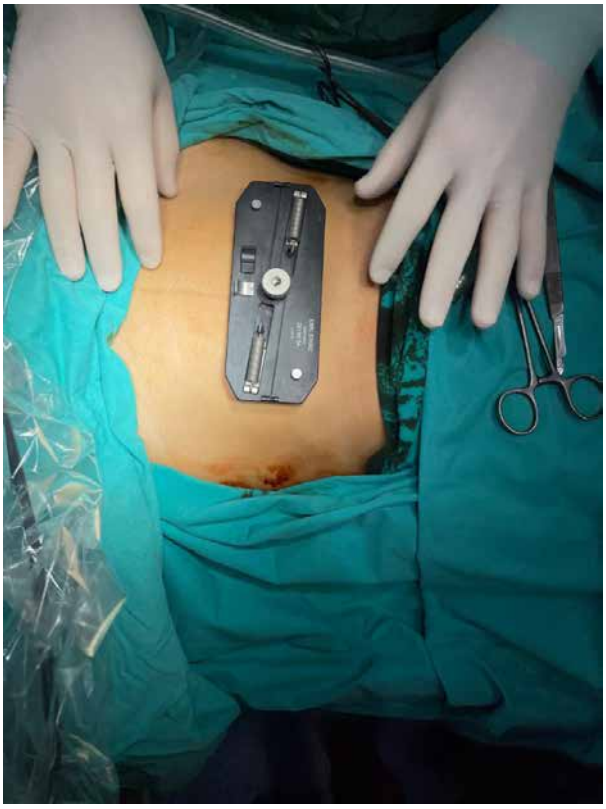

Table 1: Patient Details and Follow-up

Patients	Age	Diagnosis	Complication	Follow-up
Patient-1	20	MRKHS type 2/ left renal agenesis	Bladder injury	No intercourse, vaginal length 2cm, re-operation planned
Patient-2	22	MRKHS type 2/ left renal agenesis	None	Sexual intercourse possible, vaginal length 7 cm
Patient-3	20	MRKHS type1	None	Sexual intercourse possible vaginal length 9 cm
Patient-4	32	MRKHS type1	None	Sexual intercourse possible vaginal length 7.5 cm
Patient-5	30	MRKHS type1	None	Sexual intercourse possible vaginal length 7 cm
Patient-6	24	5a reductase deficiency	None	Sexual intercourse possible vaginal length 8 cm

SS-058 [Ürojinekoloji - Rekonstrüktif cerrahi]

Reassessing McIndoe Vaginal Reconstruction for Vaginal Agenesis: Insights from a Two-Decade Follow-Up at a Tertiary Center

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AIM: Mayer–Rokitansky–Küster–Hauser syndrome (MRKHS), a leading cause of primary amenorrhea, is a rare congenital anomaly characterized by the absence of the uterus and the upper two-thirds of the vagina, with an incidence of approximately 1 in 5,000 female live births. Despite the absence of vaginal and uterine structures, individuals with MRKHS typically exhibit normal secondary sexual characteristics and ovarian function. Surgical intervention is considered for patients who have not achieved satisfactory results with vaginal dilators or who prefer surgery after a comprehensive discussion of the benefits and drawbacks of various techniques. Several surgical approaches are available for creating a functional vagina, but due to the lack of long-term follow-up data and comparative outcome studies, no single technique is definitively preferred over others. The McIndoe procedure is one of the most commonly performed techniques by gynecologists, involving the use of a split-thickness skin graft from the buttocks. This study aims to evaluate the outcomes of a modified McIndoe technique, with a particular focus on vaginal length and sexual function in patients diagnosed with vaginal agenesis.

METHODS: Between 2004 and 2024, a total of 46 patients, including both pediatric and adult individuals with vaginal agenesis requiring reconstruction, were admitted to the Gynecology Clinic of Istanbul University Cerrahpaşa Faculty of Medicine. This cohort study evaluates the long-term outcomes of patients who underwent the modified McIndoe procedure. Sexual function was assessed using the Female Sexual Function Index (FSFI), with data collected through telephone interviews or face-to-face consultations. Statistical analyses were conducted using SPSS Version 29.0.

RESULTS: A total of 19 patients were included in the study. While all patients completed the questionnaire, vaginal length measurements were obtained from 12 patients who underwent a clinical examination. The postoperative median vaginal length was 8.4 cm (range: 6–11 cm). The median follow-up period was 120 months (range: 12–240 months). Evaluation of sexual function using the FSFI scoring system in 19 patients revealed a median overall score of 28.8, exceeding the cut-off value of 26. Only five patients had scores below this threshold. Additionally, no correlation was observed between vaginal length and FSFI score.

CONCLUSION: The findings suggest that modified McIndoe vaginoplasty is a simple, safe, and effective procedure in terms of both anatomical and sexual outcomes when performed by experienced specialists. Therefore, this technique remains a viable treatment option for patients requiring vaginoplasty.

Keywords: McIndoe, Vaginal Agenesis, Vaginoplasty

SS-059 [Jinekoloji Genel]

Laparoscopic Hemihysterectomy in a Herlyn–Werner–Wunderlich Syndrome Case

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[1]Kartal Dr. Lütfi Kırdar City Hospital, Department of Gynecological Oncology
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AIM: This case report presents a rare case of Herlyn-Werner-Wunderlich (HWW) syndrome (also known as obstructed hemivagina and ipsilateral renal anomaly (OHVIRA) syndrome) in a 16-year-old female, highlighting the clinical presentation, diagnostic imaging findings, surgical management, and postoperative outcomes.

METHODS: A 16-year-old female, with no history of sexual intercourse, who experienced pelvic pain, referred to our gynecologc oncology clinic. Ultrasonography revealed a confluent cystic lesion measuring 7.0 cm × 5.0 cm, a double uterus and cervix with right hematometra, and absence of the right kidney. (Figure 1) Subsequent magnetic resonance imaging (MRI) confirmed a double uterus with a right hemivaginal cystic lesion and obstruction of the right hemivagina, consistent with HWW syndrome.

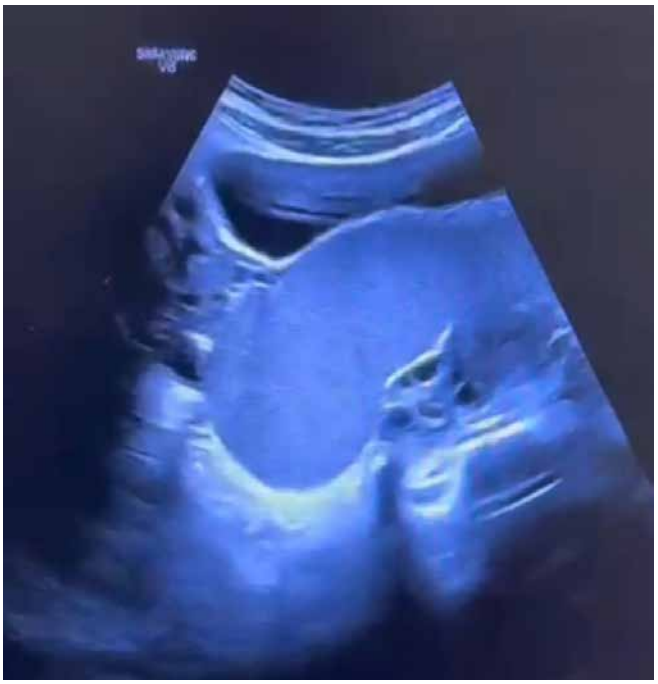
RESULTS: The patient underwent laparoscopic surgery, including right hemihysterectomy and right hematosalpingectomy. Her postoperative course was uneventful, and symptoms resolved. The patient was followed up.

CONCLUSION: Herlyn–Werner–Wunderlich syndrome, also known as OHVIRA syndrome, is a rare congenital anomaly characterized by the triad of uterine didelphys, unilateral obstructed hemivagina, and ipsilateral renal agenesis. The onset and clinical manifestations of HWW syndrome

can vary depending on the type and degree of obstruction. Common presentations include pelvic pain, dysmenorrhea, and the presence of a pelvic mass due to hematocolpos or hematometra. Diagnostic modalities such as ultrasonography and MRI are crucial in establishing the diagnosis. Early diagnosis and intervention are crucial in HWW syndrome to alleviate symptoms and prevent complications such as endometriosis, pelvic adhesions, and infertility. Advancements in minimally invasive surgical techniques, such as laparoscopy, offer effective management options for this rare congenital anomaly.

Keywords: Herlyn-Werner-Wunderlich syndrome, OHVIRA syndrome, uterus didelphys, obstructed hemivagina, hematocolpos

7.0 cm × 5.0 cm, a double uterus and cervix with right hematometra



SS-060 [Jinekoloji Genel]

Comparison of Bipolar and Monopolar Cautery Usage in Laparoscopic Tubal Sterilization

İbrahim Buğra Bahadır
Ankara Sincan Eğitim ve Araştırma Hastanesi

AIM: Female sterilization is a common choice for women seeking a permanent method of contraception.Laparoscopic tubal sterilization(LTS) has been performed since the early 1960s.This procedure is a minimally invasive surgical intervention aimed at terminating fertility by ligating, occluding, or completely removing the fallopian tubes.The energy sources used in this procedure have a significant impact on both the success of the operation and the risks of complications.Bipolar and monopolar cauteries are two primary energy modality frequently preferred by surgeons.Both methods have their respective advantages and limitations.This study evaluates two methods, one using only bipolar and the other using only monopolar, from various perspectives to determine which is safer, more effective, and feasible.

METHODS: Patients aged over 30, without any additional risk factors, who hadn't undergone abdominal surgery except for cesarean and appendectomy, and who requested LTS between August2023 and February2025 at the Sincan Training and Research Hospital, Obstetrics and Gynecology Clinic, were included in the study.Patients with a history of complicated surgery or malignancy were excluded.During the study, only one energy modality was used for cauterization (either bipolar or monopolar), as the alternative modality was unavailable at the hospital during the study period.The surgical demographic data(age, height, weight, BMI (kg/m²), preoperative and postoperative hemoglobin levels, surgical notes, and technique) of the patients were recorded and analyzed.Statistical significance was accepted at $p \leq 0.05$.

RESULTS: The average age of the participants was 33.7±4.9(30-43) years.The median gravida and parity were 3(1-5) and 2(1-5), respectively.The participants' height, weight, and BMI were 166.2±5.4(155-182)cm, 66.8±8.7(48-105)kg, and 29.1±3.8(21.5–36.4) kg/m², respectively.108 patients were evaluated.47 patients underwent surgery using only monopolar cautery, and 61 patients underwent surgery using only bipolar cautery.Preoperative contraception using methods included:33(30.5%)condoms, 21(19.4%)intrauterine devices, 12(11.1%)combined oral contraceptives, 37(34.2%)withdrawal method, and 5(4.6%)patients not using any form of contraception.The mean surgical time was 27.2±13.8(20-45) minutes for the bipolar group and 33.3±13.8(20-90) minutes for the monopolar group.Preoperative hemoglobin levels were 11.43±1.16g/dl for the monopolar group and 11.51±1.22g/dl for the bipolar group, while postoperative levels were 10.63±1.36g/dl for the monopolar group and 10.80±1.42g/dl for the bipolar group.The difference in hemoglobin levels before and after surgery was 0.815±1.168 and 0.670±1.144, respectively(p=0.314). When comparing surgical complications, 3(6.3%)patients in the monopolar group(n=47) experienced complications, with bleeding from the mesosalpinx, which was controlled by laparoscopic suturing. In the bipolar group(n=61), 1(1.6%)patient experienced mesosalpinx bleeding, which was controlled by bipolar cautery without the need for suturing(p=0.315).All 108 patients were discharged the day after the procedure, and their hospital stay durations were comparable.

DISCUSSION: In our study, 3 patients in the monopolar group experienced bleeding from the mesosalpinx, which was stopped by laparoscopic suturing.Since bipolar energy modality was unavailable, sutures were applied;however, these bleeds could have been controlled with bipolar cautery.The type of energy modality used did not significantly affect the surgical duration, hemoglobin levels, or the rate of surgical complications.Additionally, based on our study findings, it is not recommended for surgeons with limited laparoscopic experience to perform LTS using only monopolar cautery.If tubal sterilization is to be performed laparoscopically, it is recommended that bipolar energy modalities be available in the operating room.

Keywords: Bipolar coagulation, monopolar coagulation, Tubal sterilizations

SS-061 [Jinekoloji Genel]

Comparison of Transvaginal Natural Orifice Surgery (v-NOTES) and Laparoscopic Tubal Ligation: Effects on Postoperative Pain and Surgical Outcomes

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OBJECTIVE: Minimally invasive surgical techniques are increasingly utilized in gynecologic procedures to enhance patient comfort, shorten recovery time, and reduce complications. Transvaginal natural orifice transluminal endoscopic surgery (v-NOTES) has emerged as an alternative to conventional laparoscopic surgery, offering a scarless approach and potential advantages in postoperative recovery. This study aims to compare v-NOTES and laparoscopic tubal ligation (LTL) in terms of postoperative pain, intraoperative parameters, surgical outcomes, hemoglobin (HGB) and hematocrit (HCT) reductions, and female sexual function (FSFI-6 scores).

METHODS: A prospective comparative study was conducted between September 20, 2023, and December 1, 2024, at Iğdır Doctor Nevruz Erez State Hospital. A total of 43 patients undergoing sterilization via v-NOTES (n = 23) or LTL (n = 20) were included. Data on preoperative, intraoperative, and postoperative parameters were collected, including operative time, intraoperative blood loss, intra-abdominal pressure, opioid use, postoperative pain (VAS scores at 1, 6, and 24 hours), shoulder pain, hospital stay, complications, HGB and HCT reductions, and pre- and postoperative FSFI-6 scores.

RESULTS: This study demonstrated that v-NOTES offers superior postoperative outcomes compared to LTL in several key aspects:

Operative time was comparable between the groups (v-NOTES: 25 min vs. LTL: 35 min, $p > 0.05$).

Intra-abdominal pressure was significantly lower in the v-NOTES group (8 mmHg vs. 12 mmHg, $p < 0.05$), to reduced postoperative discomfort. Opioid use was 5.62% lower in the v-NOTES group, indicating reduced need for postoperative pain management ($p < 0.05$).

Postoperative pain scores (VAS at 1, 6, and 24 hours) were significantly lower in the v-NOTES group ($p<0.05$), confirming its advantage in pain reduction. Shoulder pain incidence was significantly lower in the v-NOTES group (15% vs. 87%, $p < 0.05$), likely due to lower intra-abdominal gas insufflation and pressure.

Hospital stay and complication rates were similar between both groups ($p > 0.05$).

HGB and HCT reductions were not significantly different between the groups. ($p>0.05$)

FSFI-6 scores declined postoperatively in both groups, but no significant difference was observed between v-NOTES and LTL ($p >0.05$), indicating that neither procedure had a greater impact on female sexual function.

CONCLUSION: The findings suggest that v-NOTES is a safe and effective alternative to LTL, particularly in terms of postoperative pain reduction and improved comfort. The significantly lower intra-abdominal pressure and shoulder pain incidence in the v-NOTES group emphasize its potential benefits in patient recovery. Furthermore, the comparable reductions in HGB and HCT levels indicate that v-NOTES does not pose an increased risk of blood loss. Similarly, FSFI-6 results show that v-NOTES and LTL have similar effects on female sexual function, suggesting no additional concerns regarding postoperative sexual health.

Despite these advantages, further randomized controlled trials with larger sample sizes and long-term follow-ups are necessary to better assess the long-term benefits, potential complications, and broader clinical applications of v-NOTES in gynecologic surgery. Expanding the scope of future studies could help refine patient selection criteria and optimize surgical techniques to further improve clinical outcomes.

Keywords: v-NOTES, laparoscopic tubal ligation, postoperative pain, minimally invasive surgery, female sexual function, FSFI-6.

SS-062 [Endoskopi]

Single-Trocar Bilateral Salpingectomy: A Minimally Invasive Alternative

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OBJECTIVE: Epithelial ovarian cancer (EOC) is known to originate from the fallopian tube epithelium in a significant number of cases. Therefore, opportunistic salpingectomy is recommended as a preventive strategy to reduce EOC risk. With the increasing emphasis on minimally invasive techniques, laparoscopic salpingectomy performed with a single trocar is emerging as a promising approach. This study aims to evaluate the feasibility and effectiveness of single-trocar bilateral salpingectomy as a minimally invasive alternative.

METHODS: The standard laparoscopic salpingectomy technique involves three trocars: one for the camera and two for surgical instruments. However, the procedure can be performed using a single trocar with electrocautery, minimizing surgical trauma. This method has been successfully utilized in ectopic pregnancy surgery and may also be suitable for elective bilateral salpingectomy.

In this study, surgical videos demonstrating single-trocar bilateral salpingectomy are presented to highlight trocar placement, electrocautery use, and tubal excision steps. The feasibility of this technique is evaluated based on operative time, perioperative and postoperative complications, and surgical success.

RESULTS: The analysis of patients undergoing single-trocar bilateral salpingectomy revealed promising results in terms of surgical efficiency, reduced invasiveness, and patient recovery. Consistent with existing literature, opportunistic salpingectomy has been associated with a significant reduction in ovarian cancer risk. The surgical video recordings provided visual confirmation of the procedural feasibility and effectiveness of the technique.

CONCLUSION: Salpingectomy significantly lowers the risk of ovarian cancer, and its implementation via a single trocar offers a less invasive and patient-friendly alternative. Compared to traditional laparoscopy, this technique reduces the number of trocar incisions, leading to less postoperative pain, faster recovery, and improved cosmetic outcomes. The inclusion of surgical video documentation enhances the understanding of this approach, making it a strong candidate for wider clinical adoption.

Keywords: Minimally-invasive surgery, Laparoscopy, Salpingectomy

SS-063 [Endoskopi]

Comparison of the effect of experience gain on surgical outcomes in vaginal natural orifice transluminal endoscopic surgery and conventional laparoscopic surgery

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AIM: This study examined the learning curve of a gynecologist acquiring proficiency in vaginal natural orifice transluminal endoscopic surgery (VNOTES) by analyzing case order. Additionally, it compared VNOTES to laparoscopic surgery (LAP) in terms of operative time, blood loss, hospital stay, and analgesic use.

METHODS: This retrospective observational study was conducted between May 2023 and December 2024 at Health Sciences University Istanbul Training and Research Hospital, Türkiye. Ethical approval was obtained (Approval No: 149/27.12.2024), and the study complied with the Declaration of Helsinki. Informed consent was routinely obtained from all patients. The study was conducted on LAP and VNOTES cases performed by a single surgeon (T.I.). Patients were included if the surgeon explained both LAP and VNOTES options and the method was chosen jointly. Those who declined data use or had missing data were excluded. The surgeon had prior LAP experience but no VNOTES experience at study start. He received VNOTES training in May 2024. Demographics (age, BMI, gravida, parity, prior abdominopelvic and cesarean history) were recorded. Pre- and postoperative Hb/Hct levels and hospital stay were analyzed. Operation time and postoperative Hb levels were reviewed chronologically for both groups to identify a change point. Postoperative analgesics (acetaminophen, diclofenac, opioids, combinations) and secondary outcomes (smoking, complications, drain/ICU need, pathology) were compared between LAP and VNOTES groups.

RESULTS: A total of 154 patients were included, with 114 in the LAP group and 40 in the VNOTES group. No significant differences were found between the LAP and VNOTES groups in age, BMI, gravida, parity, prior cesarean, or other abdominopelvic surgeries (all $p > 0.05$). Operation time was significantly shorter in the VNOTES group (median 77.5 min) than in the LAP group (median 144.5 min) ($p < 0.001$). Postoperative 6th-hour Hb and Hct levels were significantly higher in the VNOTES group (Hb: 11.45 vs. 10.87 g/dL, $p = 0.003$; Hct: 34.74% vs. 33.17%, $p = 0.005$). Hospital stay was also significantly shorter in the VNOTES group (median 23.5 vs. 44 hours, $p < 0.001$) (Table 1).Change points for operation time and postoperative 6th-hour haemoglobin levels were identified and compared in both groups. Based on the analysis shown in Figure 1, the change point occurred at the 27th case in the LAP group and the 33rd case in the VNOTES group. Change points for postoperative 6th-hour haemoglobin levels are shown in Figure 2. The change occurred at the 15th case in the LAP group and the 16th case in the VNOTES group. A statistically significant difference in analgesic use was found between the groups ($p < 0.001$). Comparison of smoking status, intraoperative complications, their management, drainage and ICU requirements, and pathology results between LAP and VNOTES groups is provided in Supplementary Table 1.

CONCLUSION: Our findings suggest that a gynecologist learning VNOTES may require an average of 30 cases to attain surgical proficiency. Moreover, the VNOTES approach demonstrated a favorable profile, with shorter operative times, reduced hospitalization duration, less blood loss, and lower analgesic requirements compared to LAP.

Keywords: Endoscopy, laparoscopy, natural orifice surgery

Figure 1. Change point (MBIC) of operation time (min) in LAP and VNOTES groups:

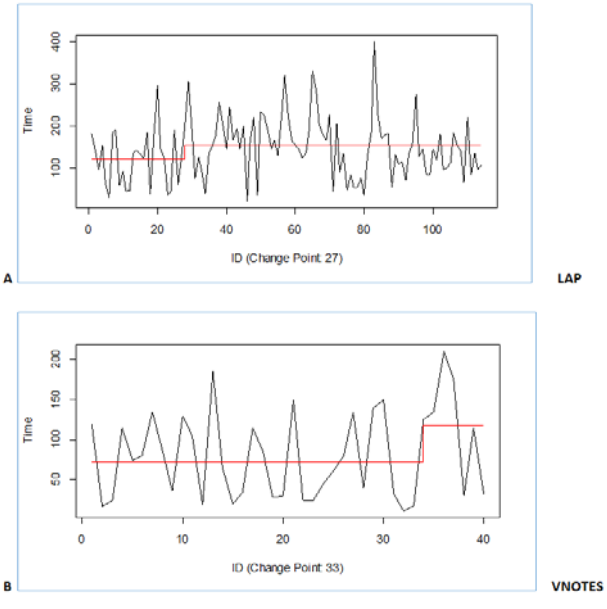
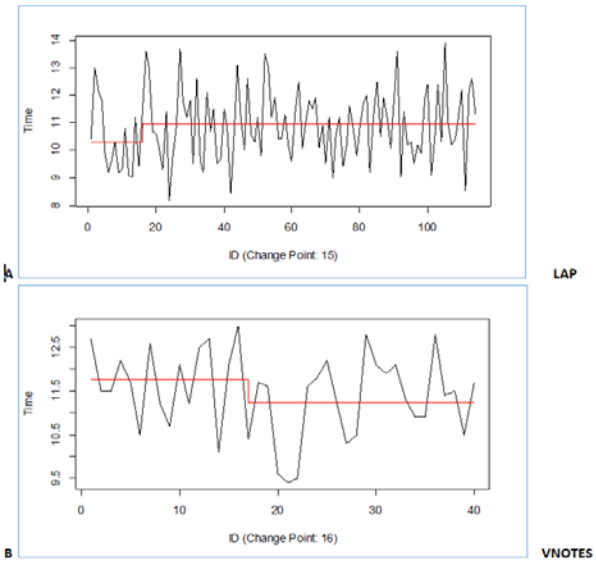


Figure 1 shows the change points according to the average change of the operation times. 'AMOC' method was used as the change point method. With

'AMOC' only one change point is calculated. As a change point for A. LAP, 27th person was obtained as a change point according to participant ID order. Participants 27 and below are grouped as 'Group 1' and 27 and above are grouped as 'Group 2'. B. As a change point for VNOTES, 33rd person was obtained as a change point according to participant ID order. Participants 33 and below were grouped as 'Group 1' and 33 and above as 'Group 2'. See Table 2 for the compared results of the groups

Figure 2. Postop Hb 6th hour change point in LAP and VNOTES groups (Manual):



Change points are given according to the postop Hb 6th hour mean change. 'AMOC' method was used as the change point method. Only one change point is calculated with 'AMOC'. As a change point for A. LAP, the 15th person was obtained as a change point according to the participant ID order. Participants 15 and below are grouped as 'Group 1' and 15 and above are grouped as 'Group 2'. B. As a change point for VNOTES, 16th person was obtained as a change point according to participant ID order. Participants 16 and below were grouped as 'Group 1' and 16 and above as 'Group 2'. See table 3 for the comparative results of the groups.

Supplementary table 1. Analysis of the relationship between groups and variables

Supplementary table 1. Analysis of the relationship between groups and variables

	Groups			Test Statistics	p
	LAP	VNOTES	Total		
Smoking					
No	91 (79,8)	30 (75)	121 (78,6)	0,173	0,678*
Yes	23 (20,2)	10 (25)	33 (21,4)		
Intraoperative Complications					
None	102 (89,5)	38 (95)	140 (90,9)		
Bladder injury	6 (5,3)	2 (5)	8 (5,2)		
Intestinal injury	1 (0,9)	0 (0)	1 (0,6)	1,950	0,941**
Ureteral injury	1 (0,9)	0 (0)	1 (0,6)		
Need for transfusion	3 (2,6)	0 (0)	3 (1,9)		
Anesthesia-Related Complication	1 (0,9)	0 (0)	1 (0,6)		
Intraoperative Complication Management					
None	106 (93)	38 (95)	144 (93,5)		
Vaginal	0 (0)	2 (5)	2 (1,3)	6,482	0,053**
Laparoscopic	6 (5,3)	0 (0)	6 (3,9)		
Abdominal	2 (1,8)	0 (0)	2 (1,3)		
Surgical Conversion					
None	110 (96,5)	37 (92,5)	147 (95,5)		
Vaginal	1 (0,9)	1 (2,5)	2 (1,3)	3,718	0,243**
Abdominal	3 (2,6)	1 (2,5)	4 (2,6)		
Laparoscopic	0 (0)	1 (2,5)	1 (0,6)		
Drain usage					
No	71 (62,3)[a]	38 (95)[b]	109 (70,8)	13,786	**<0,001***
Yes	43 (37,7)	2 (5)	45 (29,2)		
Need for Intensive Care					
No	91 (79,8)	34 (85)	125 (81,2)	0,236	0,627*
Yes	23 (20,2)	6 (15)	29 (18,8)		
Postoperative Complications					
None	105 (92,1)	39 (97,5)	144 (93,5)		
Groin and Thigh Pain	1 (0,9)	0 (0)	1 (0,6)		
Thermal Bladder Injury	1 (0,9)	0 (0)	1 (0,6)		
Pneumonia	2 (1,8)	0 (0)	2 (1,3)	5,833	0,915**
Pulmonary Embolism	1 (0,9)	0 (0)	1 (0,6)		
Cystitis	1 (0,9)	0 (0)	1 (0,6)		
Subileus	0 (0)	1 (2,5)	1 (0,6)		
Trocar Hernia	1 (0,9)	0 (0)	1 (0,6)		
Thermal Ureteral Injury	1 (0,9)	0 (0)	1 (0,6)		
Vaginal Discharge	1 (0,9)	0 (0)	1 (0,6)		
Postoperative Complication Management					
None	106 (93)	39 (97,5)	145 (94,2)	3,149	0,597**
Expectant	1 (0,9)	1 (2,5)	2 (1,3)		
Laparotomy	1 (0,9)	0 (0)	1 (0,6)		
Medical	5 (4,4)	0 (0)	5 (3,2)		
Nephrostomy-Double J Stent	1 (0,9)	0 (0)	1 (0,6)		
Pathology Results					
None	8 (7)	4 (10)	12 (7,8)		
Benign	103 (90,4)	35 (87,5)	138 (89,6)	1,352	0,763**
Malign	1 (0,9)	0 (0)	1 (0,6)		
Borderline	2 (1,8)	1 (2,5)	3 (1,9)		

* Yates Correction; **Monte Carlo Corrected Fisher's Exact Test; n(%); a-b: There is no difference between groups with the same letter.

** Yates Correction; **Monte Carlo Corrected Fisher's Exact Test; n(%); a-b: There is no difference between groups with the same letter.*

Table 1. Comparison of Variables by Groups

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Variables	Group		Total	Test Statistic	p value
	LAP (N=115)	VNOTES (N=41)			
Age	44,16 ± 11,07 43 (16 - 80)	44,28 ± 11,78 41,5 (22 - 72)	44,19 ± 11,22 43 (16 - 80)	2132,500	0,543*
BMI	27,74 ± 5,72 27,93 (16,9 - 55)	28,64 ± 5,45 27,24 (20,55 - 47)	27,97 ± 5,65 27,66 (16,9 - 55)	2106,500	0,475*
Gravida	3,31 ± 2,54 3 (0 - 13)	3,53 ± 2,39 3 (0 - 11)	3,36 ± 2,49 3 (0 - 13)	2132,500	0,539*
Parity	2,55 ± 2,17 2 (0 - 13)	2,88 ± 2,23 3 (0 - 10)	2,64 ± 2,19 2 (0 - 13)	2012,000	0,259*
Number of Previous Abdominopelvic Surgeries	1,01 ± 1,19 1 (0 - 5)	0,63 ± 0,7 1 (0 - 3)	0,91 ± 1,1 1 (0 - 5)	1992,500	0,203*
Number of Previous Cesarean Sections	0,8 ± 1,06 0 (0 - 5)	0,53 ± 0,93 0 (0 - 4)	0,73 ± 1,03 0 (0 - 5)	1947,000	0,122*
Operation Duration (Minutes)	145,78 ± 71,51 144,5 (22 - 400)	81,03 ± 55,03 77,5 (12 - 210)	128,96 ± 73,21 132,5 (12 - 400)	1034,500	**<0,001***
Preoperative Hemoglobin	12,07 ± 1,51 12,2 (8,5 - 15,6)	12,65 ± 1,15 12,7 (9,9 - 15,9)	12,22 ± 1,44 12,3 (8,5 - 15,9)	1778,000	**0,039***
Postoperative Hemoglobin (6th Hour)	10,87 ± 1,27 10,8 (8,2 - 13,9)	11,45 ± 0,94 11,55 (9,4 - 13)	11,02 ± 1,21 11,15 (8,2 - 13,9)	-3,042	**0,003***
Preoperative Hematocrit	40,33 ± 38,16 37,15 (27,2 - 442)	38,49 ± 3,32 38,5 (31,1 - 47,3)	39,85 ± 32,85 37,45 (27,2 - 442)	1756,500	**0,031***
Postoperative Hematocrit	33,17 ± 3,6 33,05 (25,5 - 43)	34,74 ± 2,69 35,2 (28,2 - 39,9)	33,57 ± 3,45 33,7 (25,5 - 43)	-2,900	**0,005***
Postoperative Hospitalization Duration (Hours)	52,11 ± 31,91 44 (12 - 176)	28,9 ± 21,73 23,5 (6 - 112)	46,08 ± 31,25 40 (6 - 176)	1108,500	**<0,001***

*Independent Samples T-Test; **Mann-Whitney U Test; Mean ± Standard Deviation; Median (Minimum–Maximum; Hemoglobin levels are expressed in grams per deciliter (g/dL), and hematocrit levels are expressed as a percentage (%).

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Table 2. Comparison of Mean Operative Times According to Change point Groups in LAP and VNOTES Groups

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	Group (Change Point)					
	Group 1		Group 2		Test İstatistiği	p
	Mean ± Standard Deviation	Median (Min–Max)	Mean ± Standard Deviation	Median (Min–Max)		
Operative Time (min) (LAP)	120,15 ± 66,35	130 (30 - 295)	153,35 ± 71,57	145 (22 - 400)	-2,111	0,037*
Operative Time (min) (VNOTES)	73,3 ± 8,69	65 (12 - 185)	117,43 ± 25,45	125 (30 - 210)	68,000	0,095**

*Independent Samples T Test;** Mann Whitney U Test; A statistically significant difference was found between the mean values of operation time (min) according to the groups for LAP (p=0,037). While the median value was 120.15 in Group 1, the median value was 153.35 in Group 2; For VNOTES, no statistically significant difference was found between the mean values of operation time (min) according to the groups (p=0.095). While the median value was 65 in Group 1, the median value was 125 in Group 2.

Independent Samples T Test; Mann Whitney U Test; A statistically significant difference was found between the mean values of operation time (min) according to the groups for LAP (p=0,037). While the median value was 120.15 in Group 1, the median value was 153.35 in Group 2; For VNOTES, no statistically significant difference was found between the mean values of operation time (min) according to the groups (p=0.095). While the median value was 65 in Group 1, the median value was 125 in Group 2.*

Table 3. Comparison of Mean Postoperative Hemoglobin Levels at 6th Hour According to Change Point Groups in LAP and VNOTES Groups

Table 3. Comparison of Mean Postoperative Hemoglobin Levels at 6th Hour According to Change Point Groups in LAP and VNOTES Groups

	Group (Change Point)					
	Group 1		Group 2		Test Statistic	p*
	Mean ± Standard Deviation	Median (Min–Max)	Mean ± Standard Deviation	Median (Min–Max)		
Postoperative Hb at 6th Hour (LAP)	10,3 ± 1,26	9,9 (9 - 13)	10,96 ± 1,25	10,9 (8,2 - 13,9)	-1,893	0,061
Postoperative Hb at 6th Hour (VNOTES)	11,77 ± 0,22	11,9 (10,1 - 13)	11,24 ± 0,19	11,45 (9,4 - 12,8)	1,793	0,081

*Independent Samples T Test; Hb: Hemoglobin (g/dL); There was no statistically significant difference between the mean values of postop Hb at 6th hour for LAP according to the groups (p=0.061). While the mean value was 10.3 in Group 1, the mean value was 10.96 in Group 2. For VNOTES, no statistically significant difference was found between the mean values of Postop Hb 6th hour according to the groups (p=0,081). The mean value was 11.77 in Group 1 and 11.24 in Group 2.

**Independent Samples T Test; Hb: Hemoglobin (g/dL); There was no statistically significant difference between the mean values of postop Hb at 6th hour for LAP according to the groups (p=0.061). While the mean value was 10.3 in Group 1, the mean value was 10.96 in Group 2. For VNOTES, no statistically significant difference was found between the mean values of Postop Hb 6th hour according to the groups (p=0,081). The mean value was 11.77 in Group 1 and 11.24 in Group 2.*

SS-064 [Endoskopi]

Comparison of systemic immune inflammatory index values in vNOTES and conventional laparoscopic surgical techniques and our secondary care hospital experiences

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AIM: Vaginal natural orifice transluminal endoscopic surgery (vNOTES) has emerged as a minimally invasive approach. In the literature, the advantages and disadvantages of vNOTES and laparoscopic surgery have been examined on many different parameters and controversial findings have been obtained. The aim of this study was to compare systemic inflammatory index values in vNOTES and conventional laparoscopic surgical techniques. METHOD: In this study, the data of 30 patients who applied to our secondary care hospital with a request for tubal ligation and underwent surgery were evaluated retrospectively, divided into two groups according to the surgical technique applied. SII (systemic immune inflammatory index) value was calculated from the data obtained from complete blood count sampling with the formula [(platelet*neutrophil)/lymphocyte]. FINDINGS: Of the 30 patients included in the study, 16 patients were operated with vNOTES and 14 patients were operated with conventional laparoscopic surgery. No significant difference was found between the groups in terms of demographic data. Systemic immune inflammatory index values were recorded as preoperative, postoperative and postoperative percentage increase values. No significant difference was observed between the SII values between the two groups (p: 0.215). Hemoglobin values of the patients were monitored similarly before and after surgery. Postoperative hematoma was observed at the colpotomy line in one patient who underwent vNOTES surgery. In addition, two patients underwent conventional laparoscopic surgery because the vNOTES method could not be used to enter the abdomen. CONCLUSION: The vNOTES method can be successfully applied as an alternative technique to conventional laparoscopic surgery in secondary care hospitals with appropriate patient selection and equipment availability. In our study, no significant difference was observed in SII parameters between the two techniques. This may be due to the limited number of samples. Studies with large patient numbers are needed to confirm the effects of both techniques on these parameters.

Keywords: Laparoscopy,NOTES,minimally invasive

SS-065 [Endoskopi]

A case report and review of literature on idiopathic ascites after laparoscopic bilateral salpingectomy

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INTRODUCTION: We present a rare complication of laparoscopic surgery, that of ascites of unknown origin following laparoscopic bilateral salpingectomy in a young female patient.

CASE REPORT: The patient is a 37-year-old G5P5 woman with no significant past medical history who wants to be a sterilization operation.Her vital signs and routine pre-operative investigation results were all within normal limits.CO2 pneumoperitoneum was created using the Verre's needle technique.An umbilical 10 mm primary port was inserted, and a 0°10 mm laparoscope connected to a camera, and light source was introduced.The operation is started after two 5 mm trocars are placed approximately 2–3 cm medial to both spina ischiadica anterior superior.The bilateral salpingectomy was performed uneventfully with the use of advanced bipolar electrosurgical surgery. The patient was comfortable on the postoperative day (POD) 0, started on oral sips, voided urine comfortably. POD 1, 24 hours following the procedure, the patient developed lower abdominal discomfort. On examination, she was apyrexial with no haemodynamic compromise. Significant infraumbilical swelling was noted, as shown in Figure1. We evaluated with an ultrasound which showed moderate ascites in pelvis, as shown in Figure2.Performed serum laboratory investigations revealed a haemoglobin of 14.9 g/dL and a white cell count of 14.4 × 10^3 /uL.Renal and liver function remained within the normal reference range.The decision was made to proceed with wound exploration under anaesthetic.Diagnostic laparoscopy was then undertaken and 1L of fluid was removed.Careful inspection of the reproductive organs, the bladder,the stomach/liver/gallbladder,the colon and the small bowel did not reveal signs of iatrogenic injury or abnormality, as shown in Figure3. Ascitic cultures did not yield any growth. Tumour markers were negative. Parameters used for rheumatological diseases were within normal range. Ascitic fluid biochemistry was negative for all values.Urea and creatinine values in spot urine were normal. Histopathological examination revealed no evidence of malignancy and erythrocytes among fibrin,PNL and few mesothelial cells.The patient was managed conservatively with diuretics,highprotein diet,higher IV antibiotics and supportive care(abdominal corset,pressure dressing as shown in Figure4).The patient was discharged on day 9 after a recovery period.No further readmissions were required and on 6-month follow-up no further adverse events or reaccumulation of fluid were reported.

DISCUSSION: This was an unusual case of ascites developing within 24 hrs of laparoscopic bilateral salpingectomy with no evidence of peritoneal contamination.After performing a systematic search on literature;we did not identify any previous reports on the development of postoperative idiopathic ascites following elective laparoscopic bilateral salpingectomy or other elective gynecologic surgery.No definitive causative factor was identified in spite of performing a thorough postoperative biochemical and cytological analysis of the accumulated fluid. Idiopathic peritoneal hypersensitivity may be the suitable diagnosis if appropriate investigations fail to identify a definite cause.

CONCLUSION: Patients should be thoroughly investigated to exclude the possibility of iatrogenic visceral injury and bleeding during laparoscopy;the fluid should be sampled surgically or by paracentesis and pathological examination should be performed.If no definitive cause for the ascites can be determined, the most likely explanation for the ascites is a peritoneal inflammatory reaction to the agents used during laparoscopy.

Keywords: ascites, idiopathic, laparoscopic salpingectomy

figure 1

figure 2

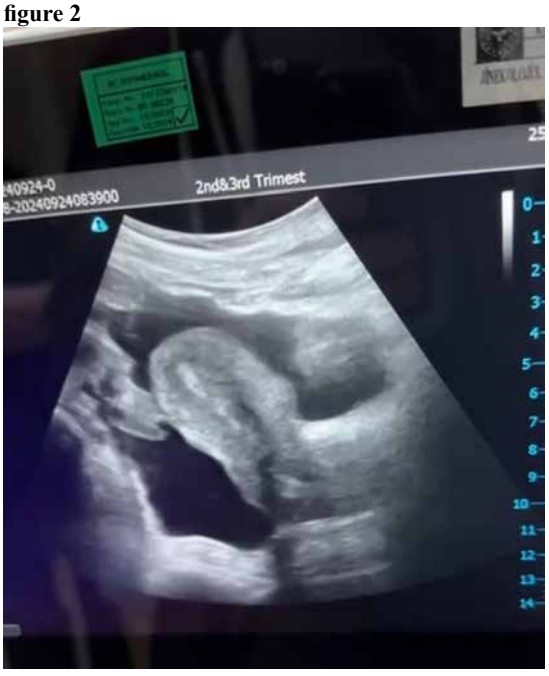


figure 3

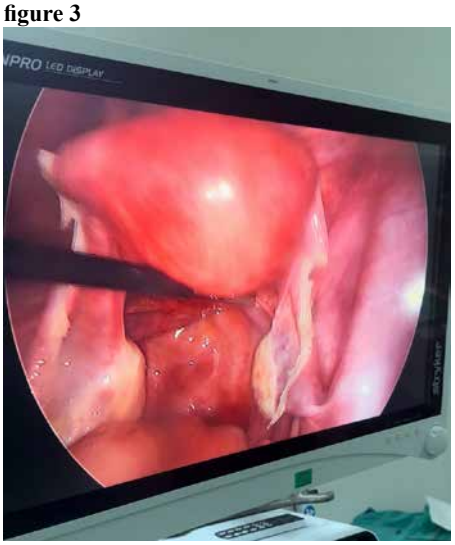
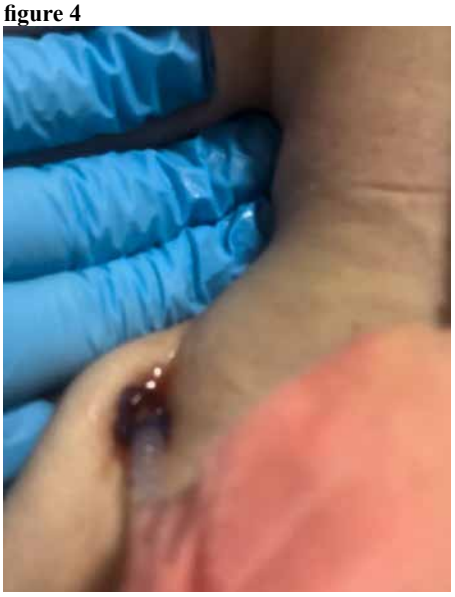


figure 4



SS-066 [Endoskopi]

Comparison of surgical site infections in laparoscopic and abdominal hysterectomy

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OBJECTIVE: Hysterectomy is one of the most common surgery performed in gynecology and obstetrics clinics. Surgical site infections are important complications of hysterectomy. Surgical site infections frequently seen after hysterectomy can be listed as wound infection, urinary tract infection, vaginal cuff infection, pelvic infection and postoperative fever. The aim of this study was to evaluate the surgical site infections in laparoscopic and abdominal hysterectomy.

METHOD: The study was performed retrospectively on patients who underwent total laparoscopic hysterectomy (TLH) (n=58) and total abdominal hysterectomy (TAH) (n=53) due to benign pathologies at the Gynecology and Obstetrics Clinic of Alanya Training and Research Hospital between January 2021 and May 2024. TLH and TAH groups were compared in terms of postoperative surgical site infections.

RESULTS: Wound infection, duration of surgery, rehospitalization, and oral antibiotic use rates were significantly higher in the TAH group ($p<0.05$). Wound infection was seen in 1 patient (1.7%) in the TLH group and in 10 patients (18.9%) in the TAH group, and found to be significantly higher in the TAH group ($p<0.05$). BMI, diabetes, rehospitalization, oral antibiotic use, prolonged duration of surgery and hospitalization rates were significantly higher in patients with surgical site infections in both groups ($p<0.05$).

CONCLUSION: In this study, we found that obesity, diabetes, prolonged duration of surgery and hospitalization are important risk factors for infective complications in hysterectomy operations. Duration of surgery was shorter and postoperative infective complication rates were lower in TLH. Therefore, TLH appears to have important advantages such as less postoperative antibiotic use and shorter hospitalization. TLH may also provide benefits with regard to nosocomial infections, antibiotic resistance and costs.

Keywords: Total laparoscopic hysterectomy, total abdominal hysterectomy, surgical site infections

Table 1

Comparison of TLH and TAH groups

Table-1.

		TAH (n:53 %47.7)			TLH (n:58-52.3%)			P
		Mean±ss/n-%		Median	Mean±ss/n-%		Median	
Age		48.5	± 5.2	48.0	50.2	± 7.8	48.0	0.458 m
BMI		27.8	± 4.6	27.3	28.3	± 4.6	28.6	0.559 x²
ASA Score	I	1	1.9%		2	3.4%		0.496 x²
	II	52	98.1%		54	93.1%		
	III	0	0.0%		2	3.4%		
Smoking	(-)	40	75.5%		50	86.2%		0.149 x²
	(+)	13	24.5%		8	13.8%		
Diabetes Mellitus	(-)	48	90.6%		52	89.7%		0.873 x²
	(+)	5	9.4%		6	10.3%		
Duration of surgery (min)		98.2	± 28.8	90.0	74.0	± 22.0	70.0	***0.000*** m
Hospitalization (day)	2	45	84.9%		55	94.8%		0.081 x²
	3	8	15.1%		3	5.2%		
Postoperative i.v. antibiotic	1	53	100.0%		56	96.6%		0.496 x²
	2 days	0	0.0%		2	3.4%		
Postoperative oral antibiotic	(-)	14	26.4%		57	98.3%		***0.000*** x²
	5 days	39	73.6%		1	1.7%		
Surgical site infeciton	(-)	43	81.1%		57	98.3%		***0.003*** x²
	(+)	10	18.9%		1	1.7%		
Postoperative intraabdominal abscess	(-)	51	96.2%		58	100.0%		0.226 x²
	(+)	2	3.8%		0	0.0%		
Rehospitalization	(-)	47	88.7%		58	100.0%		***0.008*** x²
	(+)	6	11.3%		0	0.0%		

m:Mann-whitney u test / x²:Chi square test , BMI: Body mass index

Comparison of TLH and TAH groups

Table 2

Comparison of patients with and without infective complications in TLH and TAH groups

Table-2

		SSI(+) n:11 (9.9%)		SSI (-)n:100 (91.1%)		
		Mean.±ss/n-%	Median	Mean.±ss/n-%	Median	P value
Operation	TAH	10 (90.9%)		43 (43.0%)		***0.003*** [X²]
	TLH	1 (9.1%)		57 (57.0%)		
Age		50.27+7.96	46.00	49.32+6.6	48.00	0.909 [m]
BMI		32.6+3.7	33.30	27.6+4.4	27.73	***0.000*** [X²]
ASA Score	I	0		3 (3.0%)		0.750 [X²]
	II	11 (100%)		95 (95.0%)		
	III	0		2 (2.0%)		
Smoking	(+)	4 (36.4%)		17 (17.0%)		0.120 [X²]
	(-)	7 (65.6%)		83 (83.0%)		
Diabetes Mellitus	(+)	4 (36.4%)		7 (7.0%)		***0.002*** [X²]
	(-)	7 (65.6%)		93 (93.0%)		
Duration of surgery (min)		130+23.6	130.0	80.7+24.0	85.0	***0.000*** [m]
Hospitalization (day)	2	7 (63.6%)		93 (93.0%)		***0.002*** [X²]
	3	4 (36.4%)		7 (7.0%)		
Postoperative i.v. antibiotic	1	11 (100.0%)		98 (98.0%)		0.636 [X²]
	2	0		2 (2.0%)		
Postoperative oral antibiotic	(-)	3 (27.3%)		68 (68.0%)		***0.008*** [X²]
	5 days	8 (72.7%)		32 (32.0%)		
Rehospitalization	(+)	7 (63.6%)		0		***0.000*** [X²]
	(-)	4 (36.4%)		100 (100.0%)		

[m] Mann-whitney u test / [X²] Chi square test , SSI: surgical site infection, BMI: Body mass index

Comparison of patients with and without infective complications in TLH and TAH groups

SS-067 [Obstetri Genel]

Effectiveness of Foley Catheter with Cervical Suturing for the Treatment of Postpartum Hemorrhage due to Uterine Atony

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Postpartum hemorrhage (PPH) is a leading cause of maternal mortality, with uterine atony being the most common underlying factor. Standard treatment options include uterotonics, intrauterine tamponade, blood transfusion, embolization, and surgery. However, when these methods fail, alternative approaches are necessary. This study evaluates the effectiveness of combining a Foley catheter intrauterine tamponade with cervical sutures to manage uterine atony-related PPH within the first two hours postpartum.

METHODS: In this retrospective study, 30 patients diagnosed with uterine atony who experienced persistent postpartum hemorrhage despite standard management within the first two hours after delivery were analyzed.

Inclusion criteria:

• Active postpartum hemorrhage within the first two hours after delivery

• Persistent bleeding despite standard uterotonic therapy and fluid resuscitation

• Age of at least 18 years Exclusion criteria:

• Hemorrhage attributable to retained placenta, uterine rupture, or genital tract lacerations

• Hematologic disorders such as coagulopathy or thrombocytopenia identified as the cause of bleeding

• Incomplete or insufficient medical records

RESULTS: Hemorrhage was successfully controlled in 27 out of 30 patients (90%) without requiring surgical intervention. Blood loss was estimated using a combination of Foley catheter drainage, suctioned blood volume, and subjective assessment based on soaked pads and hemoglobin level differences. The average blood loss was 1225 mL (range: 860–1680 mL), and the mean procedure duration was 27 ± 4 minutes. However, three patients (10%) experienced persistent bleeding despite initial management and required additional surgical interventions, including B-Lynch sutures and hypogastric artery ligation. No cases of recurrent hemorrhage were observed following Foley catheter removal at 24 hours. Regarding complications, one patient (3.3%) developed disseminated intravascular coagulation (DIC), necessitating hematology consultation and multidisciplinary management. The diagnosis of DIC was based on progressive thrombocytopenia, an international normalized ratio (INR) prolongation of >1.8, fibrinogen levels <150 mg/dL, and elevated D-dimer levels. Management included the administration of fresh frozen plasma (FFP), cryoprecipitate, and supportive care. Despite the development of DIC, the patient remained hemodynamically stable with conservative treatment, ultimately avoiding surgical intervention. Transient cervical edema was observed in two patients (6.6%) and was identified through speculum examination, which revealed hyperemic and edematous cervical tissue. These cases resolved spontaneously within 24 hours without requiring additional treatment. No cases of endometritis, cervical laceration, or uterine perforation were reported. Final vital signs following successful intervention indicated hemodynamic stability in all patients. The mean arterial pressure was 81 ± 5 mmHg, and the average heart rate was 92 ± 6 bpm. Urine output normalized within six hours in all cases, confirming the effectiveness of resuscitative measures.

CONCLUSION: The combination of Foley catheter intrauterine tamponade and cervical sutures is a rapid, cost-effective, and highly effective technique for managing uterine atony-related PPH within the first two hours postpartum. This approach serves as a uterus-preserving alternative, reducing the need for surgical intervention. Even in complex cases such as DIC, surgery may be avoided with appropriate multidisciplinary management. Given its high success rate, low complication profile, and feasibility, further studies with larger patient cohorts are recommended.

Keywords: uterine atony, bleeding, Foley catheter

SS-068 [Obstetri Genel]

Rupture of the spleen and splenic artery aneurysm during pregnancy – a rare case series of three cases with fetal and maternal survival

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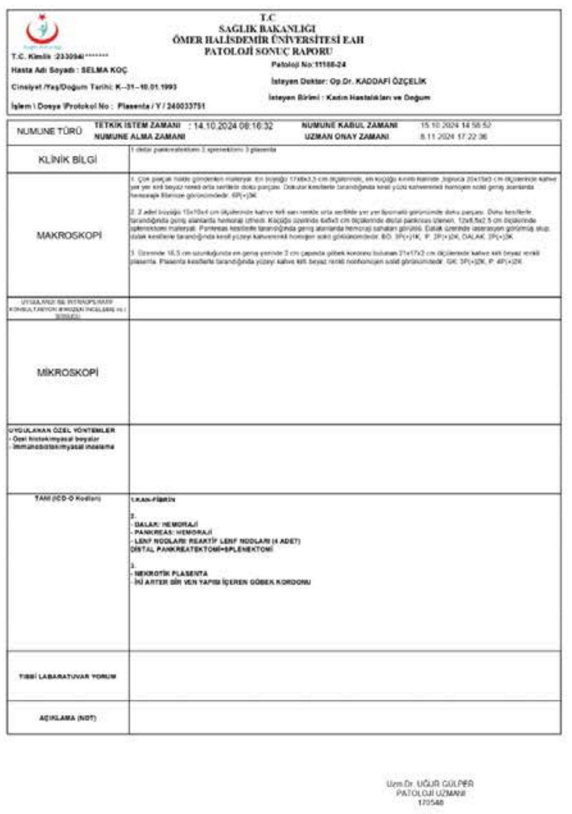
Visceral artery aneurysm, particularly splenic artery (arteria lienalis) aneurysm, is rare and often associated with pregnancy. When these aneurysms rupture, feto-maternal mortality and morbidity can be high, frequently necessitating emergency surgery. In pregnant women presenting with severe abdominal pain, anemia, and hypotension in the third trimester, uterine rupture and abruptio placentae are typically suspected. Consequently, diagnosing splenic artery aneurysm rupture becomes challenging for obstetricians. This case series of three patients aims to raise awareness of splenic artery aneurysm rupture diagnosis and establish an effective multidisciplinary approach to its management.

Keywords: pregnancy, spleen, splenic artery, aneurysm, rupture

figure 1



T.C
SAĞLIK BAKANLIĞI
ÖMER HALİSDEMİR ÜNİVERSİTESİ EAH
PATOLOJİ SONUÇ RAPORU

T.C. Kimlik :233094*******
Hasta Adı Soyadı : SELMA KOÇ
Cinsiyet /Yaş/Doğum Tarihi: K--31--10.01.1993
İşlem \ Dosya \Protokol No : Plasenta / Y / 240033751

Patoloji No: 11188-24
İsteyen Doktor: Op.Dr. KADDAFİ ÖZÇELİK
İsteyen Birimi : Kadın Hastalıkları ve Doğum

NUMUNE TÜRÜ	TETKİK İSTEM ZAMANI : 14.10.2024 08:16:32 / NUMUNE ALMA ZAMANI; NUMUNE KABUL ZAMANI 15.10.2024 14:58:52 / UZMAN ONAY ZAMANI 8.11.2024 17:22:36
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MAKROSKOPİ	[illegible]
[illegible]	
MİKROSKOPİ	
UYGULANAN ÖZEL YÖNTEMLER - Özel histokimyasal boyalar - İmmünohistokimyasal inceleme	
TANI (ICD-O Kodları)	1.KAN-FİBRİN 2. - DALAK: HEMORAJİ - PANKREAS: HEMORAJİ - LENF NODLARI: REAKTİF LENF NODLARI (4 ADET) DİSTAL PANKREATEKTOMİ+SPLENEKTOMİ 3. - NEKROTİK PLASENTA - İKİ ARTER BİR VEN YAPISI İÇEREN GÖBEK KORDONU
TIBBİ LABARATUVAR YORUM	
AÇIKLAMA (NOT)	

Uzm.Dr. UĞUR GÜLPER
PATOLOJİ UZMANI
170548

Figure 1 Pathology report

figure 2

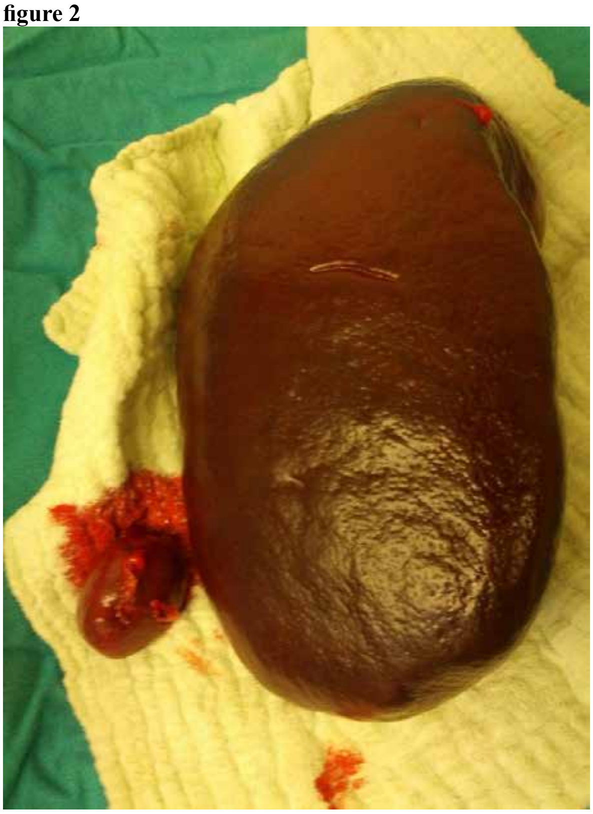

Figure 2 Splenectomy specimen with ruptured artery and accessory spleen

figure 3

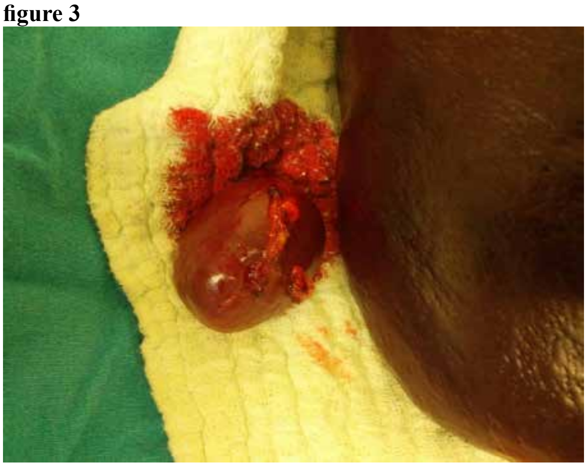

Figure 3 Splenectomy specimen with ruptured artery and accessory spleen

figure 4

Figure 4 Splenectomy specimen, ruptured artery

figure 5

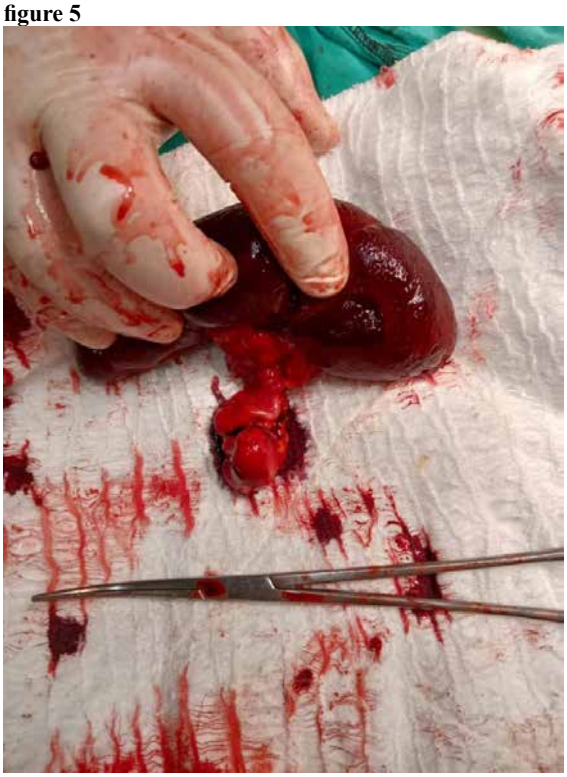

Figure 5 Splenectomy specimen, ruptured artery

SS-069 [Obstetri Genel]

Post mortem cesarean following a young woman's firearm suicide: A Case Report

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Ahi Evran Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Ana Bilim Dalı, Kırşehir

OBJECTIVE: Postmortem cesarean section has been practiced for centuries, influenced by cultural, religious, and legal traditions. The modern approach emphasizes timely intervention to optimize neonatal survival in cases of maternal cardiac arrest. Current guidelines suggest that delivery within 4-5 minutes of maternal collapse improves neonatal outcomes. This report presents a case of postmortem cesarean delivery following a young woman's suicide attempt and discusses neonatal survival under emergency conditions.

CASE: A 25-year-old woman at 36 weeks of gestation sustained a self-inflicted gunshot wound to the 2nd-3rd intercostal space. Emergency services transported her to the hospital within 25 minutes. Upon arrival, she exhibited fixed, dilated pupils, an absent pulse, and a Glasgow Coma Score of 3. Ultrasound revealed weak fetal heart activity. Despite ongoing maternal resuscitation, an emergency postmortem cesarean section was performed immediately after confirming maternal cardiac arrest. A 2800-gram male infant was delivered with an APGAR score of 0 at 1 minute and 3 at 5 minutes. Neonatal resuscitation was initiated, and the infant was admitted to intensive care. Initial blood gas analysis indicated severe acidosis (pH 6.84, pCO_2 81.5 mmHg, base excess -27.1). The newborn was placed on mechanical ventilation and hypothermia therapy, showing metabolic improvement within 15 minutes (pH 7.08, pCO_2 41.1 mmHg, base excess -19.4). The infant was referred to a tertiary center for further management of hypoxic-ischemic encephalopathy. Maternal resuscitation efforts continued for 45 minutes but were unsuccessful.

CONCLUSION: Timely cesarean delivery during maternal cardiac arrest significantly impacts neonatal outcomes. Current recommendations emphasize delivering the fetus within 4-5 minutes to reduce the risk of neurological damage. Several reports describe neonatal survival after delayed postmortem deliveries, although long-term outcomes vary. This case reinforces the importance of rapid decision-making and skilled neonatal resuscitation in emergency cesarean deliveries following maternal cardiac arrest. While maternal survival is often unachievable in severe trauma cases, prompt surgical intervention may improve neonatal prognosis. Further studies and long-term follow-ups are needed to assess the neurological outcomes of infants born via perimortem cesarean section.

Keywords: hypoxic-ischemic encephalopathy, maternal suicide, postmortem cesarean

SS-070 [Obstetri Genel]

Predicting hysterectomy for severe postpartum hemorrhage: A retrospective cohort study on the role of systemic immune-inflammatory indices in Bakri balloon tamponade outcomes

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AIM: Evaluation of the predictive value of systemic immune-inflammatory indices, in particular the Systemic Immune-Inflammation Index (SII), the Systemic Inflammatory Response Index (SIRI), and the Pan-Immune Inflammation Value (PIV), in determining the need for hysterectomy after Bakri balloon tamponade for severe postpartum hemorrhage (PPH).

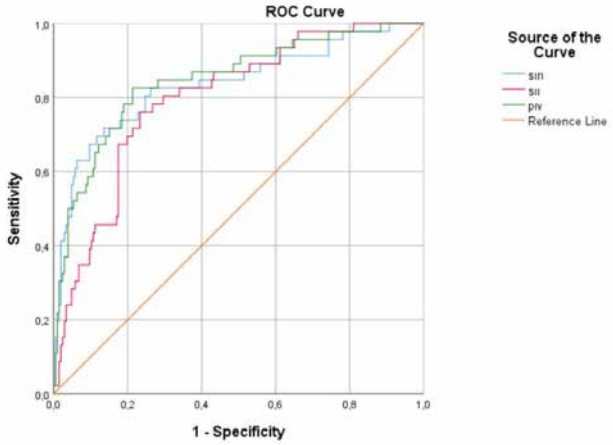
METHODS: This retrospective cohort study included 255 women with severe PPH managed with Bakri balloon tamponade at Etlik Zübeyde Hanım Obstetric and Gynecology Research Center from January 2014 to December 2022. The patients were divided into three groups: Bakri balloon only (group A, n=174), Bakri balloon with uterine artery ligation (group B, n=35), and Bakri balloon with hysterectomy (group C, n=46). Data were collected on demographic information, obstetric history, clinical parameters, and immune-inflammatory indices. The primary outcome was the need for a hysterectomy. Statistical analyses included descriptive statistics, comparative analyses, and an ROC curve analysis to assess the predictive accuracy of the indices.

RESULTS: The study revealed significant differences in the number of neutrophils, lymphocytes, and monocytes as well as in the SII, SIRI, and PIV values between the groups. Higher values of these indices were associated with a higher likelihood of Bakri balloon failure requiring a hysterectomy. ROC curve analysis showed good predictive power for SIRI (AUC = 0.835), SII (AUC = 0.798), and PIV (AUC = 0.848).

CONCLUSIONS: Systemic immune-inflammatory indices are significant predictors of Bakri balloon tamponade failure and subsequent need for hysterectomy in severe PPH. These indices could improve clinical decision-making by identifying high-risk patients, potentially improving maternal outcomes.

Keywords: Postpartum hemorrhage, Bakri balloon tamponade, Hysterectomy, Systemic immune-inflammatory indices

Receiver Operating Characteristic (ROC) curves of the inflammatory indices for postpartum hysterectomy



This figure shows the ROC curves for the Systemic Immune Inflammation Index (SII), the Systemic Inflammatory Response Index (SIRI) and the Pan-Immune Inflammation Value (PIV) for predicting the need for hysterectomy following Bakri balloon tamponade in patients with severe postpartum hemorrhage (PPH). The area under the curve (AUC) for each index is shown, with SIRI having an AUC of 0.835 (95% CI: 0.761-0.909), SII having an AUC of 0.798 (95% CI: 0.731-0.865) and PIV having an AUC of 0.848 (95% CI: 0.782-0.914). The ROC curves illustrate the sensitivity and specificity of the individual indices, with the optimal cut-off values determined for the prediction of hysterectomy. The high AUC values indicate good predictive accuracy for these indices, suggesting their potential utility in clinical practice for identifying patients at higher risk of Bakri balloon tamponade failure.

Demographic and clinical characteristics of study population (n=255)

	Group A (Only IUBT) (n=174)	Group B (IUBT+ uterine artery ligation) (n=35)	Group C (IUBT +hyseterectomy) (n=46)	p-value
Age (year)	30.4 ± 6.11	30.3 ± 6.93	34.3 ± 5.67	0.009 *
Body mass index (kg/m2)	29.2 ± 4.6	29.1± 3.71	29.1 ± 5.43	0.740 *
Gravidity (median,IQR)	3 (2)	2 (1.5)	3 (2.75)	0.288 **
Parity (median,IQR)	1 (2)	1 (2)	2 (2.5)	0.087 **
Alive (median,IQR)	1 (2)	1 (2)	2 (1.75)	0.068 **
Gestational age at delivery(week) (median,IQR)	37 (3)	37 (3.25)	37 (2)	0.117 **
Previous cesarean section (n,%)	73 (42.0)	14 (40)	25 (54.3)	0.283 ***
Birth Way Spontaneous	19 (10.9)	2 (5.7)	4 (8.7)	0.615 ***
Birth Way Cesarean section	155 (89.1)	33 (94.3)	42 (91.3)	0.615 ***
Birth Weight (g)	3260.5±311.53	3223.6±330.29	3359.2 ± 375.91	0.482 *
Transfusion rate (n,%)	127 (74.4)	28 (84.4)	38 (82.6)	0.290 ***
Fever n(%)	19 (10.9)	3 (8.6)	7 (15.2)	0.612 ***
Antibiotic administration Rate (n,%)	160 (92.5)	35 (100)	44 (95.7)	0.209 ***
Time until Bacri balloon removal (hour)	16.2±6.76	17.7±5.89	15.4 ± 8.06	0.490 *
Amount of bleeding in the first 10 minutes (median,IQR)	50 (40)	62 (103)	100 (153)	<.001 **
Amount of bleeding in the first 30 minutes (median,IQR)	100 (70)	112 (215)	250 (255)	<.001 **

** =ANOVA test, ** = Kruskal-Wallis H test, *** = Chi-Square test Abbrevations; IUBT, intrauterine balloon tamponade*

Clinical risk factors and obstetric characteristics associated with the need for hysterectomy in patients managed with Bakri balloon tamponade.

	Group A (Only IUBT) (n=174)	Group B (IUBT+ uterine artery ligation) (n=35)	Group C (IUBT+hyseterectomy) (n=46)	p-value
Preeclampsia	2 (1.1)	0 (0)	3 (6.5)	0.043
Placenta previa	93 (53.4)	8 (22.9)	25 (54.3)	0.003
Hypertension	5 (2.9)	2 (5.7)	4 (8.7)	0.204
Polihydramnios	3 (1.7)	0 (0)	4 (8.7)	0.021
Oligohydramnios	9 (5.2)	1 (2.9)	1(2.2)	0.606
Diabetes melitus	12 (6.9)	3 (8.6)	0 (0)	0.161
Abruptio placentae	6 (3.1)	1 (2.9)	3 (6.5)	0.596
Multiple pregnancy	17 (9.8)	2 (5.7)	0 (0)	0.074
Fetal macrosomia	4 (2.3)	1 (2.9)	0 (0)	0.557
Fetal growth restriction	10 (5.7)	3 (8.6)	4 (8.7)	0.932
IVF pregnancy	10 (5.7)	2 (5.7)	3 (6.5)	0.701

Rates are given according to presence in the group, Chi-Square test Abbrevations; IUBT, intrauterine balloon tamponade; IVF, In Vitro Fertilization

Comparison of complete blood count parameters and inflammation indexes of three groups

	Group A (Only IUBT) (n=174)	Group B (IUBT+ uterine artery ligation) (n=35)	Group C (IUBT+hyseterectomy) (n=46)	p-value
Prepartum Hb (gr/dl)	11.5 (7.2- 15.2)	12 (9.1-14.2)	11.65 (6.3-14.8)	0.381
Postpartum Hb (gr/dl)	8.7 (4.6-12.7)	8.6 (4.9-10.7)	8.4 (4-11.2)	0.134
Neutrophil count (x103/µL)	6.71 (1.91-70.30)	7.05 (2.61-12.59)	8.86 (2.08-30.72)	0.001*
Lymphocyte count (x103/µL)	1.71 (0.48-21.2)	1.93 (0.56-3.42)	1.50 (0.44-4.05)	0.003**
Monocyte count (x103/µL)	0.44 (0.07-5.3)	0.54 (0.14-1.02)	0.58 (0.17-2.04)	0.001***
Platelet count (x103/µL)	217 (32-426)	215 (108-467)	224 (137-405)	0.691
SIRI	1.76 (0.32-17.58)	2.23 (0.86-4.59)	3.65 (0.88-30.72)	<0.001 †
SII	816.42 (0.63-3944.33)	1499.66 (612.61-2058.18)	1471.61 (558.64-4029.00)	<0.001 ‡
PIV	374.48 (0.98-4182.85)	467.07 (163.14-1456.21)	933.63 (169.49-4208.64)	<0.001 §

*Kruskal-Wallis with Bookonni Correction used. * Pairwise comparison for neutrophil A-B: 0.688 A-C: 0.001 B-C:0.238 ** Pairwise comparison for lymphocyte A-B>0.99 A-C:0.007 B-C:0.008 *** Pairwise comparison for monocyte A-B:0.061 A-C:0.002 B-C >0.99 † Pairwise comparison for SIRI A-B:0.008 A-C: <0.001 B-C:0.006 ‡ Pairwise comparison for SII A-B <0.001 A-C <0.001 B-C >0.99 § Pairwise comparison for PIV A-B:0.077 A-C <0.001 B-C <0.001 Abbreviations; IUBT, intrauterine balloon tamponade; SIRI, Systemic Inflammatory Response Index; SII, Systemic Immune-Inflammation Index; PIV, Pan-Immune Inflammation Value; Hb, Hemoglobulin*

SS-071 [Obstetri Genel]

Investigation Of Transient Receptor Potential Channel 2 (trpm2) Activitiy In Placental Invasion Anomaly

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Placenta accreta spectrum, which encompasses abnormal placental invasions including accreta, increta, and percreta, represents serious pregnancy-related complications that can lead to significant mortality and morbidity. This study aimed to investigate the immunohistochemical expression of TRPM2, which is known to be activated by oxidative stress. A total of 44 women diagnosed with PAS and 16 healthy women were included in the study, forming two groups: the patient group and the control group. Routine paraffin embedding was performed, and sections were taken from the placentas to apply immunohistochemical staining techniques for TRPM2, VEGF, and MMP9. The samples were then examined under light microscopy, and statistical analyses were conducted. In the study, a statistically significant increase in the immunoreactivity of TRPM2, VEGF, and MMP9 was observed in the PAS group compared to the control group.

Keywords: Placenta Accreta Spectrum, Transient Receptor Potential Channel 2, Matrix Metalloproteinase 9, Vascular Endothelial Growth Factor

SS-072 [Obstetri Genel]

Maternal morbidity in high-order cesarean deliveries: a retrospective analysis

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OBJECTIVE: The increasing rate of cesarean deliveries has made the effects of repeated cesarean sections on maternal health a topic of growing concern. In women undergoing five or more cesarean sections, both intraoperative and postoperative complication risks increase. This study aims to evaluate the maternal outcomes of 5th, 6th, and 7th cesarean deliveries and examine the effects of increasing cesarean numbers on maternal health.

METHODS: This retrospective study analyzes patients who have undergone a 5th (n=185), 6th (n=43), and 7th (n=4) cesarean delivery. Data were obtained from hospital records and maternal demographic characteristics, intraoperative, and postoperative outcomes were analyzed.

RESULTS: In terms of demographic findings, the mean age of patients was 31.8±4.9 years in the 5th cesarean group and 33.2±5.1 years in the 6th+7th cesarean group (p=0.08). Although the rates of preeclampsia, chronic hypertension, and gestational diabetes were higher in the 6th+7th cesarean group, these differences were not statistically significant (p>0.05). Regarding obstetric and operative outcomes, the rate of preterm birth was significantly higher in the 6th+7th cesarean group compared to the 5th cesarean group (20.5% vs. 34%, p=0.05). The incidence of placenta previa and placenta percreta showed a slight increase in the 6th+7th cesarean group. Additionally, uterine rupture, postpartum atony, and postpartum hysterectomy rates demonstrated minimal differences as the number of cesarean deliveries increased, with no statistically significant variation (p>0.05). In terms of postoperative outcomes, the need for blood transfusion and erythrocyte suspension remained similar across groups. The average length of hospital stay was two days in both groups (p=0.87), and no significant differences were observed in operative time or the need for surgical drainage.

CONCLUSION: Our study indicates that undergoing a fifth or higher cesarean section does not significantly increase maternal morbidity, although there is a notable rise in preterm birth rates. Additionally, the increasing number of cesarean deliveries is associated with a higher incidence of preeclampsia, hypertension, and gestational diabetes, suggesting the necessity for a reassessment of long-term obstetric management strategies. These findings highlight the importance of careful selection of cesarean indications and close monitoring of multiparous patients. As a referral center with extensive experience in managing high-order repeat cesarean deliveries, our institution is well-equipped to handle these complex cases. The expertise of our clinic in managing such patients may contribute to the relatively stable maternal morbidity rates observed in our study. Future prospective studies with larger sample sizes are needed to further validate these findings and refine best practices in obstetric care for high-parity patients.

Keywords: Maternal morbidity, Obstetric complications, Preterm birth, Placenta previa

SS-073 [Obstetri Genel]

Unexpectedly low O2 saturation measurements with pulse oximetry in early postpartum period

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OBJECTIVE: We aim to attract the attention of our collegues to false-low O2 saturation measurements with pulse oximetry to prevent unnecessary expensive diagnostic tests or consultations and discuss underlying patophysiologic mechanisms.

METHOD: Case presentation and literature review

RESULTS: A 18-year-old multiparous woman, G2P2, was under routine follow-up after an uneventful spontaneous labor. Although she had no respiratory symptoms her oxygen saturation (SatO2) in room air was measured 80% with pulse oxymeter and was not increased with nasal O2 suplementation. She had tachycardia with 130 bpm. There was no sign of postpartum hemorrhage. Tests and consultations to rule out pottentially life treathening pulmonary and cardiac etiologies were organised but the patient stated that she felt herself very well and does not want any investigations in depth. We could perform a blood gas analysis and see that SaO2 was 95.5%. we searched the literature for the possible reasons underlying this discordance and saw that some variant hemoglobins and methemoglobin escape from the measurement of pulse oxymeter due to their different light absorbtion characteristics. When we returned to blood gas analysis result, we noticed that MetHb was % 9.2 (normal range: 0-2). Variant hemoglobins were ruled out with hemoglobin electrophoresis. With deeper questioning we learned that some other family members (patient' siblings and father) were investigated for a similar problem but a spesific diagnosis was not set. Drugs and environmental toxins leading to methemoglobinemia were ruled out and we set the diagnosis of congenital methemoglobinemia for this patient. CONCLUSION: Pulse oxymeter uses light at 2 wave lengths (660 ve 940 nm) to measure oxy- and deoxyhemoglobin levels. However light absorption features of some varint hemoglobins and methemoglobins are different and therefore they cannot be measured with this method leading to false-low SatO2 in pulse oxymeter discordant with blood gas analysis. This knowledge enables avoidance from expensive and sometimes invasive work-up to investigate etiology of hypoxemia.

Keywords: pulse oximetri, methemoglobinemia, hypoxemia, variant hemoglobin

SS-074 [Perinatoloji]

Challenges in Second-Trimester Termination: Hysterotomy Following Medical Failure and Postoperative Hematoma

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We present the case of a 37-year-old pregnant woman at 14 weeks and 2 days of gestation who had been followed up at an external center and was referred to our perinatology clinic due to ultrasound findings of right upper limb absence, bilateral femur shortening, severe foot deformities, and restricted fetal movements. The patient was gravida 3, para 2, with a history of two previous cesarean deliveries.

A detailed ultrasonographic evaluation confirmed amelia, bilateral femur shortening, and severe foot deformities. The family was counseled regarding the prognosis, and pregnancy termination was offered. Upon acceptance, the patient was admitted to the obstetrics and gynecology service for termination. Routine blood tests and vital signs remained stable throughout hospitalization. Prior to medical treatment, intrauterine balloon catheter placement with a Foley catheter was attempted to promote cervical ripening but was unsuccessful. Medical termination was initiated with intravaginal administration of 200 mcg misoprostol every 3 hours for five doses, constituting one treatment cycle. The patient was regularly monitored via ultrasound for signs of uterine rupture throughout the process. After four cycles, the dosage was increased, and a modified regimen was introduced in the fifth cycle, consisting of 400 mcg misoprostol (200 mcg intravaginally and 200 mcg sublingually) every 3 hours for five doses.

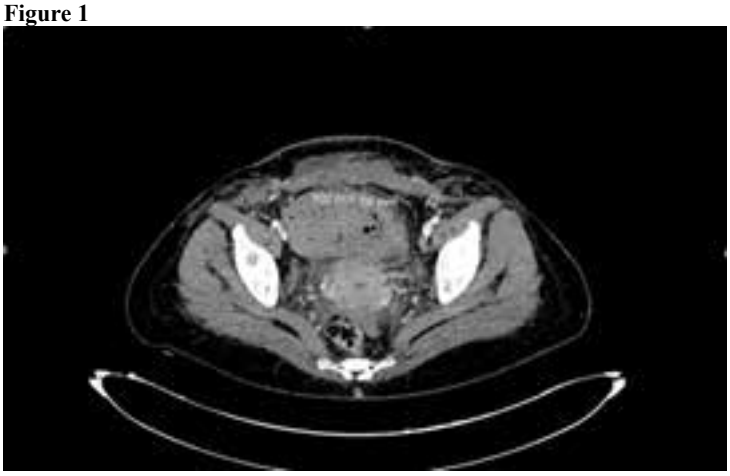
Despite this regimen, pregnancy termination was not achieved. After ruling out uterine rupture, intrauterine balloon placement was reattempted and successfully performed. The Foley catheter remained in place for 12 hours. After its removal, two additional cycles of 400 mcg misoprostol were administered at regular intervals. Despite seven cycles of medical termination, fetal expulsion was not achieved, necessitating a hysterotomy.

Postoperatively, the patient's vital signs were stable (heart rate: 127 bpm, blood pressure: 121/80 mmHg, temperature: 36.5°C, oxygen saturation: 97%). However, she developed abdominal pain, vulvar swelling, and a hematoma. Serial hemoglobin measurements showed a decline from 8.9 g/dL to 7.7 g/dL, prompting an upper abdominal and pelvic CT scan. The patient received two units of packed red blood cells (PRBC) and fresh frozen plasma (FFP).

Imaging revealed uterine incision site dehiscence and an 11×6 cm hematoma anterior to the bladder, extending to the vulva. Additional PRBC and FFP transfusions were administered due to persistent anemia (Hb: 7.9 g/dL). The patient was managed with antibiotics and local treatment for the vulvar hematoma. No further hemoglobin decline was observed, and vital signs remained stable throughout the follow-up period.

Keywords: Second-trimester termination, Hysterotomy, Medical abortion failure, Vulvar hematoma,Uterine rupture risk

Figure 1



Well-defined limited postoperative hemorrhagic area

Figure 2

Vulvar hematoma

Figure 3

Postoperative image of the fetus

Figure 4

Postoperative Day 7 Appearance of the Vulva and Surrounding Area

SS-075 [Obstetri Genel]

An uncommon congenital uterine anomaly with pregnancy: a case report

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INTRODUCTION: Mullerian anomalies, which result from the failure of fusion between the Mullerian duct and the urogenital sinus, lead to vertical fusion defects. These anomalies are observed in 7% of the general population and in 18% of women with recurrent pregnancy loss. Transvaginal sonography has high diagnostic accuracy, and the differentiation between bicornuate and septate uterus is made by measuring the distance between the two cavities and evaluating the fundal contour. These cavity defects are associated with recurrent pregnancy loss and preterm birth symptoms.

CASE PRESENTATION: A 27-year-old patient, presented for routine follow-up at 13 weeks of gestation. Her previous pregnancy had resulted in a cesarean delivery at 37 weeks due to breech presentation. She had no history of alcohol consumption, smoking, or teratogenic drug use. She had craniofrontonasal syndrome, which presents with severe phenotypic features in heterozygous females, including hypertelorism, craniosynostosis, facial asymmetry, and bifid nose. In the first-trimester screening test, NT (nuchal translucency) was measured as 0.80 mm, with a combined risk of 1/8790 for Down syndrome and 1/99000 for Trisomy 13/18. Ultrasonographic evaluation showed that obstetric measurements were consistent with gestational age, with an estimated fetal weight of 87 grams. The cervix was closed and measured 40 mm. A uterine anomaly was observed, with a double cavity and a septum separating them. The placenta was located anteriorly in the cavity where the fetus was positioned. Amniotic fluid was absent in the fetal cavity but present in the other cavity. Fetal heart rate was bradycardic. Speculum examination revealed a single cervix and vagina. The external os appeared nulliparous. The preliminary diagnosis was a combined bicornuate-septate uterus. During sonographic evaluations, it was observed that the fetus migrated across the septum into the cavity containing amniotic fluid. Following this migration, fetal heart rate returned to the normal range. Further evaluation revealed dolichocephaly, hypertelorism,

frontonasal dysplasia, and midface hypoplasia. Based on these findings, craniofrontonasal syndrome, similar to that of the patient's mother, was considered in the preliminary diagnosis.

CONCLUSIONS: According to the 2021 American Society for Reproductive Medicine Müllerian Anomalies Classification classification of Müllerian anomalies, based on imaging and examination findings, our patient was preliminarily diagnosed with a combined bicornuate-septate uterus. Literature suggests that additional imaging techniques such as 3D ultrasonography, saline infusion sonography, hysterosalpingography, and MRI can aid in diagnosing these anatomical defects. However, due to the presence of a viable pregnancy, the increasing size of the uterus, and its shape, our ability to confirm the diagnosis was limited. Studies have shown that septate and bicornuate uterus anomalies are associated with poorer pregnancy outcomes compared to other uterine anomalies. Pregnancy losses were mostly recorded in the second trimester. In conclusion, detecting these congenital uterine anomalies before pregnancy is crucial for predicting and managing pregnancy outcomes. In this case, we believe that the presence of a uterine septum may be associated with adverse pregnancy outcomes.

Keywords: Anomaly, Bicornuate, Mullerian, Pregnancy, Septate

SS-076 [Obstetri Genel]

"Midwife Polyclinic" service model: An example of good clinical practice from the capital of Türkiye

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The World Health Organization envisions a world where every pregnant woman and newborn receives quality care throughout pregnancy, delivery, and the postpartum period. Midwives are the primary care providers in many antenatal care settings. Healthcare providers emphasize the midwife-led continuity of care model as a way to establish a positive, trusting, and empathetic relationship with pregnant women. In this study, the aim is to present how midwife polyclinics should be established and their functions by presenting them in light of international literature and guidelines and by synthesizing them within the scope of evidence-based practices and to present an application example (model) that can be used at national and international levels by introducing the sample midwife polyclinic service project established within the Ankara Etlik Zübeyde Hanım Gynecology and Obstetrics Training and Research Hospital. Preconceptional counseling, pregnancy follow-up, examination and preparation for normal vaginal birth processes were managed in the midwife polyclinic.

In preconceptional care, counseling was provided by focusing on topics such as creating fertility awareness, evaluating birth perception, coping with fear of birth, planning pregnancy, screening for risk factors, evaluating environmental risk factors, evaluating mental health, evaluating possible domestic violence, eating habits, physical movement, immunization, screenings and paternal evaluation… etc. The "Preconceptional Care and Counseling Algorithm" was created by utilizing international guidelines and guides and our country's literature. According to the WHO antenatal care model, it is recommended that pregnant women undergo at least 8 (eight) follow-up calendars for necessary follow-ups and examinations. Although there are differences in the evaluation of pregnant women according to the week of pregnancy in each follow-up calendar carried out in our hospital, in general, the process of meeting the pregnant women and their relatives and initiating appropriate communication (introducing oneself, establishing eye contact, ensuring privacy, using body language), recording personal information, obtaining family history, medical and obstetric history, evaluating pregnancy complaints and danger signs during pregnancy, physical examination, conducting risk assessment, evaluating the level of knowledge about pregnancy and birth process in accordance with the week of pregnancy, determining the subjects needed in education and directing them to pregnancy school, directing them to a physician for routine examination, directing them to a perinatology physician in case of risk detection and recording the procedures performed is applied. Documentation forms have been created in the midwife polyclinic, which has been adapted to the hospital's automation system, where midwife practices are processed. The findings of the pregnant woman, who is examined and evaluated by the midwife, are processed and recorded in 10 sections on these forms. The recorded data can be documented as a whole and accessed by the physician. The scores of the risk factors are calculated and transferred to the documented data.. In this review, an example of a midwife-led preconceptional and antenatal care model was presented. Midwife polyclinic service is a potentially useful preliminary application to adapt the midwife-led care continuity model to our country.

Keywords: Midwifery, Midwifery units, Midwifery led care, Pregnancy, Preconceptional care

SS-077 [Jinekoloji Genel]

The Effect Of Vaginal Flatus On Sexual Function And Pelvic Floor Dysfunction In Women

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OBJECTIVE: Vaginal flatus is an embarrassing problem and has a significant negative impact on quality of life. It can lead to feelings of shame, sexual dysfunction and even social isolation. The aim of this study was to investigate the effect of vaginal flatus on sexual function and pelvic floor dysfunction.

METHOD: We included 154 women in this study. After the presence

of vaginal flatus in women was diagnosed by a specialist physician, women were divided into two groups as vaginal flatus (n=92) and non-vaginal flatus (n=62). All womenwere recorded the questionnaire including physical (age, body weight, height) and socio-demographic information (educational status, menstrual status, obstetric history, chronic diseases). Also, their sexual functions were evaluated with the "Female Sexual Function Index" and pelvic floor dysfunctions with the "Global Pelvic Floor Bother Questionnaire".

RESULTS: Female Sexual Function Index and Global Pelvic Floor Bother Questionnaire scores of women with vaginal flatus and women without vaginal flatus were found to be similar (p>0.05). The sexual desire subscale score of Female Sexual Function Index was found to be higher in women with vaginal flatus (p=0.002). Sexual arousal, lubrication, orgasm, satisfaction, pain-discomfort subscales of Female Sexual Function Indexwere found to be similar in both groups. Physical characteristics of women in both groups were found to be similar.

CONCLUSION: As a result of this study, it was found that the presence of vaginal flatus had no effect on sexual function and pelvic floor dysfunction. However, it is a remarkable finding that women with vaginal flatus have higher sexual desire levels. Vaginal flatus happens when air trapped in the posterior vaginal fornix is released by change of position or sexual intercourse.We thought that, women with higher sexual desire can changed position more and vaginal flatus might have occurred, however we are not sure whether the sexual desire causesvaginal flatus.

Keywords: vaginal flatus, pelvic floor dysfunction, sexual function, vaginal gas

SS-078 [Jinekoloji Genel]

Investigation of the etiology of patients diagnosed with vaginitis and evaluation of the effects of treatment on sexual functions

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OBJECTIVE: This study aimed to analyze the demographic data of patients diagnosed with vaginitis, identify factors predisposing to vaginitis, and evaluate the effects of vaginitis treatment on sexual functions. Vaginitis, a common condition affecting women of reproductive age, often leads to physical discomfort and psychological stress. Understanding its etiology and how effective treatments influence sexual health is crucial for improving patient outcomes.

METHODS: Between January and June 2024, researchers conducted a prospective evaluation of 158 patients diagnosed with vaginitis at Ankara Training and Research Hospital. The participants were divided into three groups based on their diagnoses: Candida (24.0%), Bacterial Vaginosis (47.5%), and Trichomonas (28.5%). The study collected detailed demographic data, including age, body mass index (BMI), smoking habits, and daily pad usage. The Female Sexual Function Index (FSFI) was employed to measure sexual dysfunction, with scores recorded before and after treatment. Statistical analysis was performed to assess the relationship between treatment outcomes and various patient characteristics.

RESULTS: The mean age of participants was 26.2±5.9 years, and the mean BMI was 25.3±5.2. The Trichomonas group exhibited significantly lower age and BMI compared to the other groups (p<0.05). Post-treatment FSFI scores revealed significant improvements across all diagnostic categories (p<0.05), indicating enhanced sexual function following treatment. Smoking and daily pad use were identified as factors strongly associated with higher levels of sexual dysfunction, emphasizing the need for addressing lifestyle factors alongside medical interventions.

DISCUSSION: The findings underscore the high prevalence of vaginitis and its substantial impact on sexual health. The study highlights the critical role of timely diagnosis and effective treatment in alleviating symptoms and improving quality of life. Addressing modifiable risk factors such as smoking and hygiene practices could further enhance treatment outcomes. Moreover, the observed improvements in FSFI scores post-treatment demonstrate the effectiveness of current therapeutic approaches, suggesting that personalized care plans could optimize results for patients with varying underlying conditions.

CONCLUSION: Vaginal infections are highly prevalent and significantly impact sexual health. This study demonstrates that effective treatment substantially improves sexual function, reinforcing the importance of early diagnosis and intervention. Healthcare providers should also focus on addressing modifiable lifestyle factors to enhance overall patient outcomes.

Keywords: Vaginitis, sexual dysfunction, FSFI, bacterial vaginosis, candida, trichomonas

SS-079 [Ürojinekoloji - Rekonstrüktif cerrahi]

Patient Satisfaction and Bleeding Rates Following an Introital Fascial Approach for Temporary and Permanent Hymenoplasty Techniques: A Comparative Study

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BACKGROUND: Bleeding during first sexual intercourse represents a significant sociocultural concern with potential implications for some couples.

OBJECTIVES: The aim of this study was to introduce a novel modification to temporary and permanent hymenoplasty and

evaluate both the objective and subjective success of defined techniques by assessing surgical outcomes and patient satisfaction with either temporary or permanent hymenoplasty procedures.

METHODS: A retrospective study of 246 patients was conducted between 2015 and 2023. Various parameters, including age, sexual history, pregnancies, BMI, and bleeding satisfaction, were assessed. Pain at first intercourse was rated on a visual analog scale (VAS).

RESULTS: The age at the time of operation was significantly lower in patients undergoing permanent hymenoplasty compared with those undergoing temporary hymenoplasty (24.0 years [interquartile range (IQR), 22.0-26.0 years] vs 27.0 years [IQR, 26.0-29.0 years]; P <.001). Patients undergoing permanent hymenoplasty reported significantly lower VAS scores at first sexual intercourse compared with those undergoing temporary hymenoplasty (4.0 [IQR, 2.0-5.0] vs 7.0 [IQR, 6.0-7.0]; P <.001]. Satisfaction rates were high in both groups, with all temporary hymenoplasty patients satisfied with duration of bleeding compared with 78.6% (110/140) of permanent hymenoplasty patients (P <.001).

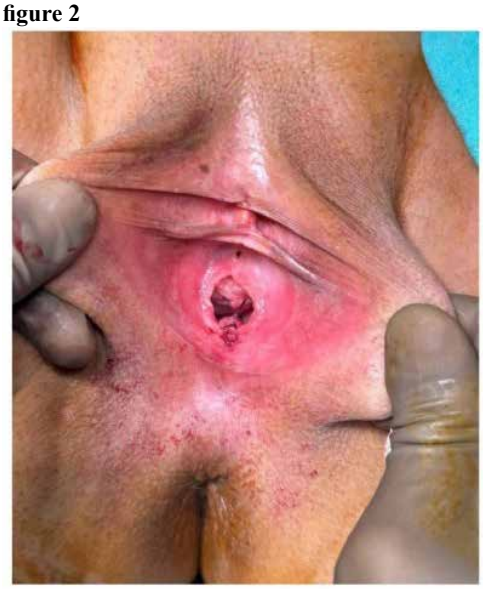
CONCLUSIONS: This study introduces a novel modified temporary and permanent hymenoplasty technique to the literature and provides the first video documentation for both temporary and permanent hymenoplasty procedures. Both hymenoplasty techniques are effective and reliable. However, temporary hymenoplasty is associated with a higher bleeding rate than permanent hymenoplasty, despite resulting in higher VAS scores.

Keywords: client satisfaction,hemorrhage, coitus, pain, fascia, history of sexual behavior, visual analogue pain scale, levels of evidence, cultural factors, surgical outcome, bleeding rate

figure 1

The before pictures of a 21-year-old female patient who underwent an intraital fascial approach for permanent hymenoplasty technique

figure 2



The after pictures of a 21-year-old female patient who underwent an intraital fascial approach for permanent hymenoplasty technique

SS-080 [Ürojinekoloji - Rekonstrüktif cerrahi]

Investigation of the Effect of Pelvic Floor Rehabilitation Exercise and Bladder Training on POPQ Measurements in Patients with Pelvic Organ Prolapse

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AIM: Pelvic organ prolapse (POP) is defined by the International Urogynecology Association (IUGA) and the International Continence Society (ICS) as the downward prolapse of one or more of the anterior vaginal wall, posterior vaginal wall, uterus (cervix), or vaginal apex. POP affects 50 percent of women, and approximately 11 percent undergo surgery for this reason. Symptoms associated with prolapse are often difficult to correlate with the anatomical site or severity of the “bulge” and are often nonspecific. In our study, we aimed to examine the effect of nocturia on quality of life during menopause and reproductive period. Pelvic Organ Prolapse Quantification system (POP-Q) refers to an objective, site-specific system for describing, quantifying, and staging pelvic support in women. In our study, we aimed to investigate the effect of Pelvic Floor Rehabilitation Exercise and Bladder Training on POPQ measurements of patients with Pelvic Organ Prolapse

METHODS: 45 patients who applied to Etlik City Hospital Urogynecology clinic, were diagnosed with POP between June 2023 and June 2024, and received Pelvic Floor Rehabilitation Exercise and Bladder Training, and were included in the study. After recording the demographic data and obstetric history of the

patients, anamnesis, physical and pelvic examination, provocative stress test and urodynamic tests were performed in the basic clinical evaluation. The patients' baseline and 6th month data were compared.

RESULTS: The mean age of the patients included in the study was 51,46. Incontinence accompanied 34 patients. 24 of the patients were in menopause. Gravide Parity median values were 3. Aa(-0,60 /-0,68), Ba(-0,69/-0,51), C(-5,48/-4,82), Ap(-1,83/-2,04), Bp(-1,97/-1,95) values showed a significant difference between the initial and 6th month values ($p<0.05$). Aa, Ap values showed a regression.

CONCLUSION: POP is a general health problem closely related to the physical and psychosocial health of women. In our study, we observed that pelvic floor rehabilitation exercise and bladder training had a significant effect on POPQ values.

Keywords: Pelvic Floor Rehabilitation Exercise, Bladder Training, POPQ

SS-081 [Ürojinekoloji - Rekonstrüktif cerrahi]

Effect of nocturia on quality of life? Comparison of menopause and reproductive period

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AIM: According to the International Continence Association, nocturia is defined as waking up at night with the need to urinate one or more times. According to a recent review, the incidence of nocturia, which is a very common condition, increases rapidly over the age of 60 compared to the age of 40-50, and is seen 4 times more frequently, reaching an annual rate of 11.5%. In our study, we aimed to examine the effect of nocturia on quality of life during menopause and reproductive period.

METHODS: Patients with nocturia complaints diagnosed with urinary incontinence who applied to Etlik City Hospital Urogynecology polyclinic between May 2023 and September 2024 were included in the study. After the demographic data and obstetric history of the patients were recorded, anamnesis, physical and pelvic examinations were performed in the basic clinical evaluation. All patients included in the study were filled out with the Pelvic floor inventory short form-20 (PFDI-20). Data were analyzed using descriptive statistics. Menopause and reproductive period results were compared.

RESULTS: Of the 99 patients included in the study, 50 were menopause and 49 were reproductive period patients. No difference was observed between the groups in terms of incontinence type ($z=0.13$), POPDI 6 ($p=0.38$), KRADI 8 ($p=0.12$), UDI 6 ($p=0.16$), and PFDI 20 ($p=0.15$) questionnaire scores.

CONCLUSION: Although pelvic floor problems affect both quality of life and sexual functions, they are often not mentioned by women and can be detected with detailed questioning. Nocturia occurs more frequently in older ages. In our study, it was found that it negatively affects quality of life but there was no difference between age groups in terms of quality of life.

Keywords: Nocturia, Menopause, Reproductive period

SS-082 [Ürojinekoloji - Rekonstrüktif cerrahi]

Urge Symptoms after Vaginal Uterosacral Plication in Urinary Incontinence Patients without Proximal Urethral Mobility: A Prospective Study

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INTRODUCTION: The primary objective of this study was to evaluate the impact of vaginal uterosacral plication on urge symptoms and quality of life in a cohort of patients with uterosacral ligament insufficiency and urge symptoms.

METHODS: A total of 40 female patients were included in the study, and their posterior fornix was supported with gauze to simulate the surgical procedure. Uterosacral plication was applied to patients who experienced a decrease in urinary incontinence, nocturia, a sense of urgency, and a decrease in urge urinary incontinence symptoms or complete recovery. Images of the bladder, bladder neck, urethra, and symphysis pubis were obtained preoperatively and 1 year postoperatively. POP-Q staging was also performed, and patients completed the Overactive Bladder Evaluation Form (OAB-V8) and the Incontinence Impact Questionnaire Short Form (ICIQ-SF).

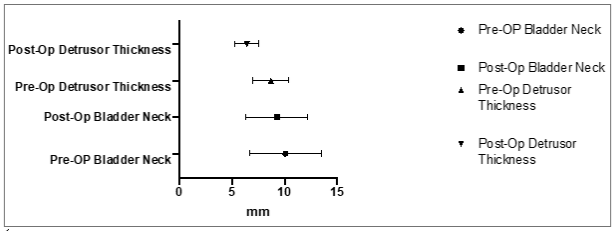
RESULTS: Results from the OAB-V8 questionnaire showed that postoperative nocturia scores improved by 72.1% compared to preoperative scores, and the need to urinate at night and waking up scores improved by 68.3%. The mean bladder neck thickness and the mean detrusor thickness were significantly decreased from 10 to 9.2 ($p < 0.0001$) and from 8.7 to 6.4 ($p < 0.0001$), respectively. The ICIQ-SF questionnaire scores showed a 68.4% improvement in urinary incontinence affecting daily life after the operation.

CONCLUSION: This study adds to the clinical evidence that uterosacral ligament support improves symptoms of overactive bladder syndromes, including urgency and nocturia. The use of pelvic floor ultrasound and the apical tamponade test is important in patient selection for the correct indication.

Keywords: Urge incontinence, Uterosacral plication, Pelvic floor ultrasound, POP-Q, OAB-V8, ICIQ-SF

figure 1

Figure 1- Pelvic Floor Ultrasound Findings Before and After Surgery



(mm: milimeter. Pre-Op DetrusorThicknessMean: 8,700±1,682. Post-Op DetrusorThicknessMean: 6,425, ±1,107. Pre-Op BladderNeckMean: 10,08±3,400. Post-Op BladderNeckMean: 9,275±2,944)

Pelvic Floor Ultrasound Findings Before and After Surgery

SS-083 [Ürojinekoloji - Rekonstrüktif cerrahi]

Cystocele And Rectocele Repair with Native Tissue Layers: Defination of the Technique

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AIM: To investigate the outcomes of central cystocele and rectocele repair using natural tissue layers. To describe a novel technique (Dogan technique)

MATERIALS-METHODS: This a retrospective cohort study. Between January 2021 and January 2023, patients who had central cystocele and rectocele higher than stage 1 were included in the study. Pelvic Organ Prolapse Quantification (POP-Q) score was used to determine the degree of the prolapsus. All cystocele and rectocele repair surgeries were performed by same physician. The patients' voiding habits were assessed using ICIQ-SF and OAB-V8. Sexual function results were assessed with FSFI questionnaire before and after the operation. Transperineal ultrasonography was performed to examine mobility of the anterior and posterior compartments.

RESULTS: Total of 36 patients were diagnosed with grade 2 and above central cystocele (19,52 %) and rectocele (n=17, 48 %). After the operation the anatomical cure of anterior and posterior compartments were achieved for all patients in the two-years follow-up. According to voiding habits before the surgery, there were symptoms of stress urinary incontinence(SUI), urge urinary incontinence (URGE), both SUI and URGE, and no incontinence at the patients; 7 (36.8%), 14 (73.7%), 5 (26.3%), 3 (15.7%) respectively. Of those URGE patients(n=5/14,35.7%)incontinence symptoms were mixed-type. After the cystocele operation, significant improvement was seen in their voiding problems according to the ICIQ-SF and OAB-V8 questionnaires ($p<0.05$). As well as significant improvement was found in sexual function according to the FSFI questionnaire ($p<0.05$).

CONCLUSIONS: We showed that strengthening the anterior and/or posterior compartments with native tissue improves urge and voiding dysfunctions via a novel technique without removing the vagina tissue.

Keywords: cystocele, rectocele, SIU, URGE, hammock theory

Deepithelialization area in rectocele repair

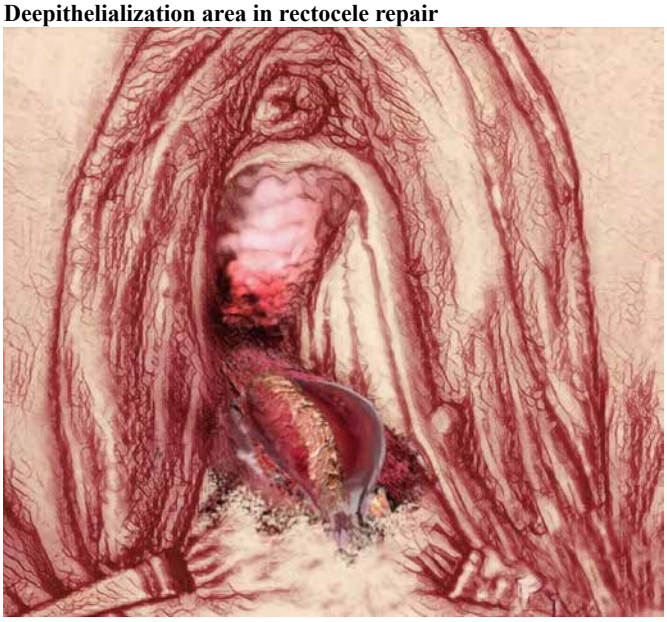


Figure 1: The procedure involves moving the bladder and creating bilateral lambdas.

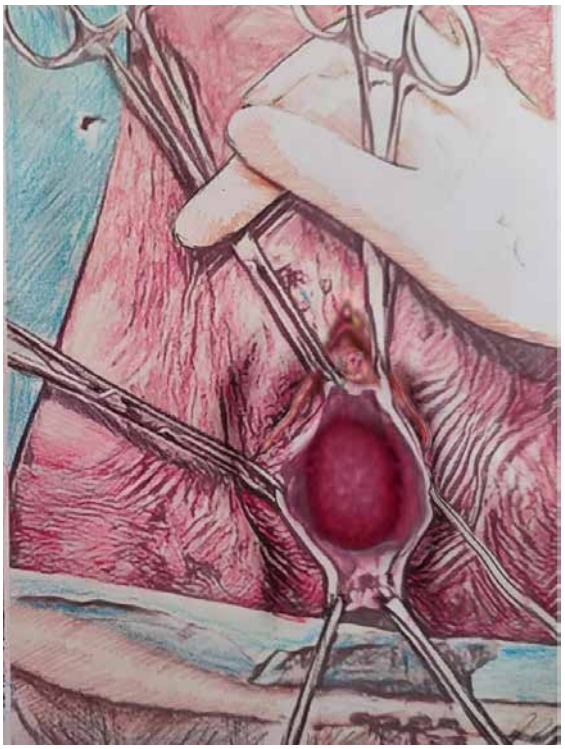
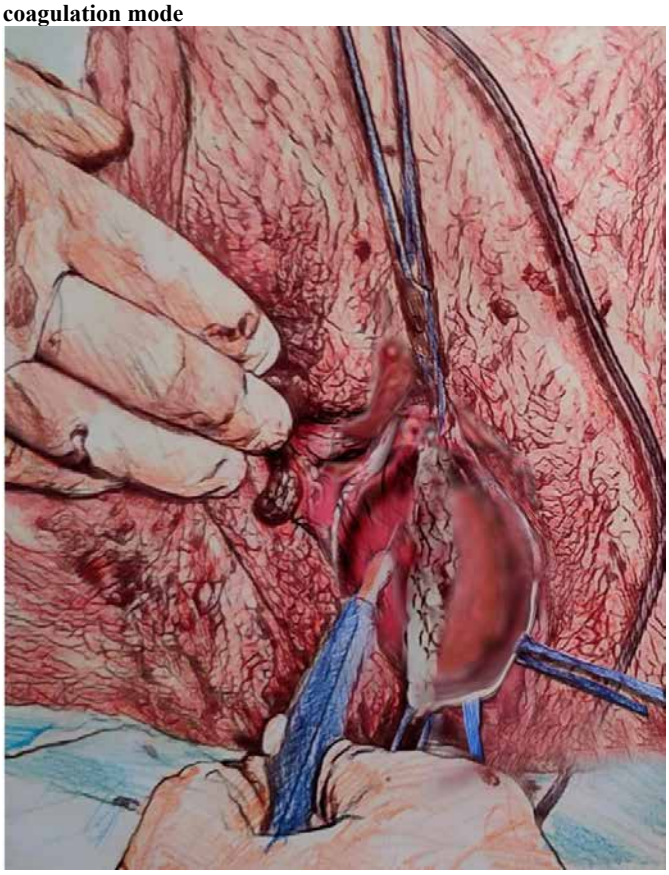
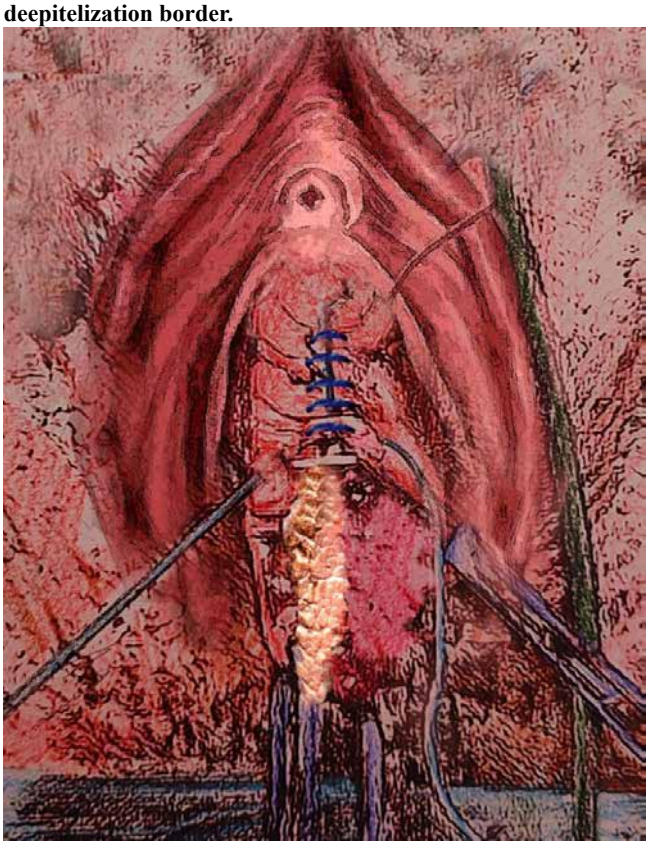


Figure 2: Deepithelialization of right lambda area, using 80w coagulation mode



Suturing the left side of the lambda to the right side of the deepitelization border.



10 Steps of the Surgical Technique

Steps	Defination
1	Empty the bladder
2	Give dorsolithotomy position to the patient
3	Vertical incision: 2cm below the urethra along the prolapsed bladder surface, up to 2cm above the cervix
4	Create vaginal lambdas
5	Mobilize the bladder
6	Complete coverage of mobilized bladder surface achieved by deepithelialization of right lambda area, using 80w coagulation mode.
7	A surgical sponge is placed between the lambda and bladder to prevent bladder damage from electrocautery.
8	The deepitelized area is thoroughly cleaned with a surgical sponge and natural tissue mesh area is prepared.
9	This area without epithelialized is placed on the opposite side of the bladder and secured at the exact corners to the intact vesico-vaginal fascia points on that side, thus ensuring the continuity of the fascia with the natural tissue.
10	The left lambda is then sutured to the vaginal border with the right lambda's deepithelialized area.

SS-084 [Jinekoloji Genel]

Clinical Comparison of McCall Kuldoplasty and Sacrospinous Ligament Fixation in Patients with Grade 2 and Above Desensus Uteri

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AIM: Our aim in this study was to clinically compare the intraoperative and postoperative outcomes of patients who underwent vaginal hysterectomy with McCall Kuldoplasty and Sacrospinous Ligament Fixation and to examine the effect of these surgical procedures on the quality of sexual life of patients.

MATERIAL-METHOD: Between 2016 and 2022, 68 patients who underwent vaginal hysterectomy with Mc Call and 35 patients who underwent SSLF at Istanbul University - Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Obstetrics and Gynecology were included in the study. Intraoperative data were obtained through automation. Patients were interviewed for recurrence and development of complications, dyspareunia and urinary incontinence. Last gynecologic examinations were examined. Sexually active patients were administered the PISQ-12 questionnaire to assess sexual quality of life. IBM SPSS Statistics 25 was used to analyze the data. $p < 0.05$ was considered statistically significant.

RESULTS: There was no difference between the two groups in terms of demographic characteristics. Among the operative data, only the operation time was significantly shorter in patients who underwent McCall Kuldoplasty. There was no significant difference between the two groups in terms of intraoperative complications, postoperative recurrence and PISQ-12 scores. There was a significant correlation between the decline in PISQ-12 scores with advancing age in the McCall group.

CONCLUSION: Both methods reduce the recurrence of pelvic organ prolapse. They do not have a significant advantage over each other except for the operation time. However, studies should be performed in larger patient groups to compare the presence of complications and recurrence.

Keywords: Desensus uteri, McCall's cuddoplasty, Pelvic organ prolapse, PISQ-12, Sacrospinous ligament fixation

SS-085 [Ürojinekoloji - Rekonstrüktif cerrahi]

Sacrospinous hysteropexy in a patient with bladder exstrophy: A case report

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AIM: Bladder exstrophy is a rare congenital anomaly that requires complex surgical reconstruction. The primary goals of treatment include achieving urinary continence, preserving renal function, and providing adequate pelvic stability. The majority of the female bladder exstrophy patients have pelvic organ prolapse. Sacrospinous hysteropexy or sacrospinous ligament fixation is commonly preferred to repair pelvic organ prolapse including uterine descensus or apical prolapse; but can also serve as an alternative approach for pelvic support in bladder exstrophy cases. This case report aims to evaluate the use of sacrospinous hysteropexy in a patient with bladder exstrophy.

CASE PRESENTATION: A 25-year-old female patient was referred to our department with symptoms of 3rd degree of uterine descensus including palpable mass and constipation (Figure 1). She had multiple reconstructive surgeries regarding bladder exstrophy including primary repair, uretero-neo-cystostomy, bladder augmentation, adhesiolysis via laparotomy and Mitrofanoff procedure. The Caucasian patient did not have any other congenital malformation or family history of bladder exstrophy. The patient, who is a virgin, had regular menstrual cycles and expressed fertility desire for future. We performed sacrospinous hysteropexy and posterior colporrhaphy (Figure 2). Postoperative follow-up for six months after surgery demonstrated satisfactory pelvic support and no major complications in the early recovery period.

DISCUSSION & CONCLUSION: Pelvic support is a critical component in the surgical management of female bladder exstrophy patients. The majority of this unique population have both pelvic organ prolapse and history of multiple abdominal surgeries (1). Regarding which approach (abdominal or vaginal) is superior, there is no universal consensus (1). Pelvic reconstruction performed via the abdominal route seems frequently impractical. Nevertheless, performing sacrospinous hysteropexy especially for the young female patients having fertility desire may be safer and more feasible. In these group of patients, sacrospinous hysteropexy remains relatively unexplored in the literature, owing to the rarity of bladder exstrophy. While this technique is well-established in pelvic organ prolapse repair, its application in bladder exstrophy patients having pelvic organ prolapse could provide additional pelvic stability. Although early results appear promising, long-term outcomes and potential complications of this technique in bladder exstrophy patients require further investigation.

Reference

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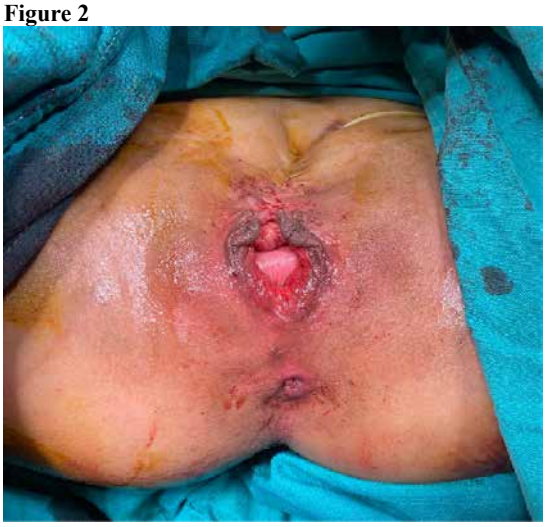
Keywords: Bladder exstrophy, pelvic organ prolapse, pelvic reconstruction, sacrospinous hysteropexy

Figure 1

Preoperative Presentation of Uterine Prolapse

Figure 2



Postoperative Presentation of Repaired Uterine Prolapse

SS-086 [Ürojinekoloji - Rekonstrüktif cerrahi]

Efficacy and safety of Le Fort colpocleisis in the treatment of pelvic organ prolapse

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Etlik City Hospital, Gynecology and Obstetrics Service

AIM: POP is a common female condition, which is defined as a decrease in one or more aspects of the vagina and uterus: anterior vaginal wall, posterior vaginal wall, vaginal vault or uterus (cervix). The choice of treatment depends on the compartment and severity of prolapse. In general, surgery remains an important treatment for severe POP and can be divided into reconstructive surgery and obliterative surgery. Le Fort colpocleisis is a well-established and proven obliterative surgery for POP and is recommended for elderly and frail patients, especially who cannot tolerate reconstructive surgery or have various medical comorbidities and do not require vaginal penetration. In this study, we aimed to investigate the efficacy and safety of Le Fort colpocleisis in the treatment of patients with POP.

METHODS: Eight patients who applied to Etlik City Hospital Gynecology Clinic due to POP, were included in the study, were not sexually active, and had additional comorbid diseases. Demographic and clinical data of patients who underwent Le Fort colpocleisis operation were examined. Data were examined with descriptive statistics methods.

RESULTS: The mean age of the patients included in the study was 72.62. Gravida median value was 4, parity median value was 3. BMI mean was 29.25. Incontinence accompanied 5 patients. The mean operation time was 99 minutes. Preoperative hemoglobin value was 13.45. Postoperative hemoglobin value was 12.46. The median hospitalization day value was 2 days. No intraoperative or postoperative complications were observed.

CONCLUSION: Le Fort colpocleisis is an effective and safe procedure for the treatment of severe POP. Because of its lower operative risk, better subjective and objective outcomes, lower rates of prolapse recurrence and perioperative complications, Le Fort colpocleisis should be considered as the recommended procedure for elderly patients with severe POP.

Keywords: Le Fort colpocleisis, POP, Elderly patients

SS-087 [Obstetri Genel]

Significance of Sonographic Awareness in Detecting Fetal Biliary Sludge: A Rare Third-Trimester Finding

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Ankara Atatürk Sanatoryum Eğitim Araştırma Hastanesi

INTRODUCTION: The presence of echogenic material in the gallbladder is a condition that is rarely and incidentally detected, most commonly during third-trimester ultrasound examinations. This echogenicity may represent biliary sludge or a dense content indicative of single or multiple gallstones. The incidence of echogenic appearance in the gallbladder varies between 0.07% and 1.15% across different countries. Its diagnosis has become more frequent with the increased use of ultrasound and advancements in ultrasound technology.

CASE: A 32-year-old patient, Gravida 3, Parity 2, presented to our clinic for the first time at 30 weeks of gestation. The patient had no known comorbidities or history of previous surgeries. First and second-trimester screening tests were assessed as low risk, and the oral glucose tolerance test was normal. Ultrasonographic evaluation performed at 30 weeks showed that fetal growth was appropriate for gestational age and amniotic fluid was sufficient. In the evaluation of fetal abdominal assessment, an increase in echogenicity was observed in the gallbladder, which was evaluated as biliary sludge. The echogenicity persisted in subsequent follow-ups until delivery. The baby was delivered vaginally, weighing 3400 grams, with Apgar scores of 9 and 10 at 39 weeks of gestation. Neonatal follow-up ultrasound evaluations showed that the increased echogenicity in the gallbladder spontaneously regressed and disappeared within two months.

DISCUSSION: The first prenatal diagnosis was reported by Beretsky and Lankin in 1983. A review of the literature indicates this rare diagnosis is almost exclusively identified in the third trimester and typically seen in isolation. On sonographic examination, the fetal gallbladder appears as a hypoechoic structure located in the right upper quadrant, beneath the right hepatic lobe and to the right of the intrahepatic portion of the umbilical vein. From the 14th gestational week, it can be visualized sonographically in nearly 100% of cases.

Several factors are associated with an increased risk of fetal biliary sludge, including placental abruption, elevated estrogen levels, narcotic use, diabetes, and medications such as ceftriaxone, furosemide, and prostaglandin E2. Other contributing factors include hemolysis due to Rhesus or ABO factor, congenital anomalies in the cardiovascular, gastrointestinal, or urinary systems, fetal demise in twin pregnancies, genetic disorders like trisomy 21, cystic fibrosis, fetal growth restriction, oligohydramnios, and fetal hepatitis.

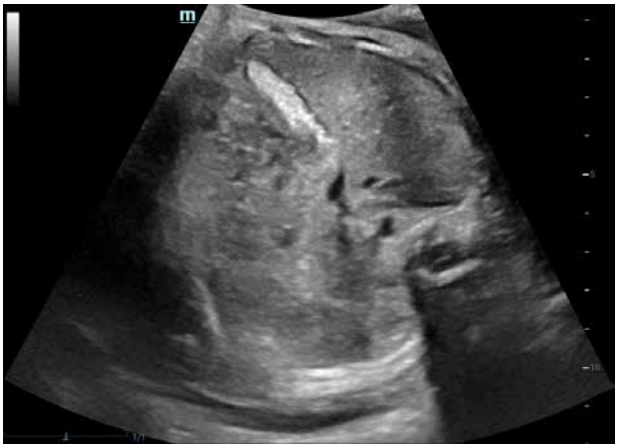
Nevertheless, the neonatal prognosis of fetal biliary sludge is generally favorable. In most cases, it resolves spontaneously without gastrointestinal symptoms or short- or long-term clinical manifestations. After breastfeeding and oral hydration, the gallbladder contracts due to increased plasma levels of cholecystokinin, facilitating the passage of viscous material into the duodenum asymptomatically, leading to resolution of the prenatal finding.

Still, in the postnatal period, biliary sludge may predispose neonates to gallstone formation or cholestasis, particularly in the presence of underlying metabolic or hematological disorders. While routine follow-up is not necessary for all cases, neonates with ongoing risk factors should be monitored for hepatobiliary dysfunction.

In conclusion, as third-trimester fetal sonographic examinations are increasingly integrated into prenatal care, clinicians should recognize the potential occurrence of fetal biliary sludge and gallstones, along with their varied sonographic presentations.

Keywords: Fetal Biliary Sludge, Third-Trimester, gallstones

third-trimester ultrasound examinations



SS-089 [Perinatoloji]

Perinatal Outcomes of Choroid Plexus Cysts in the Tertiary Centre: A Cross-Sectional Study

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OBJECTIVE: Choroid plexus cysts (CPCs) are benign structures that are frequently detected by fetal ultrasonography and are usually located in the ventricles of the fetal brain. Although choroid plexus cysts are generally considered to be a transient condition during fetal development, some studies have reported that these cysts may be associated with genetic anomalies. In particular, the association of choroid plexus cysts with chromosomal abnormalities such as trisomy 18 seems to be more prominent. While some studies have emphasised that CPCs are generally benign and should only be monitored, other studies have suggested that CPCs may be an indicator of more complex genetic and neurological problems. In this context, a better understanding of the potential impact of CPCs on perinatal outcomes may contribute to early intervention and monitoring strategies. This study aims to present the perinatal outcomes of fetuses followed up in our clinic for choroid plexus cysts and to provide an additional benefit to the existing literature.

MATERIAL and METHODS: In this study, pregnant women admitted to the Perinatology Department of Ankara Etlik City Hospital between December 2022 and December 2024 and diagnosed with fetal choroid plexus cyst were retrospectively analysed. Prenatal screening test results, invasive diagnostic test results, demographic characteristics, prenatal ultrasound findings and postnatal outcomes were reported. In the study group, 222 pregnant women with choroid plexus cysts in their fetuses were divided into two groups according to whether the choroid plexus cyst was unilateral or bilateral. Data were statistically analysed to compare 1st and 2nd trimester screening test results and perinatal outcomes between both groups. The findings were interpreted to determine the effects of unilateral and bilateral choroid plexus cysts on perinatal outcomes and the clinical significance of these conditions.

RESULTS: A total of 222 pregnant women were included in the study; 141 had unilateral and 81 had bilateral fetal choroid plexus cysts. There were no differences in maternal age, gravida and parity, but significant differences were observed in terms of week of diagnosis (18.1 ± 2.9 vs 19.3 ± 3.9; p<0.001) and cyst size (4.5 ± 2.5 mm vs 6 ± 6.2 mm; p<0.001). Amniocentesis rate was 17% in the unilateral group and 35.8% in the bilateral group (p=0.002) and NIPT was 2.8% in the unilateral group and 16% in the bilateral group (p<0.001). In the 1st trimester screening tests, significant differences were found in fβHCG MoM (p=0.018) and uE3 MoM (p=0.013). In the presence of additional anomalies, the rate of aneuploidy in amniocentesis was found to be higher and this difference was statistically significant (p=0.027).No significant difference was found between the groups in terms of labour and neonatal outcomes.

CONCLUSION: In this study, the perinatal outcomes of unilateral and bilateral choroid plexus cysts were analysed. In general, the impact of choroid plexus cysts on perinatal prognosis is limited, but more careful monitoring and evaluation is required in the presence of additional anomalies.

Keywords: Choroid plexus cyst, Unilateral, Bilateral, Perinatal outcomes

Demographic and Prenatal Characteristics of Unilateral and Bilateral Choroid Plexus Cysts

	Unilateral n=141 (63.5%)	Bilateral n=81 (36.5%)	p value
Maternal age (year)	28.2 ± 6	27.9 ± 5.7	0.822
Gravida	2 (2)	2 (2)	0.199
Parity	1(2)	1(2)	0.352
Diagnosis week	18.1 (2.9)	19.3 (3.9)	<0.001
Size (mm)	4.5 (2.5)	6 (6.2)	<0.001
Ventriculomegaly	23 (16.5%)	17 (21%)	0.383
Amniocentesis	24 (17%)	29 (35.8%)	0.002
Soft marker	37 (26.2%)	21 (25.9%)	0.959
NİPT	4 (2.8%)	13 (16%)	<0.001
fbetaHCG MoM	1.1 (0.8)	0.6 (0.4)	0.018
PAPPA MoM	0.9 (0.8)	0.8 (0.5)	0.210
AFP MoM	0.9 (0.4)	0.9 (0.6)	0.051
HCG MoM	0.8 (0.5)	1.2 (0.4)	0.088
uE3 MoM	0.6 (0.3)	0.5 (0.2)	0.013

SS-090 [Perinatoloji]

Rare genetic diagnosis in a pregnancy terminated due to skeletal dysplasia: rubinstein-taybi syndrome

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INTRODUCTION: Rubinstein-Taybi Syndrome (RSTS) is a rare genetic condition first recognized in 1963 by Drs. Rubinstein and Taybi. It is classified as an autosomal dominant disorder that manifests through a collection of distinctive clinical features including significant

postnatal growth retardation, intellectual disability, and a suite of congenital anomalies. The prevalence of RSTS is estimated to range from one per 100,000 to 125,000 live births, which renders it a relatively uncommon condition in pediatric populations. The genetic underpinnings of RSTS have been traced primarily to mutations in two key genes: the CREB-binding protein (CREBBP) and EP300, both located on chromosome 16p13.3. Pathogenic variants in CREBBP are noted to ocur as de-novo mutations, in approximately 50% to 70% of individuals diagnosed with the syndrome, while EP300 mutations account for a smaller fraction of cases. Clinical manifestations of RSTS extend beyond the hallmark physical features to encompass a wide array of associated malformations. These include cardiac anomalies, scoliosis, limb and finger malformations, renal structural defects and dismorfic face apperiance especially mild retrognatia and beak-shaped nose. The heterogeneity in clinical presentation of RSTS poses significant challenges for diagnosis and management. Variability in phenotypic expression often means that some cases may be diagnosed late or even misdiagnosed as other syndromes, further highlighting the importance of genetic testing in clarifying uncertain diagnoses

MATERIAL-METHOD: A 23-year-old female patient with her first pregnancy was referred to our clinic with the suspicion of achondroplasia in the 17th week of pregnancy. A detailed ultrasonographic examination revealed that the length measurements of both the long and short bones of the fetus were below the 1st percentile for gestational age. Pes equinavarus deformity was observed in both lower extremities. Thoracic hypoplasia, a significant predictor of lethal skeletal dysplasia, was absent. The right hand was found to be normal, while the left hand exhibited a lateral displacement from the wrist. The patient was informed by the genetics department about the genetic aspects of skeletal dysplasia.

RESULTS: The patient was offered an invasive procedure, and consent was obtained. Following amniocentesis, the patient was offered the option of termination due to skeletal anomalies. The pregnancy was subsequently terminated at the 18th week of gestation, following a request by the family for the termination. Despite the results of the karyotype and microarray tests being normal, next generation genome sequencing was additionally performed on the amniocentesis material. This revealed a VUS mutation in the CREBBP gene. Given the clinical features of the fetus were consistent with the syndrome, the genetics department evaluated the VUS as pathogenic.

CONCLUSION: In summary, Rubinstein-Taybi Syndrome is a complex genetic disorder with a broad spectrum of clinical manifestations. Its diverse phenotypic presentation necessitates a thorough multidisciplinary approach to diagnosis and management, grounded in both clinical observations and genetic testing. Understanding the genetic mechanisms and phenotypic variability of RSTS highlights the challenges faced in clinical practice and emphasizes the importance of collaborative care models in delivering effective healthcare solutions.

Keywords: Rubinstein-taybi Syndrome, genome sequencing, skeletal dysplasia

SS-091 [Perinatoloji]

Body stalk Anomaly: Case report

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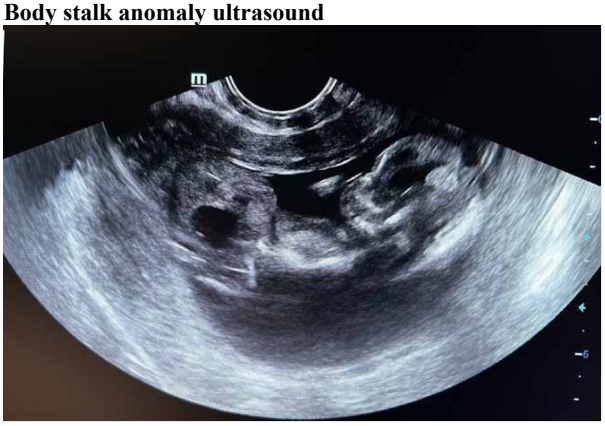
Body stalk anomaly is a rare and severe malformation syndrome, the exact pathophysiology and triggering factors of which remain unknown, characterized by abdominal wall defects, scoliosis, and a short or absent umblical cord. The estimated incidence of this rare malformation syndrome in pregnancies ranges from 1 in 14,000 to 1 in 31,000. We report a case of a 30-year-old woman who was first seen by the maternal-fetal medicine service for her first prenatal visit at 12 weeks of gestation at the Ankara training and research hospital. This was her G5P2A2 pregnancy and her initial antenatal labs were within normal limits. She was on folic acid supplementation, and there was no significant family history or medication use. At 12 weeks of gestation, her initial ultrasound showed a typical fetal crown- rump length of 57 mm, but an unusual positioning of the lower part of the embryo within the coelomic cavity, indicating a potential short umbilical cord syndrome. Additionally, multiple fetal abnormalities were noted, including a severe midline fetal abdominal wall defect with liver and bowel, severe kyphoscoliosis, absent vesica, deformed lower limbs and a short umbilical cord of 5 mm on the ultrasound scan. These ultrasonographic findings were consistent with body stalk anomaly. Due to the severity of the malformation and its deemed incompatibility with life, the family was informed of the situation and given the option of termination. With the family's written consent, the pregnancy was terminated by administering misoprostol, and the embryo was sent genetics for karyotype analysis. The embryo exhibited the following gross morphologic characteristics: it was encased by amniotic membranes, with the fetus trapped within, showing signs of immaturity and malformation. The fetal umbilical cord was anteriorly positioned, centrally inserted, and notably short at a length of 5 mm. The head displayed normal conformation, along with normal upper limbs, while the partial trunk exhibited scoliosis. Additionally, a severe omphalocele was observed in the anterior and lower abdominal wall, containing the stomach, intestine, liver, spleen and bladder. The autopsy findings also confirmed the diagnosis of body stalk anomaly. The cytogenetic studies did not reveal numeric alterations in chromosomes 13, 18, and 21. This body stalk anomaly should be considered when significant abdominal defects, axial skeletal abnormalities such as kyphosis or scoliosis, and a short or absent umbilical cord are observed. Detection of body stalk defects can occur as early as the end of the first trimester of pregnancy by ultrasound imaging. In our case, detection occurred at 12 weeks' gestation,and the ultrasound findings were consistent with those documented in the literature. Since no direct etiologic factor is known, the only preventive measure is early detection and termination of the pregnancy. Once identified through ultrasound imaging, the next step typically involves discussing options for termination. Karyotype analysis is mostly normal in body stalk anomaly cases, and patients do not have an increased risk of recurrence.Therefore, they can be reassured about future pregnancies.

Keywords: Body stalk anomaly, Congenital malformations, Anterior body wall defect, Fetal anomalies

Body stalk anomaly

Body stalk anomaly

Body stalk anomaly ultrasound



SS-092 [Perinatoloji]

Bilateral Anophthalmia and Cleft Lip/Palate: A Rare Case Report and Multidisciplinary Approach

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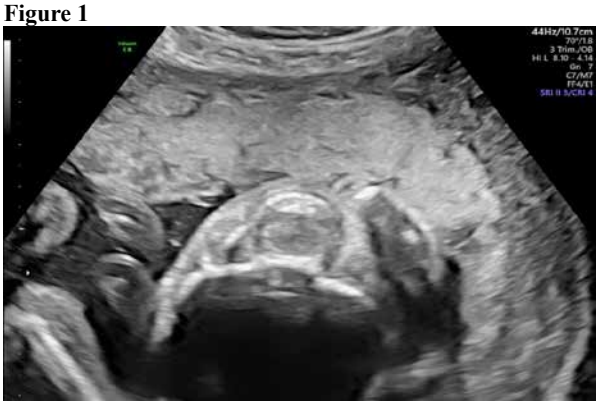
INTRODUCTION: Bilateral anophthalmia is a rare congenital anomaly characterized by the complete absence of both ocular globes. It can be associated with multiple craniofacial malformations, including cleft lip and palate, as well as systemic abnormalities. The etiology of anophthalmia is heterogeneous and may involve genetic mutations, environmental factors, or teratogenic exposures during early embryogenesis. The SOX2 gene is frequently implicated in syndromic anophthalmia, but other genetic and chromosomal abnormalities may also contribute to the condition. Prenatal diagnosis through ultrasound is crucial for early identification and parental counseling. This case report presents a fetus diagnosed with bilateral anophthalmia, cleft lip and palate emphasizing the diagnostic process, perinatal management, and genetic evaluation.

CASE PRESENTATION: A 26-year-old gravida 1 woman at 21+4 weeks of gestation was referred for a detailed fetal anomaly scan due to suspected craniofacial abnormalities. Ultrasound revealed the absence of bilateral orbital structures and lenses, confirming bilateral anophthalmia. Additionally, bilateral cleft lip and palate and a hyperechogenic bowel were detected. Fetal biometry showed mild intrauterine growth restriction, but Doppler findings were within normal limits. No major limb anomalies were observed. The case was discussed in a perinatology council, where genetic testing, including amniocentesis, chromosomal microarray analysis, extended exome sequencing (WES) was recommended to determine the underlying etiology. The family was counseled regarding the severity of the condition, potential genetic causes, and possible postnatal complications. After a thorough discussion, the parents opted for termination of pregnancy. On the 22nd week of gestation, feticide was performed using intracardiac potassium chloride injection, followed by medical induction with misoprostol. The procedure was completed without early complications, and post-procedural monitoring confirmed stable maternal status. The patient recovered without complications and was discharged with follow-up recommendations for genetic counseling and pathology results. Subsequent genetic investigations revealed that amniocentesis and chromosomal microarray analysis were normal. However, extended exome sequencing (WES) revealed a SOX2 gene defect.

CONCLUSION: Bilateral anophthalmia with cleft lip and palate is a rare and severe congenital condition with a complex etiology. Early prenatal detection using high-resolution ultrasound plays a vital role in diagnosis and parental decision-making. Genetic evaluation, including SOX2 mutation screening and chromosomal microarray, is essential for identifying underlying syndromic associations. Multidisciplinary management involving perinatologists, geneticists, neonatologists, and ophthalmologists is crucial for both prenatal counseling and postnatal care planning. This case highlights the importance of comprehensive prenatal diagnosis and individualized parental counseling in managing complex congenital anomalies.

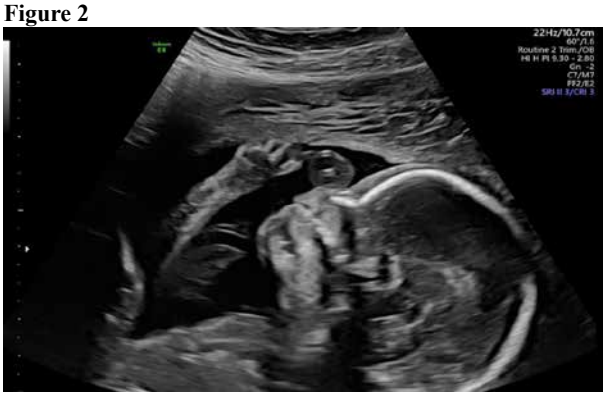
Keywords: Bilateral anophthalmia, cleft lip and palate, prenatal diagnosis, genetic evaluation

Figure 1



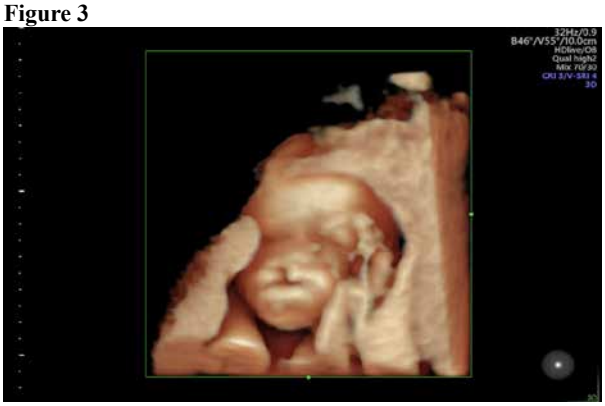
Intrauterine ultrasonography shows that bilateral orbital structures and lenses are not observed

Figure 2



Fetal profile showing absence of orbit and lens

Figure 3



Bilateral anophthalmos and cleft lip defects are clearly seen in fetal facial evaluation by 3D ultrasonography

Figure 4

Macroscopic evaluation shows bilateral anophthalmos, marked craniofacial dysmorphism and bilateral cleft lip

Figure 5

Posttermination examination shows normal development of the extremities, but facial anomalies are evident

SS-093 [Perinatoloji]

Fetal Cystic Fibrosis With Meconium Ileus: Case Report

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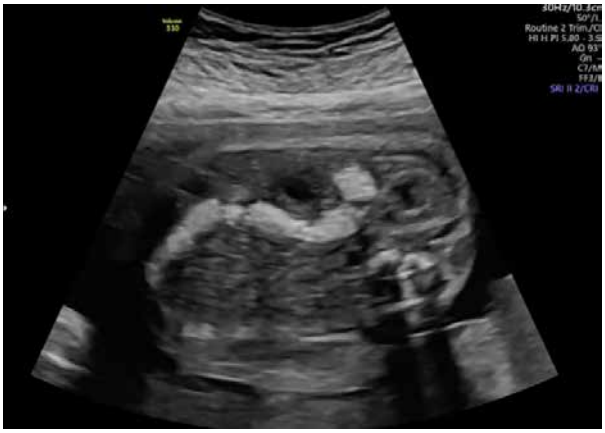
Cystic fibrosis is a common autosomal recessive disease which causes excess and abnormal concentrations of electrolyte secretions in the exocrine glands which increases the viscosity and ultimately the obstructions of the glands' ducts. The disease affects mostly and primarily the respiratory, gastrointestinal, metabolic and reproductive systems. We report a case of a 25-year-old mother (G3A2) with a history of consanguineous marriage underwent a first prenatal ultrasound at 29 weeks of gestation, which revealed meconium ileus, raising the suspicion of cystic fibrosis (CF). However, the family declined further prenatal diagnostic testing. The infant was born at the term without immediate postnatal complications but subsequently developed failure to thrive, chronic cough, and recurrent lung infections by the age of three months. She had pancreatic insufficiency, diffuse bronchiectasis and mild liver involvement, while pulmonary function tests were within the normal range. A sweat chloride test (105

mmol/L) confirmed the diagnosis of cystic fibrosis. Genetic analysis identified a complex allelic mutation (F508del/R1070Q/S466X) and further testing showed that both parents were classical CFTR carriers. Prenatal diagnosis and neonatal follow-up and treatment are extremely important. In patients without a family history, the monitoring of fetal sonographic findings is valuable for prenatal diagnosis and the follow-up process should be detailed. Carrier screening is particularly crucial for consanguineous couples and populations with high prevalence of CF. Early identification of at-risk pregnancies through prenatal genetic counselling and universal neonatal blood spot screening (formerly called the heel prick test) could facilitate early diagnosis, timely intervention and improved outcomes for affected infant which has a significant impact on survival and quality of life. Therefore, expanding early screening and intervention strategies has great importance.

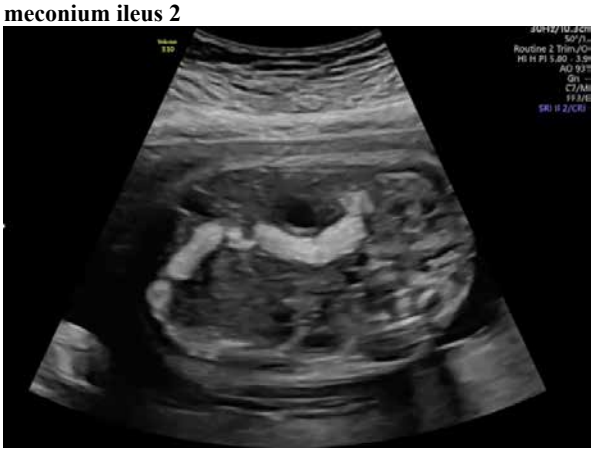
Keywords: Cystic fibrosis, meconium ileus, prenatal diagnosis

meconium ileus



fetal cystic fibrosis with meconium ileus

meconium ileus 2



SS-094 [Perinatoloji]

Prenatal diagnosis of treacher collins syndrome ın a newborn to an affected mother:ultrasound findings and postnatal outcome

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[4]Department of Obstetrics and Gynecology,Çam and Sakura City Hospital, İstanbul,Turkey

OBJECTIVE: Treacher Collins syndrome (TCS) is a congenital craniofacial disorder characterized by malar and mandibulomaxillary hypoplasia and periorbital anomalies. TCS is an autosomal dominant disorder with variable penetrance. With no gender predilection, the incidence is estimated at 1 in 50,000 live births. Mutations in the TCOF1, POLR1D, and POLR1C genes are complicit in the development of TCS, with the majority showing mutations in the TCOF1 locus on chromosome 5q31.3-q33.3. Patients born with the disorder show broad variability in phenotypic presentation. Whereas some patients can display mild periorbital deformity that can be clinically subtle, others demonstrate a more complete phenotype with severe periorbital anomalies, maxillomandibular hypoplasia, and hairline displacement with variable forms of microtia.Notwithstanding the severity, the deformity is bilateral and generally symmetric. The main presenting features reflect that of the underlying malformation in structures developed from the first and second branchial arches. Other malformations include microtia with associated conductive hearing loss and possible speech delay, mandibular hypoplasia, and retrognathia with possible airway sequelae and cleft palate (40%).

METHOD: Two-dimensional and three-dimensional ultrasound showed polyhydramnios, micrognathia, absence of nasal bone, microtia, secondary cleft palate, mandibular hypoplasia, glossoptosis, and normal limbs and vertebrae. Final diagnosis of TCS was confirmed by whole-exome sequencing. RESULTS: S. S. A 26-year-old G2P1Y0 (nsd) patient with TCS with atypical facial appearance micrognathia, auricular anomaly-microtia, and mandibular hypoplasia was evaluated at 12th gestational week. Two of his seven siblings were diagnosed with Treacher Collins syndrome. Two of the four living children of one of his siblings were diagnosed with Treacher Collins. The patient's husband has hearing loss. Therefore, in the genetic evaluation, homozygous pathogenic variant in TRIOBP gene was associated with 'deafness autosomal recessive 28' phenotype. On ultrasound, CRL was measured consistent with 12 weeks and 6 days. Inferior facial angle was 20 degrees, micrognathia was considered At 16 weeks of gestation, nasal bone was measured 2.3 mm and hypoplasia was considered. Amniocentesis was performed. At 22 weeks of gestation, in addition to micrognathia, nasal bone hypoplasia, flat forehead and both ear auricula were evaluated as microtia grade 2-3. At 28 weeks of gestation, polyhydramnios and proptosis were observed in addition to these findings. Amniocentesis revealed

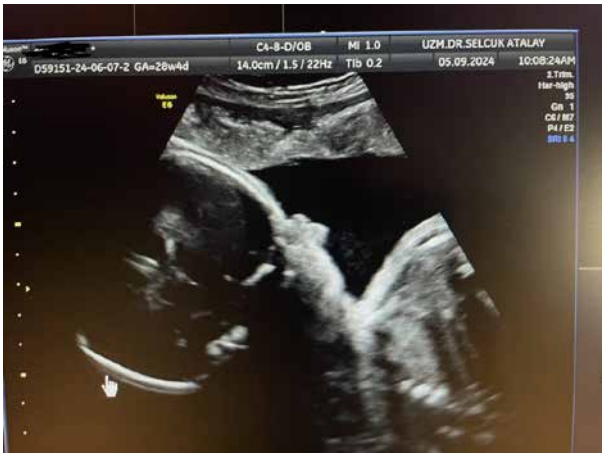
heterozygous mutation in TCOF1 gene compatible with treacher collins. At 35 weeks of gestation, the patient presented with active labor and a baby boy with an 3-5 apgar of 1950 gr was delivered by normal delivery. The patient was contacted after birth. We were informed that the baby died at the age of 4 months due to aspiration pneumonia. Conclusıon: Treatment should be tailored to the specific needs of each individual, preferably by a multidisciplinary craniofacial management team. A delivery should be planned with neonatologists and otolaryngologists present to ensure a high chance of emergency respiratory support, including tracheotomy, after delivery. Annual ophthalmology and audiology evaluations; assess for manifestations of obstructive sleep apnea, growth, and caloric intake at each visit; dental exams every six months with orthodontia exams as needed; assess speech development and educational progress annually or as needed are recommended.

Keywords: micrognatia,microtia,polyhydramnios,

micrognathia, nasal bone hypoplasia

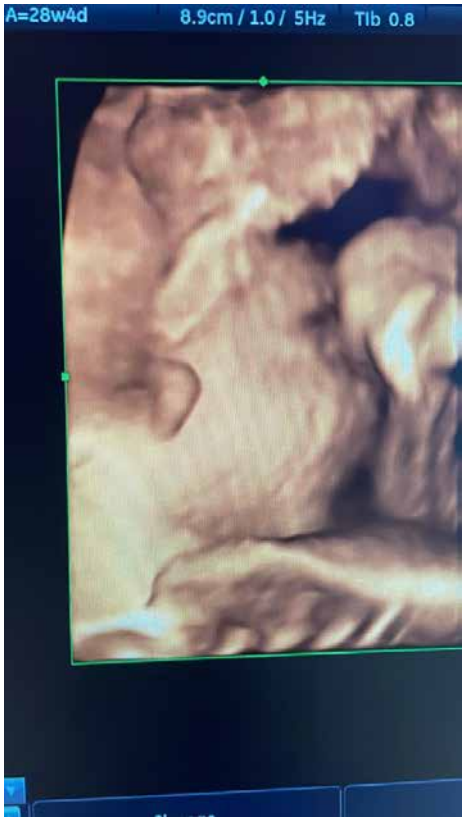
15-week ultrasound finding of micrognathia, nasal bone hypoplasia

microtia



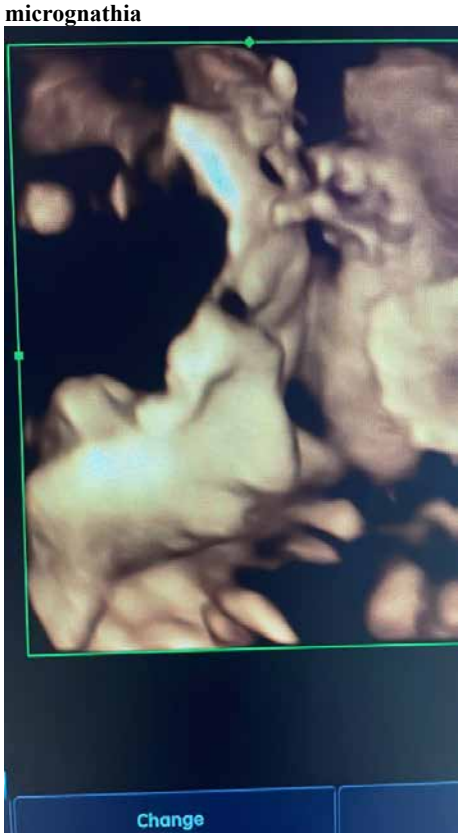
Microtia at 28 weeks

microtia



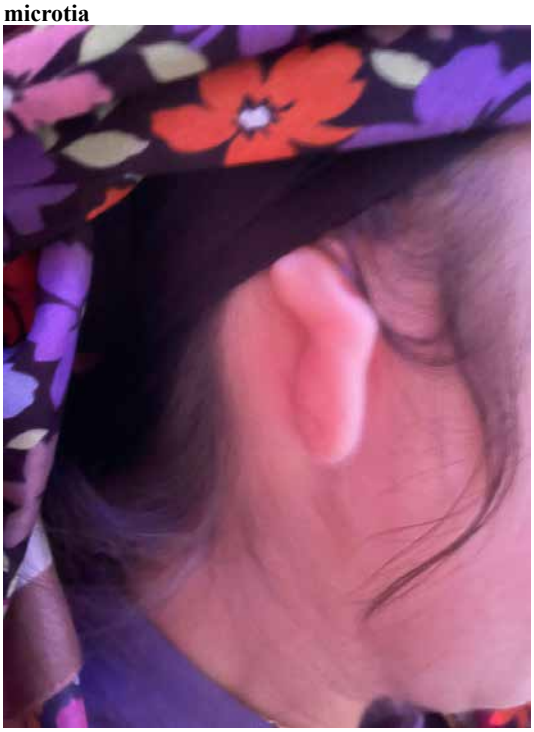
3D USG -microtia

micrognathia



3D USG-micrognathia

microtia



microtia in mother

newborn after birth

Postpartum microtia and micrognathia

SS-095 [Perinatoloji]

Assessment of genetic results after invasive procedures in cases with cardiac anomalies

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OBJECTIVE: Congenital heart defects(CHD) are the most common fetal anomalies, with an incidence of ~1% during pregnancy. Prenatal detection is essential for prognosis and counseling. Common anomalies include ventricular septal defect (VSD), atrioventricular septal defect (AVSD), hypoplastic left heart syndrome, and double outlet right ventricle (DORV). While fetal echocardiography is the primary tool, invasive genetic testing is recommended in suspected syndromic cases. This study aimed to evaluate genetic test results following invasive procedures in pregnant women with cardiac anomalies between 2019 and 2025 at Gazi University Hospital.

METHODS: This retrospective study included pregnant women diagnosed with fetal cardiac anomalies via echocardiography between 2019 and 2025. Cases with common trisomies (trisomy 13, 18, and 21) were excluded from the study. After exclusion, pregnancies with isolated or syndromic cardiac anomalies were evaluated. Depending on gestational age, chorionic villus sampling (CVS), amniocentesis (A/S), or cordocentesis was performed. Fetal DNA was analyzed using cytogenetics, FISH, microarray, and whole exome sequencing (WES). Maternal age, gestational week, type of anomaly, and genetic results were analyzed.

FINDINGS: Seventy pregnant women with cardiac anomalies were included. Most common defects were VSD (13), AVSD (10), hypoplastic left heart syndrome (7), inlet VSD (6), and DORV (5). Procedures performed: CVS (7 cases, mean 13.5 weeks), amniocentesis (62 cases, mean 21.1 weeks), and cordocentesis (1 case).

RESULTS: Genetic disorders detected:

1)SOS1 mutation: Detected in a fetus with AVSD and a family history of similar findings. Diagnosed postnatally as Noonan syndrome.

2)Trisomy 9: Identified in a fetus with AVSD and pulmonary atresia. The infant is currently being followed with a diagnosis of ASD in the fifth postnatal year.

3) 22q11.2 Deletion Syndrome: Found in two fetuses with conotruncal defects, thymic hypoplasia, and hypocalcemia. Diagnosed postnatally with DiGeorge syndrome.

4)Variants of Uncertain Significance (VUS): Reported in three cases. Further analysis was recommended based on phenotype and postnatal findings. One fetus with multiple anomalies resulted in intrauterine fetal demise at 32 weeks.

5)POLR3GL NM_032305.3 probable pathogenic variant: Associated with hypoplastic right heart syndrome. Pregnancy was terminated at 20 weeks.

6)Inv(9)(p11q13): Detected in a fetus with perimembranous VSD, resulting in a term live birth.

Eleven pregnancies were terminated due to severe anomalies including:

Hypoplastic right and left heart syndromes,

AVSD with DORV or diaphragmatic hernia,

Ectopia cordis,

Large VSD with left ventricular dilatation,

Transposition of the great arteries.

One TTTS case underwent radiofrequency ablation due to hypoplastic aortic arch.

Additionally, a fetus with AVSD, skeletal anomalies, and VUS detected by WES resulted in intrauterine fetal demise at 32 weeks.

The live birth rate was 70.2%, with a mean gestational age of 38+1 weeks and mean birth weight of 2825 g.

Genetic analysis plays a crucial role in the prenatal diagnosis and management of fetal cardiac anomalies. Our findings emphasize that even after the exclusion of common trisomies, further genetic testing reveals clinically significant results, including syndromic associations and rare variants. Although based on a relatively small sample size, our results support the value of comprehensive prenatal genetic testing. Larger studies are needed to validate these outcomes.

Keywords: Cardiac anomaly, congenital heart disease, genetic testing, invasive procedures, pregnancy

SS-096 [Perinatoloji]

Case Report: Prenatal diagnostic challenges in a fetus with Noonan syndrome despite negative PGT: a case of de novo PTPN11 mutation

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INTRODUCTION: Noonan syndrome is a relatively common autosomal dominant genetic disorder with an estimated incidence of 1 in 1,000 to 2,500 live births. It is classified within the group of RASopathies, a family of syndromes caused by mutations affecting the RAS-MAPK signaling pathway. The most frequently involved gene is PTPN11.Clinically, it is characterized by a variable phenotype including short stature, facial dysmorphism, congenital heart defects, developmental delay, and lymphatic anomalies. Prenatal diagnosis of Noonan syndrome is challenging due to the nonspecific and variable nature of sonographic findings. As the pregnancy progresses, additional anomalies may become apparent, such as polyhydramnios, fetal hydrops, pleural effusions, cardiac defects, and growth restriction. Structural cardiac anomalies, particularly hypertrophic cardiomyopathy or septal defects, are common and often serve as diagnostic clues. Craniofacial features like hypertelorism, micrognathia, and a depressed nasal bridge may also be noted on detailed anatomical survey or ultrasonography (USG).

CASE: A 32-year-old gravida 3, para 2 woman was referred to our perinatology clinic due to a history of two neonatal deaths, both resulting from multiple congenital anomalies. Her first pregnancy ended with the neonatal death of a female infant on day 7, born at 35 weeks via cesarean section. The second pregnancy also ended in neonatal death on day 3; genetic analysis of the fetus identified a homozygous ETFB variant, classified as a Variant of Uncertain Significance, consistent with a potential diagnosis of Glutaric Aciduria Type IIB. Both parents were heterozygous carriers of the same variant. The current pregnancy was conceived via IVF following preimplantation genetic testing (PGT) to exclude the ETFB variant. Despite PGT, new sonographic anomalies prompted a recommendation for amniocentesis to confirm the genetic status of the fetus; however, the parents declined all invasive testing. Serial detailed USG examination revealed multiple findings, including mild lateral ventriculomegaly (12mm)(fig.1), obliterated cavum septum pellucidum (fig.2), micrognathia, hypertelorism, leftward cardiac axis deviation and concentric myocardial hypertrophy (fig.3), a small inlet-type ventricular septal defect (VSD), renal pelvis dilatation (r6 mm). Fetal magnetic resonance imaging (MRI) was performed due to ventriculomegaly, and no additional pathological findings were identified. At 37w2d, an elective cesarean section was performed due to previous cesarean delivery and contraction pain. A male infant was delivered in breech presentation, 3350 grams, apgar scores 6/7. Physical examination revealed, including micrognathia and hypertelorism. The newborn was admitted to the NICU for further evaluation. Postnatal whole exome sequencing (WES) identified a pathogenic

variant in the PTPN11 gene, confirming a diagnosis of Noonan syndrome. CONCLUSION: In this case emphasizes the role of detailed prenatal imaging in raising suspicion for Noonan syndrome, even in the absence of classic first-trimester markers. It also highlights the limitations of PGT when underlying genetic complexity or de novo pathogenic mutations are involved.. Despite the absence of early nuchal thickening and the presence of normal first-trimester screening, progressive structural anomalies raised prenatal suspicion.

Keywords: Noonan Syndrome, PGT, prenatal diagnosis, RASopathies, fetal anomaly, Prenatal ultrasonography

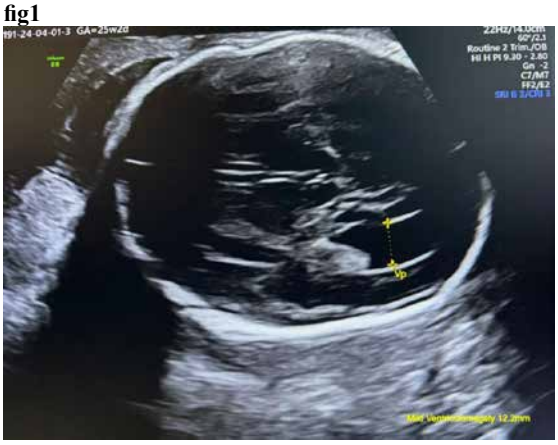
fig 2

Obliterated cavum septum pellucidi

fig 3

Leftward cardiac axis deviation and concentric myocardial hypertrophy

fig1



Mild ventriculomegaly, 12.2mm

SS-097 [Jinekoloji Genel]

The endotucker fixation of levonorgestrel-releasing intrauterine device using the hysteroscopy: a novel method in treatment of adenomyosis

Deniz Çokay[1], Tuğba Gül Yılmaz[2]
[1]Deniz Çokay
[2]Tuğba Gül Yılmaz

Adenomyosis is a gynecological condition that causes abnormal uterine bleeding. In patients with adenomyosis, the levonorgestrel-releasing intrauterine device (LNG-IUD) has been an insufficiently effective medical treatment option due to high device expulsion rates. New surgical techniques may be used in patients with a history of expulsion.

OBJECTIVES: To demonstrate the technique of fixation of an LNG-IUD with an endotucker under hysteroscopy guidance.

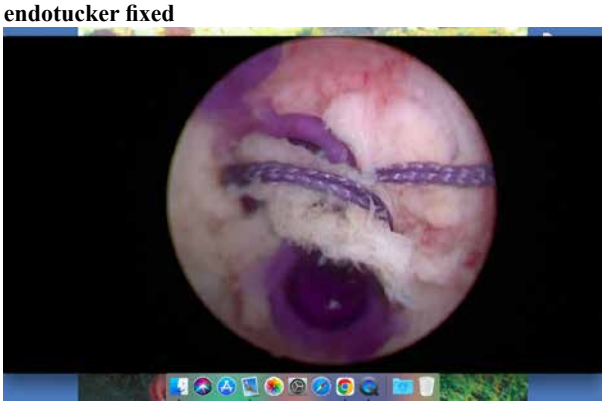
MATERIALS AND METHODS: Presentation of the technique with visuals using a 29GAUGE hysteroscope and endotacker. Informed consent was obtained from the patient. A 45-year-old multiparous woman with a history of adenomyosis for 4 years, treatment-refractory abnormal uterine bleeding, endometrial polyps on repeated biopsies, had previously had two LNG-IUD insertions. The device was expulsed one month after two insertions, and had a poor response to other medical treatments. Transvaginal ultrasonography showed diffuse adenomyosis. Consideration history of LNG-IUD expulsion, the patient was offered the option of fixation of the LNG-IUD.

RESULTS: In this novel technique case report, LNG-IUD placed and fixed with the in the uterus with endotucker by hysteroscopy. abnormal uterine bleeding and dysmenorrhea was significantly relieved in 3, months after surgery compared with before surgery. Serious IUD complications including expulsion and perforation were not observed. There was no new side effects than LNG-IUD tucker fixation.

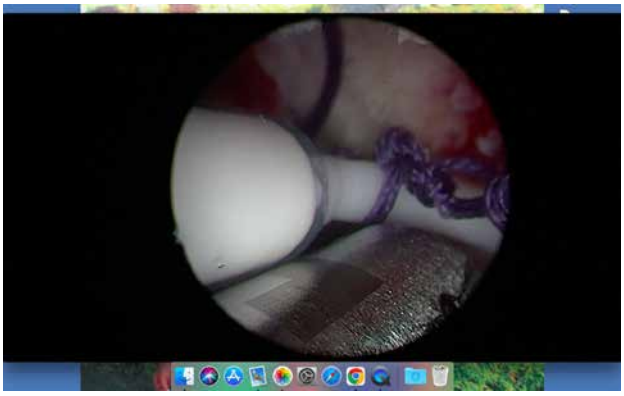
CONCLUSION: Hysteroscopy-guided endotucker fixation of the LNG-IUD is a minimally invasive, effective unique technique in the literature for patients with a history of IUD expulsion. However, further clinical studies are needed to determine the safety and efficacy of this approach.

Keywords: Adenomyosis, fixation, hysteroscopic endotucker, levonorgestrel-releasing intrauterine device

endotucker fixed



endotucker with IUD



endotucker with IUD in cavity

LOOP ON IUD

SS-099 [Jinekoloji Genel]

Could The Ca-125 Ratio Discriminate Intrauterine Pregnancy From Other Pregnancy of Unknown Location Cases?

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[2]Department of Obstetrics and Gynecology, University of Health Sciences, Bursa, Turkey

AIM: Pregnancy of unknown location (PUL) is characterized by a positive pregnancy test with no sonographic evidence of an intrauterine or ectopic pregnancy. Due to the absence of standardized follow-up protocols, PUL management remains variable. PUL outcomes include intrauterine pregnancy (IUP), failed PUL, ectopic pregnancy, and persistent PUL. Since PUL is not a definitive diagnosis, researchers have sought reliable biomarkers for accurate classification. Currently, serum β-human chorionic gonadotropin (β-HCG) and progesterone are widely used in PUL evaluation. This study aimed to assess the discriminative role of the CA-125 ratio in distinguishing intrauterine pregnancies from other PUL cases.

MATERIAL-METHODS: A total of 72 patients with PUL between January 2023 and November 2023 were included and classified into three groups based on final diagnosis: ectopic pregnancy (n=17), failed PUL (n=29) and intrauterine pregnancy (n=26). Intrauterine pregnancies were further divided into viable (n=22) and non-viable (n=4) subgroups. Age, parity, body mass index, β-HCG and CA-125 levels were recorded. β-HCG ratio was calculated by dividing β-HCG at 48 hour to initial β-HCG and CA-125 ratio was calculated by dividing CA-125 at 48 hour to initial CA-125 level. The ratios were compared between groups and ROC analysis was performed to assess their diagnostic performance.

RESULTS: The distribution of outcomes was as follows: ectopic pregnancy (23.6%), failed PUL (40.3%), and intrauterine pregnancy (36.1%), with non-viable pregnancies comprising 15.4% of intrauterine pregnancies. Demographic and laboratory characteristics of patients were shown in Table. No significant differences were observed among groups in terms of age, parity, BMI, initial β-HCG, or CA-125 levels at baseline and 48 hours. The failed PUL group exhibited significantly lower 48-hour β-HCG levels compared to the ectopic pregnancy ($p=0.004$) and intrauterine pregnancy groups ($p<0.001$).Both β-HCG and CA-125 ratios were significantly lower in the failed PUL group compared to the ectopic pregnancy ($p<0.001$ and $p=0.003$, respectively) and intrauterine pregnancy groups ($p<0.001$ and $p=0.003$, respectively). Additionally, both ratios were significantly lower in the ectopic pregnancy group than in the intrauterine pregnancy group ($p<0.001$ for both). No significant differences in β-HCG ratio ($p=0.283$) or CA-125 ratio ($p=0.811$) were found between viable and non-viable intrauterine pregnancies. A β-HCG ratio >1.81 demonstrated 100% sensitivity and 100% specificity for intrauterine pregnancy (AUC=1.000, $p<0.001$), while a CA-125 ratio >0.91 showed 88.5% sensitivity and 73.9% specificity (AUC=0.852, $p<0.001$). The β-HCG ratio had a superior discriminative performance compared to the CA-125 ratio ($p=0.001$). A strong positive correlation was observed between the β-HCG and CA-125 ratios ($r=0.790$, $p<0.001$).

CONCLUSION: Although UK guidelines suggest a β-HCG ratio above

1.63 is indicative of intrauterine pregnancy, no universal consensus exists regarding optimal cut-off values. This underscores the need for a multi-marker approach in PUL diagnosis. Our findings suggest that the CA-125 ratio can effectively differentiate intrauterine pregnancies from other PUL cases. Although it does not predict viability, its combination with the β-HCG ratio may improve diagnostic accuracy in PUL evaluation.

Keywords: β-HCG ratio, CA-125 ratio, ectopic pregnancy, pregnancy of unknown location

Demographic and laboratory characteristics of patients

	Ectopic pregnancy (n=17)	Failed PUL (n=29)	Intrauterine pregnancy (n=26)	p
Age (years)	32 (18-41)	30 (20-42)	27 (20-38)	0.370
Parity (n)	2 (0-6)	1 (0-4)	0 (0-4)	0.071
Body mass index (kg/m2)	28.66 ± 4.19	28.71 ± 4.2	27.75 ± 5.18	0.704
Initial β-HCG (mU/ml)	764 (125-1391)	778 (105-1302)	484.5 (154-1617)	0.065
β-HCG at 48 hour (mU/ml)	1079 (194-1971)	405 (78-1125)	1482.5 (310-4313)	<0.001
β-HCG ratio	1.35 (1.05-1.81)	0.67 (0.38-0.99)	2.89 (2.01-6.71)	<0.001
Initial CA-125 (U/ml)	30 (22-51)	32 (14-49)	28 (20-47)	0.595
CA-125 at 48 hour (U/ml)	28 (20-58)	27 (9-47)	29 (19-54)	0.383
CA-125 ratio	0.90 (0.78-1.14)	0.83 (0.64-1.07)	1.03 (0.85-1.23)	<0.001

SS-101 [Jinekoloji Genel]

Heterotopic pregnancy in unicornuate uterus with non-communicating rudimentary horn: surgical success and term pregnancy

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INTRODUCTION: Heterotopic pregnancy in a unicornuate uterus with a non-communicating rudimentary horn is a rare and life-threatening condition. (figure 5) The aim of this case report is to highlight the importance of early diagnosis and intervention in an extremely rare occurrence of heterotopic pregnancy located in a rudimentary horn.

CASE: A 33-year-old woman, gravida 2, para 0, with a prior inconclusive diagnosis of unicornuate uterus during diagnostic hysteroscopy, was evaluated at 6 weeks and 3 days of gestation via transvaginal ultrasound during routine prenatal care. The imaging revealed a heterotopic pregnancy: an intrauterine live gestation (crown-rump length [CRL] 3.2 mm, ~6 weeks) and an ectopic pregnancy within a right adnexal rudimentary uterine horn (CRL 2.9 mm, ~5+6 weeks) (figure 1-2,6-7). Corpus luteum was observed in the right ovary as 33x18 mm; the left ovary as 22x12 mm. (figure 3-4) Prior hysterosalpingography (HSG) or magnetic resonance imaging (MRI) had not been performed. Laparoscopic excision of the right rudimentary horn with ipsilateral salpingectomy was performed, preserving the intrauterine pregnancy. Postoperatively, vaginal progesterone (Progestan 200 mg twice daily) was administered for luteal phase support, alongside levothyroxine (Euthyrox 50 µg/day) for preexisting thyroid dysfunction. Serial serum beta-hCG monitoring and ultrasonographic surveillance confirmed the ongoing viability of the intrauterine pregnancy, which progressed uneventfully to 39 weeks of gestation. The patient's postoperative course was unremarkable, with stable vital signs, absent vaginal bleeding, and normal wound healing.

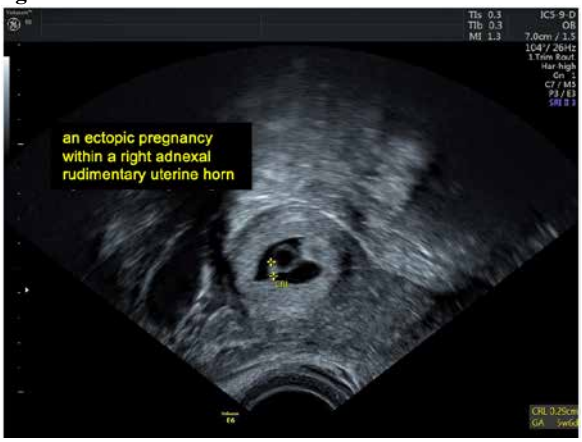
CONCLUSION: This case underscores the diagnostic and therapeutic complexities of heterotopic pregnancy in patients with congenital uterine anomalies, such as unicornuate uterus. Early multimodal imaging, timely surgical intervention, and adjunctive hormonal therapy were critical to optimizing maternal and fetal outcomes. Although the absence of prior HSG or MRI limited comprehensive anatomical assessment, the case highlights the importance of clinical vigilance in uteruses with suspected congenital malformations. The successful progression to term gestation following rudimentary horn excision demonstrates the feasibility of fertility preservation in such scenarios. This report reinforces the need for a high index of suspicion for heterotopic pregnancies in patients with uterine anomalies and advocates for individualized, multidisciplinary management to achieve favorable obstetric outcomes.

Keywords: heterotopic pregnancy, rudimentary uterine horn, unicornuate uterus

figure 1

an intrauterine live gestation

figure 2

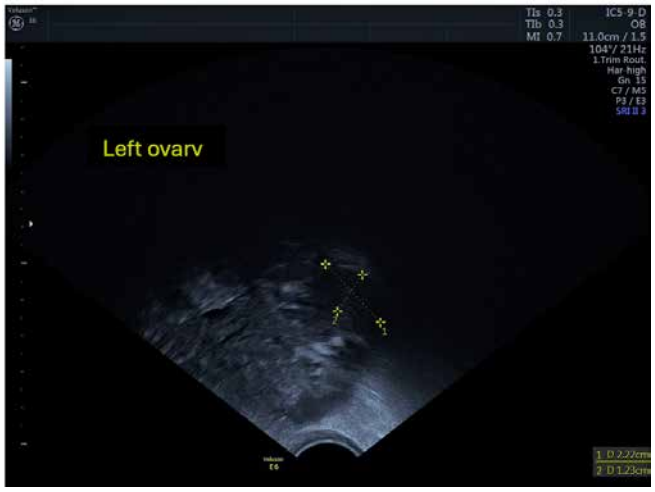


an ectopic pregnancy within a right adnexal rudimentary uterine horn

figure 3

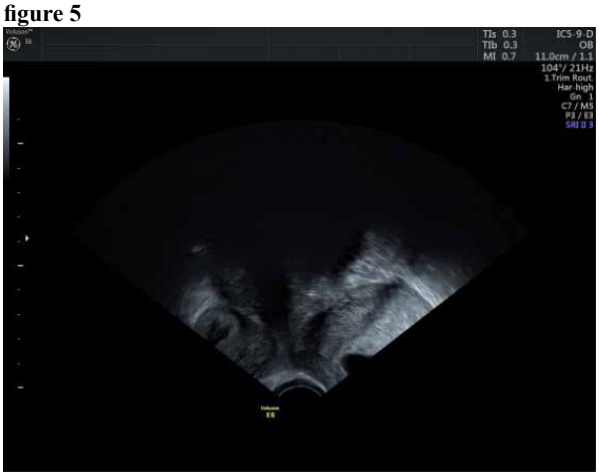
Right ovary with corpus luteum

figure 4



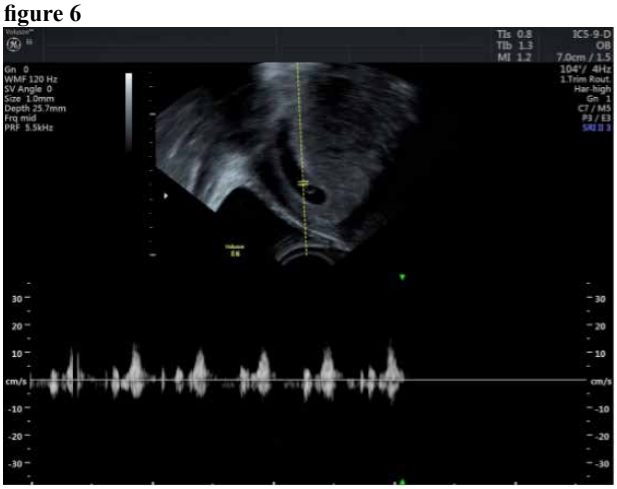
Left ovary

figure 5



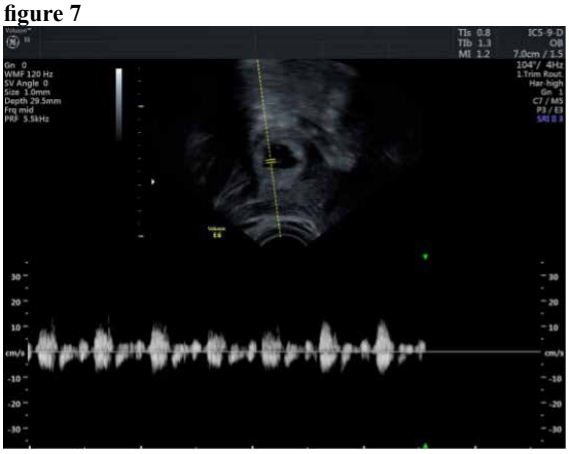
unicornuate uterus with non-communicating rudimentary horn

figure 6



an intrauterine live gestation

figure 7



an ectopic pregnancy within a right adnexal rudimentary uterine horn

SS-103 [Jinekoloji Genel]

Isolated Fallopian Tube Torsion: A Rare Cause of Acute Abdomen

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INTRODUCTION: Isolated fallopian tube torsion (TT) is a rare cause of acute abdominal pain, with an estimated incidence of approximately 1 in 1,500,000 females. It primarily affects women of reproductive age and is extremely rare in prepubertal and postmenopausal women. Possible risk factors for TT include tubal pathology (e.g., hydrosalpinx, segmental tubal agenesis, broad ligament cysts, paratubal cysts, neoplasms, tubal ligation, ectopic pregnancy), ovarian masses, infections, abnormal tubal peristalsis or spasm, and adhesions. Due to its non-specific symptoms, TT is challenging to diagnose preoperatively, and delayed treatment may lead to tubal necrosis. Laparoscopy remains the gold standard for both diagnosis and treatment.

CASE REPORT: A 28-year-old woman (G3P3) presented with a three-day history of acute lower abdominal pain and tenderness. She

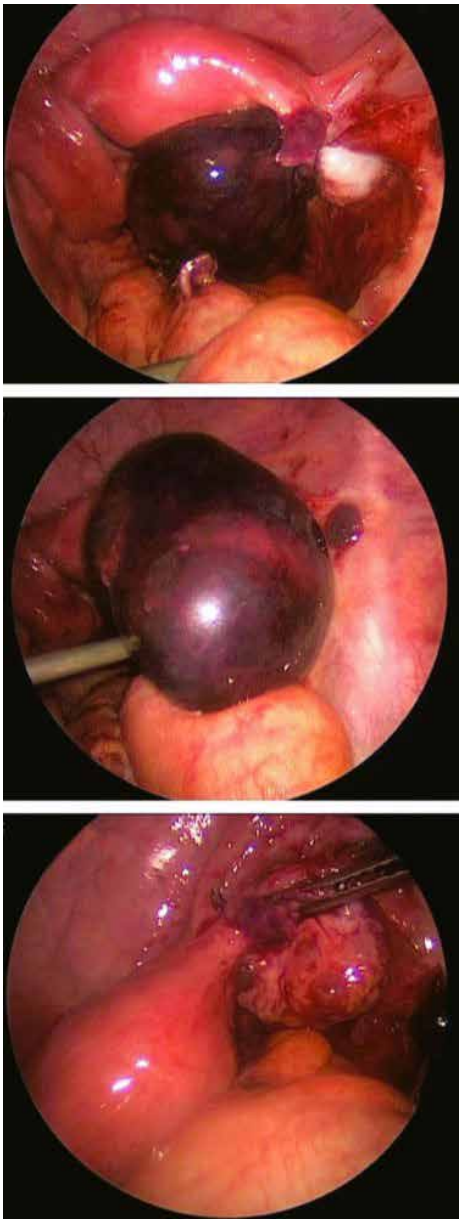
had no significant medical or surgical history. On pelvic examination, cervical motion tenderness was minimal, but right adnexal tenderness with voluntary guarding was noted. Laboratory results showed WBC: 14,160 cells/mm³, Hgb: 12.8 g/dL, platelet count: 233,000 cells/mm³, and CRP: 3 mg/L. B-hCG and tumor markers were negative. Transvaginal ultrasonography (USG) revealed a 96×67 mm unilocular hypoechoic cystic mass in the right adnexa without septation. Computed tomography (CT) showed a 108×85 mm cystic formation with wall thickening in the midline, superior to the bladder. Given the clinical findings and imaging results, an urgent laparoscopic intervention was planned, and informed consent was obtained. Upon laparoscopy, the right ovary appeared normal, but the right fallopian tube was twisted twice and showed signs of edema and necrosis. Detorsion was attempted; however, due to the absence of viability and the patient's multiparous status, a salpingectomy was performed using advanced bipolar energy. The patient was monitored for 48 hours postoperatively, with no complications observed.

DISCUSSION: Isolated TT is an exceptionally rare cause of lower quadrant abdominal or pelvic pain. It primarily affects ovulating women and is uncommon in postmenopausal and adolescent patients. Early recognition is crucial to preserve tubal function, as prolonged torsion can result in irreversible ischemic damage. Imaging modalities for TT diagnosis are limited. MRI or CT may aid in diagnosis, particularly if the ipsilateral ovary appears normal, which helps narrow the differential diagnosis. MRI findings such as hematosalpinx have been suggested as specific indicators of fallopian tube torsion. TT most frequently occurs on the right side, possibly due to the greater mobility of the ileum and appendix compared to the left-sided sigmoid colon, which is more fixed to the mesentery. Another possible contributing factor is slower venous drainage on the right, increasing susceptibility to torsion. Laparoscopic detorsion is the preferred treatment for isolated TT. However, in cases of necrosis, as seen in this case, salpingectomy is required.

CONCLUSION: Isolated TT is a rare but important consideration in women presenting with acute lower abdominal pain. Due to the lack of specific clinical, imaging, or laboratory findings, a high index of suspicion is necessary. Early laparoscopy is essential to confirm the diagnosis and preserve fertility when possible.

Keywords: torsion, fallopian tube, acute abdomen

tubal torsion



SS-104 [Endoskopi]

Laparoscopic surgery for ovarian torsion in the third trimester: challenges and insights

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OBJECTIVE: Ovarian torsion is a rare condition of pregnancy with a predicted incidence of 6 per 10,000 pregnancies. It is predominantly encountered in the first trimester and is extremely rare to occur in the third trimester. Correct diagnosis and early surgical treatment are extremely important not only to maximize the likelihood of adnexal preservation, but also to avoid complications by avoiding

or minimizing ovarian edema or tissue necrosis and preventing possible abdominopelvic inflammatory reactions. The diagnosis of pregnancy with acute abdominal pain is extremely challenging since the symptoms are nonspecific and the differential diagnosis is wide In order to successfully manage a rare third-trimester presentation of ovarian torsion using laparoscopic surgery and to emphasize the effectiveness and safety of the procedure.

CASE PRESENTATION: A 28-year-old female, gravida 2 para 1 with a history of a previous normal vaginal delivery, was admitted in the emergency maternity department at gestational age of 30+1 weeks presenting with severe abdominal pain in the right lower quadrant, nausea, and vomiting. Ultrasound revealed large bilocule 11*8 cm Dermoid cyst in right ovari with no blood flow in color Doppler suspicion of ovarian torsion. Laparoscopy confirmed torsion of right ovarian pedicle with secondary necrosis and edema. Laparoscopic detorsion and cystectomy were performed with the conservation of viable part of the ovary. The pregnancy was uncomplicated, and the patient gave birth to a 3600-gram male baby with Apgar score 9/9 via normal delivery at 40 weeks of gestation.

DISCUSSION: Third-trimester ovarian torsion that is not typically encountered accounts for only 5-10% of pregnancies presenting with torsion. Laparotomy is reported most often in the literature as the preferred surgery in these instances and often ends up being an oophorectomy due to intraoperative findings of necrosis. But laparoscopy is of great advantage such as reduced maternal morbidity and faster recovery. In women with recurrent abdominal pain during pregnancy, after exclusion of obstetric causes, ovarian torsion must be suspected with particular emphasis on patients with prior adnexal mass. Early evaluation of the ovaries and documentation of adnexal masses during pre-natal visit can enable rapid diagnosis and treatment in acute presentations.

CONCLUSION: This case underscores the importance of considering ovarian torsion in the differential diagnosis of persistent abdominal pain in pregnancy. It also underscores the safety and effectiveness of laparoscopic management even in the third trimester, resulting in improved maternal and fetal outcome.

Keywords: adnexal torsion, third trimester, laparoscopy

Figure 1: The right tube and ovary were torsioned four times

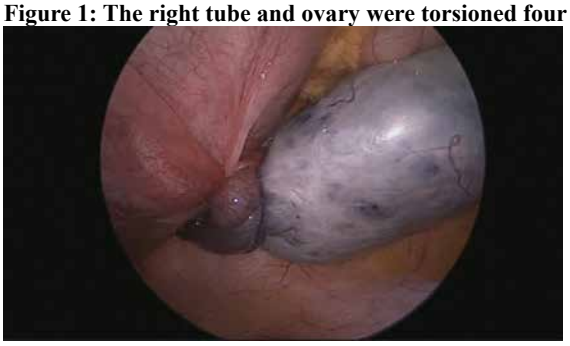
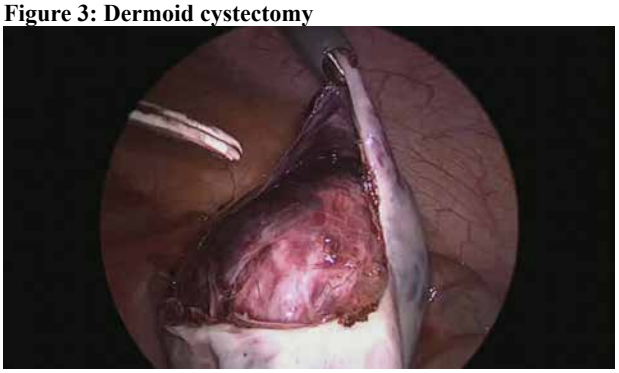


Figure 2: Image taken immediately after detorsion

Figure 3: Dermoid cystectomy



SS-105 [Jinekoloji Genel]

Retrospective Evaluation of Emergency Gynecological Procedures in a Tertiary Referral Center

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AIM: Gynecological emergencies are one of the most important problems that are frequently encountered in women of all age groups and that require detailed examination and treatment. Appropriate management of these cases has vital importance; however, it is extremely important in preserving the sexual functions and fertility of the individual. In this study, we aimed to examine the cases treated with emergency surgery in our clinic retrospectively and to help the management of emergency gynecological cases more quickly and accurately.

METHOD: Between 2015-2020 Istanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Obstetrics and Gynecology after hospitalization in the aseptic service, the information of the patients who were operated as an emergency or after the clinical condition was stabilized with medical treatment was scanned retrospectively using the hospital electronic database system and patient archive files. A total of 214 major operations (5 patients operated twice), were performed urgently in 209 patients, constituting 7.24% of 2954 operations performed for benign reasons were included in the study. Urgent minor operations (endometrial sampling, dilation, and curettage) were excluded from the study. Demographic characteristics, risk factors, complaints, physical examination

findings, blood tests, diagnostic methods, and operations of all patients were evaluated. Statistical analysis of the results was done in the SPSS Version 20 program. P<0.05 was considered statistically significant.

RESULTS: Of the emergency operations, 94 (43.9%) were due to ectopic and undetermined pregnancies, 44 (20.6%) were due to pelvic inflammatory disease (including tubaovarian abscess and peritonitis), 35 (16.4%)) due to adnexal torsion, 22 (10.3%) ovarian cysts (including cyst rupture and hemorrhagic corpus luteum cases), 11 (5.1%) due to complications after elective gynecological operations, 8 (3.7%) was done for other rare gynecological reasons. 132 (61.7%) of all operations were performed laparoscopically. When the first 4 groups with the most cases were compared, it was seen that laparoscopic surgery was performed at a statistically significant rate of 88.3% in ectopic and undetermined pregnancies. The mean age of the patients in the pelvic inflammatory disease, abscess and peritonitis group was significantly higher than the other groups. The lowest mean age was seen in the adnexal torsion group. As a result of examination, treatment and surgery of 53 patients hospitalized with a preliminary diagnosis of adnexal torsion, it was found that 35 (66%) had torsion.

CONCLUSION: With this study, we aimed to contribute to the management of emergency gynecological cases by scanning all aspects of emergency gynecological operations in our clinic, one of our country's largest health centers. As a result, we concluded that gynecological emergencies can be successfully managed laparoscopically in a suitably selected patient group and in experienced hands.

Keywords: Gynecologic Emergency, Infertility, Laparoscopy, Pelvic Pain

SS-106 [Endoskopi]

Ectopic Pregnancy Operation with vNOTES Salpingectomy in 8 Cases

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INTRODUCTION: This case report demonstrates the feasibility of transvaginal natural orifice transluminal endoscopic surgery (vNOTES) and salpingectomy for ectopic pregnancy. Ectopic pregnancy is a common and life-threatening gynecological emergency. Its management is the basis of emergency gynecological surgery and laparoscopy is the gold standard technique. Transvaginal natural orifice transluminal endoscopic surgery (V-NOTES) technique for the treatment of ectopic pregnancy is presented here. Conventional, reusable laparoscopic instruments were used and placed in an inexpensive, self-made single-port device. The self-made single-port device was constructed by assembling one surgical glove, one Alexis, two reusable 10 mm trocars and one reusable 5 mm trocar.

CASE: The patients were aged between 28 and 40 years and had a body mass index between 23.6 and 33.8 kg/m2. Five of the eight patients had previously had a vaginal delivery. For one patient, ectopic pregnancy was the first pregnancy. One of the patients had previously undergone surgery for an ectopic pregnancy, one had undergone diagnostic laparoscopy, and the other four patients had no previous surgery. All patients were placed in the lithotomy position under general anesthesia. The surgical field was sterilized and draped, and a Foley catheter was placed.Antibiotic prophylaxis was administered intravenously. Vaginal retractors were used to visualize the vaginal cavity and cervix. Posterior colpotomy was opened 1 cm below the cervix posteriorly. A medium-sized Alexis retractor with a flexible inner ring was placed in the peritoneum. A previously prepared glove port was placed at the tip of the Alexis. Pneumoperitoneum was provided with CO2. In five patients, ectopic pregnancy had ruptured preoperatively and caused hemoperitoneum; all blood clots were aspirated. After the endoscope entered the pelvic cavity, the uterus and bilateral adnexa were examined in detail and salpingectomy was performed. The procedure was terminated after bleeding control. As the last step, the vagina was sutured continuously with absorbable sutures. The operation time from incision to vaginal closure was between 22 and 68 minutes. Procedure-related hemogram decrease was between 1 and 3 mg/dl. None of the patients required blood transfusion. Postoperative 24th hour VAS scores were low for all patients, and median VAS pain scores 6 hours after surgery were 6(range 1-10).

CONCLUSION: Transvaginal NOTES (vNOTES) for ectopic pregnancy was successfully completed in all patients. No minor or major peri- or postoperative complications occurred. In this case report, vNOTES salpingectomy for unruptured or ruptured tubal pregnancy was successfully performed using reusable laparoscopic instruments and a low-cost vNOTES port. The procedures were completed within a reasonable operative time and without complications. No conversion to standard multi-incision laparoscopy or laparotomy was required. Transvaginal NOTES, as a scarless surgery, eliminates the risk of trocar site complications such as bleeding at the trocar site and causes less postoperative pain and shortens the hospital stay. The safety and efficacy of transvaginal endoscopic salpingectomy for tubal ectopic pregnancy are equivalent to those of the laparoscopic procedure. The less postoperative pain and more satisfactory cosmetic result with the transvaginal endoscopic procedure make it the more preferred method and superior to the laparoscopic approach

Keywords: Ectopic pregnancy, Salpingectomy, Transvaginal endoscopic surgery, vNOTES

SS-108 [Onkoloji]

The Impact of Adding Bevacizumab to Chemotherapy on Treatment Outcomes in Platinum-Sensitive Recurrent Ovarian Cancer and the Role of Platinum-free Interval

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OBJECTIVES: Despite significant advancements in ovarian cancer treatment, recurrent disease remains a substantial clinical challenge due to high recurrence rates and the development of drug resistance. While current evidence suggests that adding bevacizumab to platinum-based chemotherapy may improve progression-free survival (PFS) in patients with platinum-sensitive recurrent ovarian cancer (PSROC), critical questions regarding long-term effects, optimal chemotherapy pairings, and treatment duration remain unanswered. This study

evaluated the impact of bevacizumab on treatment outcomes in PSROC.

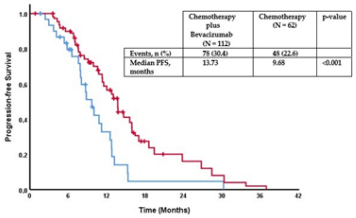
MATERIALS-METHODS: A retrospective analysis was conducted on patients diagnosed with FIGO stage III and IV epithelial ovarian cancer who experienced platinum-sensitive recurrence. Patients were divided into two groups: those receiving platinum-based chemotherapy alone and those receiving chemotherapy combined with bevacizumab. Clinical data were examined, including demographics, ECOG performance status, and germline BRCA mutation status. Treatment outcomes were compared regarding PFS and overall survival (OS).

RESULTS: Of the 174 patients included in the study, 112 received chemotherapy plus bevacizumab, while 62 received chemotherapy alone. The median follow-up duration was 40.89 months (95% CI: 36.45-43.70) in the chemotherapy plus bevacizumab group and 34.69 months (95% CI: 29.91-39.48) in the chemotherapy-alone group. The chemotherapy plus bevacizumab group demonstrated a significantly longer median PFS (13.73 months vs. 9.68 months, p<0.001). However, the two groups had no significant difference in median OS (36.53 months vs. 32.43 months, p=0.178). A platinum-free interval (PFI) of 6-12 months resulted in a median PFS of 10.76 months (95% CI: 9.79-11.74) and median OS of 27.92 months (95% CI: 21.44-34.40), while PFI >12 months resulted in a median PFS of 12.81 months (95% CI: 12.40-13.22) and median OS of 39.36 months (95% CI: 31.94-46.78) (p=0.032 for PFS and p=0.001 for OS).Multivariate analysis revealed that adding bevacizumab was an independent prognostic factor for PFS (HR: 0.48, p<0.001). Independent prognostic factors for OS included PFI more significant than 12 months (HR: 0.52, p=0.003) and optimal cytoreductive surgery (CRS) (HR: 0.56, p=0.017).

CONCLUSIONS: Our study indicates that adding bevacizumab to chemotherapy can improve PFS in patients with PSROC and may offer OS benefits in specific subgroups. Patients with a PFI exceeding 12 months and those with optimal CRS experienced improved PFS and OS. Furthermore, the specific chemotherapeutic agent added to carboplatin and bevacizumab did not significantly impact PFS.

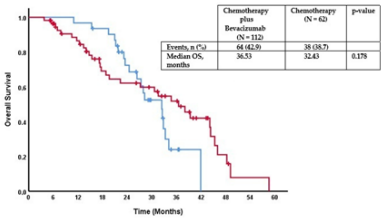
Keywords: bevacizumab, cytoreductive surgery, platinum-sensitive, platinum-free interval, ovarian cancer

Figure 1



Kaplan–Meier estimates of progression-free survival comparing chemotherapy plus bevacizumab vs. chemotherapy in patients with PSROC

Figure 2



Kaplan–Meier estimates of overall survival comparing chemotherapy plus bevacizumab vs. chemotherapy in patients with PSROC

Table 1. Characteristics of the Patients at Baseline

Factor	Total n:174	Chemotherapy plus Bevacizumab n: 112 (%)	Chemotherapy n: 62 (%)	p-value
Age-year				
≤58	94 (54.0%)	63 (56.3%)	31 (50.0%)	0.428
>58	80 (46.0%)	49 (43.8%)	31 (50.0%)	
ECOG Performence Status				
0-1	148 (85.1%)	98 (87.5%)	50 (80.6%)	0.224
2	26 (14.9%)	14 (12.5%)	12 (19.4%)	
gBRCAm				
1 or 2 mutant	32 (18.4%)	21 (18.8%)	11 (17.7%)	0.289
Wild	45 (25.9%)	33 (29.5%)	12 (19.4%)	
Unknown	97 (55.7%)	58 (51.8%)	39 (62.9%)	
FIGO Stage III	134 (77.0%)	90 (80.4%)	44 (71.0%)	0.159
Histology				
High grade serous	130 (74.7%)	88 (78.6%)	42 (67.7%)	0.116
Other or unknown	44 (25.3%)	24 (21.4%)	20 (32.3%)	
Ascite				
Yes	55 (31.6%)	33 (29.5%)	22 (35.5%)	0.413
No	119 (68.4%)	79 (70.5%)	40 (64.5%)	
Cytoreductive surgery				
Suboptimal or not performed	70 (40.2%)	42 (37.5%)	28 (45.2%)	0.324
Optimal	104 (59.8%)	70 (62.5%)	34 (54.8%)	
Location of recurrence				
Local	118 (67.8%)	80 (71.4%)	38 (61.3%)	0.170
Distant	56 (32.2%)	32 (28.6%)	24 (38.7%)	
Platinum-free interval				
6-12 months	91 (52.3%)	60 (53.6%)	31 (50.0%)	0.651
>12 months	83 (47.7%)	52 (46.4%)	31 (50.0%)	

*ECOG: Eastern Cooperative Oncology Group; gBRCAm: germline BRCA1/BRCA2 mutation; FIGO: International Federation of Gynecology and Obstetrics; PC: paclitaxel plus carboplatin; GC: gemcitabine plus carboplatin; LDC: liposomal doxorubicin plus carboplatin; *before starting treatment for platinum-sensitive recurrence*

Table 2. PFS and OS times in patients with PSROC

Factor	PFS Median (95% CI)	p-value	OS Median (95% CI)	p-value
Age-median (range)				
≤58	13.21 (11.46-14.96)	0.133	34.73 (30.22-39.24)	0.433
>58	11.20 (9.98-12.43)		30.65 (26.67-34.63)	
ECOG Performence Status				
0-1	12.77 (11.44-14.09)	0.019*	34.14 (30.87-37.41)	0.003*
2	9.11 (6.50-11.71)		23.49 (20.53-26.45)	
gBRCAm				
1 or 2 mutant	12.03 (6.51-17.54)	0.574	38 07 (35.93-40.21)	0.320
Wild	13.21 (9.23-17.18)		34.14 (26.54-41.74)	
Unknown	11.54 (10.22-12.86)		30.65 (24.12-37.19)	
FIGO Stage				
III	12.03 (10.54-13.51)	0.386	34.14 (29.63-38.65)	0.098
IV	11.54 (8.88-14.20)		31.58 (26.27-36.89)	
Histology				
High grade serous	12.55 (11.40-13.70)	0.147	32.81 (27.87-37.76)	0.776
Other or unknown	9.68 (7.83-11.53)		32.43 (29.21-35.65)	
Cytoreductive surgery				
Suboptimal or Not performed	11.20 (9.90-12.50)	0.042*	23.20 (18.27-28.12)	<0.001*
Optimal	13.73 (12.77-14.70)		38.07 (33.75-42.40)	
Second-line treatment				
Chemotherapy	9.68 (8.31-11.05)	<0.001*	32.43 (27.98-36.88)	0.178
Chemotherapy Plus Bevacizumab	13.73 (12.30-15.17)		36.53 (30.41-42.64)	
Maintenance Bevacizumab				
No	12.03 (10.05-14.00)	0.114	31.57 (16.80-46.36)	0.914
Yes	15.93 (12.97-18.90)		36.53 (26.83-46.23)	
Platinum-free interval				
6-12 months	10.76 (9.79-11.74)	0.032*	27.92 (21.44-34.40)	0.001*
>12 months	12.81 (12.40-13.22)		39.36 (31.94-46.78)	

*PSROC: platinum-sensitive recurrent ovarian cancer; PFS: progression-free survival; OS: overall survival; CI: Confidence interval; ECOG = Eastern Cooperative Oncology Group; gBRCAm: germline BRCA1/BRCA2 mutation; FIGO: International Federation of Gynecology and Obstetrics; [1] before starting treatment for platinum-sensitive recurrence; *significant*

Table 3. Cox regression model for predicting the independent factors for PFS and OS

	PFS		OS	
	HR (95%CI)	p-value	HR (95%CI)	p-value
ECOG Performence Status				
0-1	Ref	0.279	Ref	0.098
2	1.34 (0.79-2.26)		1.56 (0.92-2.63)	
Platinum-free interval				
6-12 months	Ref	0.162	Ref	0.003*
>12 months	0.77 (0.54-1.11)		0.52 (0.34-0.80)	
Cytoreductive surgery[1]				
Suboptimal or not performed	Ref	0.284	Ref	0.017*
Optimal	0.80 (0.53-1.20)		0.56 (0.35-0.90)	
Second-line treatment				
Chemotherapy	Ref	<0.001*	-	-
Chemotherapy Plus Bevacizumab	0.48 (0.33-0.70)		-	-

*PFS: Progression-free survival; OS: Overall survival; HR: Hazard ratio; CI: Confidence interval; ECOG: Eastern Cooperative Oncology Group; [1] before starting treatment for platinum-sensitive recurrens, *Significant*

SS-109 [Onkoloji]

Investigation of the relationship between preoperative hematologic inflammation indexes and the degree of myometrial invasion in endometrial cancer

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AIM: Endometrial cancer is the most common gynecological malignancy. It is the 4th most common cancer among women, but since most patients are diagnosed at an early stage, it ranks 8th in cancer-related deaths. Key prognostic factors include histological type, lymphovascular space invasion (LVSI), adnexal involvement, molecular class, and degree of myometrial invasion. Our aim in our study is to demonstrate that myometrial invasion, one of the main prognosis determinants, can be predicted by hematological inflammation indices calculated from complete blood count.

METHODS: All patients between the ages of 18 and 80 who underwent surgery for endometrial cancer at Ankara Training and Research Hospital between January 2017 and August 2023 were included. The patients' last complete blood count taken the last one month preoperatively, and final pathology reports were examined retrospectively. Hematological inflammation indices were calculated from the obtained complete blood count data and myometrial invasion degrees were determined from the final histopathology reports.

RESULTS: In our study, the relationship between hematological inflammation indices and the degree of myometrial invasion was examined, it was observed that there was no statistically significant relationship between neutrophil lymphocyte ratio (NLR) and platelet lymphocyte ratio (PLR) and the degree of myometrial invasion (p>0.05). A statistically significant relationship was

observed between systemic immune inflammation index (SII) and pan immune inflammation value (PIV) and the degree of myometrial invasion ($p<0.05$). When endometrioid type endometrial cancer was examined, it was found that only pan immune inflammation value (PIV) had a statistically significant relationship with the degree of myometrial invasion ($p<0.05$).

CONCLUSION: Our study is the first to use pan immune inflammation value (PIV) value in endometrial cancer. This is the first study examining the relationship between systemic immune inflammation index (SII) value and myometrial invasion. There is no current biomarker used in endometrial cancer. In our study, we investigated the power of hematological inflammation indices in predicting the degree of myometrial invasion, which is one of the main prognostic factors. It was observed that systemic immune inflammation index (SII) and pan immune inflammation value (PIV) values were statistically significant in evaluating the degree of myometrial invasion in endometrial cancer, when endometrioid type endometrial cancer, which constitutes 80% of all diagnosed endometrial cancers, was examined, it was seen that the pan immune inflammation value (PIV) value was statistically significant in evaluating the myometrial invasion value and that the pan immune inflammation value (PIV) value could be used to predict myometrial invasion.

Keywords: Hematological inflammation index, endometrial cancer, biochemical marker, pan-immune inflammation value

SS-110 [Onkoloji]

Prognostic Value of Mismatch Repair (MMR) Gene Defects in Endometrial Cancer

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Endometrial cancer is the most common gynecologic malignancy in women. Molecular alterations in the DNA mismatch repair (MMR) system, including microsatellite instability and loss of MMR protein expression, play a crucial role in tumorigenesis. Recent studies have suggested that MMR deficiency may serve as a prognostic and predictive biomarker in endometrial cancer, influencing both clinical outcomes and therapeutic decisions. In this study we aimed to compare the prognostic factors between MMRp and MMRd groups Materials and METHODS: A total of 413 patients diagnosed with endometrial cancer and who underwent surgery at the Gynecologic Oncology Clinic of Etlik City Hospital between October 2022 and October 2024 were included in the study. Patients with confirmed endometrial cancer via pathological examination and MMR analysis were retrospectively reviewed. Data regarding demographic characteristics, tumor size, depth of myometrial invasion, lymph node involvement, FIGO staging, MMR status, and clinicopathological features were collected from electronic medical records. Statistical analyses were conducted to compare clinicopathological characteristics between these two groups, with significance set at $p < 0.05$. RESULTS: Comparing MMR-proficient (MMRP) and MMR-deficient (MMRD) groups, no significant difference was found in terms of age (60 ± 9 vs. 60 ± 9, $p = 0.76$), body mass index, parity, or myometrial invasion depth. However, tumor size was significantly larger in the MMRD group (median 40 mm [IQR 30-65] vs. 35 mm [IQR 20-60], $p = 0.02$). Histological subtypes were not significantly different between the two groups ($p = 0.36$), yet higher-grade tumors (FIGO Grade 3) were more prevalent in the MMRD group (17.4% vs. 5.6%, $p < 0.001$). Regarding FIGO staging, advanced-stage disease (FIGO stage III–IV) was more frequently observed in the MMRD group compared to the MMRP group (15.5% vs. 11.2%, $p = 0.03$). Cervical invasion and lymph node metastasis rates did not show a statistically significant difference between the groups ($p = 0.15$ and $p = 0.17$, respectively). Surgical approaches were also similar between the two groups ($p = 0.26$). However, the detailed comparison of clinicopathological features (Table 1) indicates that the MMRD group had a higher proportion of patients with high-grade tumors and advanced-stage disease CONCLUSION: MMR defects are increasingly recognized as important prognostic markers in endometrial cancer. Our study found that the MMRD group had significantly larger tumor size, higher tumor grade, and more advanced-stage disease compared to the MMRP group. The significantly higher rate of Grade 3 tumors and advanced-stage disease in the MMRD group suggests that this subgroup may exhibit more aggressive biological behavior. These findings support the impact of MMR status on the clinical and pathological course of endometrial cancer and highlight its importance in prognostic and therapeutic decision-making.

Keywords: Endometrial Cancer, Mismatch Repair Deficiency, Prognostic Risk Factors

Table 1. Comparison of Clinicopathological Characteristics of Patients with MMRP and MMRD Positivity

Table 1. Comparison of Clinicopathological Characteristics of Patients with MMRP and MMRD Positivity

Variable	MMRP (n=323)	MMRD (n=90)	p-value
Age (years)	60 (9)	60 (9)	0.76
BMI	34 (29-29)	32 (29-38)	0.29
Parity	3 (2-4)	3 (2-3)	0.68
Tumor size (mm)	35 (20-60)	40 (30-65)	0.02*
Histological type			0.36
Endometrioid	290 (89.8%)	78 (86.7%)	
Clear cell	6 (1.9%)	2 (2.2%)	
Serous	10 (3.1%)	2 (2.2%)	
Mixed	6 (1.9%)	5 (5.6%)	
Carcinosarcoma	4 (1.2%)	0 (0%)	
Other	7 (2.2%)	3 (3.3%)	
Myometrial invasion			0.23
Non-invasive	40 (12.4%)	8 (8.9%)	
< 1/2 invasion depth	176 (54.7%)	42 (46.7%)	
≥ 1/2 invasion depth	104 (32.3%)	31 (43.3%)	
Uterine serosal invasion	2 (0.6%)	1 (1.1%)	
Cervical invasion	30 (9.3%)	12 (13.3%)	0.15
Lymph node metastasis	22 (7.7%)	10 (12.5%)	0.17
FIGO Grade			0.00**
Grade 1	227 (75.4%)	46 (50.0%)	
Grade 2	57 (18.9%)	30 (32.6%)	
Grade 3	17 (5.6%)	16 (17.4%)	
FIGO Stage			0.03*
Stage 1	233 (72.1%)	51 (56.7%)	
Stage 2	54 (16.7%)	25 (27.8%)	
Stage 3	29 (9.0%)	10 (11.1%)	
Stage 4	7 (2.2%)	4 (4.4%)	
Surgical approach			0.26
Laparotomy	90 (27.9%)	28 (31.1%)	
TLH	165 (51.1%)	38 (42.2%)	
Robotic	63 (19.5%)	21 (23.3%)	
Vaginal	4 (1.2%)	1 (1.1%)	
Vaginal + L/S	1 (0.3%)	2 (2.2%)	

* $p < 0.05$, ** $p < 0.001$

SS-111 [Onkoloji]

HPV as a Potential Source for Breast Cancer

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Breast cancer is the most commonly diagnosed cancer in women worldwide and is also the leading cause of cancer-related deaths among women. Despite advances in treatment methods and the understanding of the molecular structure of cancer, its high prevalence and mortality persist. While the relationship between Human Papillomaviruses (HPV) infection and the development of genital tumors is widely accepted, there is a lack of conclusive data regarding the impact of these viruses on breast lesions in the literature. Given the conflicting reports on the association between HPV and breast lesions, the aim of this study is to determine the presence of HPV-DNA in breast cancer tissues in patients who underwent surgery at our hospital.

In our study, a total of 834 breast cancer cases operated on in Acıbadem Healthcare Group Hospitals between 2019 and 2022 were screened, and among these cases, those who were BRCA (-) and under the age of 50 were included in the study group to exclude known breast cancer risk factors. A total of 91 breast cancer tissues from 90 patients were included in the study group. The identified cases underwent HPV-DNA screening at the Acıbadem LABMED laboratory using the PCR method. Subsequently, selected patients were subjected to HPV mRNA screening at the Acıbadem Mehmet Ali Aydınlar University Pathology Laboratory.

Data from 91 tissues operated on by a single surgeon at our center and evaluated by a pathologist specialized in breast pathology were used in our study. High-risk HPV was not detected in the results of HPV-DNA PCR tests conducted for all patients. Given that the mRNA test yielded negative results for a total of 46 patients to assess the accuracy of the results and enhance the test's specificity, the study was concluded.

The exploration of underlying mechanisms and the biology of complex and multifactorial diseases like breast cancer holds a significant place in the literature. Following a literature review, our study aimed to investigate the presence of the HPV genome in breast cancer tissues and normal breast tissue. Following PCR and mRNA tests conducted in breast cancer tissues, no presence of HPV was detected in our study group. The complex interplay of genetic, viral factors, and environmental influences in breast cancer development necessitates further research. Future research efforts, including large-scale multicenter studies and analyses of the impact of HPV vaccination, are crucial to advance our understanding of the complex mechanisms driving breast cancer oncogenesis.

Keywords: breast cancer, etiology, human papillomavirus, viral oncogene, carcinogenesis

SS-112 [Onkoloji]

The relationship of preoperative panimmune inflammatory value and ca125 value in patients diagnosed of ovarian cancer, investigation of the power of predictivity in prediction of optimal cytoreducation and prognosis

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AIM: Utilizing the therapeutic role of tumor microenvironment and chronic inflammation in cancer, measurement of uncontrolled inflammatory response can be used as a biomarker to predict cancer prognosis. The aim of this study; Comparing the value of pan-immune inflammation value (PIV), which is one of the peripheral blood count indexes, in the last 1 month preoperatively in ovarian cancers, which is the most common cause of death due to gynecological cancers, with the serum CA-125 value in the same period and evaluate whether they can be used to predict postoperative surgical staging (FIGO), optimal cytoreduction, prognosis, and survival.

METHODS: Between January 2015 and August 2022, 62 patients who underwent debulking operation with suspicion of malignancy in our clinic and were diagnosed with ovarian cancer according to the pathology results were retrospectively analyzed. Serum CA-125 and PIV values of the patients in the last 1 month preoperatively were determined. FIGO staging of the patients was performed by looking at the pathology results, surgery notes and imaging reports. The type of cytoreduction performed according to the residual tumor burden was determined.

RESULTS: Our study is the first and only study comparing preoperative serum CA-125 values with PIV in patients with ovarian cancer. Although these two values were not statistically correlated with each other ($p=0.056$; $r=0.244$), both were found to be statistically related to the stage of the disease, the type of cytoreduction applied, and disease-free survival. Serum CA-125 value was not associated with overall survival time ($p=0.534$; $r=-0.080$), but PIV value was also found to be statistically associated with overall survival time ($p=0.019$; $r=-0.298$). However, when sensitivity, specificity, positive predictive values and areas under the ROC curve were examined, no superiority of preoperative PIV over serum CA-125 was observed in terms of predicting optimal cytoreduction.

CONCLUSION: Although the preoperative PIV was not correlated with the serum CA-125 value, it was observed that the high values of both independently of each other were associated with late surgical stage, poor disease-free survival, and suboptimal cytoreduction, and it was observed that the PIV value was not superior to CA-125. However, the PIV value has the potential to be used as an independent biomarker. The sample size of this study is limited as it is a single center study. Further multicenter studies with larger sample sizes and longer follow-up are needed.Our study may shed light on different studies in terms of evaluating target-specific treatments and the response to these treatments. For this, there is a need for studies in which PIV is also evaluated in the treatment follow-up.

Keywords: Pan-immune inflammation value (PIV), CA125, Ovarian cancer, Optimal cytoreduction

SS-113 [Onkoloji]

Preliminary outcomes of Omentopexy Procedure in cervical cancer

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BACKGROUND AND AIM: Cervical cancer remains a significant health burden, necessitating radical hysterectomy as a primary surgical treatment. However, this procedure can lead to complications, impacting recovery and quality of life. The omentum, known for its vascular support, immune-modulating properties, and growth factor secretion, has been utilized as an autologous tissue flap to enhance healing. This study investigates the preliminary outcomes of omentopexy in cervical cancer surgery.

METHODS: This retrospective study included 73 cervical cancer patients who underwent surgery between July 2019 and July 2024. Patient demographics, tumor characteristics, imaging modalities, surgical details, and postoperative outcomes were retrieved from hospital records. Data were analyzed using SPSS 27, with continuous variables presented as mean ± standard deviation or median (range).

RESULTS: The mean age was 46 years, with 56.2% being premenopausal. Squamous cell carcinoma was the most common histological type (67.1%). MRI was used in 49.3% of cases, with PET-CT in 23.3%. Tumors were ≤2 cm in 57.5% of patients, and hydronephrosis was detected in 4.1%. The mean preoperative hemoglobin level was 12.4 g/dL. Surgical approaches included Type 3 hysterectomy (54.8%), pelvic lymphadenectomy (87.7%), and para-aortic lymphadenectomy (61.6%). Ovarian transposition was performed in 54.8% of premenopausal patients. Omentopexy was applied in 28.8%. The mean hospital stay for omentopexy patients was 9.3 days. Urination disorders requiring urology follow-up occurred in 6.8%. Postoperative pathology confirmed squamous cell carcinoma in 45.2% and adenocarcinoma in 19.2% of cases. Lymphovascular invasion was detected in 37%. The mean tumor size was 2.4 cm, slightly larger than preoperative measurements. The median number of pelvic and para-aortic lymph nodes removed was 28.2 and 12, respectively. FIGO stage IB1 was present in 30.1%, and stage IV in 4.1%. Postoperative complications were observed in only 5.5% of cases. Blood tests before discharge showed preserved renal function (BUN: 18.8 mg/dL, creatinine: 0.81 mg/dL). Adjuvant therapies included internal radiotherapy (30.1%), external radiotherapy (35.6%), and chemotherapy (23.3%). The mean follow-up was 42 months.

DISCUSSION: Squamous cell carcinoma (67.1%) remained the most common histology, consistent with epidemiological data. The use of PET-CT (23.3%) highlights its increasing role in staging and treatment planning alongside MRI. Tumor size discrepancies between pre- and postoperative measurements suggest challenges in accurate preoperative assessment. The surgical approach, with 54.8% undergoing Type 3 hysterectomy and high lymphadenectomy rates (87.7% pelvic, 61.6% para-aortic), aligns with standard treatment protocols. The detection of lymphovascular invasion in 37% reinforces its prognostic significance. The application of omentopexy in 28.8% of patients suggests a potential benefit in recovery, as reflected by a relatively low complication rate (5.5%) and a hospital stay of 9.3 days in this group. The rate of postoperative urinary dysfunction (6.8%) is consistent with known complications of radical pelvic surgery, particularly when extensive lymphadenectomy is performed.

CONCLUSION: Omentopexy appears to be a feasible and well-tolerated adjunct in cervical cancer surgery, potentially improving recovery and reducing complications. However, further studies with larger cohorts and extended follow-up periods are required to confirm its long-term oncological and functional benefits.

Keywords: Cervical Cancer, complications, Omentopexy Procedure

SS-116 [Onkoloji]

A Rare Case: Definition and Management of Perivascular Epithelioid Cell Tumor (PEComa)

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INTRODUCTION: Perivascular epithelioid cell tumors (PEComa) are histologically and immunohistochemically distinctive mesenchymal neoplasms composed of epithelioid or spindle cells that are immunoreactive for both smooth muscle and melanocytic markers. They are rarely seen in the uterus. Differential diagnosis in the uterus includes leiomyosarcoma, endometrial stromal sarcoma, ovarian sex cord stromal tumor-like uterine tumor, germ cell tumor. A few cases have been reported in the cervix outside the uterus. There is no comprehensive study due to its clinical rarity. They have been reported as case reports in the literature. Since there are a limited number of cases, treatment and management are also controversial.

CASE PRESENTATION: A 55-year-old female patient applies to the outpatient clinic due to intense pelvic pain. The patient has a history of four normal births and one cesarean section. The patient, who has no disease, has no history of previous operations other than cesarean section. Upon the detection of myoma in the examination of the patient, the decision for surgery is made. The patient undergoes laparoscopic hysterectomy bilateral salpingo-oophorectomy. The patient's final pathology result came as PEComa with uncertain malignant potential (WHO 2020), and the gynecological oncology team was consulted. The patient underwent PET-CT. Tumor marker values were examined.CA 15-3:28.9 and other markers were within normal limits. The patient, who did not have pathological FDG uptake in PET-CT, was evaluated by the gynecological oncology tumor council. The tumor council decided to offer the patient local radiotherapy or close follow-up. The patient did not accept radiotherapy. The patient continues to come for follow-ups. Discussion It is almost impossible to make a PEComa diagnosis in the preoperative period radiologically and clinically. In the cases reported in the literature, the diagnosis was usually made in the pathology material after hysterectomy performed for benign reasons. Since patients usually apply to outpatient clinics with complaints such as pelvic pain and abnormal uterine bleeding, these findings do not help distinguish the disease from other uterine tumors. The imaging methods used are also not very effective in diagnosis. In imaging, leiomyoma can be confused with leiomyosarcoma. Uterine PEComas represent a tumor ranging from benign to malignant. There are cases that malignant PEComas can metastasize distantly to

the lungs and liver. The management of uterine PEComas has not been fully determined due to the small number of cases. Patients should be offered the option of hysterectomy as treatment first. If possible, bilateral salpingo-oophorectomy should also be added. If the mass has spread to the cervix, type 3 hysterectomy should also be considered as an option. After the pathology result, after imaging is performed for the patients, it is seen that the best option is to follow up and start treatment with a joint decision between the clinics.

CONCLUSION: We presented a rare PEComa case. The definitive diagnosis was made in the hysterectomy material. The patient should be carefully examined with the pathology result, and although there is no definitive evidence for treatment options at the moment, a follow-up plan should be made according to the patient.

Keywords: PEComa, Malignancy, Pelvic Pain

SS-117 [Onkoloji]

Pregnancy and vulvar cancer

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INTRODUCTION: Vulvar cancer during pregnancy is a rare condition. This case aims to present the approach to early stage vulvar cancer in early weeks of pregnancy. Case presentation: A 42 year-old, 13 weeks and 2 days pregnant patient has had vulvar itching for 1.5 years. VIN 2-3 (vulvar intraepithelial neoplasia) was detected in the vulvar biopsy taken from the right labium majus at an external center. Pathological examination of the excision material revealed a squamous cell carcinoma tumor size of 1.8 cm, invasion depth of 0.5 cm, and the tumor continued in the medial and inferior surgical margins, and was focally adjacent to the superior surgical margin. In the patient's examination, no visible lesion was observed in the vulva, and the excision area was seen to be located on the right lateral side of the midline. The patient was evaluated with an abdominal MRI, no parailiac and inguinal lymphadenopathy was observed, and no significant mass was detected in the vagina and vulva region. Obstetric examination of the patient: G5P3A1Y3, since the crl (crown-rump length) measurement was too large for the double test, the double test could not be performed, the family was informed about amniocentesis and NIPT (Non-invasive prenatal test). The Gynecological oncology surgery council decided on radical local wide deep excision and right inguinofemoral lymphadenectomy. Under spinal anesthesia, radical local wide deep excision was performed in the area where the tumor was removed and right inguinofemoral lymph node dissection was added.

Final pathology result was reported as follows:

Vulvar intraepithelial neoplasia, HPV independent, vulva, 12 reactionary lymph nodes, right superficial inguinal region, 2 reactionary lymph nodes, right deep inguinal region, Surgical margins are intact.

With these results, the Gynecologic oncology surgery council recommended follow-up for the patient.

CONCLUSION: Vulvar cancer is a rare cancer during pregnancy because it is seen in older ages and less frequently than other gynecological malignancies. In vulvar cancer, in T1 (tumor limited to the vulva, no extension to adjacent perineal structures) lesions, radical local wide deep excision should be performed, leaving a tumor-free surgical margin of ≥ 1 cm. Lymphadenectomy is recommended in stage 1B and above tumors, as in this patient, because the risk of lymph node metastasis is ≥ %8. Since the patient's tumor size was <2 cm and it was located ≥2 cm lateral to the midline, only right unilateral lymphadenectomy was performed and enough.

Keywords: cancer, pregnancy, vulva

SS-118 [Onkoloji]

Coexistence of Endometrial Serous Carcinoma and Yolk Sac Tumor: A Rare Case Report

Sıtkı Özbilgeç
Konya Şehir Hastanesi

BACKGROUND: Endometrial serous carcinoma (ESC) is a high-grade endometrial malignancy associated with poor prognosis, predominantly seen in postmenopausal women. Yolk sac tumors (YSTs) are rare germ cell malignancies, typically arising from the ovary, with extragonadal presentations being extremely uncommon. The coexistence of ESC and YST in a single patient represents a rare and diagnostically challenging phenomenon.

Case Presentation: We present a 77-year-old postmenopausal female who was admitted with complaints of vaginal bleeding and abdominal distension. Imaging revealed endometrial thickening and widespread ascites. Ascitic fluid analysis and diagnostic laparoscopy with biopsies were inconclusive. Radiological imaging identified peritoneal carcinomatosis and liver capsule implants. Due to diagnostic uncertainty, the patient underwent exploratory laparotomy. Optimal debulking surgery was performed, including total abdominal hysterectomy with bilateral salpingo-oophorectomy, pelvic and para-aortic lymphadenectomy, omentectomy, and peritoneal biopsies. Intraoperative frozen section analysis of the uterus suggested benign findings, while tumor deposits on bowel surfaces were confirmed as malignant.

Postoperative pathology revealed a coexistence of ESC and YST. Immunohistochemistry identified ESC with p53 mutation and p16 positivity and confirmed YST through positive AFP, SALL-4, and Glypican-3 staining. Despite an uneventful immediate recovery, the patient succumbed to thromboembolic complications on postoperative day two.

DISCUSSION: This case underscores the diagnostic challenges associated with ESC and YST coexistence. Extragonadal YSTs are hypothesized to originate via somatic dedifferentiation or from embryonic remnants. Diagnostic difficulties arose from overlapping histopathological features, with frozen sections failing to identify malignancy in the uterine specimen. Immunohistochemical evaluation played a pivotal role in confirming the dual pathology. The aggressive nature of both malignancies, compounded by their rarity, posed significant management challenges.

Cytoreductive surgery remains a cornerstone in managing advanced gynecological malignancies. However, YST components often require tailored chemotherapy regimens, emphasizing the need for personalized treatment approaches. The patient's rapid deterioration highlights the importance of vigilant monitoring for thromboembolic complications in high-risk individuals.

CONCLUSION: The coexistence of ESC and YST is an exceedingly rare occurrence with significant diagnostic and therapeutic implications. This case highlights the need for a multidisciplinary approach and thorough pathological evaluation in managing complex malignancies. Enhanced awareness of such rare tumor combinations can improve diagnostic accuracy and inform treatment strategies. Further research is needed to elucidate the underlying pathogenesis and optimize clinical outcomes.

Keywords: Endometrial serous carcinoma, Yolk sac tumor, Extragonadal malignancy, Cytoreductive surgery, Immunohistochemistry, Rare tumor combination

hastanın patoloji raporu

T.C
SAĞLIK BAKANLIĞI
Konya Şehir Hastanesi
TIBBI PATOLOJİ TETKİK SONUÇ RAPORU
(Laboratuvar Ruhsat No: 608/1)

İslem No	: 5013210874	Rapor No	: 42544 / 2024
Hasta Adi Soyadi	: KİRAZ KOYUNCU	Isteyen Servis	: JİNEKOLOJİK ONKOLOJİ
TC Kimlik No	: 53332281***	Isteyen Doktor	: SITKI ÖZBİLGEÇ
Cinsiyet /Doğ.Tar/Yaş	: Kadın / 24.10.1946 / 77	Istem Tarih/Saat	: 22.08.2024 10:55:00
Doku Alinis Yeri	: Uterus, BBT	Numune Alim Tarih/Saat	: 22.08.2024 10:56:04
Numune Türü	: FROZEN	Numune Kabul Tarih/Saat	: 22.08.2024 12:39:17
Tetkikler	: Frozen İncelemesi	Onay Tarih/Saat	: 23.09.2024 09:52:42
Ön Tanısı	:		
Klinik Bulgu	: ENDOMETRİUM CA ?		

MAKROSKOPİ
Serviks fundus yüksekliği 10,5 cm, isthmuslar arası mesafesi 5,5 cm, ön-arka çapı 3,5 cm olan total histerektomi + bilateral salfingooferektomi materyalidir. Endometrium kalınlığı 0,1-0,2 cm, myometrium kalınlığı 1,2 cm olup kaviteyi tamamen doldurmuş 4x3x2 cm boyutlarında polipoid lezyon izlenmiştir. Üzerinde 5 cm uzunluğunda, 1 cm çapında tubası bulunan 2x2x1 cm boyutlarında sağ taraf over. Kesitlerinde korpus luteum izlenmiştir. Üzerinde 4 cm uzunluğunda, 0,6 cm çapında tubası bulunan 2x1,5x1 cm boyutlarında sol taraf over. Kesitinde korpus luteum ve korpus albikanslar izlenmiştir. Ayrıca sol adneks komşuluğunda overle ilişkisi bulunmayana 2x1,5x1 cm boyutlarında sert kıvamda nodüler lezyon dikkati çekmiştir. (FR1-4: Polip, endometrium: Bir kısmından 4 parça 4 kasette; FA1-2: Serviks Bir kısmı 2 parça 2 kasette; FA 3: Polip sap kısmı Tamamı 1 parça 1 kasette; FA 4-5: Polip Bir kısmı 4 parça 2 kasette; FA6-9: Endometrium Bir kısmı 4 parça 4 kasette, FA10: Sağ tuba Bir kısmı 2 parça 1 kasette, FA11-12: Sağ over Tamamı 2 parça 2 kasette, FA13: Sol tuba Bir kısmı 2 parça 1 kasette, FA14-15: Sol over Tamamı 2 parça 2 kasette, FA16: Sol adneks yanı nodüler lezyon Tamamı 2 parça 1 kasette, YP1-5 polip tamamı; YP6-40; Tuba ve endometrium, tamamı 34 kasette takibe alındı).

HİSTOKİMYA/İMMÜNOHİSTOKİMYA
İmmünohistokimyasal boyalar: FA-16 nolu bloğa: CK7, EMA, Pax8, NapsinA, P504S, WT1, ER, p53, Kalretinin, D240, Vimentin, CK5/6, CA9, SALL4, CDX2, CK20, PR, CD30, OCT4, Glypican3, PanCK, AFP, YP-4 nolu bloğa p53, pax8, p16, ER, WT1

TANI
Total histerektomi + bilateral salfingo-ooferektomi materyali;
SERVİKS: KRONİK SERVİSİT, SKUAMÖZ METAPLAZİ, NABOTH KİSTLERİ
KORPUS: SEROZ KARSİNOM (ENDOMETRİAL POLİP ÜZERİNDE), YOLK SAC TÜMÖRÜ İNFİLTRASYONU (SEROZADA), ATROFİK ENDOMETRİUM
SAĞ-SOL OVER: YOLK SAC TÜMÖRÜ İNFİLTRASYONU
SAĞ-SOL TUBA: YOLK SAC TÜMÖRÜ İNFİLTRASYONU
SOL ADNEKS YANI KİTLE: YOLK SAC TÜMÖRÜ

YORUM
- Seröz karsinom polip yüzeyinde 6 mm çapında bir odakta izlenmiştir. Lenfovasküler ve perinöral invazyon görülmemiştir.
- Yolk sac tümörü sol adneks yanında izlenen nodüler lezyonda, tüm uterus serozasında, tuba ve over yüzeylerinde yaygın olarak izlenmektedir.
- Adneks yanında overden bağımsız olarak izlenen tümöre uygulanan immünohistokimyasal çalışmada EMA, p504S, SALL4, Glypican3, pansitokeratin ile (+), sitokeratin7, CA9, CDX2, AFP ile fokal (+), Pax8, NapsinA, WT1, östrojen, p53, kalretinin, D240, vimentin, sitokeratin5/6, sitokeratin20, progesteron, CD30, OCT4, östrojen ile (-) ekspresyon izlenmiştir.
- Seröz karsinom odağında ise p16 ve pax 8 ile (+), ER ve WT-1 ile (-) eskpresyon izlenmiştir, p53 mutanttır.
- Aynı hastaya kayıtlı 42762/24 protokol numaralı karaciğer üstü ve subdiafragmatik tümöral doku ile diğer peritoneal odaklarda aynı morfolojide tümör izlenmiştir.

FROZEN TANI
ENDOMETRİUM:BENİGN

Uzm.Dr. SÜMEYYE KOZACIOĞLU
Patoloji Uzmanı
Dip.Tescil No: 145740

hastada seröz endometrium kanseri ve yolc sac tümörü birlikteliği mevcuttur.

SS-119 [Onkoloji]

Uterine Inversion in Endometrial Cancer Case Report

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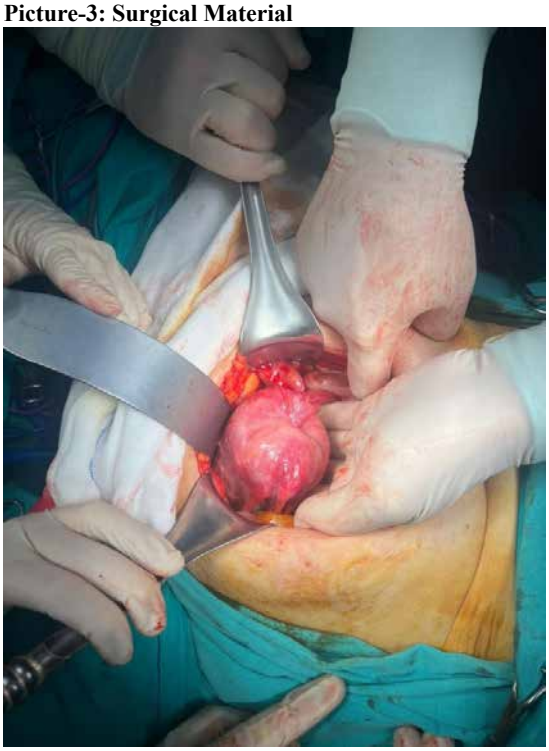
Uterine inversion is a condition characterized by the partial or complete inversion of the fundus towards the endometrial cavity (1). Although it frequently occurs as an acute complication of birth, it also rarely occurs as a result of an endometrial or myometrial mass due to non-puerperal causes (2). Uterine inversions that occur in the non-puerperal period mostly occur as chronic cases. Non-puerperal uterine inversion usually occurs in the third decade and later. The most common etiological cause is tumor lesions (3). Factors causing tumor-induced uterine inversion; It is stated as tumor size, uterine region where the lesion is located, thickness of the tumor pedicle, presence of cervical dilatation and thin uterine wall (5-6). An 81-year-old patient applies to our outpatient clinic with a complaint of vaginal bleeding that has been going on for 2 months. When the patient's detailed anamnesis was taken, she stated that she had been in menopause for 35 years, had never been pregnant or given birth before, and had been changing 6 pads a day for 2 months due to this bleeding. The patient has heavy menstrual bleeding during vaginal sterile speculum examination. At the same time, approximately 3 cm of tumor formation is observed in the endocervical canal. In the transvaginal ultrasonography of the patient, the size of the uterus has increased and the endometrium is observed irregularly. Bilateral ovaries could not be evaluated clearly. Endocervical curettage and biopsy were taken from the patient. The patient underwent total abdominal hysterectomy + bilateral salipngoophorectomy + pelvic-paraaortic lymph node dissection + total omentectomy + cytology. Frozen examination sent from the patient intraoperatively was reported as high grade endometrial adenocarcinoma. The patient's final pathology was endometrial adenocarcinoma (Endometrioid type) Grade 3. As a result, non-puerperal uterine inversion is a very rare complication. It most commonly develops due to tumoral lesions. It is important to know this complication, which obstetricians are very unlikely to encounter when looking at the literature, and to identify it radiologically. Typically, keeping magnetic resonance imaging findings in mind will increase the chances of early intervention of this clinical entity

Keywords: uterin inversion, non-puerperal, endometrial cancer, position, reduction

Picture-1: Surgical Material

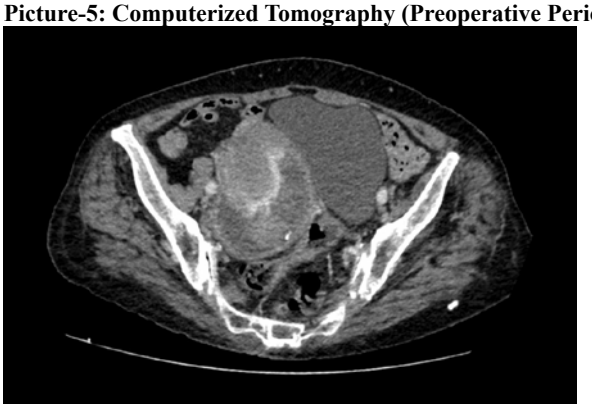
Picture-2: Surgical Material

Picture-3: Surgical Material

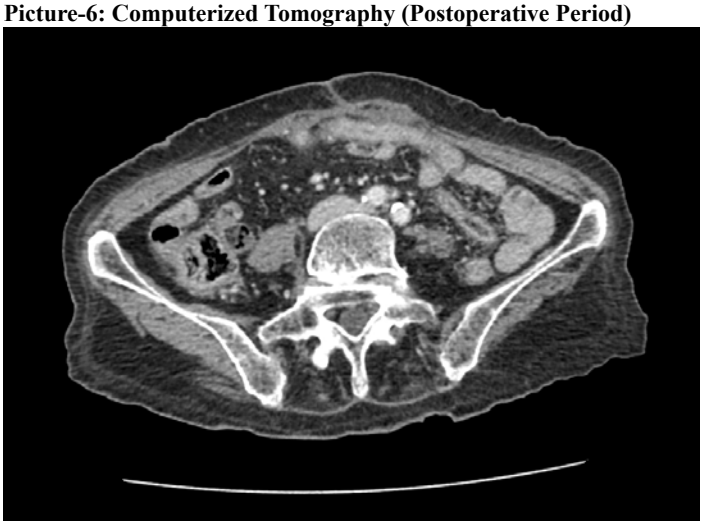


Picture-4: Surgical Material

Picture-5: Computerized Tomography (Preoperative Period)



Picture-6: Computerized Tomography (Postoperative Period)



SS-120 [Onkoloji]

A rare case: Aggressive angiomyxoma

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Aggressive angiomyxoma is a very rare soft tissue tumor that originates in the pelvic and perineal area, especially in women of reproductive age. Although it is classified as benign in the 2020 World Health Organization (WHO) classification, aggressive local growth and frequent recurrences are observed. Preoperative diagnosis is difficult due to the non-specificity of the complaints, symptoms, and imaging findings. Surgical excision is the preferred method of treatment. Hormonal therapy and radiotherapy may be considered as alternative adjuvant treatments.

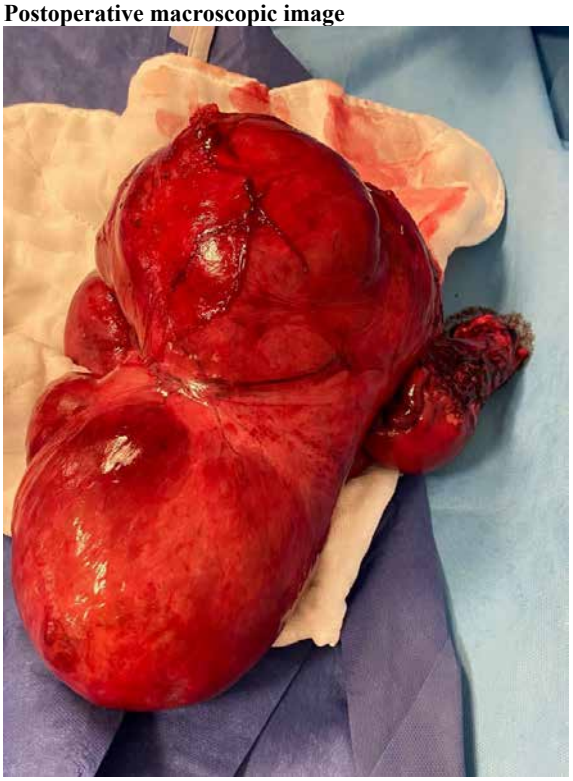
Case report: A 36-year-old female patient presented to our clinic complaining of rapid growth of her abdomen and shortness of breath for 1 month. During a bimanual examination, a mass was palpated that is thought to be uterine in origin and extended to the xiphoid, causing a 4 cm dilatation of the cervix. Thoracic and abdominal computed tomography revealed a 29*23 cm heterogeneous mass consisting of mostly non-contrasting cystic areas associated with the uterus. Exploratory laparotomy revealed a mass that started at the cervix-lower uterine segment level, covered the entire corpus, and extended to the ligamentum latum, parametriums, and rectovaginal space. The patient, who had no desire for fertility, underwent a hysterectomy and a bilateral salpingectomy. Histopathologic examination revealed an aggressive angiomyxoma of uterine origin. It was reported that the tumor did not persist in the surgical margins. Immunohistochemical staining revealed that desmin, SMA, ER, and PR were positive.

Discussion: Aggressive angiomyxoma is a very rare tumor. The most common location (32%) is the vulva, but it can also originate from the pelvic cavity, vagina, or perineum. Estrogen and progesterone receptor positivity is also detected in almost all cases and forms the basis for hormone therapy as a treatment option. The treatment of locally aggressive tumors is surgical excision. Recurrence rates of between 20% and 71% are reported in the literature. The time to recurrence can range from 1 month to 20 years. Although the disease is defined as non-metastatic, 2 cases of distant metastasis and death from the disease have been reported in the literature. There is insufficient data to show that positive surgical margins increase disease recurrence. Therefore, radical interventions that deprive the patient of the chance of fertility or reduce her quality of life should be avoided in order to preserve negative surgical margins. Post-operative medical treatment and regular, long-term follow-up care are very important to reduce the recurrence rate. Hormone therapy can reduce the recurrence rate, but studies are still needed on how long it should be used. Although radiotherapy has also been used as an adjuvant treatment method, its effectiveness is limited due to low mitotic activity. The use of hormone therapy prior to surgery may be beneficial as it shrinks the tumor if fertility is desired or radical surgery is avoided due to the size and location of the tumor.

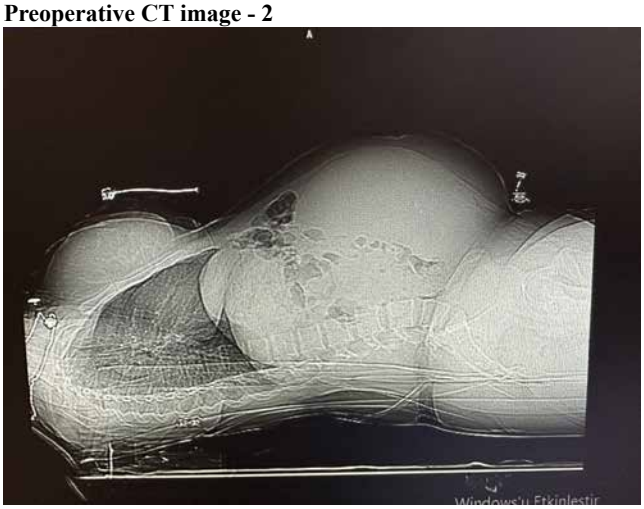
Summary: Aggressive angiomyxoma is a very rare tumor. Knowledge of the benefits of hormone therapy in the preoperative and/or postoperative phase protects patients from unnecessary surgical risks. Long-term and regular follow-up care is necessary.

Keywords: Aggressive-angiomyxoma, surgical resection, myxoma

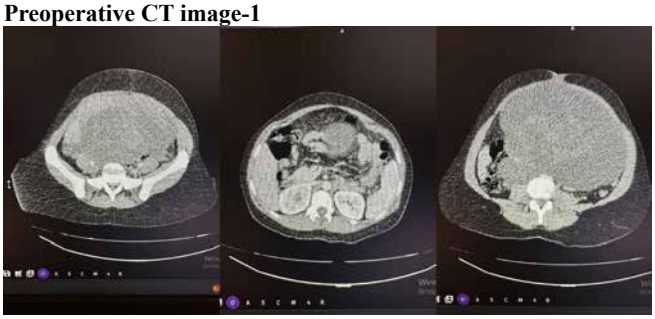
Postoperative macroscopic image



Preoperative CT image - 2



Preoperative CT image-1



SS-121 [Onkoloji]

A Case Report: Mesonephric-like Adenocarcinoma Arising from an Endometriotic Cyst in the Ovary

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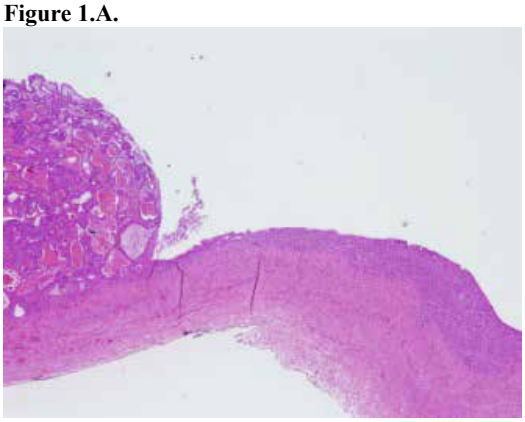
AIM: Mesonephric-like adenocarcinoma (MLA) is a rare gynecologic malignancy, and ovarian MLA is even less common compared to other forms of MLA. Unlike prototypical mesonephric adenocarcinomas, which originate from remnants of the Wolffian duct, recent studies suggest that MLA may arise from Müllerian structures. Here, we present a case of ovarian MLA associated with an endometriotic cyst, supporting a possible Müllerian origin.

METHOD: This report is presented as a retrospective case study. CASE: A 53-year-old female was referred to our clinic for a second opinion regarding an incidental adnexal mass. Transvaginal ultrasound revealed a 10 cm diameter solid-cystic right adnexal mass with solid components measuring 74 x 45 mm and 25 x 30 mm. Preoperative tumor markers were within normal limits. The patient underwent laparotomic hysterectomy and bilateral salpingo-oophorectomy. During surgery, the adnexal mass was evaluated by frozen section, initially reported as at least a borderline serous tumor. Based on this result, the surgery was completed with an omental biopsy. The patient experienced an uneventful postoperative recovery and was discharged without complications. Histopathological examination demonstrated a tumor characterized by tubular, glandular, and papillary patterns (Figure 1B). Immunohistochemical analysis showed positive staining for GATA3 (GATA binding protein 3)(Figure 2.A.), PAX8 (paired box gene 8) (Figure 2.B.), focal positivity for CD10, and wild-type staining for P53. Negative staining was observed for TTF-1 (thyroid transcription factor-1), ER (estrogen receptor)(Figure 3.A.), and PR (progesterone receptor) (Figure 3.B.). The tumor capsule was intact with areas of necrosis but showed no lymphovascular invasion. The final diagnosis was MLA(Figure 1.A.). Follow-up PET/CT and thoracic CT scans performed two months post-surgery revealed no metastasis. The patient's case was reviewed by the Gynecological Oncology Council and staged as FIGO stage IA (International Federation of Gynecology and Obstetrics, 2018). The patient was referred to medical oncology for adjuvant chemotherapy with paclitaxel and carboplatin. Genetic testing identified a KRAS (G12D) mutation, aligning with recent studies suggesting KRAS mutations as molecular hallmarks of uterine and ovarian MLAs. Currently, the patient is under surveillance with planned CT imaging.

DISCUSSION: Previously, it was presumed that MLA originated from Wolffian duct remnants; however, ovarian MLAs have shown associations with Müllerian-derived lesions, particularly endometriotic cysts. Endometrioid carcinoma (ECC) was considered in the differential diagnosis due to overlapping clinicopathological features. However, the presence of KRAS mutation and negativity for ER and PR facilitated differentiation from ECC. The grading system is not recommended due to its poor prognostic correlation despite a relatively benign microscopic appearance. CONCLUSION: MLA is a rare neoplasm commonly misdiagnosed as female adnexal tumors of Wolffian origin, STK11 tumors, or ECC. Prognostic data remain limited, making definitive conclusions about disease progression challenging. Optimal management strategies are not yet established. Further characterization of MLA is essential to enhance understanding of its origin, prognosis, and effective treatment approaches.

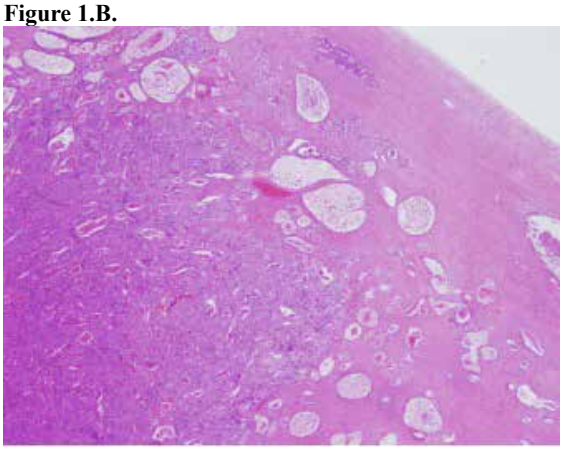
Keywords: Endometriotic Cyst, Mesonephric-like adenocarcinoma, Müllerian-derived lesions, Ovarian Mesonephric-like adenocarcinoma

Figure 1.A.



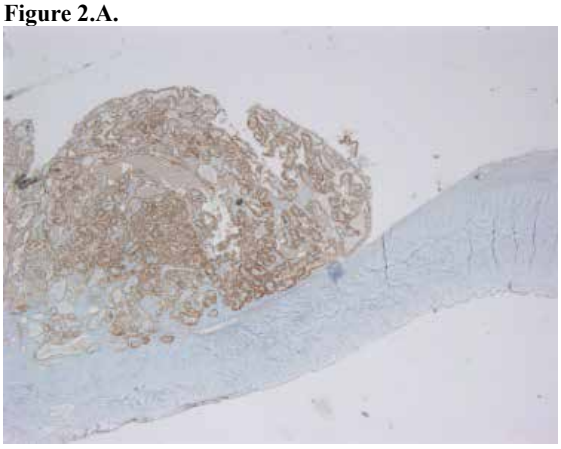
A. Endometriotic cyst with adjacent tumor tissue, hematoxylin and eosin staining, magnification x40.

Figure 1.B.



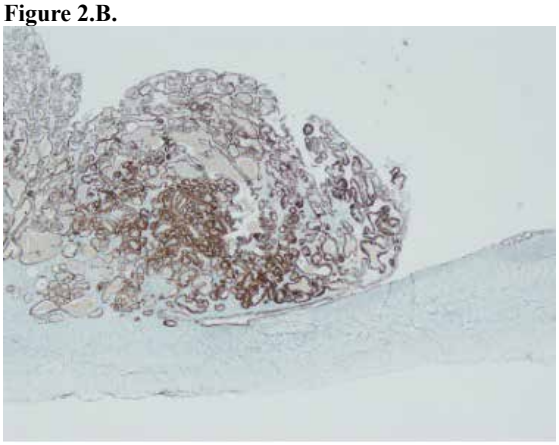
B. Pathological image demonstrating destructive tubular patterns and glands with luminal eosinophilic secretions, magnification x100.

Figure 2.A.



Immunohistochemical staining showing positive GATA3 expressions at magnification x100.

Figure 2.B.



Immunohistochemical staining showing positive PAX8 expressions at magnification x100.

Figure 3.A.

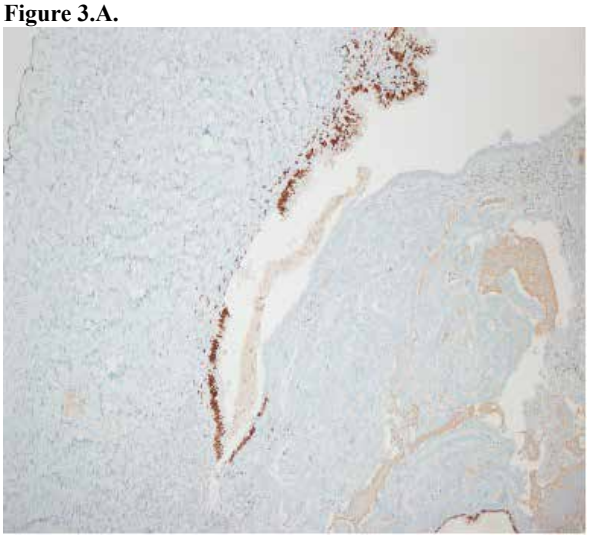


Figure 3. Immunohistochemical staining demonstrating negative ER staining in tumor tissue but positive staining in adjacent endometriotic cyst tissue, magnification x100.

Figure 3.B.

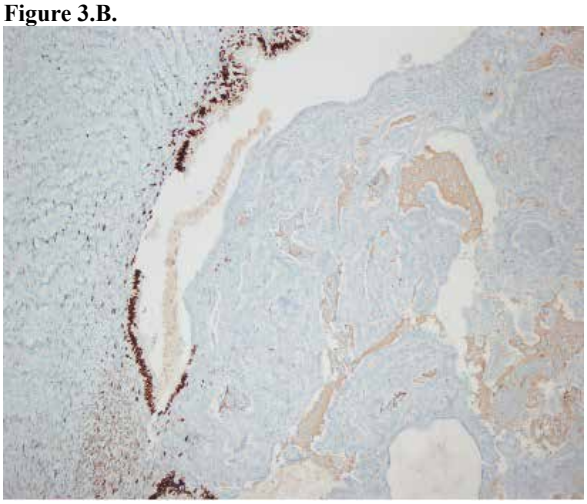


Figure 3. Immunohistochemical staining demonstrating negative PR staining in tumor tissue but positive staining in adjacent endometriotic cyst tissue, magnification x100.

SS-122 [Onkoloji]

Growing Teratoma Syndrome: A Rare Clinical Scenario from Diagnosis to Treatment

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INTRODUCTION: Ovarian germ cell tumors (OGCTs) are rare neoplasms that primarily affect young women and often consist of mixed histological subtypes. These tumors generally respond well to

chemotherapy, significantly improving patient outcomes. However, a rare phenomenon known as Growing Teratoma Syndrome (GTS) can develop either during or after treatment.

GTS is characterized by the enlargement of mature teratomatous masses despite the normalization of tumor markers and the administration of appropriate chemotherapy. This syndrome is particularly important to recognize because, unlike other germ cell tumor components, GTS does not respond to chemotherapy or radiotherapy. Instead, the only effective treatment is complete surgical excision. If left untreated, these enlarging masses can lead to complications such as mass effect, compression of surrounding structures, or even malignant transformation.

In this report, we present a rare case of stage III mixed germ cell tumor of the ovary complicated by GTS after chemotherapy. This case highlights the importance of early diagnosis and surgical intervention in managing GTS.

CASE: A 22-year-old woman underwent surgical staging at our institution, and the final pathology confirmed a FIGO stage III mixed germ cell tumor of the ovary, composed of: %40 mature teratoma, % 30 yolk sac tumor, %25 dysgerminoma, % 5embryonal carcinoma Fertility-preserving surgery was performed. Preoperative tumor markers were elevated: AFP: 3,000 ng/mL, β-hCG: 917 IU/L, CA-125: 163 U/mL

The patient then received four cycles of BEP (bleomycin, etoposide, cisplatin) chemotherapy, which she tolerated well. Following chemotherapy, her tumor markers normalized: AFP: 0.9 ng/mL, β-hCG: 0.2 IU/L

Four months after completing treatment, MRI revealed multiple intra-abdominal cystic implants. However, tumor markers remained within normal limits. Given the concern for GTS, a laparotomy was performed. Multiple implants were identified on the pelvic peritoneum, diaphragm, and colon mesentery, and all visible lesions were surgically removed. Histopathological examination of the resected specimens confirmed the presence of mature teratoma without any malignant components, leading to the diagnosis of Growing Teratoma Syndrome (GTS). The patient has remained under regular follow-up with no evidence of recurrence, and her current disease-free survival is 33 months.

CONCLUSION: Although rare, Growing Teratoma Syndrome (GTS) should always be considered in patients with enlarging residual masses despite normalized tumor markers after chemotherapy for ovarian germ cell tumors. Since GTS does not respond to further chemotherapy or radiotherapy, early recognition and complete surgical excision are critical for preventing complications.

This case highlights the importance of long-term follow-up, as delayed diagnosis may lead to unnecessary chemotherapy or complications from tumor growth. A multidisciplinary approach involving oncologists, radiologists, and surgeons is essential for ensuring the best possible outcome for these patients.

Keywords: Delbulking Surgery, Fertility Sparing Surgery, Growing Teratoma Syndrome, Germ Cell Tumor, Ovarian Immature Teratoma,

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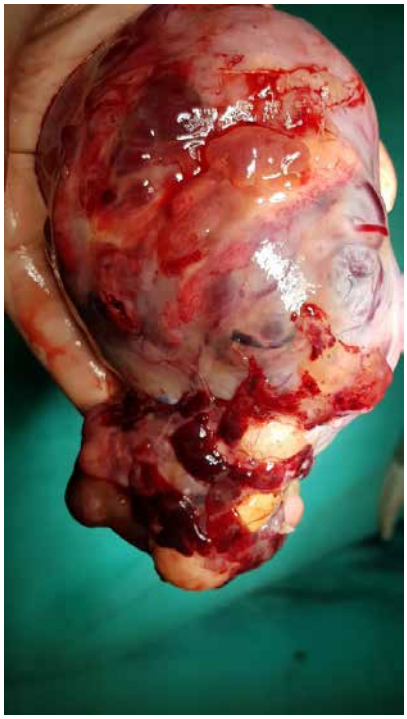

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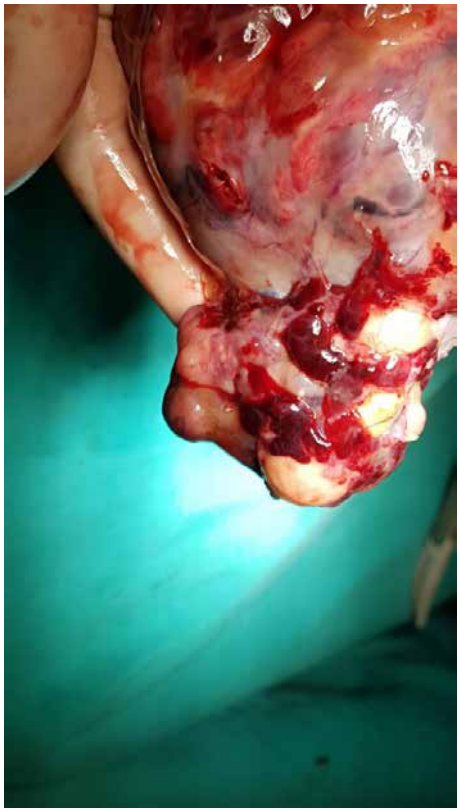

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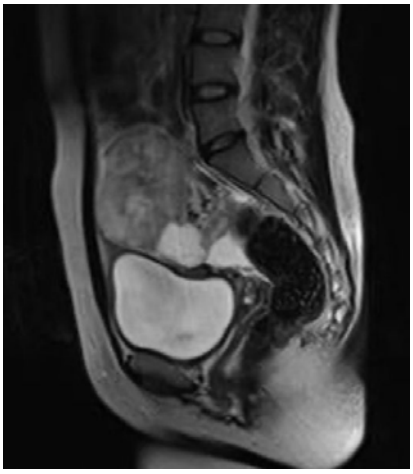

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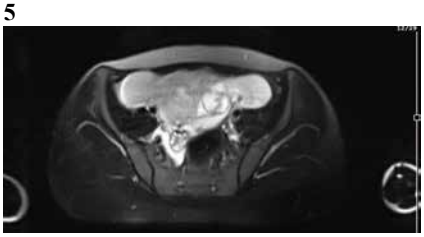

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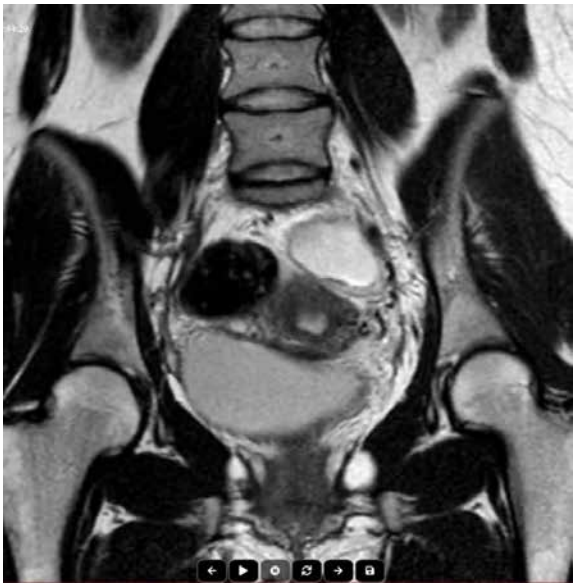

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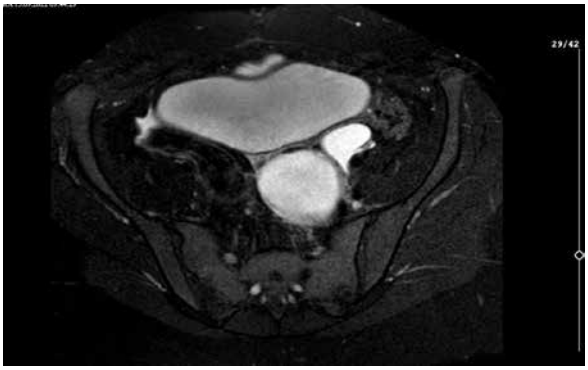

09/2022

SS-125 [Jinekoloji Genel]

Evaluation of oropharyngeal and anal swab samples in patients with HPV positivity

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[3]Gaziantep University
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OBJECTIVE: Human papillomavirus (HPV) positivity is associated with cervical, oropharyngeal, and anal cancers. There is insufficient data in the current literature regarding the effectiveness of obtaining oropharyngeal and anal swabs from patients with HPV positivity is an effective method for detecting potential pathologies.

MATERIALS-METHODS: Patients whose pathology results are reported as cervical intraepithelial neoplasia (CIN) 1, CIN 2, and CIN 3, are recruited. We aimed to evaluate HPV-positive women presenting to the Obstetrics and Gynecology clinic, whose cervical pathology results were reported as CIN 1, CIN 2, and CIN 3, by collecting oropharyngeal and anal swab samples. A total of 30 women of reproductive age, who consented to participate, were included in the study. The results of this screening method's effectiveness were presented. RESULTS: In examining HPV positivity through anal samples, 20 patients were HPV positive (66,7%). The types of HPV showed variability. In examining oral samples, only 2 patients were HPV positive (6,7%). Both of the patients had HPV 16, while one had an accompanying type. CONCLUSION: Future larger-scale studies will determine whether obtaining oral and anal swab samples in patients with HPV positivity will alter clinical management.

Keywords: Anal, cervical, human papillomavirus, oropharyngeal, screening

SS-126 [Jinekoloji Genel]

Atypical Endometrioma

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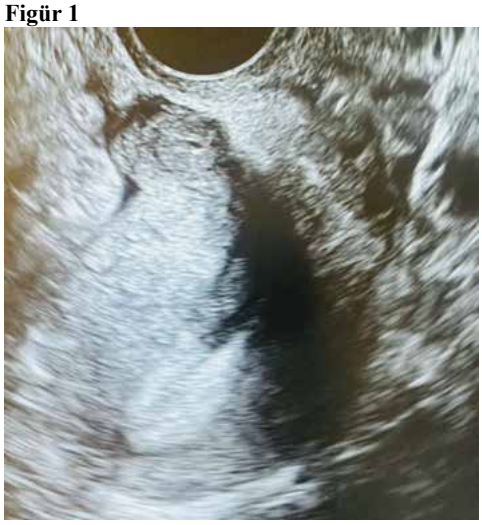
INTRODUCTION: Endometriosis is a common chronic disease characterized by the growth of endometrial glands and stroma outside the uterine cavity. Although endometriosis is a widespread and benign process, ectopic endometrial tissue and the resulting inflammation can cause dysmenorrhea, dyspareunia, chronic pain, and infertility. Lesions are typically found in the pelvis but can occur in multiple locations, including the intestines, diaphragm, pleural cavity, and abdominal wall. Cesarean scar endometriosis is a type of extra-pelvic endometriosis that develops due to the implantation of endometrial cells at any location along the previous cesarean section incision, including the skin, subcutaneous tissue, abdominal wall muscles, intraperitoneal region, and uterine scar (1). Endometrioma is a well-defined cystic mass of endometriosis and ectopic endometrial tissue (2). Although ultrasound is the most commonly used initial imaging method, the findings are nonspecific. The detection of hyperintense (hemorrhagic) foci on T1 fat-suppressed sequences strongly supports the diagnosis when evaluated using MRI (magnetic resonance imaging), which is the most sensitive imaging modality for cesarean scar endometriosis. The nonspecific nature of masses such as the endometrioma observed in the uterine scar line in our case may lead to misdiagnosis and delays in treatment.

Case: A 28-year-old patient, gravida 2, para 2, with a history of two previous cesarean sections, presented to our clinic with menstrual irregularities. The patient had bleeding episodes lasting 15 days every 28 days. Ultrasonographic examination revealed a heterogeneous lesion measuring approximately 18 × 15 mm, extending into the pelvic fat planes beyond the uterine serosa and associated with the cesarean scar. (Endometriotic nodule? Atypical endometrioma?). The described endometriotic focus appeared adherent to the left ovary and adjacent colonic loops. MRI findings showed a lesion at the level of the C-section scar, in connection with the uterine cavity, appearing hyperintense on T2-weighted sequences, cystic in density, and showing intermediate intensity on T1-weighted images without contrast enhancement or diffusion restriction. A retraction appearance was noted between the lesion and adjacent bowel loops, suggesting an endometriotic nodule. Considering the homogeneous content and signal characteristics of the lesion, atypical endometrioma was suspected. The patient was advised to undergo surgery due to her symptoms and imaging findings, but she declined surgical intervention. Instead, oral contraceptives containing dienogest were prescribed. CONCLUSION: Non-ovarian endometriomas developing after gynecological surgeries (e.g., cesarean section, myomectomy, or hysterectomy) may be more common than previously thought. These endometriomas can present as painful masses in the abdominal wall, cesarean scar, or other extra-ovarian locations. Diagnostic tools such as ultrasound or MRI can help differentiate endometriomas from other postoperative complications, such as hernias or abscesses. Early diagnosis is crucial to prevent delays in management, which may include surgical excision or hormonal therapy.

Keywords: Endometrioma,atypical location,uterine scar

Figür 1



USG Image

Figür 2

Şekil 1 : Uterus(kırmızı ok) retrovert olarak izlenmekte olup, C/5 hattı ile ilişkili T2A serilerde hiperintens sinyal değişikliği gösteren nodüler lezyon(mavi ok) izlenmektedir.

MRI Image

SS-127 [Jinekoloji Genel]

Ovarian Torsion Secondary to Giant Paratubal Cyst: A Case Report

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INTRODUCTION: Paratubal Cysts are adnexal masses originating from paramesonephric, mesonephric or mesothelial origins. Paratubal cysts constitute approximately 10% of all adnexal masses. They are often unilateral and benign. They usually don't exceed 8 cm in size, in rare cases the maximum diameter of the cyst may exceed 15 cm. They are mostly asymptomatic. However, sometimes they may cause complications such as cyst rupture and rarely adnexal torsion. CASE PRESENTATION: A 36-year-old obese woman who had a cesarean section presented to the emergency department with complaints of groin pain that started 4 days ago and gradually increased. At the time of presentation, the patient's heart rate was 110/min, she had no fever and had increased pelvic tenderness in the right lower quadrant. Beta-HCG levels and C-reactive protein were negative. The patient, who had no surgical history other than a cesarean section, had a "cystic structure extending 141 mm towards the right adenexium at the level of the umbilicus" in her pelvic tomography report. In transvaginal USG, the uterus was anteverted, the endometrium thickness was 6 mm, and the left ovary was normal. There was 15 cm well-circumscribed serous cystic structure in the right adnexal area, and the right ovary had increased in size. We decided to perform an operation on the patient and started the operation with diagnostic laparoscopy. We saw that the giant cyst was not of ovarian origin, but had torsioned the ovary 7 full turns. After detorsioning the ovary, we proceeded to laparotomy and observed that the cyst was paratubal. We terminated the operation after performing a right salpingo-oophorectomy. We discharged the patient with recovery 3 days after the operation. Pathology results reported paratubal cyst and congested tube.

DISCUSSION: In most cases of paratubal cyst, no clinical symptoms are observed. However, sometimes patients may present with lower abdominal pain, nausea and vomiting. Physical examination shows peritoneal irritation findings and sometimes fever, which are similar to ovarian torsion. In differential diagnosis, other causes of acute abdomen such as ovarian cyst rupture or torsion, ruptured ectopic pregnancy, acute appendicitis, renal colic, intestinal pathologies should be considered. In cases presenting with severe abdominal pain, considering the possibility of ovarian torsion is important in terms of shortening the intervention process and preventing organ or function loss. In our case, laparotomy was preferred due to the size of the cyst. It could have been decided to perform laparotomy after laparoscopic aspiration of the cyst or to remove it directly laparoscopically. However, intraperitoneal spread of cyst components could have occurred. In this case, if the cyst is malignant, there could be tumor seeding in the peritoneal cavity or paracentesis tract. In this case we performed salpingo-oophorectomy because we saw that ovarian blood flow did not return when we switched to laparotomy.

CONCLUSION: Paratubal cysts are rare cases and are mostly asymptomatic. In young women, suspicion of adnexal torsion should be considered in the presence of severe abdominal pain. In this case, urgent surgical treatment is required to prevent deterioration of ovarian function and fertility

Keywords: paratubal cyst, laparotomy,ovarian torsion

FİGURE 1: CT scan demonstrating the largest dimensions of the cyst

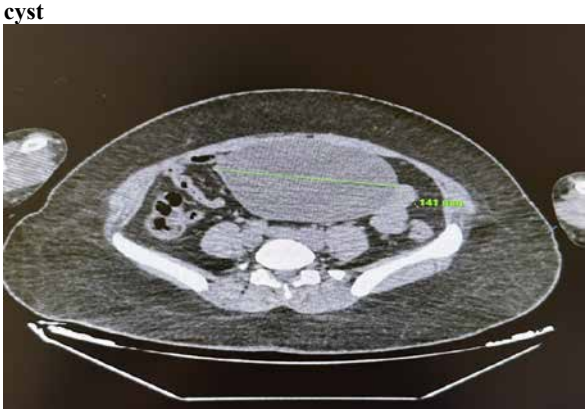

FİGURE 2: Intraoperative image showing the adnexa on a simple paratubal cyst.

FİGURE 3: Post cystectomy of paratubal cyct and over

FİGURE 4: Post cystectomy of paratubal cyct and fimbriae

SS-128 [Jinekoloji Genel]

Cesarean Scar Endometriosis: Legal Processes And Physician Liability

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INTRODUCTION: The number of cesarean deliveries is steadily increasing in obstetrics and gynecology, and complications associated with these procedures occasionally become subjects of legal proceedings. Cesarean scar endometriosis, a rare but significant condition, can lead to severe symptoms and is often perceived by patients as a result of surgical negligence, exposing physicians to unjust complaints. In this case report, a patient with post-cesarean scar endometriosis is discussed, along with the legal challenges physicians may encounter and the expectations of patients.

CASE: A 28-year-old female with no additional medical conditions and an uncomplicated pregnancy was scheduled for an elective cesarean section at 39 weeks of gestation due to a previous cesarean delivery. The operation was completed without complications, resulting in the birth of a healthy infant weighing 3300 grams. The patient was discharged in good health on the 48th postoperative hour. Two years after the cesarean section, the patient presented to the general surgery outpatient clinic with complaints of severe abdominal pain, particularly during menstruation. A superficial ultrasound revealed a 2x2 cm solid lesion located on the left side of the incision line, and the CA-125 level was measured at 55. Surgical removal of the suspected lesion was performed, and the excised tissue underwent histopathological examination. The pathology report identified a 4x4.5x4 cm firm, fibrotic mass with areas of adipose tissue, cystic spaces, and hemorrhagic regions. The definitive diagnosis was confirmed as cesarean scar endometriosis. Upon receiving the pathology results, the patient filed a complaint claiming that a "foreign body was left inside her" during the cesarean section and sought legal action. However, histopathological analysis confirmed that the excised tissue was not a foreign object but fibrotic tissue containing endometriotic foci.

DISCUSSION: Cesarean scar endometriosis is a known complication of uterine incisions performed during cesarean sections and other gynecological surgeries. However, patients often receive misleading guidance, leading to unjustified legal claims and financial compensation demands against physicians. The increasing frequency of malpractice lawsuits encourages a defensive approach to medical practice, impacting the physician-patient relationship. The ease of initiating legal proceedings subjects healthcare providers to unnecessary stress and reputational damage. In such cases, it is crucial for physicians to assert their legal rights and consider counterclaims against baseless allegations. This case underscores the importance of recognizing post-cesarean complications and highlights the need for physicians to take precautions against unfounded accusations. Proper patient education on medical complications and meticulous record-keeping during surgical procedures are essential for protecting both patients' rights and physicians' professional integrity.

CONCLUSION: Obstetricians and gynecologists frequently face unjust complaints related to surgical complications. In rare but clinically significant cases such as cesarean scar endometriosis, raising patient awareness plays a critical role in safeguarding physicians' legal and professional security. Physicians should provide comprehensive patient education and be prepared for potential legal challenges. This case report aims to emphasize the importance of legal preparedness for physicians and the necessity of accurate patient information regarding surgical complications.

Keywords: Cesarean Scar Endometriosis, Medical Liability, Legal Proceedings

SS-129 [Perinatoloji]

Rare case of uniparental chromosome 19 dysomy

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INTRODUCTION: Uniparental dysomy (UPD), a condition that has been recognised since the 1980s, occurs when all or part of a homologous chromosome pair is transmitted from a single parent. This condition does not conform to Mendelian inheritance principles, and is therefore termed maternal UPD if both homologous chromosomes are inherited from the mother, and paternal UPD if they are inherited from the father. A variety of mechanisms have been identified that cause UPD. The most widely recognised mechanism is that of meiotic errors. An error in meiosis I leads to heterodisomy, whilst an error in meiosis II leads to isodisomy. Other, less prevalent mechanisms include self-mapping of monosomic homologues, loss of one of the trisomic homologues, mitotic correction of marker chromosomes, correction of trisomies due to Robertson type translocations and mosaicism in the placenta has been identified. Chromosome 19 has several unique features. Compared to other chromosomes, UPD 19 was found to have a higher density of repeat sequences and higher GC content. The reason why UPD 19 is rarely seen in the literature may be due to the fact that it has intrauterine lethal consequences

or that it cannot be reported due to the lack of spesific phenotypes. Paternal UPD 19 syndrome is generally linked to growth retardation. Studies of specific genes located on chromosome 19 revealed the following observations. The deletion of PEG3 in mice has been demonstrated to result in growth retardation. Consequently, the presence of two paternal copies of PEG3 has been linked to early-onset IUGR. Furthermore, loss of the CTNNB1 gene has been linked to mental retardation and microcephaly. Finally, homozygosity for a mutation in the RYR1 gene has been linked to congenital core myopathy. MATERIAL-METHOD: A 28-year-old female patient with a first pregnancy was referred to our clinic with a diagnosis of intrauterine growth restriction (IUGR) when she was 20 weeks and 3 days pregnant according to her last menstrual period. The patient had no significant medical history, nor any co-morbidities and not undergone screening tests of her own accord. Ultrasonographic examination revealed several anomalies, including mild dysmorphic facial features and polyhydramnios. Also it revealed that biometric measurements of fetus consistent with a gestational age of 17-18 weeks. RESULTS: Amniocentesis was recommended to the patient and performed after her consent. Following the reporting of the amniocentesis result as UPD 19, it was ascertained through chromosome analysis of the parents that this UPD was of paternal origin. The family was provided with genetic counselling. The available options for further management and termination were presented in detail. Following the family's request for termination and the recommendation of the Genetics Department, the procedure of fetoscyte was performed. CONCLUSION: UPD has been identified on almost every chromosome and it is imperative to consider the potential role of UPDs in diseases with unexplained etiology. Consequently, the significance of invasive genetic procedures should not be underestimated, even in cases where findings are non-specific, such as early-onset IUGR.

Keywords: Uniparental dysomy, early-onset intrauterine growth restriction, invasive genetic diagnosis

VİDEO BİLDİRİLER

VS-01 [Endoskopi]

A challenging series of first-trimester abortions complicated by placental invasion abnormality

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Placenta accreta is a potentially life-threatening condition that can complicate a first-trimester abortion, leading to serious vaginal bleeding. This report details the fertility-preserving management of three cases with retained placenta following first-trimester pregnancy loss, treated using a hysteroscopic approach.

INTRODUCTİON: Placenta accreta (PA) is characterized by abnormal placental invasion into the myometrium and, in severe cases, reaching the uterine serosa. We report three pregnancies complicated by first-trimester placental invasion abnormalities, presenting with moderate vaginal bleeding and an unknown uterine mass within the myometrium following dilation and curettage.

Case Reports

Case 1: A 38-year-old, G5 P0 A4 woman with a history of uterine septum resection by hysteroscopy, conceived via IVF-PGD due to a hereditary chromosomal translocation.

Case 2: A 27-year-old, G3 A1 woman with a previous C-section, achieved pregnancy through intrauterine insemination, resulting in fetal loss at 10 weeks.

Case 3: A 22-year-old woman referred with missed abortion at 6 weeks of gestation.

The patients underwent dilation and curettage. Each presented to our clinics with pain and vaginal bleeding approximately one month later. Transvaginal ultrasonographies revealed well-defined echogenic masses without vascular flow in the uterine wall (1 case in the posterior wall and 2 cases in the fundal area). Their serum Beta-HCG levels were all under 0.01 mIU/mL at the time of admission. Placental invasion abnormality was suspected as myometrial invasion was visualized. All patients underwent conservative treatment and were successfully treated by hysteroscopy. Retained placental tissue was removed using a bipolar resectoscope loop (26 Fr.) under concurrent transabdominal ultrasound guidance. The pathology specimens confirmed the presence of necrotic and inflammatory placental tissue. Surgical resolution and an uneventful postoperative course were recorded in all three cases.

Discussion: Although the presentation of PA in a first-trimester pregnancy is extremely rare, it holds clinical significance as it may lead to post-evacuation bleeding. The abnormal invasion pattern of placenta in PA leads to the failure of complete placental separation from the uterus at the time of dilatation and curettage. Retained placental tissue can become embedded within the uterine myometrium, resembling an unusual solid uterine mass. The main risk factor for PA is uterine scarring resulting from previous uterine surgeries such as cesarean section or other invasive procedures to the uterine wall. Assisted reproductive technology (ART) has also been reported as a risk factor for PA. The standardization of clinical diagnosis of PA in the first trimester has yet to be established. Likewise, the management of PA in such an early pregnancy is still challenging. Definitive surgical procedures, such as hysterectomy, are the most preferred non-conservative management option. Conservative management includes uterine artery embolization, transcatheter arterial chemoembolization, laparoscopic hysterotomy, and hysteroscopic resection of entrapped placental tissue.

Conclusion: Placental invasion abnormalities in early pregnancy may be associated with infertility or cause varying degrees of post-abortion bleeding. Conservative options should be considered, especially in patients desiring future fertility. Fertility preservation in such patients can be managed with hysteroscopic resection, as an alternative to hysterectomy.

Keywords: Placenta accreta, abortion, uterine neoplasm, hysteroscopy, fertility-sparing surgery

VS-02 [Jinekoloji Genel]

Laparoscopic abdominal cerclage

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AIM: To present two cases of cervical insufficiency successfully managed with laparoscopic abdominal cerclage following prior failed transvaginal cerclage, highlighting the feasibility and safety of this approach in both pregnant and non-pregnant patients.

METHODS: Two patients diagnosed with cervical insufficiency, both with a history of prior failed transvaginal cerclage, were selected for laparoscopic abdominal cerclage. One patient was non-pregnant at the time of surgery, while the second was 8 weeks pregnant. In both cases, the indication for transabdominal cerclage was established based on their obstetric history. A laparoscopic transabdominal approach was used to place a nonabsorbable Mersilene tape at the level of the internal cervical os following bladder dissection and exposure of the lower uterine segment. The tape was tied posteriorly with minimal uterine manipulation, and hemostasis was ensured before completion.

FINDINGS: Both procedures were successfully completed without intraoperative complications. The non-pregnant patient recovered uneventfully, was discharged on postoperative day one, and is currently 18 weeks pregnant with regular antenatal follow-up. The pregnant patient tolerated the procedure well, with confirmed fetal cardiac activity and no signs of uterine irritability or complications. Follow-up visits showed intact cerclages and satisfactory healing. Both patients continue antenatal care, with a cesarean delivery planned at term for the pregnant patient.

CONCLUSION: Laparoscopic abdominal cerclage is a valuable and safe surgical option for women with cervical insufficiency, particularly in cases with a history of failed transvaginal cerclage. It offers clear advantages, including reduced postoperative pain, shorter hospital stay, and faster recovery. Our cases demonstrate that, when performed by experienced surgeons with careful technique and minimal uterine

manipulation, laparoscopic cerclage is feasible in both pregnant and non-pregnant patients. Importantly, abdominal cerclage should be considered the next step in management for patients with clear indications based on prior obstetric history or anatomical factors, supporting its role as an effective strategy in selected high-risk populations.

Keywords: cerclage, abdominal, laparoscopic

VS-03 [Jinekoloji Genel]

Laparoscopic approach to mature cystic teratoma

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OBJECTIVE: To present a laparoscopic approach for the management of a unilateral mature cystic teratoma.

METHODS: This study involves a video presentation demonstrating the laparoscopic excision of a mature cystic teratoma.

RESULTS: A 27-year-old female patient was incidentally diagnosed with an ovarian cyst. Transvaginal ultrasonography (TVSUG) revealed an 8–9 cm cyst with dense echogenic content in the left ovary, suggestive of a dermoid cyst. The right ovary was normal, and no free fluid was detected in the abdominal cavity. The cyst was successfully excised via laparoscopy. Intraoperative findings confirmed the presence of a mature cystic teratoma with typical dermoid components. The total operative duration was 50 minutes.

CONCLUSION: Mature cystic teratoma is a common benign germ cell tumor occurring in women of reproductive age, often containing elements such as adipose tissue, teeth, and bone. Laparoscopic excision provides a minimally invasive and effective surgical approach, allowing complete cyst removal with favorable postoperative outcomes. This technique ensures optimal preservation of ovarian function while minimizing surgical morbidity, thus enabling patients to maintain a healthy reproductive and overall quality of life.

Keywords: Mature Cystic Teratoma, Laparoscopic Cystectomy, Ovarian Tumors, Minimally Invasive Surgery

VS-04 [Jinekoloji Genel]

Chronic pelvic pain caused by 15 years old needle

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52 years old patient presented with a complaint of chronic pelvic pain, the severity of which varied with position, for 3 years. Previously, she had repeated applications to urology and general surgery. The patient had 3 previous cesarean sections and umbilical hernia repair operations. Since TVUSG was normal, a contrast-enhanced computer tomography of abdomen was performed. A 3 cm long foreign body was observed on the inner surface of the anterior abdominal wall. Laparoscopy was performed for diagnostic purposes.

During exploration, an adhesive omentum piece was observed on the anterior abdominal wall. The adhesion was separated with sharp and blunt dissection. No foreign body appearance was observed on the uterus, bilateral ovaries, tubes and anterior abdominal wall. There were changes secondary to chronic inflammation on the omentum surface at the level of the transverse colon. The omentum piece separated from the anterior abdominal wall was examined again. A syringe needle was observed wrapped in omental tissue. The needle was removed.

Since the patient's last abdominal surgery was a cesarean section with umbilical hernia repair in 2009, it was thought that this surgery was the cause of the needle.

In the postoperative follow-up, the patient's pelvic pain complaint completely disappeared.

Keywords: Chronic pelvic pain,foreign body, laparoscopy

VS-05 [Endoskopi]

Single umbilical incision laparoscopic tubal ligation

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OBJECTIVE: The purpose of this study is to demonstrate the feasibility of laparoscopic tubal ligation through a single umbilical incision (procedure 1) in women with indications such as possible pelvic adhesions and cosmetic concerns, and to compare this technique with the technique using umbilical 10 mm and suprapubic 5 mm trocars (procedure 2).

METHOD: The first procedure was performed in 17 women with two 5 mm trocars inserted through a 1 cm umbilical incision using 4 mm or 5

mm, 30° optic and Ligasure. The results were compared with the second procedure performed to 102 women.

RESULTS: The mean operation time was longer in the first procedure than in the second procedure (24 min vs 11 min). In the first procedure, gas leakage from the fascia incision could not be prevented in one case, therefore the second trocar was placed suprapubically and the operation was completed. No complications were observed in the intraoperative or early postoperative period with either surgical procedure. The first procedure had better cosmetic results. CONCLUSION: Single umbilical incision laparoscopic tubal ligation can be considered as a cost-effective and accessible alternative to the single port laparoscopic surgery system. Compared with the second procedure, this technique may also reduce the risk of umbilical hernia and risk of injury in the presence of severe omental pelvic adhesion. Long operation time, low light intensity and restricted perspective are the limitations. Although these disadvantages, single umbilical incision laparoscopic tubal ligation appears to be safe to perform.

Keywords: Laparoscopy, single incision, tubal ligation

VS-06 [Obstetri Genel]

Ruptured Cesarean Scar Pregnancy at the End of First Trimester: A Case Report

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OBJECTIVE: This case report aims to highlight the crucial importance of rapid diagnosis and timely intervention in obstetric emergencies, specifically by detailing the diagnosis and management of spontaneous uterine rupture in early pregnancy. Uterine rupture occurring in the first trimester, though rare, can be a life-threatening complication, especially in patients with a history of uterine surgery. This case emphasizes the critical significance of prompt diagnosis and rapid treatment through the presentation of a patient admitted at 12 weeks and 5 days of gestation with lower abdominal pain and spotting.

METHOD: The preoperative, intraoperative, and postoperative management of a patient who underwent emergency surgery with preliminary diagnoses of uterine rupture and acute abdomen based on clinical and radiological findings was evaluated.

FINDINGS: A 26-year-old patient (G2P1) with a prior cesarean section presented to the emergency department at 12+5 weeks of gestation by her last menstrual period, reporting lower abdominal (pelvic) pain and spotting. Upon examination, the patient was normo-hypotensive and tachycardic. Laboratory investigations revealed a hemoglobin level of 7 g/dL. Ultrasonographic examination showed an intrauterine pregnancy consistent with 12+4 weeks, irregularity in the myometrium of the lower uterine segment, and significant free fluid in the abdomen, including Morrison's pouch, containing widespread clots. An emergency laparotomy was planned with preliminary diagnoses of acute abdomen and uterine rupture.

During laparotomy, approximately 3000 cc of blood and clots were evacuated. A full-thickness rupture along the previous cesarean scar line in the lower uterine segment was identified. Pregnancy tissue protruded through the rupture site, indicating progression of pregnancy outside the uterine cavity through the scar. Fetal and placental tissues were carefully removed. Following cleansing of the rupture area, the uterine defect was repaired using a double-layer vertical continuous suture technique, restoring uterine integrity. Throughout the operation, hemodynamic stabilization and coagulation support were achieved with transfusion of 4 units of packed red blood cells, 2 units of fresh frozen plasma, tranexamic acid, fibrinogen, Voluven, and 1 unit of platelets.

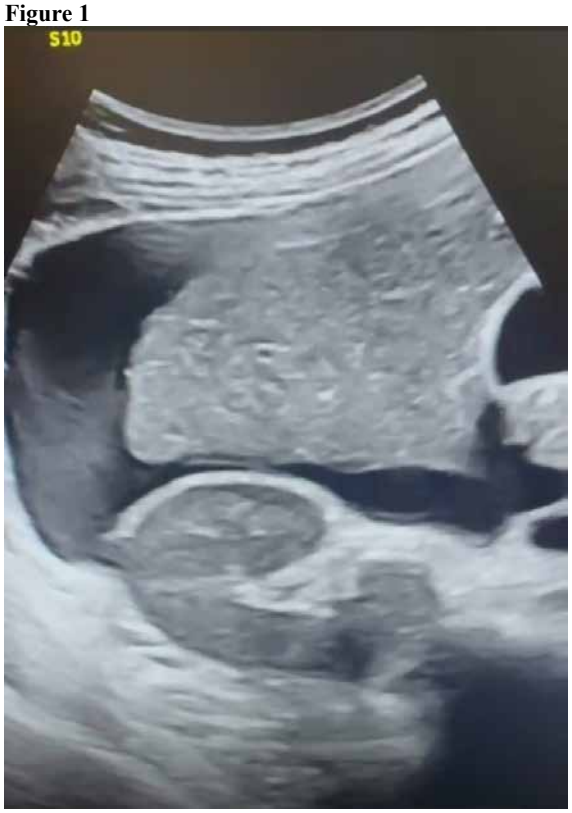
Postoperatively, the patient was admitted to the intensive care unit for close monitoring, demonstrating rapid improvement in vital signs. Control ultrasound indicated a normal uterine appearance with a myometrial thickness of 7 mm and no free fluid in the abdominal cavity. The patient was discharged in good condition.

CONCLUSION: Cesarean scar pregnancy (CSP) is a rare but increasingly reported condition, largely due to rising cesarean rates and improved diagnostic capabilities. While early diagnosis in the first trimester allows for conservative treatment, delayed detection significantly raises the risk of uterine rupture and severe hemorrhage.

Management should be tailored based on gestational age, clinical stability, and fertility considerations. In unstable cases, like ours, urgent surgical intervention is often required. This case emphasizes the importance of early recognition in women with prior cesarean deliveries presenting with pain or bleeding. Timely diagnosis and appropriate management are key to reducing maternal morbidity and preserving reproductive potential.

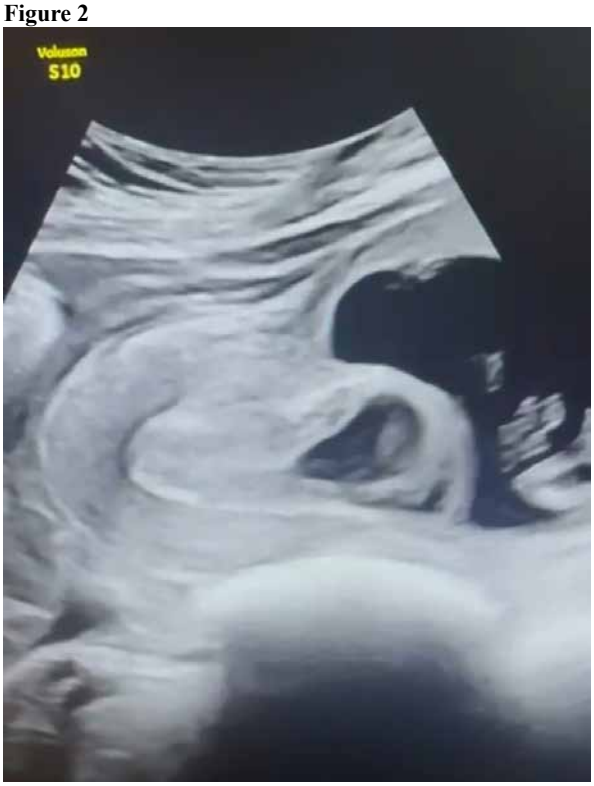
Keywords: Cesarean Scar Pregnancy,Early Diagnosis, Emergency Laparotomy, Hemoperitoneum, Uterine Rupture

Figure 1



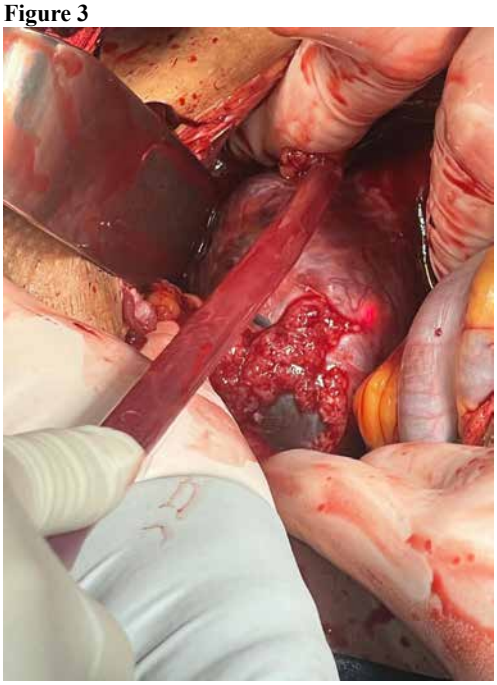
Free fluid observed in Morrison's pouch on transabdominal ultrasound.

Figure 2



The implantation site of the cesarean scar pregnancy on transabdominal ultrasound.

Figure 3

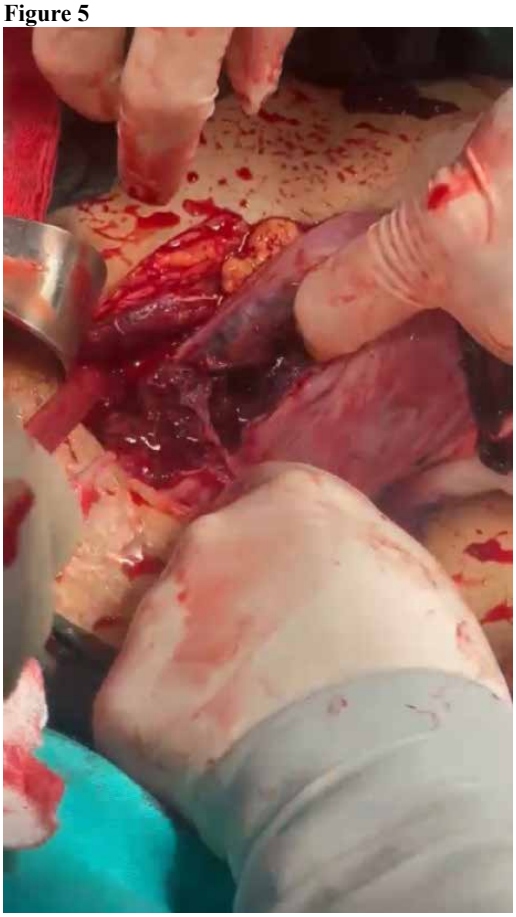


Gestational sac protruding through the ruptured cesarean scar site.

Figure 4

Fetus within an unruptured gestational sac.

Figure 5



Ruptured cesarean scar site

VS-07 [Ürojinekoloji - Rekonstrüktif cerrahi]

Laparoscopic modified Davydov procedure in a case of testicular feminization

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INTRODUCTION: Testicular feminization, also known as Androgen Insensitivity Syndrome, is a rare disorder causing a female phenotype due to a defect in the AR gene of the X chromosome, with a genotype of 46 XY.

CASE: This report describes the laparoscopic modified Davydov procedure performed to create a neovagina in a 25-year-old patient with Androgen Insensitivity Syndrome.

DISCUSSION: The laparoscopic modified Davydov procedure has been primarily mentioned in the literature for creating neovagina in cases of Rokitansky Mayer Kuster Hauser Syndrome, making our case the second reported instance.

CONCLUSION: The laparoscopic modified Davydov procedure was found to be successful both anatomically and functionally in our testicular feminization case.

Keywords: Androgen Insensitivity Syndrome, FSFI, Laparoscopic Modified Davydov Procedure, Neovagina, Testicular feminization

VS-08 [Endoskopi]

Vaginal management of an adolescent patient with OHVIRA syndrome via hysteroscopy

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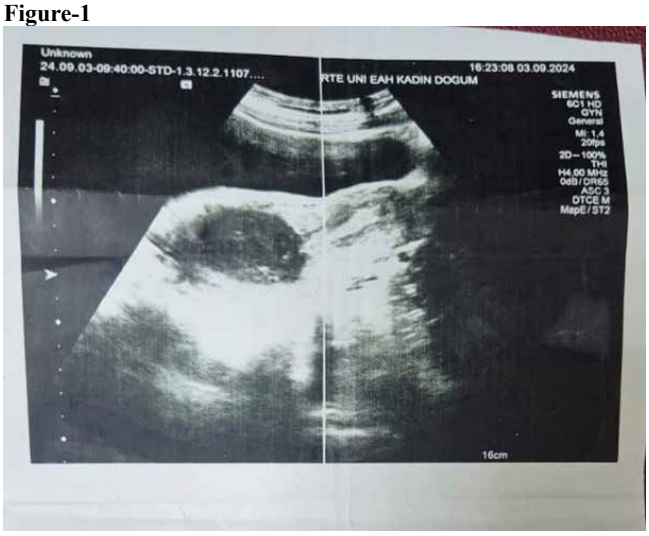
INTRODUCTION: OHVIRA syndrome(OS) is a rare congenital developmental anomaly of the female genitourinary system characterized by uterine didelphys, obstructed hemivagina, and ipsilateral renal anomaly. Patients usually remain asymptomatic, until they present with pelvic pain and mass due to blood accumulation in the obstructed hemivagina after menarche. Early diagnosis and surgical treatment of OS, is based on history, clinical findings, imaging modalities such as ultrasonography and magnetic resonance imaging (MRI) and direct visualization via vaginoscopy, hysteroscopy, and/or laparoscopy. Here, we report the surgical management of an adolescent patient with OS, diagnosed by pelvic ultrasonography and MRI.

CASE: A 13-year-old virgin patient was referred to us with preliminary diagnosis of a pelvic mass. A hypoechoic cystic mass measuring 56*31 millimeter associated with the endometrial cavity was observed on the pelvic ultrasonography (Figure-1). Hymen was annular on pelvic examination. The patient's menstrual cycles were regular and started six months ago. She had dysmenorrhea and light menstrual bleeding during her menstrual periods. She had a history of left renal agenesis (Figure-2). Pelvic MRI revealed uterus didelphys, and hematometrocolpos due to left-sided obstructive hemivagina, confirming the diagnosis of OS (Figure-2, Figure-3). Due to cultural reasons, the integrity of the hymen was important for the family. So we performed vaginoscopy using a hysteroscope to visualize the vagina. During the procedure, right cervical os was visible and a large protrusion area resulting from the accumulation of menstrual blood was observed on the left side of the vagina. After a longitudinal incision was made in the high located vaginal septum using a hysteroscopic bipolar hook electrode, a large amount of menstrual blood was drained from the left uterine cavity (Figure-4). Then the left cervical os could be seen. Intraoperative ultrasonography showed that drainage was complete. The patient was discharged after two days. We observed that hematometra didn't recur, one month later.

CONCLUSION: Müllerian duct defects may be seen in association with variations in other systems, especially the renal system. The presence of didelphic uterus with obstructed hemivagina and ipsilateral renal agenesis is is defined as OS, also known as Herlyn-Werner-Wunderlich syndrome. OS should be considered in the differential diagnosis of adolescents with renal anomalies presenting with a pelvic mass, cyclic pelvic pain, and menstrual problems. The average age of diagnosis is 14. Early diagnosis and surgical treatment will prevent complications such as pyocolpos and endometriosis due to retrograde menstruation, and preserve fertility. Inability to perform transvaginal ultrasonography and examination in virgins, menstrual bleeding from the unobstructed side, lack of clinical suspicion may lead to a delay in diagnosis. Diagnosis can be made by detecting renal agenesis and a retrovesical mass due to hematocolpos on ultrasonography. MRI is more sensitive than ultrasonography in determining uterine anomalies, and helps planning proper treatment. The vaginoscopic drainage of hematometrocolpos will relieve symptoms. This minimally invasive approach, providing advantages such as direct visualization, reduced postoperative pain, and maintenance of hymen integrity, is a good treatment option in adolescents with OS.

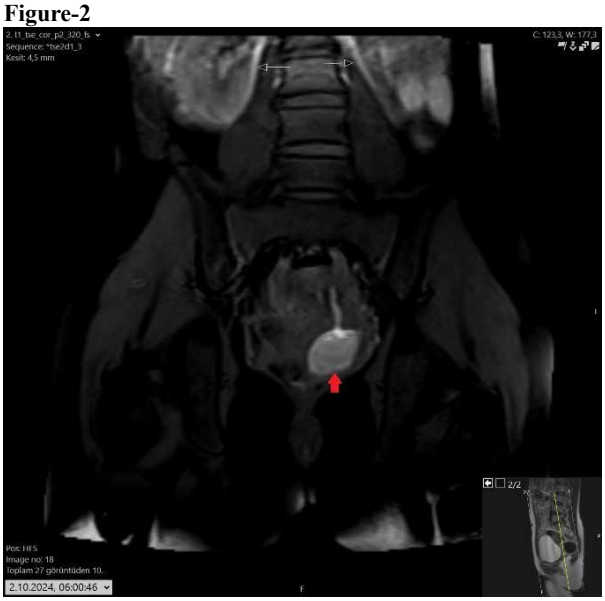
Keywords: Hematometrocolpos, OHVIRA syndrome, vaginoscopic treatment.

Figure-1



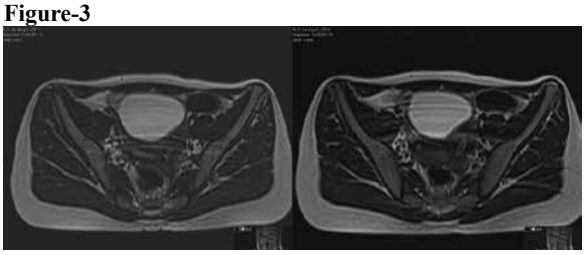
Hypoechoic cystic mass on the pelvic ultrasonography

Figure-2



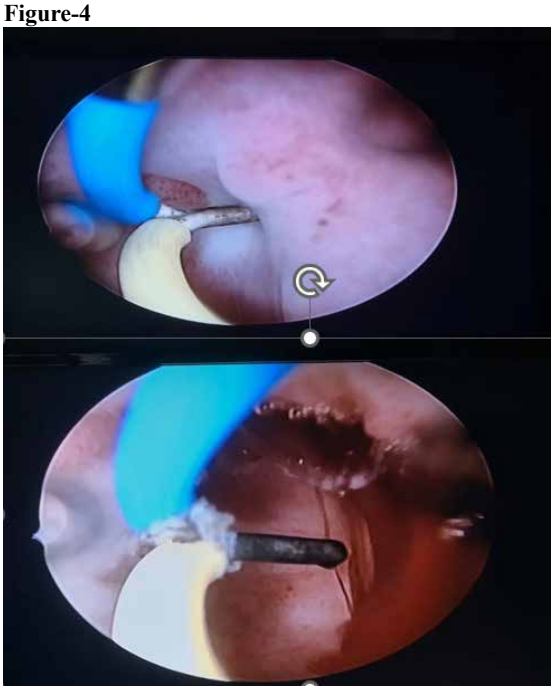
T1-weighted coronal MRI scan: The images indicated by the black arrows show the right kidney, while no kidney is observed in the left renal fossa (left renal agenesis). The image indicated by the red arrow shows a hematocolpos, identified by the bleeding signal.

Figure-3



T2-weighted axial MRI scan showing the images indicated by the arrows. Right and left horn of the uterus in the case of uterus didelphys.

Figure-4



Drained menstrüel blood after procedure

VS-09 [Endoskopi]

A Rare Case of Endometriosis with Vaginal İnvolvement

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Thirty-seven years old, nulliparous patient with dyspareunia and dysmenorrhea was evaluated. The patient with dense adhesions in the parametrium, rectum, uterus and ovaries and endometriosis involvement in the posterior wall of the vagina was planned for surgery. We aimed to present the case in which we performed laparoscopic excision of endometriosis, parametrium, myomectomy and primary bowel repair. The most interesting aspect of this case was endometriosis with vaginal involvement.

Keywords: laparoscopy, endometriosis, vaginal involvement

VS-10 [Endoskopi]

Laparoscopic Diagnosis and Management of an Incorrectly Placed Mirena with Cervical Embedding: A Rare Complication Case

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INTRODUCTION: Intrauterine devices (IUDs) are widely used contraceptive methods worldwide. However, rare complications such as incorrect placement and embedding can occur during insertion. This case report presents the laparoscopic diagnosis and management of a Mirena (hormonal IUD) that was inadvertently embedded several centimeters below the cervix rather than properly placed within the cervical canal, making it undetectable on ultrasound.

CASE PRESENTATION: A 42-year-old patient presented with persistent pelvic pain and irregular bleeding following Mirena insertion. Gynecological examination and ultrasonography failed to visualize the IUD within the uterus. Radiological imaging confirmed that the Mirena had been incorrectly embedded below the cervix rather than within the endometrial cavity. Laparoscopic exploration was performed, confirming the diagnosis, and the IUD was successfully removed using minimally invasive surgical techniques.

CONCLUSION: This case highlights the importance of careful imaging and proper technique during IUD placement. Laparoscopy serves as a safe and effective approach for diagnosing and managing rare complications such as cervical embedding.

Keywords: Intrauterine device, Mirena, cervical embedding, contraceptive complications, IUD malposition, minimally invasive surgery.

VS-11 [Ürojinekoloji - Rekonstrüktif cerrahi]

Laparoscopic pectopexy: steps and effectiveness of the procedure

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INTRODUCTION: Apical prolapse is defined as the downward displacement of the uterus, cervix or vaginal apex. Sacrocolpopexy is considered the gold standard surgery in apical prolapse surgeries based on its suitability for reestablishing the physiological axis of the vagina (1). However, factors such as postoperative defecation disorder, development of stress urinary incontinence (SUI), injury to the hypogastric nerves, and the length of the learning curve are disadvantages of sacrocolpopexy. Surgical adhesions and the narrowing of the pelvic area by the mesh used are shown to be the cause of outlet obstruction. The mesh used in pectopexy is fixed to both iliopectineal ligaments. Studies in the literature show that the iliopectineal ligament is stronger than the sacrospinous ligament and the arcus tendineus of the pelvic fascia (2). The height after fixation corresponds to the S2 level, similar to sacrocolpopexy. At the same time, the mesh is located away from the ureter and intestines, reducing the complaints of defecation due to the operation. Not being related to the hypogastic body is also reassuring for the clinician. We aim to present the surgical steps of the laparoscopic pectopexy operation that we applied to a stage 2 descensus uteri case in our clinic with a video presentation. CASE: A 43-year-old female patient with a history of 3 spontaneous vaginal births applied to the urogynecology clinic with complaints of palpable swelling and urinary incontinence. She had no previous surgical operation or known disease. The patient was diagnosed with stage 2 cystocele and stage 2 descensus uteri, and a decision was made for laparoscopic pectopexy. The operation was initiated under general anesthesia with three 5-gauge and one 10-gauge trocars as standard endoscopic surgery. The incision was extended from the right round ligament to the left round ligament and the vaginal apex, and the peritoneal layer was dissected along the bladder. In patients who underwent hysterectomy, the anterior and posterior parts of the vaginal apex are prepared for mesh fixation. To expose the pectineal ligament, the peritoneum is opened between the right round ligament and the right medial umbilical ligament, staying in the medial part of the right external iliac vein. Attention should be paid to the obturator nerve located caudally in the region. The same preparation is repeated on the left side. Both ends of the polyvinylidene fluoride (PVDF) monofilament mesh (15 cm) are fixed to both pectineal ligaments with prolene or Ethibond 2.0 sutures in a tension-free position. The peritoneum is closed with an absorbable suture. Discussion and CONCLUSION: Pectopexy is an alternative surgical method to sacrocolpopexy in young patients who are planned to undergo uterus-preserving surgery due to its applicability, ability to be performed with a laparoscopic approach, relatively short learning curve, and lack of serious complications.

Keywords: Laparoscopy, pectopexy, pelvic organ prolapse

VS-12 [Ürojinekoloji - Rekonstrüktif cerrahi]

Partial Colpocleisis (LeFort Procedure) in the Management of Advanced Pelvic Organ Prolapse: A Case Report

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Pelvic organ prolapse (POP) is a clinical challenge in elderly, high-risk patients, often requiring tailored surgical approaches. This case report presents the successful application of partial colpocleisis (LeFort procedure) in a non-sexually active patient with advanced POP, focusing on surgical technique, outcomes, and quality-of-life improvements.

INTRODUCTION: POP is common in postmenopausal women and can significantly impact quality of life. Surgical options depend on functional status, sexual activity, and prolapse severity. In non-sexually active women with advanced prolapse and comorbidities, the LeFort procedure provides effective symptom relief with minimal risk while preserving key pelvic structures.

CASE PRESENTATION: A 72-year-old woman with a history of hypertension and chronic obstructive pulmonary disease (COPD) presented with a vaginal mass, urinary retention, and chronic pelvic pain. She reported her last menstrual period occurring 20 years ago, indicating a prolonged postmenopausal state. The patient stated that she had been experiencing symptomatic pelvic organ prolapse for the past 15 years, with progressive worsening of her symptoms. She has had Gravida 10, Parity 10 and no history of previous surgeries. On physical examination, total vaginal prolapse was noted. Ultrasonography revealed a prolapsed bladder, bowel, and partial uterus. MRI was planned for further assessment. Preoperative evaluation confirmed the absence of malignancies. Given her condition and comorbidities, partial colpocleisis was chosen as the surgical approach.

SURGICAL TECHNIQUE: The patient was placed under spinal anesthesia, and a vaginal antiseptic solution was applied. An elliptical excision of the anterior and posterior vaginal epithelium was performed, followed by meticulous closure using absorbable sutures. The lateral vaginal walls were preserved to allow for drainage of menstrual blood, and the vaginal canal was obliterated. Upon completion of the LeFort procedure, the prolapse was reduced, and a stress test was performed, which was positive. Additionally, a Q-tip test revealed a 35-degree urethral hypermobility, indicating occult stress urinary incontinence. Given these findings, a trans-obturator tape (TOT) procedure was performed in the same session to address the incontinence. Hemostasis was achieved, and the procedure was well tolerated with no intraoperative complications.

POSTOPERATIVE COURSE: The patient recovered well, experiencing mild vaginal discharge in the first postoperative week. She was discharged on postoperative day 2 with antibiotic prophylaxis and pelvic rest instructions. At 3 months, she reported complete symptom resolution and improved quality of life.

DISCUSSION: Partial colpocleisis (LeFort procedure) offers a highly effective solution for advanced pelvic organ prolapse in non-sexually active women, providing substantial relief from symptoms such as vaginal bulging and incontinence. This technique preserves critical

pelvic structures while demonstrating a favorable safety profile, with fewer complications compared to alternative interventions like sacrocolpopexy or colporrhaphy. Given the irreversible nature of the procedure, it is crucial to conduct thorough patient selection and provide comprehensive counseling, particularly regarding its impact on sexual function.

CONCLUSION: Partial colpocleisis (LeFort procedure) is a safe and effective surgical option for elderly, non-sexually active patients with advanced POP. This case highlights its role in symptom relief with minimal complications. Proper patient selection and counseling on its irreversible nature remain essential.

Keywords: LeFort, Colpocleisis, Pelvic Organ Prolapsus

VS-13 [Ürojinekoloji - Rekonstrüktif cerrahi]

Özerkan Modification in Laparoscopic Sacrohysteropexy: A Novel Mesh-Free Approach for Uterine Preservation

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INTRODUCTION: Uterine prolapse is a prevalent condition requiring surgical intervention to restore pelvic support and improve quality of life. Laparoscopic sacrohysteropexy is a well-established uterine-preserving procedure, but traditional techniques often rely on synthetic mesh, which carries risks such as erosion, infection, and chronic pelvic pain. This case report presents a modified laparoscopic sacrohysteropexy technique (Özerkan Modification) that eliminates the use of mesh while utilizing Mercilene tape suture for uterine suspension, offering a safer and durable alternative.

CASE PRESENTATION: A 43-year-old multiparous woman presented with symptomatic stage 2-3 uterine prolapse, reporting pelvic heaviness, vaginal bulging. She was counseled on uterine-preserving surgical options and opted for laparoscopic sacrohysteropexy without synthetic mesh.

The Özerkan Modification was performed with the following steps:

• Precise dissection of the uterosacral and cardinal ligaments.

• Use of Mercilene tape suture as an alternative to mesh for uterine suspension.

• Secure fixation of the tape to the sacral promontory, providing robust and long-lasting pelvic support.

The procedure was completed without complications, with minimal blood loss and a smooth intraoperative course.

RESULTS: The patient's early postoperative recovery was uneventful, with immediate resolution of prolapse symptoms and a successful anatomical correction on examination. The use of Mercilene tape suture ensured adequate support without the risks associated with mesh, addressing concerns related to foreign body reactions.

CONCLUSION: The Özerkan Modification of Laparoscopic Sacrohysteropexy demonstrates that mesh-free uterine suspension is feasible while maintaining durability and efficacy with Mercilene tape suture. This case highlights the potential of this modified technique as a safer alternative for uterine-preserving prolapse repair, minimizing complications while ensuring strong pelvic support. Further studies are warranted to evaluate long-term outcomes and establish its role in clinical practice.

Keywords: Laparoscopic Sacrohysteropexy, Mesh-Free Sacrohysteropexy, Özerkan Modification, Mercilene Tape, Pelvic Organ Prolapse

VS-14 [Endoskopi]

Which is more difficult for a large uterus, performing a total laparoscopic hysterectomy (TLH) or removing the uterus?

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AIM: Laparoscopic hysterectomy is increasingly preferred as a minimally invasive option for the surgical removal of large uteri. This surgical method offers shorter recovery times and lower complication rates compared to traditional open surgery while preserving women's fertility potential. Large uteri may complicate the surgery; however, these challenges can be overcome with appropriate techniques and experienced surgeons. Laparoscopic techniques can be applied with different modifications, taking into account the size, location, and general condition of the uterus as well as the patient's overall health. This abstract aims to provide an overview of the minimal invasive management of complications occurring during laparoscopic hysterectomy for a large uterus and its extraction through the abdomen.

METHOD: A 44-year-old female patient was evaluated by urology due to complaints of frequent urination. Upon evaluation, an intramural myoma measuring 7x6 cm was observed, causing pressure on the endometrium anterior wall and junction of fundus of the uterus. On gynecological evaluation, the patient, who had a history of abnormal uterine bleeding, pelvic pressure, and pressure symptoms, was planned for total laparoscopic hysterectomy. During laparoscopic hysterectomy, especially during colpotomy, the uterine artery vaginal branch was inadvertently opened, leading to bleeding and difficulties in visualization. After controlling the bleeding, the procedure continued, and the hysterectomy was completed. However, during the removal of the uterus from the abdomen, a laceration occurred at the anterior edge of the vaginal cuff. The laceration was repaired laparoscopically. Following the repair, due to a shift in the vaginal axis, a suspicion of ureteral kink arose. A diagnostic cystoscopy was performed, and jet flow was observed from both ureteral orifices. A guide was advanced through the ureters, and no resistance was encountered. It was confirmed that the ureteral axis was not disrupted.

CONCLUSION: Managing a large uterus during a total laparoscopic hysterectomy (TLH) can be challenging, particularly due to the difficulty of uterine manipulation, increased tissue handling, and

potential for bleeding. However, with careful and meticulous laparoscopic techniques, successful outcomes can be achieved. Effective management of complications, when recognized early, is crucial to minimizing risks and ensuring a safe procedure. This case highlights the importance of expertise in laparoscopic surgery and the ability to address complications promptly to achieve favorable results.

Keywords: Laparoscopic hysterectomy (TLH), Large uterus, Complications, Vaginal cuff laceration, Ureteral kink

VS-15 [Jinekoloji Genel]

Difficult hysterectomy due to endometriosis, bilateral salpingectomy and ureterolysis

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OBJECTIVE: Endometriosis can severely affect pelvic structures, leading to advanced adhesions and anatomical distortions. This case report aims to share the details of a difficult hysterectomy, bilateral salpingectomy, and ureterolysis surgery due to advanced-stage endometriosis. The technical resolution and methodology of difficult hysterectomy, bilateral salpingectomy, and bilateral ureterolysis are visually described. This presentation aims to serve as an essential educational material in gynecological surgery and contribute to the improvement of surgical techniques.

METHODS: A 33-year-old patient with complaints of chronic pelvic pain, abnormal uterine bleeding, dysmenorrhea, and progressive dyspareunia was evaluated in the clinic. The patient had previously undergone medical treatment for endometriosis, but her symptoms persisted. Preoperative imaging and bimanual examination suggested advanced pelvic adhesions. A total laparoscopic hysterectomy, bilateral salpingectomy, and bilateral ureterolysis were planned and performed, with the details of the procedure described.

FINDINGS: During surgery, the extent of deep endometriotic lesions was assessed, and the pelvic organs were examined. Endometriotic foci were detected around the uterus, ovaries, rectovaginal septum, and bilateral ureters. The degree of pelvic adhesions, technical modifications in the surgical procedure, and the duration of the operation were recorded. The postoperative period was monitored, assessing the recovery process and pain levels.

CONCLUSION: This video presentation outlines the technical details of laparoscopic hysterectomy procedures and intraoperative challenges. Surgical management of advanced-stage endometriosis presents a significant challenge due to deep pelvic infiltration, dense adhesions, and ureteral involvement. In cases of deep infiltrative endometriosis, particularly those involving the rectovaginal septum or rectosigmoid colon, a well-planned surgical approach is crucial. Successful outcomes require surgical expertise, the use of appropriate surgical equipment, and multidisciplinary collaboration.

Keywords: Deep endometriosis, endometrioma, hysterectomy, laparoscopi, minimally invasive surgery

VS-16 [Jinekoloji Genel]

Challenging Total Laparoscopic Hysterectomy in a Patient with Dense Pelvic Adhesions

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OBJECTIVES: Laparoscopic hysterectomy has lower rates of blood transfusion, wound infection, venous thromboembolism, and incisional hernia compared to abdominal hysterectomy. However, it has a higher rate of vaginal cuff dehiscence. Laparoscopic hysterectomy is associated with less postoperative pain, shorter hospital stay, and faster recovery. This method provides better quality of life and body image improvements in the early postoperative period. Additionally, laparoscopic hysterectomy yields more favorable outcomes in terms of sexual function compared to abdominal hysterectomy.

METHODS: We presented a total laparoscopic hysterectomy case in a patient with history of previous pelvic infection and surgery.

RESULTS: A 52-year-old female patient presented with abnormal uterine bleeding. From her history, it was learned that she did not respond to medical treatment and had a history of myomectomy and pelvic infection. Total laparoscopic hysterectomy and bilateral salpingo-oophorectomy were recommended and performed. The final pathology revealed no significant findings other than adenomyosis.

CONCLUSIONS: We wanted to present a video case report of a total laparoscopic hysterectomy performed on a patient with a history of pelvic surgery and infection, resulting in a highly adhesive pelvis and a surgically challenging case.

Keywords: pelvic surgery, adhesion, total laparoscopic hysterectomy

VS-17 [Jinekoloji Genel]

A Difficult Laparascopic Hysterectomy Presentation in a Patient with Large Uteri and Dense Adhesions

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A 48 year old woman referred to our clinic for endometrial intraepithelial neoplasia. The patient's body mass index was 32 kg/m2Total laparascopic hysterectomy and bilateral salpingo-oophorectomy was planned. The patient was G3P3, and had a history of two cesarian section for twin and triplet pregnancy. Preoperative ultrasound examination revealed that uterus was 13*6.7 cm,endometrial thicknes was 9 mm and bilateral ovaries was normal appereance. After providing pneumoperitoneum through the supraumbilical veres access, entry into the abdomen was made. Dense adhesions were observed between uterus and anterior abdominal wall and bladder. After dissection of adhesions, total laparascopic hysterectomy and bilateral salpingo-oophorectomy was performed.

Keywords: Laparascopic Hysterectomy,Dense adhesions,Large uterus

VS-18 [Jinekoloji Genel]

Laparoscopic total hysterectomy of a didelphys uterus with a ureteral anatomic alteration

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Laparoscopic Hysterectomy in a Patient with Uterus Didelphys and Double Cervix with Ureter Anomaly: A Surgical Video Report

INTRODUCTION: Uterus didelphys is a rare congenital Müllerian anomaly characterized by complete failure of Müllerian duct fusion, often associated with urinary tract anomalies. Here, we present a laparoscopic hysterectomy performed in a 48-year-old patient with uterus didelphys and double cervix, highlighting key surgical considerations and challenges.

CASE PRESENTATION: A 48-year-old female presented with abnormal uterine bleeding. Imaging confirmed uterus didelphys with two distinct endometrial cavities and a double cervix. Due to the high incidence of concurrent urinary tract anomalies in Müllerian malformations, preoperative magnetic resonance imaging (MRI) was obtained, revealing a left ureter with an aberrant course. Given the abnormal ureteral anatomy, additional precautions were taken to minimize the risk of iatrogenic injury.

SURGICAL TECHNIQUE: A laparoscopic hysterectomy was planned. Preoperatively, cystoscopy was performed, and bilateral ureteral stents were placed to enhance intraoperative ureteral identification. To facilitate uterine manipulation and ensure precise dissection, an illuminating uterine manipulator was used. During surgery, the ureters and uterine arteries were meticulously dissected before proceeding with further surgical steps. The presence of two separate endocervical canals and two cervix necessitated sequential placement of the uterine manipulator into each cervix, first left and then right one, allowing for systematic dissection and safe resection of the uterus.

RESULTS: The laparoscopic hysterectomy was successfully completed without intraoperative complications. The patient had an uneventful postoperative course and was discharged on postoperative day one. Histopathologic examination confirmed benign pathology.

CONCLUSION: Laparoscopic hysterectomy in patients with uterus didelphys and associated urinary tract anomalies requires careful preoperative evaluation and intraoperative precautions. The use of preoperative MRI, cystoscopic ureteral stent placement, and an illuminating uterine manipulator were helpful in preventing complications and ensuring surgical success. Our video highlights a stepwise approach to safe laparoscopic hysterectomy in rare but surgically challenging anomalies like this case.

Keywords: Laparoscopic Hysterectomy, Didelphys uterus, ureter anomaly

VS-19 [Jinekoloji Genel]

Intraoperative management of ureteral transection in the middle of a deep endometriosis case

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INTRODUCTION: Deep infiltrative endometriosis (DIE) is a complex pathology that presents significant technical and clinical challenges in gynecologic surgery. Ureteral involvement by endometriotic tissue increases the risk of iatrogenic injury during surgery. Ureteral transection is a rare but serious complication that requires prompt intraoperative diagnosis and appropriate surgical management. This case report discusses the intraoperative management of ureteral transection encountered during deep endometriosis surgery.

CASE PRESENTATION: A 42-year-old female patient with chronic pelvic pain and dysmenorrhea, who had previously failed medical treatment, was diagnosed with deep endometriosis involving the rectovaginal septum and the left pelvic sidewall based on preoperative evaluation. The patient underwent radical endometriosis surgery via laparotomy with a multidisciplinary team. During the procedure, the left ureter was found to be densely adherent to the endometriotic tissue, and complete transection of the ureter occurred during dissection.

INTRAOPERATIVE MANAGEMENT: Upon identifying the ureteral transection, immediate intraoperative evaluation of the proximal and distal ureteral ends was performed. As the distance between the ureteral ends was short, a primary end-to-end ureteroureterostomy was planned. A careful anastomosis was performed using fine, absorbable sutures. To ensure ureteral integrity and maintain urinary flow, a temporary ureteral stent (double-J catheter) was placed. The postoperative period was uneventful, with no urinary complications, and follow-up renal function

tests remained within normal limits.

DISCUSSION: Ureteral injuries during gynecologic surgery are often caused by pelvic anatomic distortion and adhesions. Rapid intraoperative diagnosis, careful assessment of the ureter, and appropriate repair techniques are crucial in preventing long-term complications. Ureteroureterostomy is a preferred approach when the proximal and distal ureteral ends can be mobilized sufficiently to allow a tension-free anastomosis. Postoperative stenting and close clinical follow-up significantly enhance success rates.

CONCLUSION: Ureteral transection occurring during deep endometriosis surgery can be successfully managed with early recognition and appropriate surgical intervention. A multidisciplinary approach is essential for preserving anatomical structures and achieving optimal surgical outcomes. This case highlights the importance of intraoperative awareness and management of ureteral injury in gynecologic surgery.

Keywords: Deep infiltrative endometriosis, ureteral transection, intraoperative management, ureteroureterostomy, gynecologic surgery

VS-20 [Jinekoloji Genel]

Laparoscopic management of intraligamentary myoma in an obese patient with multiple surgeries

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Uterine myoma is the most frequent benign tumor of female genital tract. Intraligamentary myomas in the broad ligament are rare frequently mimic an adnexal mass. We present a case of 54 years old patient with 14 cm adnexal mass fibroma? or intraligamentary myoma with cystic degeneration, who is referred to the Gynecologic Oncology Department with complains of severe pain. The patient's body mass index was 42kg/m2 and has past laparatomic surgeries, cholecystectomy and umblical henia repair. After providing pneumoperitoneum through the supraumbilical veres access, entry into the abdomen was made. In the supraumbilical region, adhesions of the omentum and intestines were observed above the entry trocar. An approximately 14 cm intraligamentary, retroperitoneal myoma was observed in the right iliac region. After careful dissection, the mass was placed in an endobag and hysterectomy was performed. The right ureter was visualized. This case is interesting for its rareness and diagnostic dilemma, because degenerative myomas can imitate malignant mass. Total laparoscopic hysterectomy with vaginal morcellation of the specimen in endobag was performed. The patient was discharged from the clinic next day.

Keywords: intraligamentary myoma,adnexal mass,laparascopy

VS-21 [Jinekoloji Genel]

Laparoscopic hysterectomy without a manipulator, endometrioma excision, and vaginal septoplasty in a patient with uterus didelphys and vaginal septum: a case report

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OBJECTIVE: This case report presents a patient with uterus didelphys, a longitudinal vaginal septum, and an endometrioma who underwent laparoscopic hysterectomy, endometrioma excision, and vaginal septoplasty without the use of a uterine manipulator. Due to the inability to insert a manipulator, a vaginal tampon was placed through one side of the vaginal septum.

METHOD: A 49-year-old female patient, gravida 4, with two previous dilatation and curettage (D&C) procedures and two cesarean sections, presented with complaints of malodorous vaginal discharge and pelvic pain. On physical examination, a double cervix and a vaginal septum were detected, while adnexal structures were free. Preoperative magnetic resonance imaging (MRI) revealed a uterus didelphys variation with a double cavity and double cervix. Additionally, a 39×32 mm lesion in the left ovary with restricted diffusion findings, suggestive of an endometrioma, was reported. Laboratory tests showed a CA-125 level of 36, with all other tumor markers within normal ranges.

RESULTS: Intraoperatively, uterus didelphys was confirmed, with a 3-4 cm rudimentary uterine horn on the right and a 5 cm uterine horn on the left. A 4 cm endometrioma was observed in the left ovary, while the right ovary appeared normal. Bilateral retroperitoneal dissection was performed to visualize the ureters. The uterine arteries were clipped with hemoclips at the origin of the hypogastric artery. The bladder and rectum were properly mobilized and retracted. The uterine ligaments were sequentially isolated, clamped, cut, and ligated. The vaginal septum was sealed and excised along the midline using Ligasure. The specimen was retrieved and sent for histopathological examination, which revealed; endometrial polyp, adenomyosis, endometriosis within the left ovary, endometriotic foci within the left fallopian tube.

CONCLUSION: A uterine manipulator was not utilized during the procedure. The patient underwent laparoscopic endometrioma cyst excision, hysterectomy, bilateral salpingo-oophorectomy, and vaginal septum excision. To prevent postoperative complications, a vaginal tampon was placed at the end of the procedure and removed on postoperative day 1. No additional pathological findings were observed. Given the absence of a uterine manipulator, the presence of a vaginal septum, and the coexisting endometrioma, particular attention was paid to ureter visualization throughout the procedure. Due to the abnormal anatomical structures, careful dissection and exposure of the surgical planes were performed. There were no intraoperative or postoperative complications, and the patient was safely discharged in good condition.

Keywords: Endometrioma, laparoscopic hysterectomy, longitudinal vaginal septum, minimally invasive gynecologic surgery, uterus didelphys

VS-22 [Jinekoloji Genel]

V-NOTES Hysterectomy in a Large Uterus: A Case Report

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OBJECTIVE: The removal of a large uterus presents significant challenges for surgeons, particularly in terms of minimizing surgical trauma, achieving complete resection, and reducing recovery time. Traditionally, hysterectomy for large uteri has been performed using abdominal or laparoscopic approaches. However, with advances in minimally invasive surgery, Vaginal Natural Orifice Transluminal Endoscopic Surgery (V-NOTES) has emerged as a promising technique for such procedures. This study presents our experience with hysterectomy using the V-NOTES technique in a patient with a large uterus.

METHODS: A 45-year-old woman, who had given birth vaginally twice, presented with complaints of menorrhagia and pelvic pain. On examination, her uterus was found to be enlarged to the size of a 16-week pregnancy, and ultrasonography revealed a 12 cm mass consistent with a myoma. Preoperative evaluation showed normal serum LDH and tumor markers, with no abnormal findings on imaging. Endometrial biopsy confirmed a benign pathology. As the patient preferred a minimally invasive approach, she was deemed suitable for hysterectomy using the V-NOTES technique. The surgical procedure was performed under general anesthesia in the lithotomy position using a single-port technique.

RESULTS: The procedure was successfully completed without intraoperative complications. The uterus was removed using a single-port system via the vaginal route. The extracted specimen weighed 1036 grams. The patient's postoperative course was uneventful, with minimal pain reported. She was discharged on the second postoperative day, and no complications or infections were observed at the two-week follow-up. The final histopathological examination confirmed benign fibroid disease.

CONCLUSION: V-NOTES hysterectomy may be a safe and effective method for managing large uteri. It has been shown to offer advantages over traditional abdominal or laparoscopic techniques, including reduced postoperative pain, faster recovery, and scarless surgery. This case contributes to the literature on the use of V-NOTES for large uteri and demonstrates that this technique can provide the benefits of minimally invasive surgery in large uterus procedures.

Keywords: V-NOTES Hysterectomy,Minimally Invasive Surgery,Myomatous Uterus,Large Uterus

VS-23 [Jinekoloji Genel]

V-NOTES Hysterectomy in a Uterus with Large Myoma

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OBJECTIVE: Vaginal Natural Orifice Transluminal Endoscopic Surgery (V-NOTES) is an innovative technique that integrates the benefits of vaginal access with minimally invasive surgery. The feasibility of V-NOTES hysterectomy in patients with an enlarged uterus has been documented in a limited number of cases. This case report aims to describe the surgical procedure and clinical outcomes of V-NOTES hysterectomy performed on a patient with a 7 cm submucosal myoma.

CASE PRESENTATION: A 50-year-old multiparous woman presented with chronic pelvic pain and abnormal uterine bleeding. Pelvic examination and imaging revealed a 7 cm submucosal myoma. Preoperative probe curettage yielded benign histopathological findings. After evaluating surgical options, V-NOTES hysterectomy was planned.

The patient had a history of a previous cesarean section, and intraoperative assessment revealed bladder adhesions to the uterus. Careful dissection was performed to mobilize the bladder and achieve an adequate surgical plane. The hysterectomy was successfully completed using the V-NOTES technique. The postoperative course was uneventful, and the patient was discharged on postoperative day 2 without complications. Follow-up evaluations indicated an optimal recovery, with no late surgical complications reported.

CONCLUSION: V-NOTES hysterectomy appears to be a safe and feasible surgical approach for patients with bladder adhesions due to previous cesarean section and large submucosal myomas, provided that appropriate patient selection is ensured and the procedure is performed by experienced surgeons. Given its minimally invasive nature, superior cosmetic outcomes, and favorable postoperative recovery, this technique may be a valuable alternative in select cases.

Keywords: V-NOTES Hysterectomy,Submucosal Myoma,Minimally Invasive Surgery

VS-24 [Endoskopi]

Laparoscopic Myomectomy: Excision of Two Fibroids (6 cm in the Posterior Wall, 5 cm in the Anterior Wall) Department of Obstetrics and Gynecology, Akdeniz University, Antalya, Turkey

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A 30-year-old virgin patient presented with complaints of dysmenorrhea, abdominal pain, and pollakiuria. A transabdominal examination revealed multiple fibroids, including one approximately 4.5 cm in size on the anterior part of the uterus and another on the posterior part, the largest measuring approximately 6.5 cm. MRI showed: A fibroid in the midsection of the uterine corpus, anteriorly located, measuring approximately 42×37 mm in the sagittal plane, with a T2 hyperintense cystic degenerative area in the central portion, consistent with a type 2-5 fibroid. Another fibroid in the midsection of the uterine corpus, posteriorly located, connected to the uterus via a pedicle, measuring approximately 49×36 mm in the sagittal plane, appearing T2 hypointense, consistent with a type 7 fibroid. Two type 4 fibroids were observed: one measuring 7×6 mm in the posterior fundus of the uterus and another measuring 14x11 mm in the right lateral wall of the corpus. There was approximately 2–2.5 cm of free fluid in the pouch of Douglas. No pathological lymph nodes were observed in the pelvic region. The patient was advised to return for follow-up in six months. The patient returned three months later with increased pain. A repeat transabdominal examination revealed that the anterior fibroid had grown to 6 cm in size and was compressing the bladder. There was no significant change in the size of the posterior fibroid (6.5 cm). The patient was informed, and laparoscopic myomectomy was planned. Under general anesthesia, following the necessary sterilization and draping, a 10 mm trocar was inserted through the umbilicus to enter the abdominal cavity. After achieving intra-abdominal pressure with carbon dioxide insufflation, additional 5 mm trocars were inserted from the left lower, left upper, and right lower quadrants. Upon inspection, the upper abdomen, including the liver and spleen, appeared normal. After placing the patient in the Trendelenburg position, two fibroids were observed: A type 2-5 fibroid in the anterior uterus and A type 7 fibroid in the posterior uterus. Both ovaries appeared normal and age-appropriate. The uterus was elevated using atraumatic graspers. The approximately 6 cm pedunculated type 7 fibroid in the posterior uterus was excised at the pedicle level using a LigaSure device. The excision site was sutured continuously in a single layer using a V-Loc suture. For the approximately 5 cm type 2-5 fibroid in the anterior uterus, the bladder peritoneum was dissected sharply and bluntly to mobilize the bladder. The fibroid was dissected and excised with the aid of a LigaSure device. The myometrium was sutured continuously in a single layer using a V-Loc suture. Hemostasis was achieved.The two excised fibroids were removed using an endobag through the 10 mm trocar site with cold knife morcellation. After peritoneal closure, instrument, gas, and sponge counts were verified, and hemostasis was confirmed. The abdominal cavity was restored to its anatomical position, and the skin was sutured with rapid absorbable sutures.

Keywords: Laparoscopic surgery, myomectomy, large fibroids, virgin, pelvik pain, dysmenorrhea

VS-25 [Endoskopi]

A new surgical approach for fibroids: v-notes myomectomy - case report -

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INTRODUCTION: Vaginal Natural Orifice Transluminal Endoscopic Surgery (V-NOTES) is a minimally invasive surgical technique that utilizes the vaginal route for access to the peritoneal cavity, eliminating the need for abdominal incisions.V-NOTES has been performed in many kinds of gynecologic procedures, such as adnexal surgery, hysterectomy and myomectomy (1).The use of this technique for myomectomy has grown in popularity because to its potential benefits, which include decreased postoperative pain, quicker recovery, and better cosmetic results.This method offers an alternative to open myomectomy and standard laparoscopic procedures, especially when vaginal access is available.

METHOD: A 42-year-old patient was admitted to the clinic with complaints of low back pain and constipation. Patient with two spontaneous vaginal deliveries has no comorbidities.On tvusg; ovarian natural, endometrium 3 mm uterine posterior wall 60x50 mm Figo 6 fibroids were observed.With symptomatic issues, the patient was advised to have a myomectomy.The patient was prepared in the lithotomy position and a posterior colpotomy was performed. Then the GelPOINT V-PATH ring was placed through the posterior colpotomy with the help of the alexis retractor. A pneumoperitoneum was created up to 14 mm Hg of CO2 insufflation.To get the bowel to retract, patients were then put in the Trendelenburg posture.Myoma enucleation with THUNDERBEAT was carried out similarly to a standard laparoscopy. The uterine defect was closed with double layer v-loc no:1-0.After bleeding control, the fibroid was removed from the abdomen with the GelPOINT V-PATH system.The vaginal wound was closed with no:2–0 Vicryl suture.

CONCLUSION: V-NOTES can achieve the best aesthetic outcomes compared to traditional laparoscopy without requiring the invasion of abdominal muscles and fascia or any issues associated to the trocar (2). Additionally, the removable incision retractor that protects the colpotomy makes it easier to retrieve specimens and reduces the possibility that tumors may leak into the peritoneal space (3). Patients may experience less pain following the procedure than they would from a conventional skin incision because the vaginal fornix is innervated by visceral nerves (4).Although it offers benefits, there are limitations as well, such as a steep learning curve, strict patient selection requirements, and surgical restrictions.Further studies comparing V-NOTES myomectomy with other minimally invasive procedures are needed for determining its safety, efficacy, and long-term outcomes.

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Keywords: myomectomy, scarless surgery,natural orifice transvaginal endoscopic surgery

VS-26 [Endoskopi]

vNOTES-assisted vaginal myomectomy or laparoscopic myomectomy: a comparative analysis of minimally invasive techniques

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INTRODUCTION: Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) has emerged as a promising minimally invasive technique for myomectomy, offering potential benefits over traditional laparoscopic approaches. Recent studies have evaluated the efficacy, safety, and recovery outcomes associated with vNOTES-assisted vaginal myomectomy (Jan Baekelandt, 2018). A retrospective study involving 282 patients compared vNOTES with conventional multiport laparoscopy and transumbilical laparoendoscopic single-site surgery (LESS) for myomectomy. The findings indicated that vNOTES had the shortest anal exhaust time, suggesting a quicker return of bowel function. However, it also exhibited a higher postoperative infection rate compared to the other methods. Notably, the operative time increased by 3.5 minutes for each 1 cm increase in myoma size, and intraoperative bleeding increased by approximately 12 ml. Despite these variations, vNOTES demonstrated comparable efficacy and safety to existing minimally invasive surgeries, with distinct advantages in postoperative recovery (Hou et al., 2022). Baekelandt reported successful removal of fibroids via vNOTES without complications or conversions to standard laparoscopy. All patients were discharged within 24 hours, with some leaving as early as 12 hours post-surgery. This underscores the potential of vNOTES to facilitate rapid recovery and minimize hospital stays. An analysis of 2,000 vNOTES cases revealed an overall complication rate of 4.4%, comparable to existing minimally invasive surgical techniques. The most common intraoperative complications included rectal injuries and hemorrhage, primarily associated with severe adhesions. Postoperative complications, such as infections, were observed but remained within acceptable limits. These findings highlight the importance of careful patient selection and preoperative evaluation to minimize risks (Hou et al., 2023).

CASE REPORT: A 30-year-old, G1P0A1 patient presented with secondary infertility and abnormal uterine bleeding. Gynecological examination and transvaginal ultrasonography revealed a 45×50 mm mass consistent with a FIGO type 2-5 leiomyoma, compressing the endometrial cavity and located on the posterior uterine wall. The patient had an unremarkable medical history, a BMI of 23.51, and a preoperative hemoglobin (Hb) level of 13.2 g/dL. After preconception counseling, myomectomy was planned. vNOTES myomectomy was performed. At the 20th postoperative hour, the patient experienced a 2 g/dL drop in Hb and required a total of two doses of IV paracetamol for analgesia. The patient was discharged without complications.

DISCUSSION: vNOTES-assisted vaginal myomectomy has emerged as a minimally invasive alternative to laparoscopic myomectomy, offering several advantages in selected patients. The absence of abdominal incisions reduces postoperative pain, accelerates recovery, and improves cosmetic outcomes. Additionally, the transvaginal approach minimizes intra-abdominal adhesion risks and blood loss, making it a favorable option in appropriate cases. However, despite its benefits, vNOTES is not universally applicable. The technique demands a steep learning curve, requiring expertise in vaginal surgery and advanced endoscopic skills. Furthermore, the approach may be challenging for large fibroids or those in posterior locations. The lack of long-term data on sexual function outcomes and potential postoperative infections remain concerns.

CONCLUSION: In carefully selected patients, vNOTES offers a safe and effective alternative to laparoscopic myomectomy. Future research and growing surgical experience will determine its broader applicability and refine patient selection criteria.

Keywords: vnotes, vaginal, myomectomy, minimally invasive technique, laparoscopy

VS-27 [Jinekoloji Genel]

Case Report: Pelvic infection mimicking ovarian cancer: Pelvic actinomycosis

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Introduction Actinomycosis infections are rare but serious, resulting from bacterial invasion into deeper tissues following the disruption of mucosal barriers. Common triggers include prolonged use of intrauterine devices (IUDs), surgical interventions, or trauma. Pelvic actinomycosis can lead to periovarian chronic granulomatous reactions, causing adhesions with surrounding organs and the development of solid masses. These masses often mimic malignancies due to their appearance. This report presents a case of pelvic actinomycosis resembling ovarian cancer, characterized by bilateral pelvic masses. Case Presentation A 40-year-old female presented with a 1-week history

of abdominal distension, pain, nausea, vomiting, and significant weight loss (5 kg in 15 days). Her medical history includes G:4; P:3 (NSVD), C:1. She had used an intrauterine device (IUD) for 8 years, which was removed 3 years ago. Her last menstrual period was 2 years ago. Physical examination revealed a mass extending 4 finger-widths above the umbilicus and fullness in the parametrium.

• Ultrasound: Irregular semisolid masses measured 82x51 mm in the right adnexa and 71x48 mm in the left adnexa. A myoma measuring 38x36 mm was noted in the left uterine corpus. Hydronephrosis was detected in the left kidney.

• Laboratory FINDINGS: WBC 27,010/ml; CRP 202,7 mg/L.

• Tumor markers: CA-125: 49.2 U/mL; CA19-9: 3.08 U/mL; CA15-3: 3.11 U/mL.

• Contrast-enhanced pelvic magnetic resonance imaging (MRI): Malignant-appearing lesions measuring 85x44 mm in the right adnexal region and 72x35 mm in the left adnexal region. Multiloculated, thick-walled abscess consistent with a collection extending from the umbilicus to the presacral area. Evidence of omental fat stranding and irregular thickening, suggestive of peritoneal carcinomatosis. Multiple lymph nodes noted in the para-aortic-caval region. Dilatation of proximal jejunal loops with air-fluid levels, indicative of ileus. The patient was hospitalized with suspected bilateral ovarian cancer, tubo-ovarian abscess, and ileus. Interventional radiology performed omental biopsy and abscess drainage, with samples sent for culture.

• Abscess culture: Fusobacterium nucleatum and Actinomyces israelii were identified.

• Omental biopsy: Findings revealed mixed-type inflammatory cell infiltration and evidence of fat necrosis. Repeat omental biopsy showed no neoplastic formation.

Following antibiotic therapy with meropenem and doxycycline, total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, and appendectomy were performed. Dense adhesions were removed, and abscesses excised.

Postoperative recovery was uneventful, and the patient was discharged on the 10th day.

Pathology: Bilateral tubo-ovarian abscesses with Actinomyces sulfur granules.

Discussion Actinomycosis is a chronic, granulomatous, and suppurative infection caused by gram-positive anaerobic bacteria of the Actinomyces species. Its ability to form masses and spread between tissue layers can lead to adhesions and solid masses involving surrounding organs. Pelvic actinomycosis is a rare form of actinomycosis, accounting for approximately 3% of cases. Adhesions may result in abdominal symptoms such as pain, distension, nausea, vomiting, and weight loss. Diagnosis is established through microbiological culture and histopathological examination. Conclusion Actinomycosis is a rare condition with diverse clinical presentations. Due to its resemblance to solid masses, it can often be mistaken for malignancies. Pelvic actinomycosis should be considered in cases with pelvic masses, particularly in individuals with a history of IUD use.

Keywords: Pelvic actinomycosis, Pelvic inflammatory disease, Ovarian cancer imaging

VS-28 [Endoskopi]

Video Case: Laparoscopıc hysterectomy left salpıngoopherectomy rıght salpıngectomy segmental colorectal resectıon appendectomy double j catheter

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The patient who had dysmenorrhoea, dyspareunia, painful defecation, chronic pelvic pain and menometrorrhagia resistant to medical treatment was treated surgically. Surgically laparoscopic hysterectomy left salpingoopherectomy right salpingectomy segmental colorectal resection double j stent appendectomy was performed. The ovarian appendix colon material and uterine serosal surface pathology were reported as endometriosis. The patient's symptoms regressed to a great extent.

Keywords: chronic pelvic pain,dysmenorrhoea,endometriosis,laparoscopy,

VS-29 [Onkoloji]

Partial Gastrectomy in a Case of Platinum-Sensitive Oligometastatic High-Grade Serous Ovarian Cancer

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OBJECTIVES: While ovarian cancer account for only about 19% of all gynecologic malignancies, it is responsible for 42% of deaths related to gynecologic cancers. Primary surgery aiming for the complete macrospic resection of all tumours, followed by combination chemotherapy with carboplatin and paclitaxel, continues to be the cornerstone of treatment. In patients with a platinum-free interval longer than 6 months complete resection followed by chemotherapy provides longer overall survival and disease-free survival compared to chemotherapy alone. We want to share a platinum-sensitive recurrent ovarian cancer case that recurred in an atypical location.

METHODS: In this report, we present a case of stage 3C2 high-grade serous carcinoma where the patient experienced an isolated gastric serosal recurrence 18 months after platinum-based chemotherapy.

RESULTS: A 65-year-old female patient who presented with abdominal pain underwent a CT scan that revealed an adnexal mass, ascites, and omental peritoneal implants. Cytological examination reported a diagnosis of high-grade serous adenocarcinoma, and subsequently, cytoreductive surgery was performed. After adjuvant carboplatin-paclitaxel chemotherapy, an isolated lesion

was observed in the distal stomach on PET-CT at the 18th month due to an increase in CA-125 levels. Gastroscopy revealed a 5 cm mass protruding inward from the mucosa and from the outside. The case was discussed in a multidisciplinary tumor board. The patient, considered to have a platinum-sensitive oligometastatic recurrence, was recommended surgical excision. A partial gastrectomy with excision of a suspicious lymph node was performed. The gastrectomy specimen, removed along with the mass, was consistent with high-grade serous carcinoma and the surgical margins were clear, although the lymph node was positive. The tumor board decided on a platinum-based chemotherapy regimen for the patient.

CONCLUSIONS: We reported a case of platinum-sensitive recurrent ovarian cancer that recurred in an atypical location. In platinum-sensitive recurrent oligometastatic ovarian cancer, if complete resection is achievable, adjuvant platinum-based chemotherapy after resection is associated with improved overall survival compared to chemotherapy alone, and this should be considered in the management of our patients.

Keywords: platin-sensitive-recurrence, ovarian cancer, partial gastrectomy

VS-30 [Onkoloji]

Laparoscopic para-aortic lymph node dissection in a case of endometrium cancer

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Etlik Şehir Hastanesi

In the surgical management of endometrial carcinoma, laparoscopic approaches have been demonstrated in multiple studies to be superior to laparotomy in several aspects, including reduced blood loss, fewer severe postoperative complications, less postoperative pain, and an earlier return to normal activities during the recovery period. Previously, in the surgical treatment of endometrial carcinoma, laparotomy was the preferred approach when para-aortic lymph node dissection was required. However, with recent advancements, this preference has shifted in favor of laparoscopy.

A 57-year-old female patient presented to an external center with a complaint of postmenopausal bleeding. Following an endometrial biopsy performed at the external center, which revealed endometrioid adenocarcinoma, she was referred to our clinic for further evaluation and management. On examination, endometrial thickening and a mass-like appearance within the cavity were observed, with no additional remarkable findings. A decision was made to proceed with laparoscopic hysterectomy, bilateral salpingo-oophorectomy, and intraoperative frozen section analysis. Preoperative PET-CT imaging revealed an enlarged uterus containing a soft tissue density lesion with indistinct margins on non-contrast CT, measuring 5.5 × 5 cm in metabolic dimensions, with pathological FDG uptake (SUVmax: 17.44). No pathological metabolic activity was detected in lymph nodes, the largest measuring 12 mm in diameter, within the left external and internal iliac regions. The intraoperative frozen section analysis revealed endometrioid-type endometrial adenocarcinoma, Grade 2, with a tumor diameter of 6.5 cm, invading more than half of the myometrial wall. Based on these findings, the procedure was extended to include laparoscopic pelvic and para-aortic lymph node dissection and omentectomy, and the surgery was completed accordingly. Postoperative final pathology results revealed “endometrial adenocarcinoma, endometrioid type, Grade 3, with the largest tumor diameter measuring 6.5 cm, deep invasion into the myometrial wall (greater than 1/2), and the presence of lymphovascular invasion (>4)”.

In our clinic, the Gynecological Oncology Department at Etlik City Hospital, minimally invasive techniques are primarily preferred for the surgical treatment of endometrial carcinoma. In this video-case presentation, we will share an example of the laparoscopic paraaortic lymph node dissection procedure, which we frequently perform.

Keywords: Endometrial cancer, Laparoscopy, Para-aortic Lymph Node Dissection

VS-31 [Onkoloji]

Robotic-assisted hysterectomy with sentinel lymph node mapping in endometrial cancer: secrets of pelvic retroperitoneal anatomy

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AIM: to evaluate our practice of robotic sentinel lymph node dissection and demonstration of the pelvic retroperitoneal space in endometrial cancer patients

METHOD: the patient who applied to our center with a complaint of postmenopausal bleeding and whose endometrial biopsy result showed grade 1 endometrioid type endometrial cancer was evaluated radiologically as disease limited to the uterus. The patient, who was classified as having low-risk endometrial cancer according to the European Society of Gynecological Oncology, underwent hysterectomy and bilateral salpingo-oophorectomy with robotic sentinel lymph node dissection (da Vinci X® robotic system) using indocyanine green.

RESULTS: pathology result was reported as endometrioid adenocarcinoma grade 1, four reactionary lymph nodes (2 right sentinel, 2 left sentinel). The neoplasm observed in the endometrium was 4 cm in diameter, superficial invasion (<1/2 inv), lymphovascular invasion negative, p53 wild pattern, loss of expression with PMS2, MMRd positive. Lymph nodes were evaluated with ultrastaging.

CONCLUSION: robotic-assisted hysterectomy has become a widely and increasingly used modality of minimally invasive surgery in the treatment of endometrial cancer. According to the recommendation of the National Comprehensive Cancer Network guidelines, hysterectomy, bilateral salpingo-oophorectomy and sentinel lymph node dissection are now required for surgical treatment in all endometrioid grades (grades 1-2-3) endometrial cancers. Sentinel lymph node dissection is a less invasive technique for finding occult metastases in normal-appearing lymph nodes while avoiding full pelvic lymph node surgery. Minimally invasive techniques such as robotic surgery have advantages over laparotomy because they provide less scarring, less postoperative pain

and a faster recovery period.

Keywords: endometrium, robotic, sentinel

VS-32 [Onkoloji]

Robotic Sentinel Lymph Node Biopsy: The Hidden Sentinel in the Obturator Region

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AIM: With this video, we present a demonstration of the surgical technique for robotic sentinel lymph node (SLN) biopsy in the obturator region for endometrial cancer

METHOD: A 55-year-old patient presented to our center with a complaint of postmenopausal bleeding. An endometrial biopsy revealed endometrioid-type endometrial cancer, Grade 1. Radiological evaluation indicated that the disease was confined to the uterus, with no evidence of metastasis. The patient subsequently underwent robotic hysterectomy and bilateral salpingo-oophorectomy with bilateral SLN biopsy. For SLN mapping, a total of 2 ml of indocyanine green (ICG) dye was injected into the cervical stroma—0.5 ml superficially (1-3 mm deep) and 0.5 ml deeply (1 cm)—at the 3 and 9 o'clock positions.

RESULT: After accessing the left retroperitoneal space, the first and second lymph nodes were visualized at the left external iliac region using Firefly mode of the Da Vinci Xi system. Dissection was then continued in the obturator region, where Firefly mode revealed lymphatic channels crossing the left obliterated umbilical artery. These channels were traced to the true SLN in the obturator region. The SLN, along with two additional lymph nodes, was dissected and sent to pathology separately for further evaluation. Final pathology confirmed as FIGO 2023 Stage IA2 endometrioid-type endometrial carcinoma. Results of ultra-staging of the SLN were negative.

CONCLUSION: While performing a SLN biopsy, the first identified lymph node may not always be the true sentinel node. It is essential to continue the dissection of the obturator region to thoroughly assess for additional lymph nodes that may represent the true sentinel node.

Keywords: sentinel lymph node biopsy, endometrial cancer, robotic surgery

VS-33 [Onkoloji]

Posthysterectomy staging of endometrium cancer – Pelvic, paraaortic and sentinel lymphadenectomy

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BACKGROUND AND AIM: Surgical staging of endometrial cancer, the most common malignancy in gynecological oncology, should be conducted in a way that minimizes morbidity. The extraperitoneal approach is a convenient and safe alternative to laparoscopic para-aortic lymphadenectomy. Sentinel lymph node mapping plays an important role in determining the extent of the disease and in the treatment decision. In this video, extraperitoneal para-aortic lymphadenectomy and sentinel lymph node mapping performed for the staging of a patient diagnosed with endometrial cancer in pathology after hysterectomy are presented.

METHODS: A 47-year-old woman, gravida 2, parity 2. She had one vaginal delivery and one cesarean delivery. She has comorbidities of diabetes and arrhythmia. She underwent vaginal hysterectomy at an external center after endometrial biopsy revealed endometrial hyperplasia. Postoperative pathology revealed grade 2 endometrioid adenocarcinoma grade 2. The tumor had invaded less than half of the myometrium. No endocervical or lymphovascular invasion was seen. Gynecological examination: Vulva and vagina are normal, no lesion on the cuff. PET-CT showed physiologic involvement of the left ovary. Laparoscopic staging surgery was planned. The operation was initiated with laparoscopic extraperitoneal paraaortic lymph node dissection. Sentinel lymph node mapping was performed with indocyanine green dye applied to the vaginal cuff. Staging surgery was completed with laparoscopic pelvic lymphadenectomy and bilateral salpingo-oophorectomy.

RESULTS: The patient was discharged without complications on the 7rd postoperative day. No metastasis was found in 35 pelvic lymph nodes and 44 paraaortic lymph nodes in postoperative pathology. Bilateral ovaries and tubes were normal. The patient received brachytherapy in radiation oncology.

CONCLUSION: This case highlights the value of a minimally invasive, targeted approach to staging endometrial cancer after hysterectomy. Combining laparoscopic extraperitoneal para-aortic lymphadenectomy with sentinel lymph node mapping using indocyanine green dye effectively staged the disease with minimal morbidity.

Keywords: endometrium cancer, lymphadenectomy, minimally invasive

VS-34 [Onkoloji]

vNOTES Hysterectomy and Sentinel Lymphadenectomy with Methylene Blue for Early Stage Endometrial Cancer

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OBJECTIVE: This video demonstrates the feasibility and surgical technique of vaginal natural orifice transluminal endoscopic surgery (vNOTES) for hysterectomy, bilateral salpingo-oophorectomy (BSO), and sentinel lymph node (SLN) mapping using methylene blue in early-stage endometrial cancer.

A 62-year-old patient with biopsy-confirmed endometrioid endometrial carcinoma underwent vNOTES hysterectomy, BSO, and SLN dissection. After cervical injection of methylene blue, transvaginal access was established using a vNOTES port. The uterus, adnexa, and sentinel lymph nodes were identified and excised using a combination of standard laparoscopic instruments and electrosurgical energy devices. The procedure was performed in a minimally invasive manner with careful preservation of surrounding structures.

RESULTS: The total operative time was 60 minutes, with minimal blood loss. Bilateral sentinel lymph nodes were successfully identified in the pelvic region. No intraoperative or postoperative complications were observed. The patient had an uneventful recovery and was discharged on postoperative day 2. Histopathological examination confirmed the absence of lymph node metastasis.

CONCLUSION: vNOTES hysterectomy with sentinel lymphadenectomy using methylene blue is a safe and feasible approach for early-stage endometrial cancer. This technique offers the advantages of minimal invasiveness, reduced postoperative pain, and enhanced cosmetic outcomes. The use of methylene blue for sentinel node mapping provides a cost-effective alternative to conventional tracers. Further studies are needed to validate oncologic outcomes and optimize patient selection for this approach.

Keywords: endometrial cancer surgery, sentinel lymph node, vNOTES, vNOTES hysterectomy

VS-35 [Onkoloji]

Sentinel Inguinal Lymph Node Dissection in A Case of Keratinized Squamous Cell Vulvar Cancer

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OBJECTIVES: In vulvar cancer inguinal-femoral lymph node dissection (IF-LND) carries a significant risk of complications, with approximately two-thirds of patients experiencing wound dehiscence, lymphocyst formation, or lymphedema. In early-stage vulvar cancer, the rate of metastasis following IF-LND is less than one-third of cases. Vulvar cancer exhibits predictable patterns of lymphatic drainage. However, it is noteworthy that 75% of mortality in vulvar cancer is attributed to inguinal recurrence, which is challenging to treat and generally fatal. When lymph node metastasis is absent, the rates of inguinal recurrence vary according to the surgical approach employed, with systematic lymph node dissection showing approximately 1% recurrence, superficial lymph node dissection showing 5-7% recurrence, and sentinel lymph node biopsy in selected patients showing less than 3% recurrence. In this case we want to present a case of sentinel lymph node dissection in vulvar squamous cell cancer.

METHODS: We presented a stage 3B vulvar squamous cell cancer patient in this video abstract.

RESULTS: A 60-year-old woman with a history of diabetes (DM) and hyperlipidemia (HL) presented with a vulvar mass. A punch biopsy confirmed the diagnosis of vulvar squamous cell carcinoma. Notably, on physical examination, no palpable lymph nodes were detected, although PET CT revealed pathologic FDG uptake in the vulvar mass. The patient subsequently underwent a total vulvectomy combined with bilateral inguinal lymph node dissection and a right inguinal sentinel lymph node dissection. Histopathological examination demonstrated a moderately differentiated, keratinized squamous cell carcinoma with a stromal invasion depth of 3 mm and a maximum tumor diameter of 2.7 cm. Perineural invasion was observed, while lympho-vascular space invasion was absent and both lateral and deep surgical margins were clear. In the lymph node assessment, two non-tumorous metastatic lymph nodes were identified in the right inguinal sentinel group, with additional reactive lymph nodes found bilaterally (8 on the right and 10 on the left). The disease was staged at 3b, and adjuvant chemoradiotherapy has been planned as part of her postoperative management.

CONCLUSIONS: Patients who undergo sentinel lymph node biopsy experience significantly lower complication rates and maintain a higher quality of life compared to those who undergo complete lymph node dissection.

Keywords: inguinofemoral lnd, sentinel, vulva cancer

VS-36 [Endoskopi]

Laparoscopıc Low Anterıor Resectıon In A Case Of Endometrıosıs Wıth Colon Involvement

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Endometriosis is the presence of functional endometrial tissue in ectopic areas outside the uterine cavity. Ectopic endometrial tissue most commonly involves the pelvic organs, ovaries, douglas pouch, sacrouterine ligaments, pelvic peritoneum, rectovaginal septum and cervix. The prevalence of endometriosis varies between 3% and 37% in women of reproductive age. The most prominent symptoms of intestinal endometriosis are periodic rectal bleeding, pelvic pain, abdominal pain, constipation, diarrhea and bloating. The severity of these symptoms varies between cases. In addition to these vague complaints, it may also cause symptoms such as intestinal stenosis and acute abdomen. Here we report a patient who presented with dyspareunia, chronic pelvic pain, constipation and dysmenorrhea and was diagnosed with endometriosis. A 36 years old nulliparous patient underwent laparoscopic endometriosis operation and low anterior resection.

Keywords: laparoscopy, endometriosis, low anterior resection

VS-37 [Endoskopi]

Laparoscopic Bilateral Salpingo-Oophorectomy, Trachelectomy, and Excision of Parasitic Myomas from the Vaginal Sidewall: A Complex Surgical Approach

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OBJECTIVE: This video presentation demonstrates a complex laparoscopic procedure involving bilateral salpingo-oophorectomy, trachelectomy, and excision of parasitic myomas from the vaginal sidewall in a patient with a history of multiple gynecologic surgeries.

CASE DESCRIPTION: A 50-year-old female with a history of three prior myomectomies and a subtotal hysterectomy presented with postcoital bleeding and suprapubic pain. Imaging revealed multiple solid masses, the largest measuring 35×25 mm. Colposcopic biopsy confirmed CIN 2, and despite undergoing LEEP with negative margins, trachelectomy was recommended due to persistent cervical pathology. The patient opted for definitive surgical management. Intraoperatively, laparoscopic bilateral salpingo-oophorectomy and trachelectomy were performed. A bladder injury occurred and was repaired laparoscopically. Additionally, three leiomyomas located on the left vaginal sidewall were excised. Histopathological analysis confirmed the benign nature of all excised specimens.

CONCLUSION: This case highlights the feasibility of laparoscopic management in complex gynecologic pathologies, demonstrating that vaginal myomas can be excised through the vaginal route. The video provides a step-by-step demonstration of the surgical technique and key intraoperative considerations.

Keywords: Laparoscopic surgery, Parasitic leiomyomas, Trachelectomy,

POSTER BİLDİRİLER

PS-01 [Jinekoloji Genel]

Management of Cirrhosis-Related Ascites Through Transvaginal Drainage Following Hysterectomy:A Case Study

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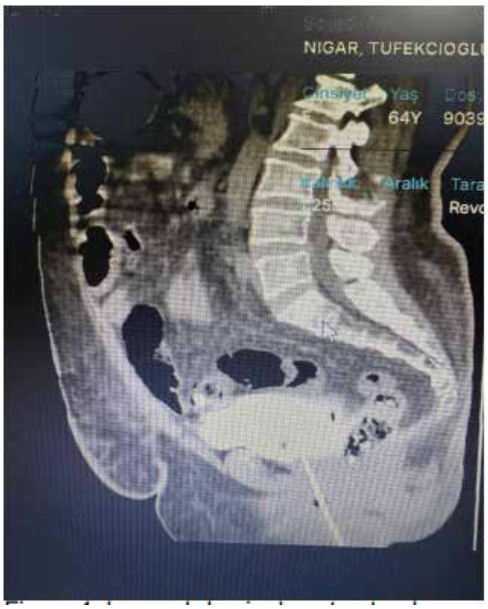
Summary: This study explores the novel use of transvaginal drainage for the management of cirrhosis-related ascites in a patients who have undergone hysterectomy.Ascites is a common complications in cirrhotic patients. Traditional approaches such as paracentesis or surgical interventions may carry increased risks or limitations in such cases. In this report, we present a case where ascitic fluid was coincidentally drained transvaginally, occurring after hysterectomy. And it shows us its feasibility and potential advantages, including minimal invasivness and reduced risk of infections.

Case Presentation: A 64-year-old patient applied to our clinic with complaints of postmenopausal bleeding. The patient, whose bleeding and endometrial irregularity continued, underwent hysterectomy. The patient's medical history included Type 2 DM, obesity, HT and cirrhosis, thought to have developed after NASH. Pre-op imaging revealed widespread ascites in the abdomen that had been ongoing for the last 1 year. In the second week after the surgery, the patient complained of abundant vaginal serous discharge, but no ascites was observed in the abdomen on ultrasonography. Speculum examination revealed serous fluid leaking from the vaginal cuff.Then, due to suspicion of fistula, the patient underwent contrast-enhanced lower abdominal CT examination. Contrast material was administered into the bladder and rectum. No passage to the abdomen or vagina was observed. Fistula was ruled out. It was thought that the patient's ascites in the abdomen were draining from the vaginal cuff. In the patient's next check-up, it was detected in the abdominal ultrasound that after the vaginal cuff epithelialization process was completed, the discharge had stopped and there was a re-accumulation of ascites in the abdomen.

Results and Discussion: The disappearance of the patient's edema and swelling with the drainage of ascites from the vaginal cuff and the regression of abdominal pain complaints made us think that this method could be used as an adjunct to treatment. In patients with ascites caused by cirrhosis, especially in cases where intra-abdominal anatomic and surgical changes such as hysterectomy limit the drainage method, the transvaginal drainage method can be a safe and effective alternative. Although traditional methods include ultrasound-guided abdominal paracentesis, transjugular intrahepatic portosystemic shunt (TIPS) or laparoscopic drainage, these approaches have limitations in some patients due to the reasons described above.There are studies in the literature that the vaginal route can be used for ascites drainage in OHSS patients. Transvaginal drainage applications were previously tried in 2015 and 2017 due to abscess and pelvic fluid accumulation after gynecological cancer surgery. However, there is no previous study in the literature on the use of this method in a patient with cirrhosis.This case demonstrates that the vaginal route provides a natural transition point for accessing the intra-abdominal cavity, providing a minimally invasive alternative, especially in patients with a history of surgery. Vaginal drainage provided rapid relief without increasing the risk of infection and improved the patient's general clinical condition.The procedure was well-tolerated, with no significant complications, and contributed to the patients overall recovery.However, large case series and comparative studies are needed for this method to be widely used.

Keywords: hysterectomy, ascites, transvaginal drainage, cirrhosis

BT abdomen



PS-02 [Jinekoloji Genel]

Transendometrial Cesarean Myomectomy: Case Report

Cengiz Şanlı
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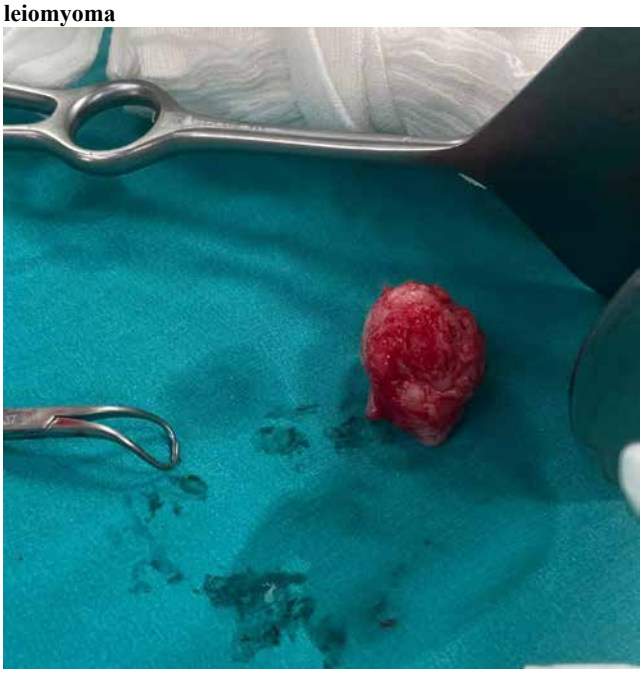
Uterine myomas are the most common benign tumors in women of reproductive age and their frequency increases with age until menopause. Today, the risk of myoma during pregnancy increases with increasing maternal age. Although most women with myomas have asymptomatic pregnancies, some may develop complications such as spontaneous abortion, premature birth, IUGR i(ntrauterine growth restriction) and abruption. The risk of complications also increases with the increase in myoma diameter. There are still hesitations about removing myomas during a cesarean section due to the difficulty in controlling bleeding and the possibility of hysterectomy.

In myomectomy performed with an incision made from the endometrium during a cesarean section, the need for sutures for hemostasis, blood loss, and postoperative adhesions are less common compared to transserosal myomectomy.

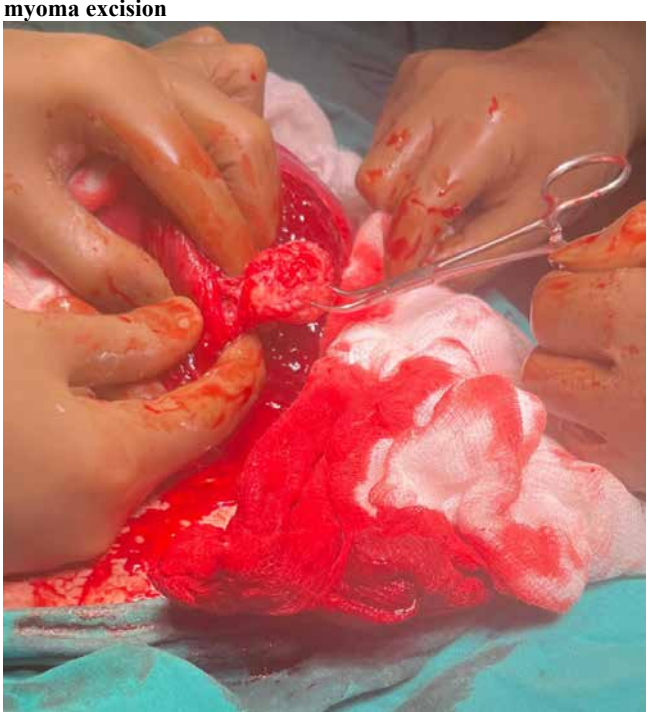
In this study, we aimed to present a case of transendometrial myomectomy that we performed during a cesarean section.

Keywords: myomectomy, ceserean birth, ceserean myomectomy

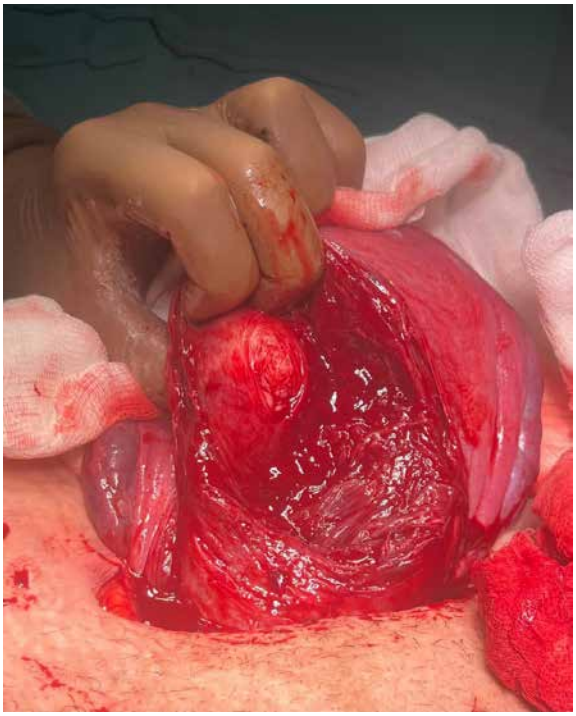
leiomyoma



myoma excision



transendometrial incision



type 5 myoma

PS-03 [Jinekoloji Genel]

Angiolipoleiomyoma of the uterus: a rare case report and review of the literature

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In recent years,mesenchymal tumors consisting of vascular components, mature adipose tissue,and smooth muscle have been recognized as rare variants of leiomyomas.These tumors have been described in the literature under various names, including lipoleiomyomatous tumors,hamartomas,benign lipomatous lesions,and benign mixed mesodermal tumors.

Due to the lack of an official classification by the World Health Organization (WHO), most reported cases in the literature have been classified under angiomyolipoma (AML) or angioleiomyoma (ALM). These tumors have also been referred to in the literature as PEComas, composed of perivascular epithelioid cells, which test positive for markers such as desmin, caldesmon, and SMA, and show immunoreactivity particularly with anti-human melanoma (HMB-45).

One of the rare tumors of the uterus previously classified under PEComas but recently identified as a distinct entity is angiolipoleiomyoma (ALLM). ALLM consists of three histological components: abnormal vascular structures, adipose tissue cells, and smooth muscle cells. It is a rare tumor with an incidence rate of 0.06%.

A literature search was conducted using the keyword “angiolipoleiomyoma” on PubMed and Google Scholar,up to June 2024.Animal studies were excluded from the review. As noted in the introduction, due to the lack of a clear classification, the most recent diagnostic criteria were utilized to identify 31 ALLM cases. A 40-year-old G4P4 patient presented to the emergency department with heavy vaginal bleeding.Except for a history of diabetes mellitus (DM), her medical history was unremarkable. Her hemoglobin level was 6.8 g/dL and hematocrit was 23.9% upon admission. Emergency erythrocyte and fresh frozen plasma transfusion were administered.

Pelvic ultrasound revealed a cystic-solid mass with a hyperechoic, heterogeneous appearance adjacent to the right side of the uterus. A protruding 5 cm active bleeding mass, suspected to be a myoma in statu nascendi, was excised, followed by dilation and curettage. After stabilizing the patient, an MRI was performed. MRI demonstrated a lobulated mass (90x52 mm) containing mildly hyperintense areas on T1A images, with heterogeneous hyperintensity and punctate enhancement on post-contrast imaging. The mass was excised via Pfannenstiel incision, and the final pathology confirmed ALLM.

ALLM is usually identified in patients aged 40 years and older (with the exception of one 26-year-old case). It is always benign, sharing some histopathological features with leiomyomas but distinguished by its vascular and adipose components.

Typically located in the uterine corpus, these masses range from 2 cm to 16 cm in size, with an average diameter of 7.5 cm. They are often associated with tuberous sclerosis, as 69-80% of tuberous sclerosis patients have concurrent ALLM.

Despite their generally asymptomatic nature, they can occasionally cause irregular menstrual bleeding.

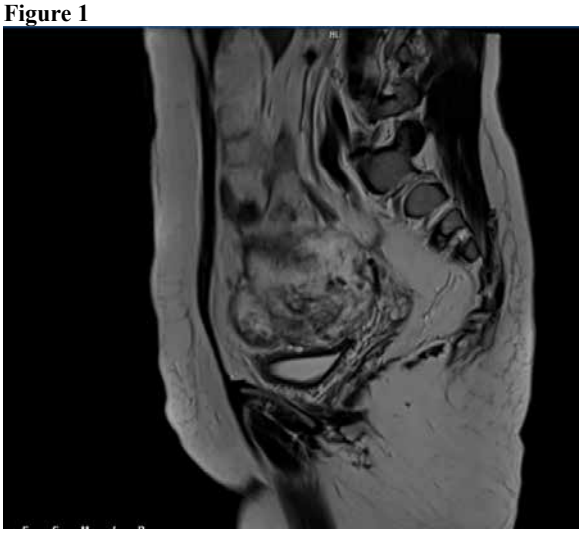
Diagnostic imaging, including ultrasonography, CT, and MRI, may be utilized for preoperative evaluation. However, imaging findings are non-specific.

Histologically, immunohistochemistry differentiates ALLM from ALM based on HMB-45 negativity. Verocq et al. reported KRAS and KIT mutations in a case of ALLM in 2022.

The aim of this ALLM case report is to contribute to the classification of benign uterine tumors and enhance diagnostic accuracy by providing clinical insights and imaging characteristics.

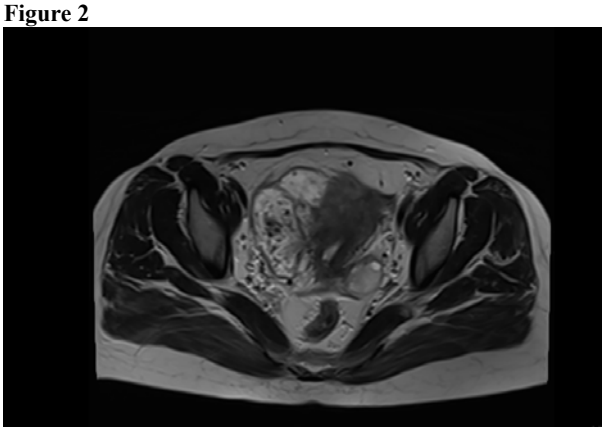
Keywords: angiolipoleiomyoma, rare uterine tumor, pecoma

Figure 1



MRI findings of the tumor.

Figure 2



MRI findings of the tumor.

Figure 3

A literature review of ALLM cases.

PS-04 [Jinekoloji Genel]

Ovarian torsion in large ovarian cysts: case presentation and management

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1. INTRODUCTION

Ovarian cysts are common pathologies encountered in gynecological examinations. Most ovarian cysts are small, asymptomatic, and typically detected incidentally. However, cysts larger than 10 cm are defined as "large ovarian cysts" and require separate evaluation for their management.

Ovarian torsion is most commonly seen in cysts ranging from 4 to 10 cm in size, while torsion in large ovarian cysts is a rare occurrence.

2. AIMS AND METHODS

The purpose of this study is to examine the diagnosis and treatment of large ovarian cysts, a rare etiology causing ovarian torsion, and to establish an approach for their management.

3. PATIENT INFORMATION

Patient Information: A 38-year-old female, G4P4Y4 (NSD, C/S*3).

Presenting Complaints: The patient presented with right lower quadrant pain, nausea, vomiting, and acute abdomen.

Comorbidities: None.

Previous Surgeries: C/S*3 (3 cesarean sections).

Urinary Ultrasound (17/02/2025): The bladder is not sufficiently filled. The lumen appears normal. The uterus appears normal. EDCK (Endometrial Thickness): 14 mm. An 11 cm heterogenous lesion with peripheral solid components and blood supply from the wall was observed in the midline of the abdomen. There was 4x3 cm of free fluid in the adjacent area.

Pathological Laboratory FINDINGS: CA-125: 493 (elevated).

Transvaginal Ultrasound (17/02/2025):

Uterus AV-AF, endometrial thickness 18 mm. On the left ovary, a heterogeneous cyst measuring 12x11 cm containing peripheral solid formations was observed.

Minimal free fluid in the Douglas pouch was noted.

4. SURGERY AND PATHOLOGY RESULT

The patient underwent laparotomy with right salpingo-oophorectomy + omentum biopsy + abdominal washing on 17/02/2025 due to suspected ovarian torsion and acute abdomen.

The pathology report confirmed endometrioma.

5. CONCLUSION

Ovarian torsion is typically associated with functional cysts; however, in rare cases, endometriomas and large tumors may also lead to torsion. Endometriomas and large tumors are less common but significant causes of ovarian torsion. These conditions can complicate the diagnostic process because these tumors often reach large sizes, and their clinical presentation may overlap with more common causes. Therefore, in any patient presenting with suspected ovarian torsion, it is crucial to consider all potential diagnoses carefully and utilize appropriate advanced imaging techniques.

Keywords: endometrioma, ovarian cysts, ovarian torsion

image-1

image-2

image-3

PS-07 [Jinekoloji Genel]

Abnormal Uterine Bleeding in a Patient with Multiple Myomas

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OBJECTIVE: Multiple myomas are common benign tumors in women and are frequently associated with abnormal uterine bleeding. This study aimed to evaluate the diagnosis, treatment (laparotomic myomectomy), and pathology processes of a patient with multiple myomas.

METHOD: A 30-year-old, G0P0 (no pregnancies or deliveries) female patient presented with complaints of abnormal uterine bleeding. During the speculum examination, the patient was noted to have menstrual bleeding, and the perineum, vulva, vagina, and cervix appeared normal.

• Ultrasonography (USG): Multiple myomas were observed, the largest being 3 cm, with several others under 1 cm within the cavity. The myomas were predominantly located posteriorly.

• MRI Imaging: The borders of the myomas were not clearly defined, and adenomyosis was suspected.

Preoperative tests revealed:

• Negative serology,

• Blood type: O Rh positive,

• Hemoglobin: 12.4 g/dl,

• Hematocrit: 36.8%,

• No coagulation disorders,

• Normal liver and kidney function tests,

• Negative beta-HCG levels.

SURGERY: The patient underwent laparotomic myomectomy, left paratubal cyst excision, and intrauterine device (IUD) insertion on November 1, 2024. During the surgery, more than 40 myomas were removed, and the pathology results confirmed benign leiomyomas. No malignancy was detected in the left paratubal cyst.

Findings

• November 13, 2024: During the postoperative follow-up, the patient's physical examination and USG findings were noted as normal.

• November 25, 2024: At the follow-up visit, the patient reported yellowish discharge and a 5-day delay in her menstrual cycle. Speculum examination revealed monilial leukorrhea, and USG showed an endometrial thickness of 7 mm. Appropriate treatment was prescribed.

• January 6, 2025: Follow-up USG showed an endometrial thickness of 6 mm, and the IUD was observed in place.

• January 30, 2025: The patient reported no menstrual irregularities or complaints.

• March 4, 2025: Office hysteroscopy was performed:

o No irregularities were observed in the endometrial cavity.

o No bleeding focus was detected.

o 2-3 millimetric myomas were observed at the entrance of the right tubal ostium.

o The left tubal ostium was noted as normal.

• Ongoing Follow-Up: Since the patient does not currently desire pregnancy, follow-up care continues with the use of an intrauterine device (IUD), and a control appointment has been scheduled.

CONCLUSION: Laparotomic myomectomy is an effective method for alleviating symptoms in cases of multiple myomas. This case highlights the importance of regular follow-up, accurate diagnosis, and treatment processes.

• Pathology FINDINGS: The myomas were confirmed to be benign, and the surgical treatment was successfully performed.

• Postoperative Process: Regular follow-up and the absence of complications supported the success of the treatment.

Keywords: Abnormal Uterine Bleeding, Postoperative Follow-Up,Complication-Free Recovery

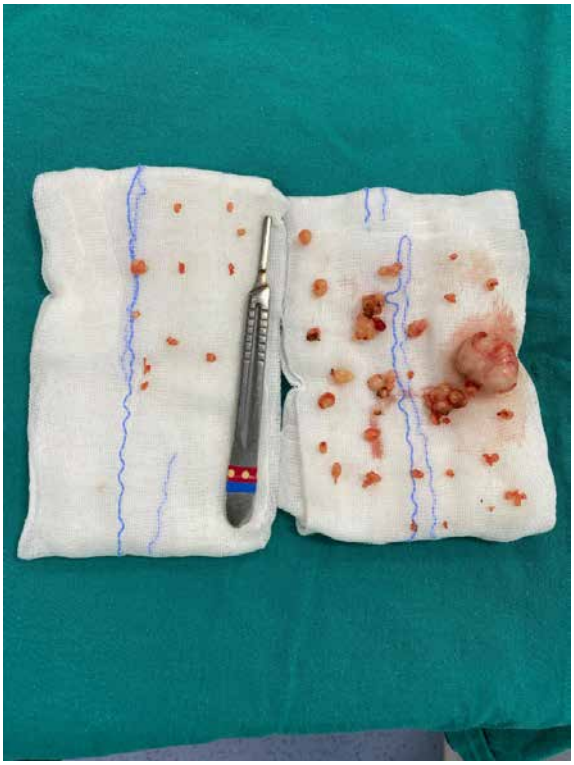
HISTEROSKOPI

Office Hysteroscopy

MYOMA UTERI

MYOMA UTERI

MYOMA UTERI



INTRA MULTIPLE UTERINE MYOMAS

PS-08 [Jinekoloji Genel]

Case report: Whirlpool sign at ovarian torsion

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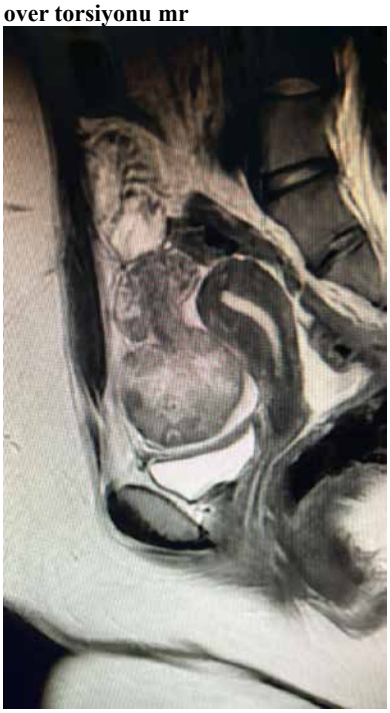
INTRODUCTION: Ovarian torsion is a gynecological emergency characterized by the complete or partial rotation of the ovary and its vascular pedicle, leading to compromised blood flow. It accounts for approximately 3% of emergency gynecological cases and, if untreated, may result in ischemic necrosis, leading to severe complications. (1,2) Ovarian torsion can occur at any age, from the fetal period to postmenopausal stages; however, it is most frequently diagnosed in women of reproductive age. It should always be considered in cases of acute lower abdominal pain. The literature suggests that the right ovary is more commonly affected due to the protective effect of the sigmoid colon on the left ovary and the greater length of the right infundibulopelvic ligament, which increases the likelihood of rotation around its axis. (3) Clinically, ovarian torsion presents with acute, severe unilateral pelvic pain, often accompanied by nausea, vomiting, and tenderness. Differential diagnoses include ectopic pregnancy, ruptured ovarian cyst, and appendicitis. Imaging modalities such as Doppler ultrasonography, CT and MRI aid in diagnosis. Urgent surgical intervention is required to prevent ovarian infarction. This report presents a case of ovarian torsion with the characteristic “whirlpool sign” on MRI, highlighting its diagnosis and management in a reproductive-aged woman.

CASE REPORT: An 18-year-old nulligravid woman (G0P0) presented with sudden-onset, severe, diffuse abdominal pain. She denied nausea, vomiting, or anorexia. Her medical history was unremarkable, with no comorbidities or prior surgeries. On physical examination, tenderness was noted in the right lower quadrant. Laboratory findings revealed leukocytosis (WBC: 18,060 cells/mm³), anemia (Hgb: 10.2 g/dL), and elevated C-reactive protein (CRP: 109 mg/L). Platelet count was 280,000 cells/mm³. Serum β-hCG and tumor markers were negative. Abdominal ultrasonography showed an enlarged left ovary (68 × 45 mm) containing a 33 × 30 mm anechoic cystic lesion. Doppler assessment raised suspicion of decreased vascularization in the left ovary. The right ovary appeared normal. Additionally, 25 mm of free fluid was detected in the Douglas pouch. Contrast-enhanced pelvic MRI revealed the characteristic "whirlpool sign," indicating torsion. The right ovarian pedicle appeared twisted, measuring 84 × 54 mm, with areas of necrosis within the ovarian parenchyma and significant reduction in contrast enhancement, confirming ovarian torsion. A 6 cm adjacent cystic lesion was also noted. Given the clinical and radiological findings, emergency laparoscopy was performed following informed consent. Intraoperatively, the uterus appeared normal, but the right ovary and fallopian tube were necrotic (~10 cm) with three complete twists. After detorsion and a 30-minute observation period, absent reperfusion necessitated salpingo-oophorectomy, performed using advanced bipolar energy.

CONCLUSION: Ultrasonography (USG) is the first-line imaging modality in emergency settings due to its accessibility and rapid assessment capabilities. However, MRI plays a crucial role in confirming the diagnosis and assessing prognosis. The progression of untreated adnexal torsion to abscess formation is rare, and mortality remains extremely low. Urgent surgical intervention is essential to prevent ovarian necrosis. In this patient, inconclusive ultrasonographic findings led to MRI imaging, which demonstrated the "whirlpool sign," enabling a timely and accurate diagnosis and guiding surgical decision-making.

Keywords: OVARY, TORSİON, WHİRLPOOL SİGN

over torsiyonu mr

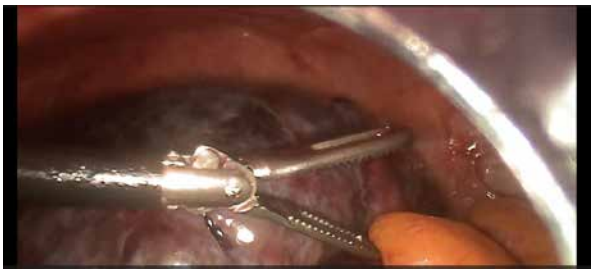


mr görüntüsü

OVER TORSİYONU VAKA

OVER TORSİYONU VAKA

OVER TORSİYONU VAKA 3



PS-10 [Jinekoloji Genel]

Low-grade appendiceal mucinous neoplasm (LAMN) mimicking a genital tract tumor: a rare case report

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INTRODUCTION: In women of reproductive age, particularly in emergency settings, it is essential to rule out conditions such as intrauterine/extrauterine pregnancy and ovarian torsion when they present with pelvic or lower abdominal pain and abnormal uterovaginal bleeding. If the pain shifts towards the right adnexal region, the possibility of appendicitis should also be considered. Some appendiceal tumors can invade the right adnexal area, mimicking genital tract pathologies. Pelvic ultrasonography and conventional imaging techniques may not always provide definitive information regarding the origin of a mass. In

this study, we aim to contribute to the literature by presenting a rare case of an appendiceal tumor that mimicked a genital tract tumor.

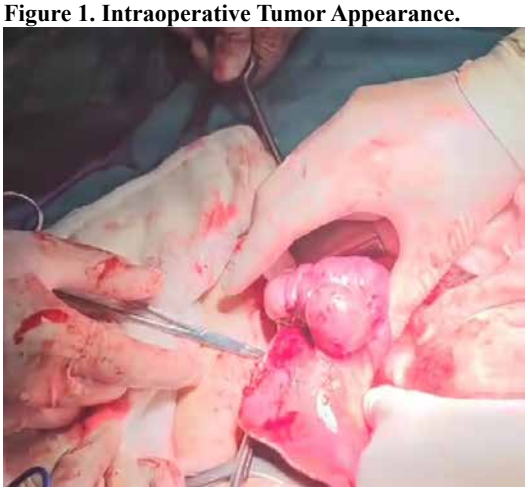
CASE REPORT: A 40-year-old woman (G1P1) with irregular menstrual bleeding presented to the emergency department with persistent abdominal pain accompanied by nausea. After evaluation, acute appendicitis could not be ruled out. Additionally, a right adnexal mass was detected through gynecological examination and ultrasonography, leading to a preliminary diagnosis of pedunculated myoma torsion, and a decision was made to perform a Pfannenstiel laparotomy. The patient's medical history included a previous cesarean section, a left hemiplegic attack (for which she was taking acetylsalicylic acid), and a smoking history of 20 pack-years. Intraoperatively, the mass was found to be adherent to the uterus and tubo-ovarian complex on the right side, with the appendix also involved in this conglomerate structure. A perioperative consultation with General Surgery was requested. A total abdominal hysterectomy, right unilateral salpingo-oophorectomy, right salpingectomy, and appendectomy were performed. Frozen section analysis suggested a benign pathology, and the surgery was concluded accordingly (Figure 1). The operation lasted 55 minutes, and the patient's hemoglobin level decreased by 0.7 g/dL. The final pathology report diagnosed low-grade appendiceal mucinous neoplasm (LAMN) with negative surgical margins, no lymphovascular or perineural invasion, and an in situ 4 cm tumor (Figure 2). The patient has been followed up without complications at her 6-month postoperative General Surgery check-up.

DISCUSSION: Borges et al. (World J Clin Cases, April 6, 2021; 9(10): 2334-2343) reported a case of low-grade mucinous appendiceal neoplasm (LAMN) initially presenting as an ovarian lesion. Their literature review identified 23 similar cases. Additionally, a large case series indicated that the median age at LAMN diagnosis is 61 years. The differential diagnosis also includes mucinous adenocarcinoma of the appendix, high-grade appendiceal mucinous neoplasm, pelvic foreign body, and subserous uterine fibroid. In a separate report, Vavinskaya et al. (2016) described a rare presentation of LAMN associated with pseudomyxoma peritonei. The patient initially exhibited mucinous and bloody vaginal discharge. Upon pathological examination, LAMN was found to have secondarily involved the peritoneum, ovaries, and endometrial surface.

CONCLUSION: As a low-grade tumor requiring careful monitoring, interdisciplinary collaboration between gynecologists, general surgeons, and pathologists is essential for accurate diagnosis and optimal patient care. According to the American Society of Colon and Rectal Surgeons' Clinical Practice Guidelines, appendectomy alone is an effective treatment for LAMNs with clear margins and no signs of perforation or peritoneal spread.

Keywords: Low-Grade Appendiceal Mucinous Neoplasm, LAMN, adnexal mass, appendectomy

Figure 1. Intraoperative Tumor Appearance.



The intraoperative image illustrates a low-grade appendiceal mucinous neoplasm (LAMN) identified during surgery. The appendix appears distended and mucin-filled, with a smooth or mildly irregular external surface. It is closely associated with the right adnexal structures, creating a conglomerate formation involving the uterus and tubo-ovarian complex.

Figure 2. Postoperative Specimen Appearance.

The postoperative specimen includes a total abdominal hysterectomy (TAH), right unilateral salpingo-oophorectomy (USO), left salpingectomy, and appendectomy. The excised uterus exhibits a myomatous appearance, indicative of leiomyomas. Additionally, on the right side, a conglomerate mass is observed, comprising the adnexal structures and the appendix.

PS-13 [Jinekoloji Genel]

Postmenopausal case of isolated fallopian tubal torsion: a rare gynecological emergency in a rare patient group

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OBJECTIVE: Isolated fallopian tubal torsion is a rare gynecological emergency in which the fallopian tube twists on its own axis without involving the ovary. It is most commonly seen in women of reproductive age (18–45 years). This study presents a case of isolated fallopian tubal torsion in a postmenopausal patient and discusses the diagnostic and treatment process.

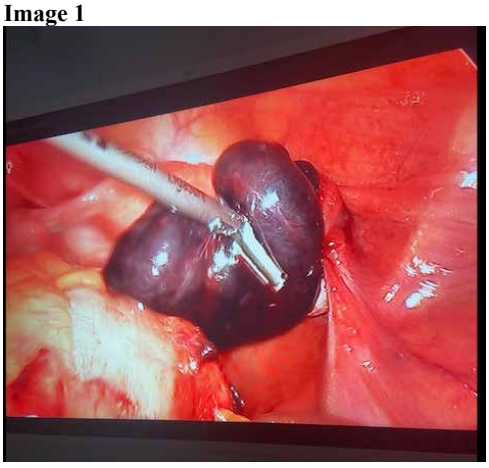
CASE: A 52-year-old female patient presented to the emergency department with right lower quadrant pain persisting for one week and newly developed nausea and vomiting. On physical examination, defense and rebound tenderness were detected in the right lower quadrant. Transvaginal ultrasonography revealed a cystic lesion of approximately 6.3 × 5.1 cm in the right adnexa, independent of the ovary, with septations protruding into the lumen. A diagnostic laparoscopy was performed.

RESULTS: During exploration, the right fallopian tube appeared dilated, congested, and torsed. A Morgagni hydatid cyst was also observed. The procedure was completed with laparoscopic right salpingectomy.

CONCLUSION: Isolated fallopian tubal torsion is a rare condition that can be challenging to diagnose due to its similarity to other acute abdominal pathologies. A definitive diagnosis is usually made during surgery, and if not recognized early, complete loss of tubal blood flow may occur. In adolescent and reproductive-age patients, early diagnosis is crucial for fertility preservation. Additionally, if the diagnosis is delayed, necrotic tissue may lead to peritonitis, abscess formation, or sepsis. Therefore, isolated fallopian tubal torsion should be considered in the differential diagnosis of acute pelvic pain, particularly in cases suspected of ovarian torsion.

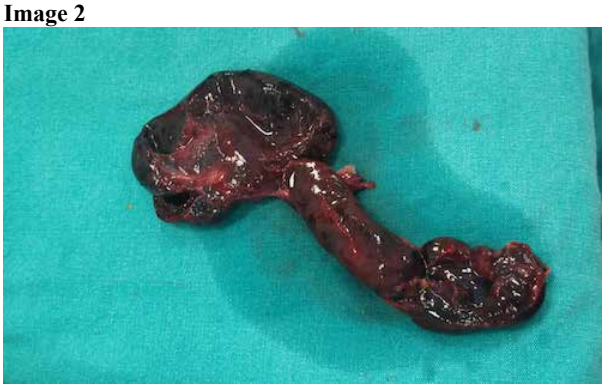
Keywords: isolated tubal torsion, salpingectomy, postmenopausal patient, gynecological emergency

Image 1



Right fallopian tubal torsion laparoscopic exploration

Image 2



Right Fallopian Tube Specimen

PS-14 [Jinekoloji Genel]

Large Myometrial Cystic Degeneration in the Postmenopausal Period: A Rare Case Report

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OBJECTIVE: In this case report, we aimed to present a 60-year-old patient who presented with vaginal bleeding in the postmenopausal period and was diagnosed with a cystic degenerated myoma, and to emphasize the clinical importance of cystic degenerated myomas.

METHODS: The clinical characteristics, imaging findings, surgical treatment, and histopathological results of a 60-year-old female patient who presented with postmenopausal bleeding were retrospectively evaluated. Additionally, a literature review was conducted to compile current information about cystic degenerated myomas.

RESULTS: Transabdominal ultrasonography revealed a well-circumscribed, heterogeneous mass measuring 105x95 mm containing cystic areas associated with the uterus. Magnetic resonance imaging identified a uterine-originating mass in the left lateral wall of the uterine corpus, measuring 107x95x92 mm at its widest point, which appeared hypointense on T1-weighted images, heterogeneously hyperintense on T2-weighted images, with septations that showed contrast enhancement. Pre-operative endometrial sampling revealed “endometrium under estrogenic effect.” The patient underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy, and pathological examination identified a cystic degenerated leiomyoma measuring 107x95 mm.

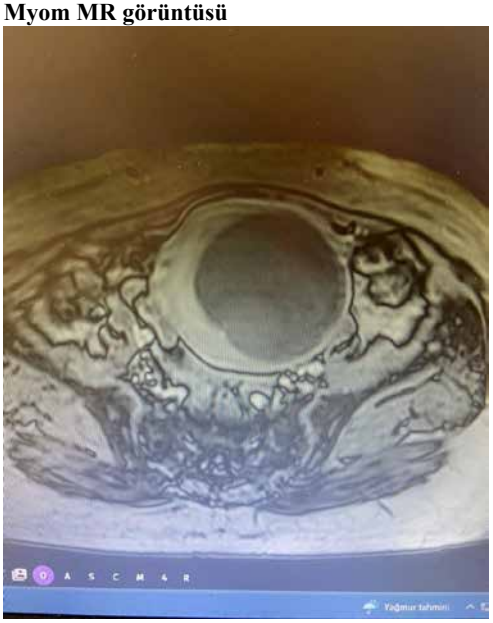
CONCLUSION: Cystic degenerated myomas are rare lesions that can occur even in the postmenopausal period and may cause abnormal uterine bleeding. Cystic degenerated myomas should be considered in the differential diagnosis of patients presenting with postmenopausal bleeding. While imaging methods are helpful in diagnosis, definitive diagnosis is made by histopathological examination. Surgical approaches should be preferred in treatment, and the possibility of malignancy should be ruled out.

Keywords: Cystic degenerated myoma, hysterectomy, postmenopausal bleeding

kistik dejenere myom

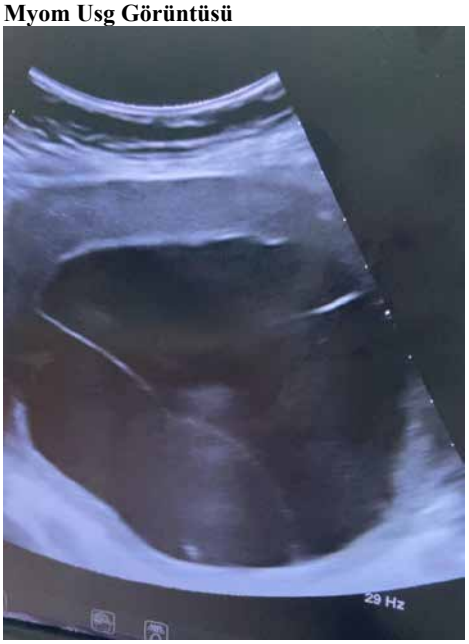
kistik dejenere myom patoloji materyali

Myom MR görüntüsü



preoperatif MR görüntülemesi

Myom Usg Görüntüsü



Preoperatif Usg görüntülemesi

piyes

perop histerektomi materyali

PS-15 [Jinekoloji Genel]

A Submucous Myoma Vaginally Prolapsed in Association with Uterine Prolapse

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OBJECTIVE: The aim of this case report is to present a case of prolapsed submucosal myoma causing pelvic endometriosis and uterine prolapse and to discuss the surgical treatment of these diseases within the framework of current literature.

METHODS: A 50-year-old woman with a history of two vaginal deliveries who presented with a palpable mass in the vagina and was evaluated. The diagnosis was confirmed through clinical examination, transvaginal ultrasonography, contrast-enhanced pelvic magnetic resonance imaging (MRI) and histopathologic examination. She was diagnosed with third degree uterine prolapse, pelvic endometriosis and prolapsed submucosal fibroids and underwent vaginal myomectomy, laparoscopic hysterectomy and bilateral salpingo-oophorectomy.

FINDINGS: Preoperative imaging revealed an 8×6 cm nodular mass protruding from the cervix. MRI showed hypointense plaques in the posterior part of the uterus consistent with endometriosis. Postoperative histopathologic evaluation revealed that the excised mass was an infected leiomyoma nodule with additional findings of adenomyosis and endometriosis. The surgical procedure was successfully completed and the patient was discharged on the 3rd postoperative day without any complications.

CONCLUSION: Submucosal fibroids with prolapsed peduncles usually become symptomatic before reaching a large size and most

commonly present with abnormal uterine bleeding, vaginal mass sensation and foul-smelling vaginal discharge in case of infection. Surgical management becomes more complex in the presence of concomitant uterine prolapse and pelvic endometriosis. The effects of pelvic endometriosis on the uterine support structures have not been clearly demonstrated in the literature and this is an important factor to be considered in the surgical planning process. This case report highlights the importance of a multidisciplinary approach in surgical management of a rare case of prolapsed fibroid, uterine prolapse and pelvic endometriosis. Further large-scale clinical studies are needed to better understand the potential relationship between uterine prolapse and endometriosis and to determine optimal surgical strategies.

Keywords: Pelvic Endometriosis, Submucosal Myoma, Uterine Prolapse

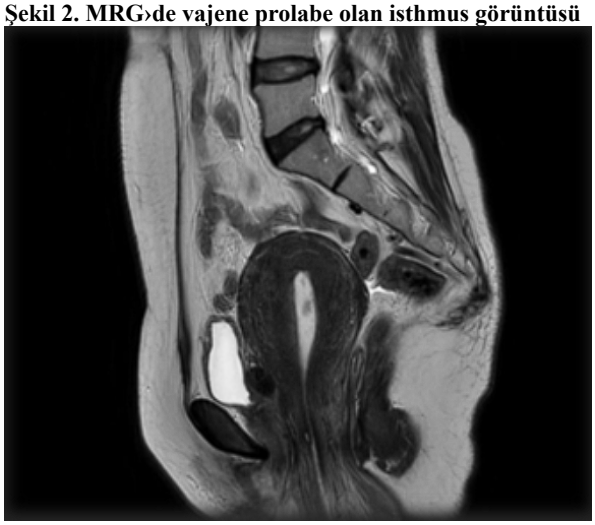
Image of prolapsed uterus and fibroids

Şekil 1. Prolabe uterus ve miyom görüntüsü

Şekil 1. Prolabe uterus ve miyom görünütüs

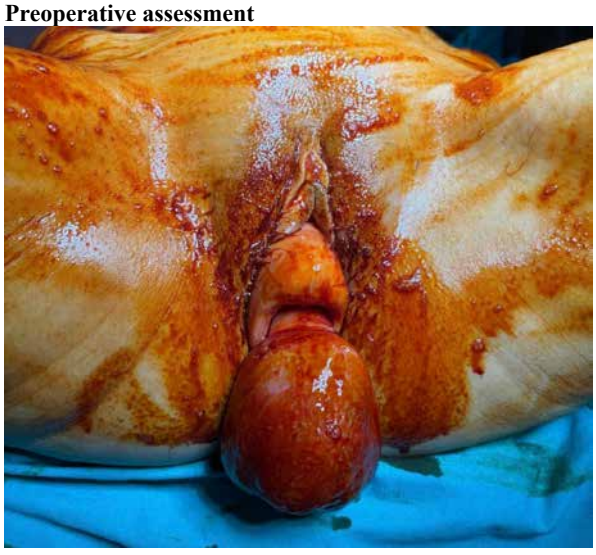
Isthmus prolapsing into the vagina on MRI

Şekil 2. MRG›de vajene prolabe olan isthmus görüntüsü

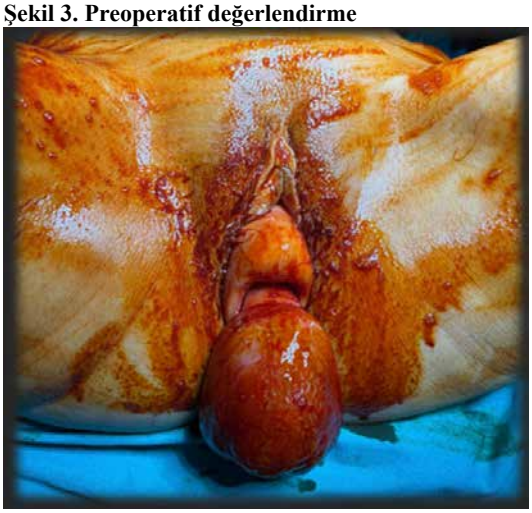


Şekil 2. MRG›de vajene prolabe olan isthmus görüntüsü

Preoperative assessment

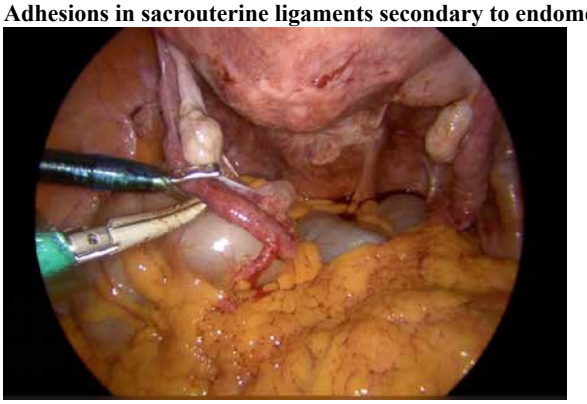


Şekil 3. Preoperatif değerlendirme

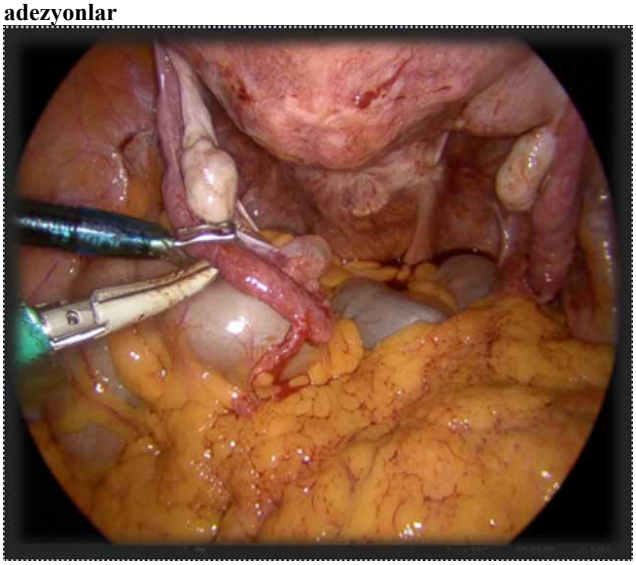


Şekil 3. Preoperatif değerlendirme

Adhesions in sacrouterine ligaments secondary to endometriosis

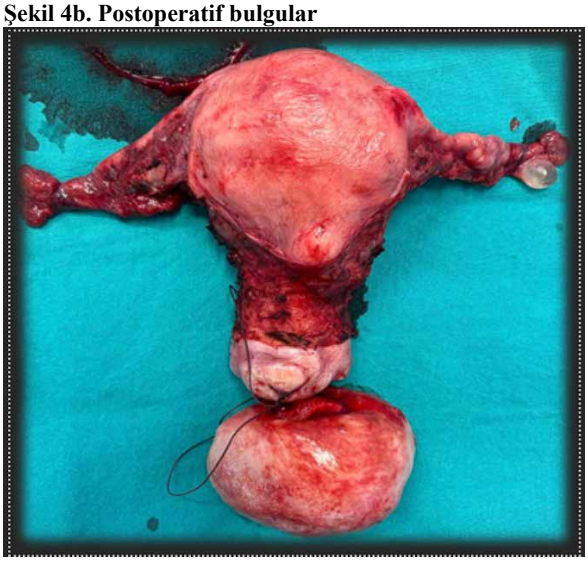


Şekil 4a. Sakrouterin ligamentlerde endometriozise sekonder adezyonlar



Şekil 4a. Sakrouterin ligamentlerde endometriozise sekonder adezyonlar

Şekil 4b. Postoperatif bulgular



Şekil 4b. Postoperatif bulgular

PS-16 [Jinekoloji Genel]

Vulvar Fibroadenoma: A Rare Case Report

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OBJECTIVE: The primary aim of this case report is to contribute to the medical literature by presenting an extremely rare case of vulvar fibroadenoma and to emphasize the importance of considering ectopic breast tissue-derived lesions in the differential diagnosis of vulvar masses in gynecological practice.

METHODS: We evaluated the clinical characteristics, physical examination findings, and imaging results of a 47-year-old female patient who presented with a complaint of genital swelling. A pedunculated mass measuring 15×10×3 cm located on the right labium majus was surgically excised and sent for histopathological examination. The patient was regularly followed up for 1 year postoperatively.

RESULTS: Patient history revealed that the mass had appeared within the past year and grown gradually. Physical examination identified a pedunculated mass on the right labium majus measuring 15 cm in diameter with a smooth surface and mobility. Upon palpation, the lesion had a firm-elastic consistency and was non-tender. No ulceration, necrosis, or inflammatory signs were observed on the surface of the mass. Superficial ultrasonography demonstrated a solid mass lesion measuring 15×10×3 cm in the right labium majus with well-defined borders, homogeneous echogenicity, and internal vascularity. No cystic components, calcifications, or areas of necrosis were detected within the lesion. Doppler examination revealed a low-resistance arterial flow pattern within the mass, indicating high vascularity. The ultrasonographic findings were consistent with a benign fibroepithelial lesion such as fibroadenoma or fibroma. As a vulvar fibroadenoma originating from ectopic breast tissue was suspected, bilateral breast ultrasonography was performed and evaluated

as normal, with no pathological findings in the breast. This suggested that the vulvar lesion was not associated with primary breast pathology but represented an isolated lesion originating from ectopic breast tissue. Histopathological examination of the lesion revealed fibroepithelial proliferation consisting of stromal and epithelial components consistent with fibroadenoma. Immunohistochemical studies showed positive staining for estrogen and progesterone receptors in the epithelial cells.

CONCLUSION: Fibroadenomas are benign tumors typically found in breast tissue and, when occurring outside the breast, are most commonly seen in axillary ectopic breast tissue. Cases of ectopic breast tissue and associated fibroadenomas have been reported in other locations including the chest wall, abdomen, inguinal region, vulva, perineum, and extremities. Vulvar fibroadenoma is extremely rare, with approximately 50-60 cases reported in the literature to date. In a review study of 26 cases published by Dhaoui et al. in 2017, the average size of vulvar fibroadenomas was reported to be between 2-5 cm. Our case of a "giant vulvar fibroadenoma" measuring 15 cm stands out as one of the largest reported in the literature. It is noteworthy that these lesions can reach giant dimensions while maintaining a slow growth pattern and benign character. Total excision of the mass is sufficient for treatment, and no recurrence or complications were observed during the one-year follow-up period in our case. In conclusion, although rare, fibroadenomas should be considered in the differential diagnosis of patients presenting with vulvar masses.

Keywords: Ectopic breast tissue, Benign vulvar tumor, Fibroepithelial lesion, Vulvar fibroadenoma, Vulvar mass

Vulvar Fibroadenoma

Vulvar Fibroadenoma

Vulvar Fibroadenoma

Vulvar Fibroadenoma

Vulvar Fibroadenoma

Vulvar Fibroadenoma

PS-17 [Jinekoloji Genel]

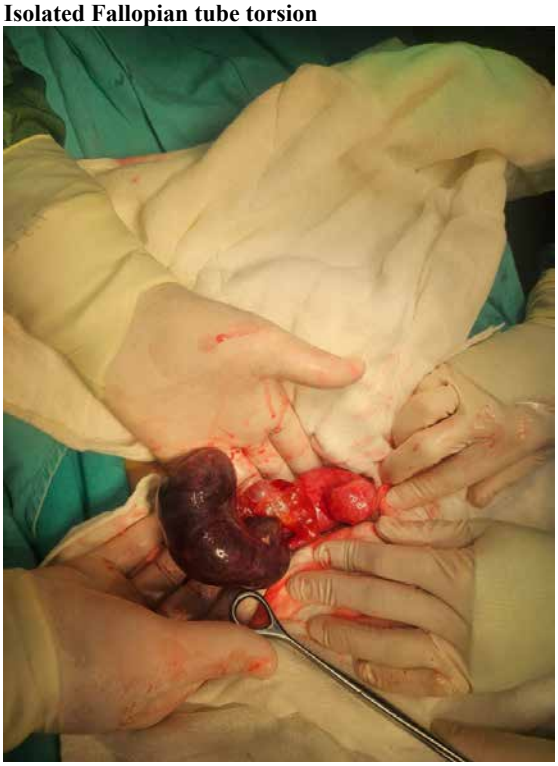
Isolated tubal torsion following tubal ligation: A rare case

Selin Güney, Mert Cenker Güney
Van bölge eğitim araştırma hastanesi, Van

Tubal torsion usually occurs as a part of adnexal torsion that affects an ovary and the adjacent tube; however, isolated tubal torsion is an extremely rare, with an incidence of approximately 1 in 1,500,000. Our Patient who is a 42-year-old premenopausal woman, G4P4, who had left salpingooferectomy and right tubal ligation because of left adnexial torsion 5 years previously, presented to the emergency room for 10/10 sharp right lower quadrant abdominal pain and nausea, The patient's examination of abdomen was with exquisite focal tenderness to palpation in the right lower quadrant. Her speculum and bimanual examination were benign, without cervical motion tenderness. Transvaginal ultrasound revealed normal-sized uterus, with adnexal complex of mixed echogenic components on the right. Doppler studies showed positive flow to the ovary but was absent in the center of this complex adnexal mass. CT scan of the abdomen and pelvis showed the absence of appendicitis or other abdominal pathologies, with minimal fluid in the pelvis and enlarged undefinied adnexial mass (7 cm × 5.5 cm) with few cysts suggestive of ovarian torsion. The patient was admitted for diagnostic laparotomy which revealed a isolated right fallopian tube torsion. Salpingectomy procedure was performed. The patient recovered well and was discharged home on post-operative day 1 with great improvement in her symptoms. Pathology subsequently revealed the mass to be a torsed and partially necrosed section of fallopian tube.

Keywords: Acute pelvic pain, Fallopian tube, Torsion,

Isolated Fallopian tube torsion



PS-18 [Jinekoloji Genel]

Chronic Vulvar Dermatosis in a Paraplegic Patient: A Case Report

Ümran Kaya, Mehmet Kağıtcı, İlknur Merve Ayazoğlu
Recep Tayyip Erdoğan Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum ABD, Rize

AIM: Vulvar dermatoses are common conditions encountered in gynecology clinics, often requiring a multidisciplinary approach for accurate diagnosis and management. This case report aims to present a chronic vulvar lesion in a paraplegic patient, highlighting the importance of a thorough diagnostic workup and multidisciplinary collaboration in managing such conditions.

CASE PRESENTATION: A 44-year-old woman, gravida 1, para 1, with a history of normal vaginal delivery, presented to our clinic with complaints of vaginal discharge. On vaginal examination, a red, atrophic-appearing lesion measuring approximately 5 × 3 cm was observed on the bilateral labia majora and minora (Figure 1). The vaginal walls appeared intact, and no discharge was noted on the lesion or within the vaginal canal. Transvaginal ultrasonography revealed no pathological findings. The patient reported that the vulvar lesion had been present for approximately one year, but she had not sought medical attention for it previously. Her medical history revealed that she had been paraplegic for ten years following a traffic accident 20 years prior, resulting in the loss of motor function and sensation in both lower extremities. Laboratory tests showed only a minimal elevation in C-reactive protein (CRP) levels, with no other significant abnormalities. A vulvar punch biopsy was performed under local anesthesia. Histopathological examination revealed hyperkeratosis, acanthosis, and inflammatory granulation tissue, with no evidence of malignancy. Based on these findings, the patient was referred to the dermatology clinic for further evaluation and management.

DISCUSSION: Vulvar lesions encompass a wide range of conditions, including lichen sclerosus, lichen planus, psoriasis, infectious etiologies, tumors, inflammatory dermatoses and pigmentation changes. Accurate diagnosis and management of these lesions require a multidisciplinary approach involving gynecology, dermatology, and, when necessary, urology. The etiology of vulvar dermatoses is often multifactorial. Disruption of the vulvar barrier in a moist, poorly ventilated environment, combined with chronic irritation, can predispose patients to these conditions. In paraplegic patients, additional factors such as prolonged immobility, reduced sensation, and potential neglect of genital hygiene may further increase the risk of chronic vulvar lesions. Hyperkeratosis, characterized by epidermal thinning (atrophy), and acanthosis, marked by diffuse epidermal hyperplasia (thickening), are common histopathological findings in vulvar dermatoses.. A detailed patient history, including family history and genetic predispositions, along with a thorough physical examination, is crucial for accurate diagnosis. Malignancies must always be excluded during the evaluation of vulvar lesions. This case underscores the importance of considering chronic vulvar dermatoses in paraplegic patients, who may be less likely to seek medical attention due to sensory deficits or mobility challenges.

CONCLUSION: Vulvar lesions are complex conditions that necessitate a multidisciplinary approach, particularly involving gynecology and dermatology. A detailed history, thorough physical examination, and histopathological evaluation are critical for accurate diagnosis. In paraplegic patients, who may face challenges in accessing healthcare,

a proactive approach to evaluating vulvar lesions is essential to rule out malignancies and other serious conditions. This case highlights the importance of considering chronic vulvar dermatoses in patients with sensory and mobility impairments and emphasizes the need for timely and comprehensive care.

Keywords: chronic vulvar dermatoses, dermatosis, Vulvar lesions

Vulvar dermatosis in a paraplegic patient

PS-19 [Jinekoloji Genel]

Title Acute Urticaria and Angioedema Associated with the Use of Levonorgestrel-Releasing Intrauterine System: A Case Report and Literature Review

Merve Genco, Mehmet Genco
Iğdır Doktor Nevruz Erez Devlet Hastanesi

Abstract OBJECTIVE: Levonorgestrel-containing intrauterine systems (LNG-IUS) are widely used for contraception and treatment of abnormal uterine bleeding. However, they can rarely lead to serious allergic reactions. This study aims to present a case of a 38-year-old woman who developed acute urticaria and angioedema two months after the insertion of LNG-IUS and to synthesize similar cases in the literature.

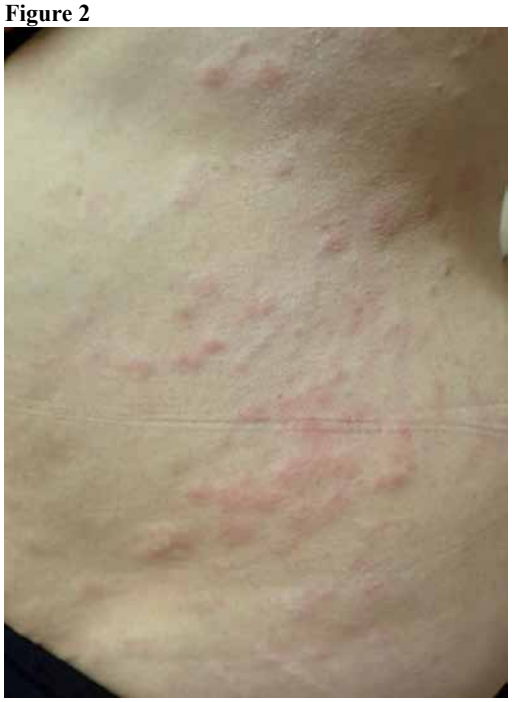
MATERIALS-METHODS: The patient's clinical findings, laboratory results, and treatment process were examined in detail. Allergic reactions associated with LNG-IUS and similar intrauterine devices were investigated in the literature.

RESULTS: Two months after LNG-IUS was inserted for the treatment of abnormal uterine bleeding, the patient developed widespread urticaria and angioedema on her face. The urticarial lesions on the patient's back and torso are presented in Figures 1 and 2. Despite daily treatment with 15 mg of oral methylprednisolone and 5 mg of desloratadine, her symptoms did not improve. The patient was evaluated by an allergist, and the removal of LNG-IUS was recommended. After the removal of the device, she responded to systemic therapy, and her symptoms completely disappeared within 15 days.

CONCLUSION: Although acute urticaria and angioedema developing during the use of LNG-IUS are rare, clinicians should be aware of this potential side effect. In allergic reactions related to LNG-IUS, symptoms can completely resolve with the removal of the device and appropriate medical treatment.

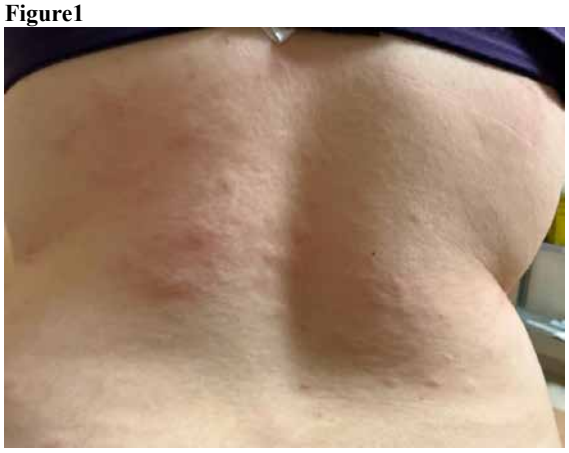
Keywords: Levonorgestrel, intrauterine device, acute urticaria, angioedema, allergic reaction

Figure 2



The urticarial lesions on the patient's torso are presented in Figures 2.

Figure1



The urticarial lesions on the patient's back presented in Figures 1.

Table 1

Author (year)	Patient Age	Clinical Presentation	Onset After Insertion	Treatment	Outcome
Chen et al. (2019) [7]	42	Acute urticaria, severe itching	2 hours post-insertion	Oral methylprednisolone 10 mg/day + desloratadine 5 mg/day	Symptoms resolved within 3 days; device removal recommended
Prętnicka et al. (2020)[9]	35	Urticaria, mild facial edema	2 hours post-insertion	Oral methylprednisolone 20 mg/day + fexofenadine 180 mg/day	Rapid improvement after removal of the IUD; complete resolution
Smith et al. (2021) [11]	37	Recurrent urticaria, angioedema	2 weeks post-insertion	High-dose oral antihistamines (cetirizine 10 mg twice daily)	Partial resolution; complete remission only after device removal
Garcia et al. (2022) [12]	40	Diffuse urticaria, neck angioedema	24 hours post-insertion	Intravenous corticosteroids, subcutaneous antihistamines	Symptoms resolved in 48 hours following device removal
Jones et al. (2022) [13]	28	Persistent urticarial plaques, pruritus	1 month post-insertion	Oral corticosteroids (prednisone 15 mg/day) + H1/H2 blockers	Symptoms gradually subsided over 2 weeks; device removal led to complete resolution

Table 1. Summary of previously reported cases of acute urticaria and/or angioedema associated with LNG-IUS use.

PS-20 [Jinekoloji Genel]

Ultrasonography-assisted removal of nonpalpable contraceptive implants: A case report

Nazan Akgün Koruk
Kocaeli Karamürsel State Hospital

OBJECTIVE: In this case report, we describe the localization of a contraceptive implant in the subfascial plane of the upper arm. Ultrasound imaging was utilized to distinguish the implant from the surrounding tissue, facilitating accurate localization and enabling successful removal.

METHODS: The contraceptive implant should be inserted subdermally and palpated immediately after insertion to confirm correct placement. Failure to properly insert the implant may go unnoticed unless palpation is performed. Improper or deep insertion of the implant may lead to complications such as paraesthesia, migration, intravascular insertion, bruising, local irritation, pain, itching, fibrosis, scarring, abscess, or even pulmonary artery migration. Exploratory surgery should be avoided. The implant should be located before removal to prevent injury to deeper neural or vascular structures. If the implant is deeply placed, it should be removed cautiously by healthcare providers familiar with the arm's anatomy. Imaging methods such as X-ray, CT, ultrasound (with a high-frequency, 10 MHz or greater, linear array transducer), or MRI can effectively locate non-palpable implants. If localization fails, etonogestrel blood level testing may be used to confirm the presence of the implant. If the implant cannot be found in the arm, imaging techniques should be applied to the chest due to potential migration to the pulmonary vasculature.

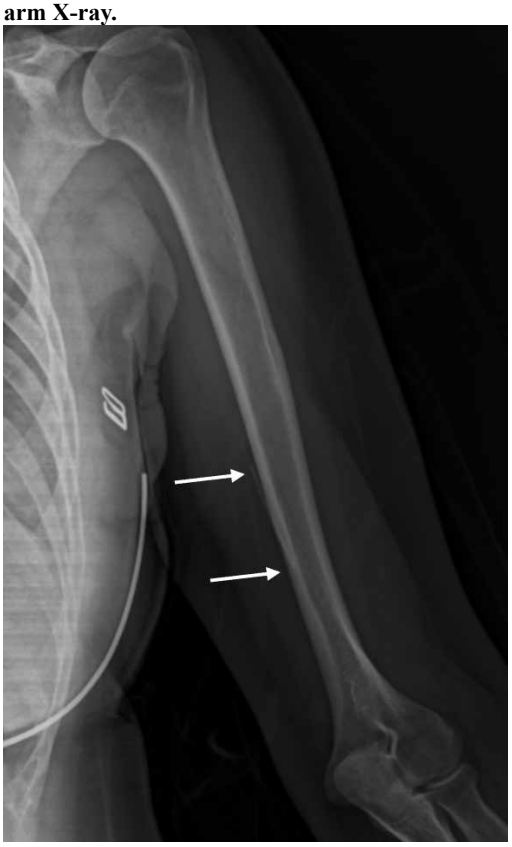
RESULTS: Our 30-year-old patient, who has two children, presented to our clinic for the removal of a contraceptive implant that had been in place for three years and had expired. The patient had used two implants over the course of six years, both of which were asymptomatic. Both implants were inserted by the same physician through the same incision site. The patient reported that she could palpate the first implant but has not been able to feel the second implant since its insertion. An incision scar was observed on the left upper arm, but the implant could not be palpated. The presence of the implant was confirmed by an upper arm X-ray. Subsequently, superficial ultrasound imaging revealed the implant's echo approximately 3 cm above the incision line. Local anesthesia was administered to the area under sterile conditions, and the implant was removed under ultrasound guidance. The procedure was completed without any intraoperative or postoperative complications. Following the removal, the patient opted for an alternative contraceptive method and was provided with counseling on available options. The patient was scheduled for follow-up visits to monitor the healing process and ensure no complications occurred. The incision site healed without any signs of infection or other issues.

CONCLUSION: Deeply placed implants should be localized and removed promptly to prevent the potential risk of distant migration. High-frequency point-of-care ultrasonography proves to be an effective tool for localizing non-palpable contraceptive implants, enabling successful in-office removal.

Keywords: contraceptive implant, nonpalpable, ultrasonography-assisted

Figure 1: The implant marked with a white arrow on the superficial ultrasound.

Figure 2: The implant marked with two white arrows on the upper arm X-ray.



PS-21 [Jinekoloji Genel]

A Case of Giant Intraligamentary Myoma

Aziz Kaan Yabalak
Department of Obstetrics and Gynecology, Şanlıurfa Training and Research Hospital, Şanlıurfa, Turkey

INTRODUCTION AND OBJECTIVE: Leiomyomas are the most common benign tumors originating from the smooth muscle cells of the uterus. Their incidence increases during the reproductive period and decreases in the postmenopausal period. Although nearly half of myomas are asymptomatic, they may present with abnormal uterine bleeding, dysmenorrhea, infertility, abdominal swelling, and compression symptoms on surrounding organs. Myomas larger than 10 cm are classified as giant myomas. While small and asymptomatic myomas can be monitored periodically, large myomas usually require surgical treatment. Myomectomy is preferred in reproductive-aged women to preserve fertility. In this case report, we aim to discuss a patient who presented with a diagnosis of uterine myoma and was found to have a giant myoma on ultrasound. MATERIALS-METHODS: A 34-year-old female patient, gravida 1, parity 1, with one vaginal delivery, had her first menstruation at 13 years old, with a regular menstrual cycle (28 days/4 days/3–4 pads). She presented to our outpatient clinic due to a previously diagnosed uterine myoma one year ago. The patient had no additional complaints other than abdominal pain. She had no history of chronic disease, smoking, or allergies. She was a hepatitis B carrier and had previously undergone an eye surgery.

FINDINGS: Abdominal and transvaginal ultrasonography revealed a retroverted uterus with an endometrial thickness of 8 mm and a well-defined mass measuring 98 × 59 mm originating from the anterior uterine wall (myoma), with no bilateral adnexal pathology. Abdominal examination showed a uterus of approximately 10–12 weeks in size. Myomectomy surgery was planned for the patient. Preoperative smear, probe curettage, and routine preoperative tests were performed.

Cervical smear: Negative for intraepithelial lesion or malignancy.

•Probe curettage: Endometrial polyp, secretory endometrium.

•Hgb: 15.6 g/dL

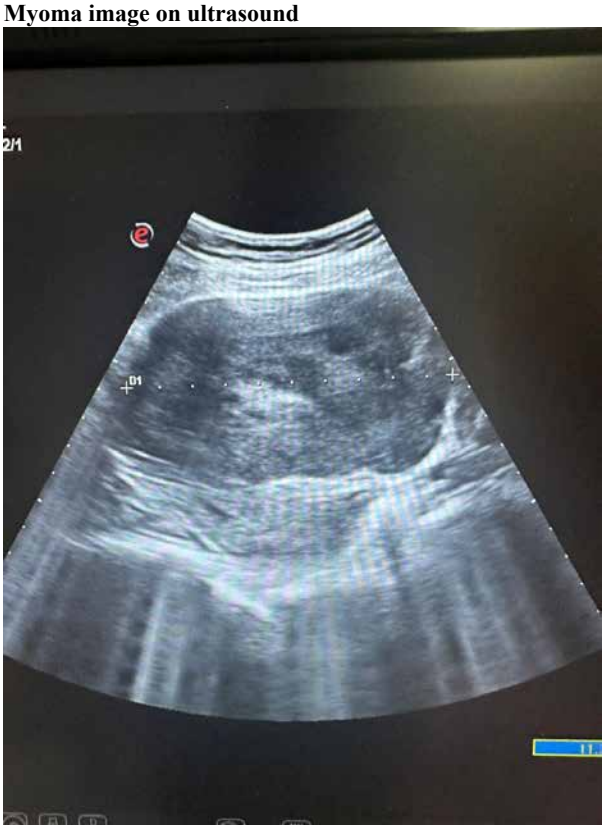
•Beta-hCG: Negative

•Anesthesia risk classification: ASA I

Under spinal anesthesia, a pfannenstiel incision was made to access the abdominal cavity. Observation revealed a giant myoma, approximately 10 cm in size, originating from the anterior uterine wall and growing into the broad ligament. The uterus, bilateral ovaries, and fallopian tubes appeared normal. A standard myomectomy was performed, and the defect was repaired using baseball sutures. No early complications were observed. The patient was discharged on the first postoperative day. On the 10th postoperative day, the wound site was clean and intact, and ultrasonography showed an endometrial thickness of 6 mm with normal bilateral ovaries. CONCLUSION: In conclusion, giant myomas (>10 cm) detected by imaging methods should be surgically removed, even if asymptomatic.

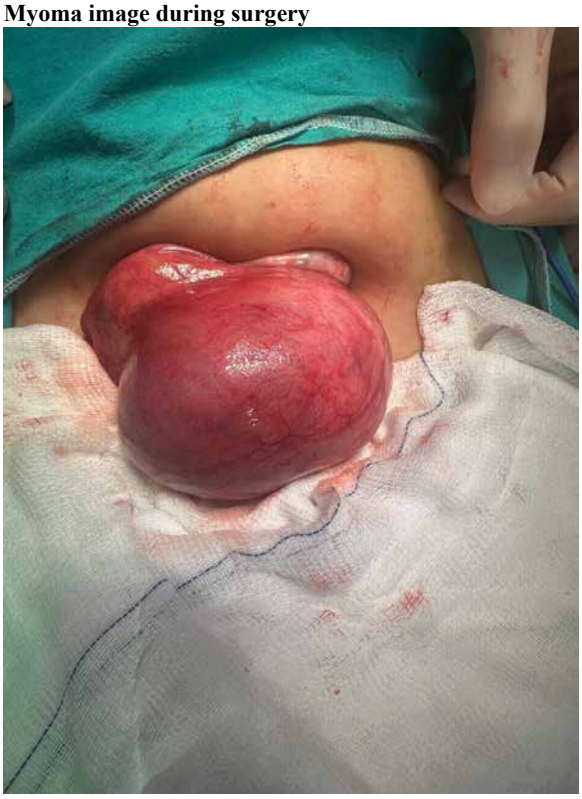
Keywords: excision, giant myoma, intraligamentary myoma, myomectomy

Myoma image on ultrasound



Myoma size on abdominal ultrasound

Myoma image during surgery

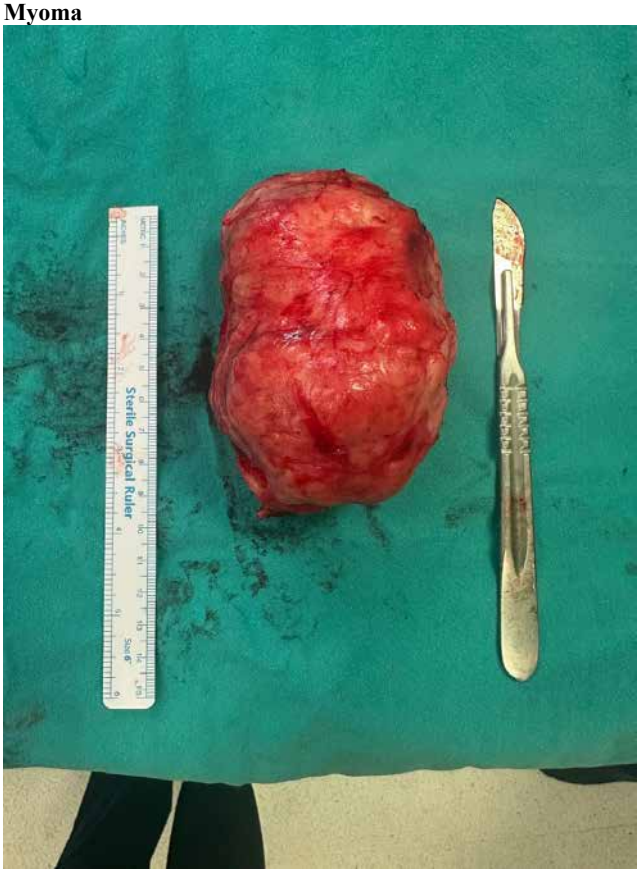


Myoma and uterus relationship during surgery

Relationship between myoma and uterus on ultrasound

Relationship of anterior wall myoma with uterus on ultrasound

Myoma



Macroscopic image of the removed myoma.

PS-22 [Jinekoloji Genel]

Episiotomy Scar Endometriosis. Case Presentation

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[2]OBGYN department of General hospital Lazarevac, Lazarevac, Serbia

[3]Military Academy of Belgrade,Belgrade, Serbia

INTRODUCTION: Endometriosis is an enigmatic frequent benign gynecological disease among women of reproductive age with estimated that 10-15% of reproductive aged women suffer from pelvic endometriosis.

Episiotomy scar endometriosis is an uncommon condition with very rare incidence.

Aim: We would like to show patients with episiotomy scar endometriosis.

Method: A 32-year-old woman, G-1 P-1, presented with cyclic tumor and pain in the episiotomy area, with significant impairment of her daily quality of life. She had a delivery one year ago and symptoms start three months after delivery.

Detail gynecological examination, like Pap smear and ultrasound were normal. Clinical examination revealed a palpable mass in the episiotomy area. The sizes of palpable mass had different sizes depend of menstrual cycle and a probable clinical diagnosis of scar endometriosis was considered, with further investigation being recommended.

RESULTS: The patient was surgically treated by local excision of the mass. Postoperative there were no complications, and wound pp and the histopathology examination of the mass confirmed the diagnosis of endometriosis in the episiotomy scar.

CONCLUSIONS: Usually, endometriosis presents three main variants: ovarian endometrioma, superficial peritoneal disease and deep infiltrating endometriosis, while episiotomy scar endometriosis remains a very rare condition, it should be considered in all patients with an anterior vaginal delivery and a painful perinea mass during menstrual cycle. The surgical treatment is the first options for treatment.

Keywords: endometriosis, episiotomy,treatment

Cystis endometriosis

Episiotomy scar and tumor mass

Intraoperative tumor and chocolate content

PS-23 [Jinekoloji Genel]

Evaluation of Clinical, Biochemical, Ultrasonographic Findings and Skin Type in Polycystic Ovary Syndrome According to Body Mass Index

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OBJECTIVE: This study aimed to compare the clinical characteristics, laboratory and ultrasonographic findings, hormonal parameters, Ferriman-Gallwey scores, and skin types of women diagnosed with polycystic ovary syndrome (PCOS) based on body mass index (BMI).

METHODS: A total of 134 women diagnosed with PCOS according to the Rotterdam criteria and who voluntarily agreed to participate were included in the study. The study was conducted between May 15 and September 15, 2024, at the Obstetrics and Gynecology outpatient clinic of İzmir City Hospital. Patients were divided into two groups based on their BMI: Group 1 included patients with BMI <25, and Group 2

included patients with BMI ≥25. The groups were compared in terms of clinical characteristics, Ferriman-Gallwey scores, biochemical and hormonal profiles (FSH, LH, Estradiol, TSH, Prolactin, Total Testosterone, DHEAS, fasting blood glucose, HbA1c, HDL, LDL, triglycerides, and cholesterol), ultrasonographic findings, and skin type. Data analysis was performed using SPSS software.

RESULTS: This study examined The The The data of 134 patients with PCOS. Of the patients, 46.3% had a normal body mass index and were underweight (group 1=62), whereas 53.7% were overweight and obese (group 2=72). No statistically significant differences were found between the two groups in terms of age, height, systolic and diastolic blood pressure measurements, menstrual frequency, polycystic ovary appearance on ultrasound, skin type, and acne findings (p>0.05). When hormonal values were compared, no difference was found in FSH, LH, Prolactin, Estradiol and DHEAS values, whereas Total Testosterone and TSH levels were significantly higher in Group 2 patients (p<0.05). When lipid profiles were compared, HDL values were lower and LDL values were higher in Group 2 patients (p<0.05). PBG and HbA1C levels were significantly higher in group 2 (p<0.05). Group 2 patients had significantly higher Ferriman Gallwey Scores than Group 1 patients (p<0.05). In addition, in the Phenotype A distribution between the two groups, phenotype A was more common in group 2 patients, whereas Phenotype D was more common in group 1 patients (p<0.05).

CONCLUSION: PCOS is the most common endocrine disorder in women of reproductive age, with increasing prevalence worldwide, and lifelong effects from adolescence to postmenopause. Phenotypic characteristics of individuals diagnosed with PCOS were significantly related to body mass index. Obesity can exacerbate the clinical picture of PCOS by increasing metabolic and hormonal disorders, such as glucose intolerance, dyslipidemia, and hyperandrogenism. These findings emphasize the importance of considering BMI in the management of PCOS and can guide individualized treatment approaches. Early recognition of these women, necessary screening tests, and treatments are important to prevent these diseases and reduce future comorbidities to prevent their progression. Dermatological features can provide early clinical clues for the recognition of PCOS, and can be a visible marker for underlying metabolic and endocrine diseases. The treatment of these cutaneous conditions can improve the patient's quality of life and psychological status. Prospective studies, including objective assessments, are required to determine the relationship between PCOS and skin findings.

Keywords: Polycystic ovary syndrome, body mass index, skin type

Table 1: Comparison of Metabolic Laboratory Parameters According to BMI Groups

	Group 1 (BMI <25)	Group 2 (BMI ≥25)	P value
PBS	84,45±7,99	94,99±40,08	0,032*
HbA1C	4,97±0,37	5,28±0,96	0,02*
TC	167,97±35,25	174,76±38,58	0,292*
HDL	63,73±15,75	48,50±14,14	0,001*
LDL	87,29±25,50	103,19±30,97	0,002*
TG	99,12±71,40	138,35±171,51	0,095*

** Independent Samples t-test, PBS: Postprandial Blood Sugar, HDL: High Density Lipoprotein, LDL: Low Density Lipoprotein, TG: Triglycerides, TC: Total Cholesterol*

Table 2: Comparison of Ultrasonography Findings, Skin Types, Acne Severity and Phenotype Distributions According to BMI Groups

	Group 1 (BMI <25)	Group 2 (BMI ≥25)	P value
TV US			
No	1(20)	4(80)	
Yes	61(47,30)	68(52,70)	0,23**
Skin Types			
Normal	10(50)	10(50)	
Dry	19(54,30)	16(45,70)	
Oily	10(37)	17(63)	
Mix	23(44,20)	29(55,80)	0,566**
Acne			
No	11(45,80)	13(54,20)	
Mild	27(44,30)	34(55,70)	
Moderate	18(48,60)	19(51,40)	
Severe	6(50)	6(50)	0,969**
Phenotypes			
A	23(35,90)	41(64,10)	
B	1(20)	4(80)	
C	21(47,70)	23(52,30)	
D	17(81)	4(19)	0,002**

***Chi-Square Test, TV US: Transvaginal Ultrasonography*

Table 3: Comparison of Skin Types According to Phenotype Groups

	Phenotypes				
	A (n=64)	B (n=5)	C (n=44)	D (n=21)	P value
Skin Types					
Normal	9(45)	0	5(25)	6(30)	
Dry	18(51,4)	1(2,9)	8(22,9)	8(22,9)	
Oily	13(48,1)	2(7,4)	9(33,3)	3(11,1)	
Mix	24(46,2)	2(3,8)	22(42,3)	4(7,7)	0,272**

***Chi-Square Test*

PS-24 [Jinekoloji Genel]

Case Report: A Ruptured Ovarian Ectopic Pregnancy - Laparoscopic Partial Ovarian Excision

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INTRODUCTION: Ectopic pregnancy(EP) occurs when fertilized ovum implants outside of the uterine cavity. The various risk factors for EP include fallopian tube injuries, pelvic inflammatory disease, contraceptive failure, smoking, age >35 years, previous EP, and assisted reproductive techniques. Tubal EP is the most common, but ovarian, cervical, and scar EP are also found. Ovarian EP accounts for 1–3% of cases and 0.03–0.09% of all pregnancies. We aimed to share this rare case of ovarian EP that we operated on under shift conditions in our clinic and to emphasize the importance of preliminary diagnosis in the emergency department.

CASE: A 23-year-old female patient who presented to the emergency

department(ED) with syncope and abdominal pain is consulted by the on-call gynecologist and obstetrician based on the computed tomography(CT) result. The CT report states, 'Disseminated free fluid is observed in the abdomen. 5cm heterogeneous hypodense appearance is observed in the right adnexal area. Intrauterine device(IUD) is observed in the uterine cavity. It is recommended that the case be evaluated for cyst rupture and EP rupture.' Vital signs indicated a temperature of 36.3°C, pulse rate of 110bpm, blood pressure of 80/50mmHg. In the tests performed, hemoglobin was 8.3; BHCG has not yet been reported. The patient does not know the date of her last menstrual period. She has had one previous vaginal birth. In the gynecological examination, the abdomen was distended, and widespread tenderness was observed. In ultrasonography, diffuse fluid filling the liver and spleen was observed in the abdomen. Uterus was anteverted, endometrium was 8mm, IUD was in a normal location. A heterogeneous cystic structure of approximately 5cm was observed in the right adnexal area. Upon observation of hemodynamic instability in the patient, she and her husband were informed about the possible EP and she underwent emergency surgery after obtaining consent. 2000cc of coagulum were extracted from the abdomen via laparoscopic surgery. Uterus, bilateral fallopian tubes and left ovary were observed as normal. An EP focus was evident in the right ovary. The ectopic focus and damaged ovarian tissue were excised with the help of energy modalities. The patient's IUD was removed, and the endometrial cavity was cleaned by probe curettage. The operation concluded with hemostasis and the insertion of silicone drain in Douglas pouch. The preoperative BHCG was reported as 19160. The patient was given the intraoperative replacement of 2 units of erythrocyte suspension and 1 unit of fresh frozen plasma. The drain was removed at 24 hours postoperatively. The patient was discharged after 36 hours of hospitalization, 12 hours in intensive care. The pathology result was consistent with EP.

CONCLUSION: A ruptured EP can cause major internal bleeding, accounting for approximately 4% to 6% of all maternal deaths. It is important to keep the preliminary diagnosis of EP in mind in all women of reproductive age who apply to the ED with complaints such as abdominal pain. If surgical treatment is required, the first choice should be the organ-preserving laparoscopic approach, if possible.

Keywords: gynaecological emergencies, laparoscopy, ovarian ectopic pregnancy

right ovarian ectopic pregnancy

right ovarian ectopic pregnancy

PS-25 [Jinekoloji Genel]

Uterine Leiomyoma with Pelvic Lymph Node Metastasis: A Case Report

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Benign metastatic leiomyoma is a rare condition in which histologically benign smooth muscle cells metastasize to extrauterine sites. Metastases are usually seen in the lungs, liver, lymph nodes, skin, bladder, esophagus, and skeletal muscles. Benign metastatic leiomyoma is often misdiagnosed as a malignant tumor before surgery until pathologically confirmed. Multiple simultaneous metastases, including lymph node metastases, are extremely rare in benign metastatic leiomyoma, and studies on the prognosis and treatment of those with multiple lymph node metastases are scarce. The disease is usually seen in women of late reproductive age or premenopausal age, and most of them have a history of leiomyoma that was surgically treated with myomectomy or hysterectomy. The pathological origin of benign metastatic leiomyoma remains unclear. In this case, uterine leiomyoma metastasizing to the left pelvic lymph node was observed. There were no problems in the patient's gynecologic oncology follow-up. Although it is a rare case, long-term surveillance and careful follow-up are recommended for such patients for early detection of recurrence or distant metastases. Since treatment options are limited, new drugs or treatment strategies should be examined and considered. In addition, it is thought that long-term follow-up may be useful in examining the implications in clinical practice. A 54-year-old patient presented with a complaint of groin pain that had been ongoing for a week. The patient, who had been in menopause for 7 years, had 3 normal spontaneous vaginal births and 1 cesarean section. The patient's vaginal examination was normal. The uterus appeared anteverted in the transvaginal ultrasonography. A 50*45 mm myoma, thought to originate from the posterior part of the uterus, was observed. An approximately 20 cm leiomyosarcoma-compatible appearance originating from the posterior part of the uterine corpus was observed. Bilateral adnexa could not be clearly evaluated. No fluid was observed in the Douglas. In the upper and lower abdomen computerized tomography performed on the patient, the size of the uterus increased, and a mass lesion originating from the anterior part of the uterine corpus, measuring 9*24*19 cm, with regular borders, thin walls, containing contrasting and distinctly heterogeneous soft tissue densities and septal structures, and containing cystic-necrotic components was observed. The lesion identified on tomography initially suggested sarcomatous lesions of the uterus. No additional pathology was detected on thoracic computed tomography. The patient's computed tomography is given in Figures 1 and 2. The patient underwent total abdominal hysterectomy + bilateral salpingo-oophorectomy + bilateral pelvic bulky lymph node dissection + omentum biopsy with a preliminary diagnosis of uterine leiomyosarcoma. The material was sent to pathology during the operation. The material removed from the patient during the intraoperative period is shown in Figure 3. Intraoperative pathology revealed a degenerated leiomyoma. Postoperative tomography image is shown in Figure 4. The final pathology result of the patient was reported as leiomyoma with leiomyoma nodules and left pelvic lymph node metastasis. The patient's pathological images are shown in Figures 5,6,7.

Keywords: Leiomyoma, metastasis, pelvis, benign, lymph node.

Figure 1: Preoperative Computed Tomography.

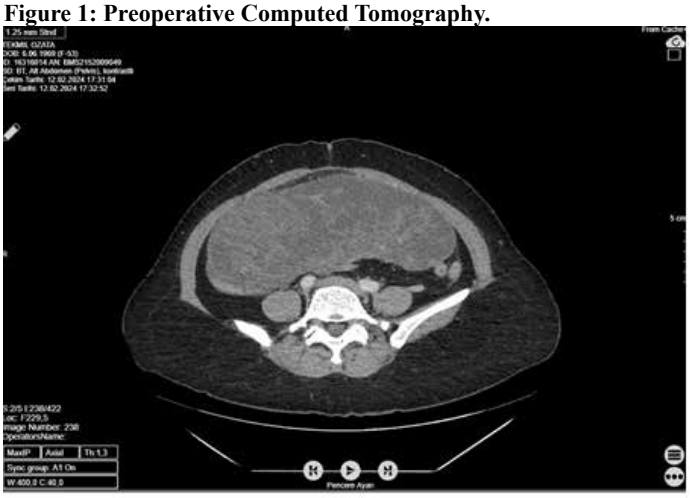


Figure 2: Preoperative Computed Tomography.

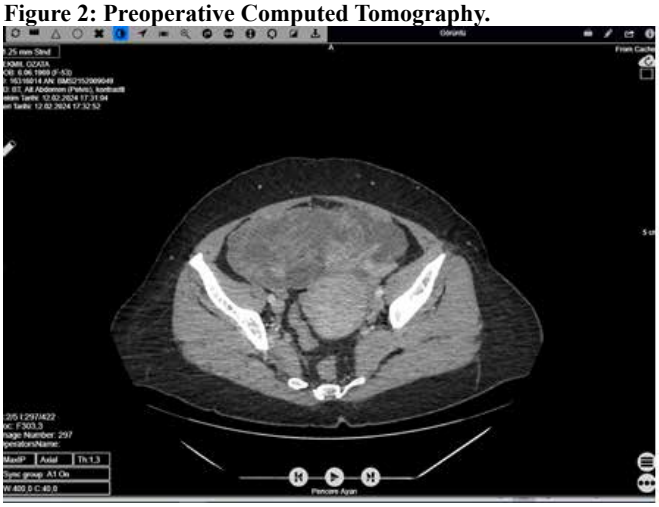


Figure 3: Material removed during the intraoperative period.

Figure 4: Post-operative Control Computerized Tomography.

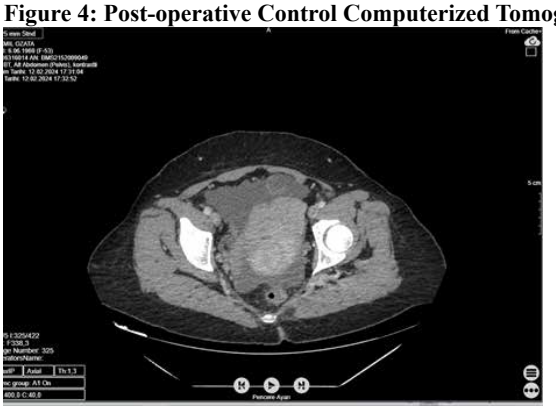


Figure 5: Large-sized, degenerating leiomyoma in the uterus.

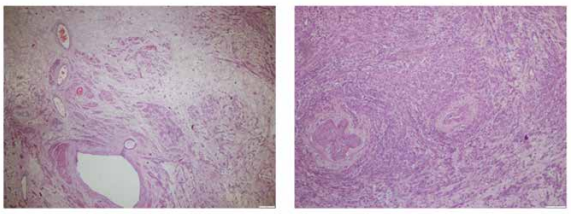


Figure 6: Right image; pleomorphism and marked atypia, left image; extensive necrosis area and grade 3 leiomyosarcoma.

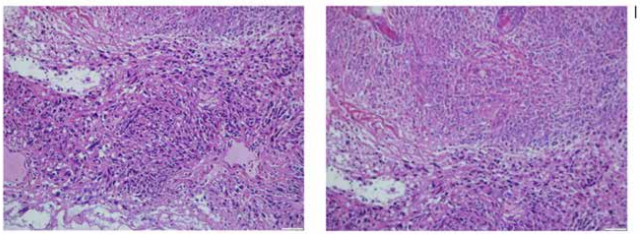
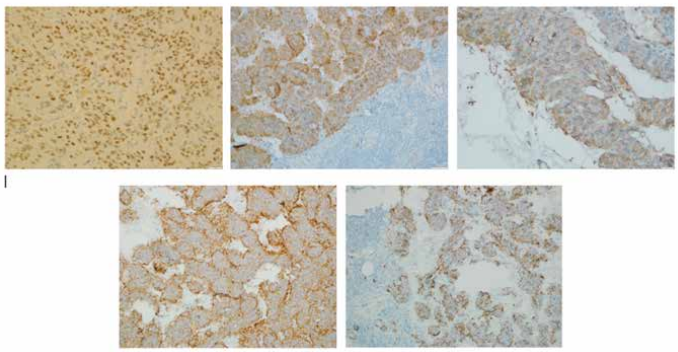


Figure 7: In order; Estrogen (+), SMA (+), Calponin (+), Desmin (+), Caldesmon (+) cells.



PS-26 [Obstetri Genel]

Isolated Scrotal White Papules and Transient Trombocytopenia in a Neonate: A Diagnostic Puzzle

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SUMMARY: Neonatal dermatological conditions present a broad spectrum, ranging from benign, self-limiting rashes to severe, life-threatening disorders. Accurate diagnosis is often challenging due to overlapping clinical features and rarity of certain conditions. In this report, we discuss a term neonate presenting with isolated scrotal and anal lesions accompanied by transient trombocytopenia. Infections such as fungal and bacterial infections can be transmitted from mother to the newborn, leading to cutaneous manifestations. These infections can lead to various clinical presentations in neonates, and our case represents a particularly rare example of this phenomenon.

CASE PRESENTATION: A 39-week-old term male neonate was born via spontaneous vaginal delivery to a multiparous mother with no significant prenatal complications. On postnatal examination, the newborn was active and stable. However, isolated white scaly papular lesions were observed in the scrotal and perianal region, with no signs of inflammation, erythema, or systemic involvement. No additional cutaneous or congenital anomalies were identified. The mother reported experiencing a pruritic vaginal infection during the last month of pregnancy, for which she self-administered a topical antifungal. Following dermatology consultation, fungal culture was reported as negative. Laboratory results were unremarkable except for transient trombocytopenia, which spontaneously resolved within 24 hours and mildly elevated infection markers. While Enterococcus faecium was isolated from the lesion culture. Blood culture was sterile. Given the uncertain etiology, the neonate was admitted for close monitoring and empirical treatment, which included; intravenous ceftriaxone, topical antifungal application and tegaderm dressing for local wound care. The lesions gradually resolved over 7-10 days, without further progression.

DISCUSSION AND CONCLUSION: While the differential diagnosis is extensive, simple diagnostic methods can aid in differentiating between them. Given their ubiquitous presentation, it is sometimes difficult to differentiate among self-limiting noninfectious pustular dermatosis such as erythema toxicum neonatorum, transient neonatal pustular melanosis, miliaria putulosa etc., and potentially life threatening infections such as herpes simplex virus, varicella zoster virus infections. But a clear knowledge and understanding of each entity with its clinical presentation, progression, prognosis and treatment would enable a dermatologist to offer correct diagnosis and treatment and avoid needless confusion. The most common causes of infectious pustular skin lesions include bacterial infections, which may be initially localized. Fungal infections in a neonate should be suspected when discrete pustular lesions are present with a background of erythema. Congenital candidiasis results due to intrauterine candidal infection of fetus. Onset of cutaneous lesions usually starts within 6 days of life. In neonates born through vaginally maternal flora and previous infections can be transmitted to the newborn either vertically or during delivery, leading to concurrent bacterial and fungal infecitons. Our case is considered a rare example of this phenomenon. However, this case emphasizes that neonatal dermatological conditions cannot always be diagnosed based solely on standart algorithms but rather require a combination of clinical expertise, patient-specific context, and experience. The rarity of this presentation, combined with the absence of similar cases in the literature, makes this report particularly valuable for guiding clinicians in managing similar cases in the future.

Keywords: newborn scrotal papul, trombocytopenia, benign neonatal dermatosis, differential diagnosis, fungal infection

resim 1

resim 2

PS-27 [Obstetri Genel]

A Rare Case Report: Fetal Nasopharengeal Teratom

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[2]Nizip Statement Hospital

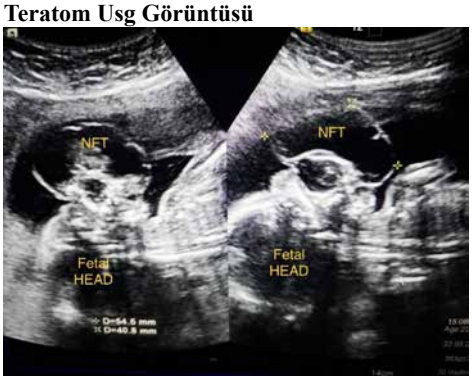
INTRODUCTION: Teratoma is the most common extragonadal germ cell tumor of the neonatal period. While it most commonly involves the sacral region, one of the rarest types is nasopharyngeal teratoma. In this case report, a case of nasopharyngeal teratoma is presented. CASE: A twenty-nine-year-old patient with gravida 4 and parity 3, a history of three cesarean deliveries, and a 21-week pregnancy according to the last menstrual date was referred to us. In the evaluation, a single, live fetus with an average measurement of 21 weeks and 3 days was observed. A 50x40 mm mass thought to have originated from the nasopharynx was seen in the fetal head region. Doppler examination of the mass showed decreased vascularization. No additional risk factors or anomalies were detected. The family was informed and the necessary consents were obtained. The pregnancy was terminated. A single 400-gram fetus was delivered. In the macroscopic observation of the fetus, a mass protruded from the mouth was observed. The pathological examination confirmed that the mass was a teratoma originating from the nasopharynx. No complications were observed after the hysterectomy performed on the mother.

CONCLUSION: Nasopharyngeal teratomas are very rare among germ cell tumors. The most important difficulties in these cases are premature birth and the resulting prematurity, neonatal airway obstruction, pulmonary atresia or hypoplasia, and morbidity resulting from the need for early intervention after birth. In these cases, polyhydramnios due to difficulty swallowing is frequently observed in the neonatal period. If surgery is not planned in the newborn in the early period, mortality is quite high. At the same time, termination is another option in cases where surgery cannot be performed depending on the family's decision. With the development of ultrasonography and fetal magnetic resonance imaging techniques, these cases can be diagnosed at an early stage. Today, fetal surgery can be offered in a limited number of centers in the world, but the success rates have not yet reached a sufficient level.

Keywords: Fetal Mass, Germ Cell Tumor, Nasopharyngeal Teratoma,

Teratom Resim

Teratom Usg Görüntüsü



PS-28 [Obstetri Genel]

Delayed Onset of Posterior Reversible Encephalopathy Syndrome (PRES) Following Cesarean Section

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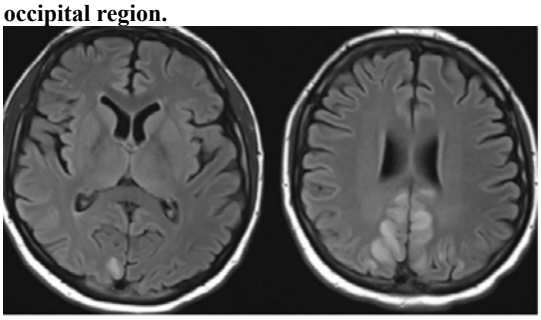
Posterior Reversible Encephalopathy Syndrome (PRES) is a clinical-radiological syndrome associated with headache, seizures, altered consciousness, and visual disturbances and is usually associated with hypertension. It is a rare condition in pregnancy, but can lead to serious consequences. In this case report, a 33+4-week pregnant patient with PRES with gestational hypertension is discussed. The patient presented with blurred vision and high blood pressure (TA, 180/100 mm Hg). An emergency caesarean section was performed because of progression of visual loss. In the second week after discharge, the patient again presented with similar symptoms. MR imaging revealed vasogenic edema, and a diagnosis was made in the parieto-occipital region. His symptoms rapidly regressed after antihypertensive treatment and seizure prophylaxis. Control MRI showed a decrease in edema, and the patient was discharged on the 7th day of treatment. No recurrence or complications were observed at the six-month follow-up. This case of pregnancy- associated hypertension emphasizes that should be considered in the differential diagnosis and early diagnosis and effective treatment may lead to complete regression of the disease.Posterior Reversible Encephalopathy Syndrome

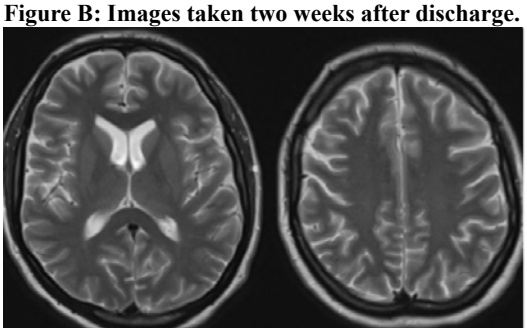
Keywords: Cesarean section,Posterior Reversible Encephalopathy Syndrome, Pregnancy, Hypertension, Visual Impairment,

Figure A: Vasogenic edema in the paramedian, parietal and occipital region.



Vasogenic edema in the paramedian, parietal and occipital region.

Figure B: Images taken two weeks after discharge.



Images taken two weeks after discharge.

PS-29 [Obstetri Genel]

Spontaneous tubal torsion in pregnancy: an uncommon cause of acute pain

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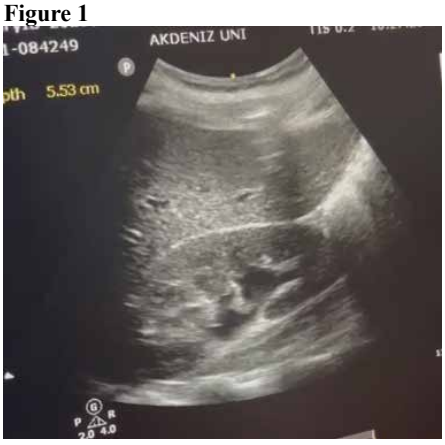
Akdeniz University, Faculty of Medicine

Tubal torsion is a rare but serious condition, particularly during pregnancy, and its diagnosis can be challenging due to overlapping symptoms with other acute abdominal pathologies. A 17-year-old primigravida at 31 weeks of gestation presented with acute right abdominal and pelvic pain, dysuria, nausea, vomiting, and costovertebral angle tenderness. Ultrasound and MRI revealed a hydropic right fallopian tube, a paratubal cyst, and right-sided hydronephrosis. Laboratory findings showed leukocytosis and elevated C-reactive protein levels, while urinalysis was unremarkable. Despite initial conservative management with antenatal corticosteroids, neuroprotective magnesium therapy, and antibiotic treatment, worsening pain and rising inflammatory markers led to cesarean delivery. Intraoperative findings confirmed a necrotic, torsed right fallopian tube and a twisted paratubal cyst. A right salpingectomy and paratubal cyst excision were performed, with histopathological examination confirming tubal infarction. This case highlights the diagnostic challenges of tubal torsion in pregnancy and underscores the importance of timely surgical intervention in cases of persistent pain and inflammatory response despite conservative management.

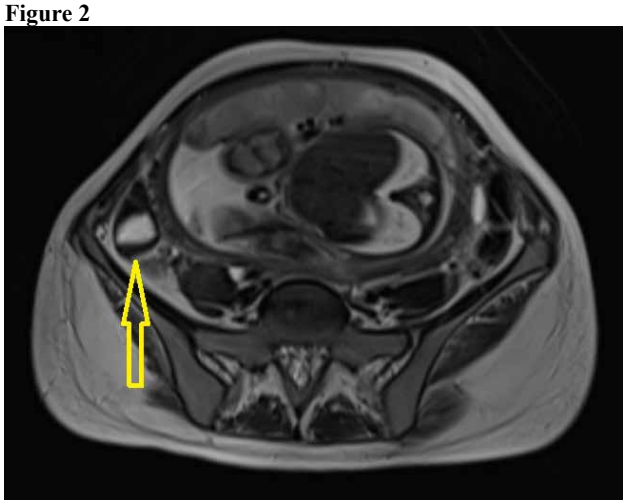
Keywords: Tubal torsion, pregnancy, acute abdomen, emergency

Figure 1



Right renal hydronephrosis

Figure 2

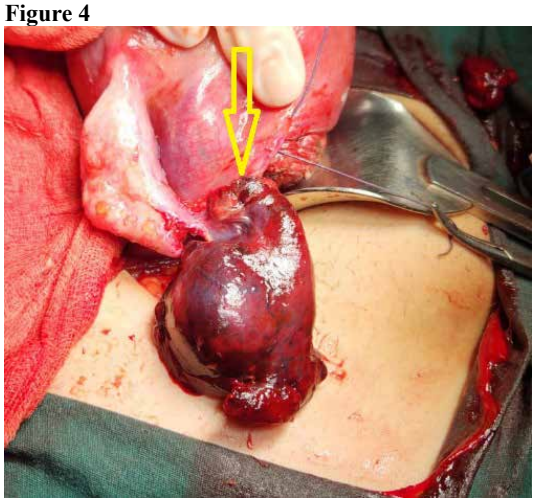


Tubal torsion on MRG

Figure 3

Tubal torsion on MRG

Figure 4



Intraoperative torsion of right tuba

PS-30 [Obstetri Genel]

Triple Vertical Suturing for the Management of Uterine Atony in a Severe Preeclampsia Patient Receiving Magnesium Sulfate

Can Dinç, Ömer Faruk Öz
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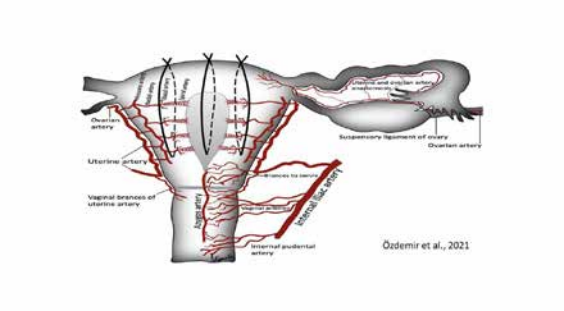
Postpartum hemorrhage remains the leading cause of maternal morbidity and mortality. Although various treatment options are available, some may pose a risk to future fertility. Nonsurgical interventions for the reduction and control of bleeding due to uterine atony are applied in a rapid sequence until hemostasis is achieved. All patients with uterine atony undergo uterine massage, manual compression, administration of uterotonic agents, and tranexamic acid. If these measures fail to control bleeding and the patient remains hemodynamically stable, uterine compression sutures can be applied. These sutures have been shown to effectively reduce uterine blood loss related to atony, and various techniques have been described in the literature. Among these, triple vertical uterine compression sutures represent a novel approach for managing uterine atony.

In patients with severe preeclampsia, intrapartum and postpartum seizure prophylaxis with magnesium sulfate is routinely administered based on evidence from randomized trials demonstrating a significant reduction in the risk of eclampsia. While some reviews suggest that magnesium sulfate is not associated with an increased risk of atonic postpartum hemorrhage, data on this relationship remain inconclusive.

In this case report, we describe a patient with severe preeclampsia who was receiving magnesium sulfate prophylaxis and developed uterine atony during a cesarean section. To manage the bleeding, we successfully applied triple vertical uterine compression sutures.

Keywords: Three vertical compression sutures, Uterine atony, Magnesium sulfate prophylaxis

Triple Vertical Suture Technique



Triple vertical suturing in the management of uterine atony

PS-31 [Obstetri Genel]

Strategy Proposals for Increasing Fertility Rate for Türkiye

Gonca Karataş Baran
Etlik Zübeyde Hanım Kadın Hastalıkları Eğitim ve Araştırma Hastanesi, Sağlık Bakım Hizmetleri Müdürlüğü, Ankara Türkiye

Fertility rates in the world are on a downward trend. The increasing elderly population and decreasing young population have serious effects on the country's economy, social structure and welfare. The aim of this study is to determine strategies to increase fertility rates in Turkiye and to examine the impact of these strategies on the country's population dynamics by considering their economic, social and cultural effects. Fertility and population dynamics are the main factors affecting a country's population structure and growth. Among the factors affecting fertility rates, individual and family level factors play a very important role. Factors such as women's level of education, their status in working life, age at marriage and birth control are the factors that affect individuals' fertility preferences. Family structure, income level, family communication and family planning are also among the factors that determine fertility rates. The primary recommendation for Turkiye's fertility rate increase strategies is to develop policies that support equality within the family. Increasing women's level of education and increasing their participation in the workforce can affect women's fertility decisions. In addition, providing supports such as maternity leave and childcare services is also important. Gender equality awareness should be spread and men should be encouraged to take more responsibility for childbirth and childcare. In addition, economic support should be increased to reduce the burden of childbirth and childcare costs throughout the country. The implementation of these strategies will be important steps to increase Turkiye's fertility rate. In order to effectively implement fertility rate increase policies in Turkiye, international best practices should be adapted to Turkiye's socio-economic and cultural structure. The effects of policies implemented in Turkiye from the past to the present and the current situation analysis will be important reference sources for the future success of fertility rate increase strategies. Clear success criteria should be determined for the evaluation of fertility rate increase policies and these criteria should be monitored regularly.

Keywords: Fertility; Fertility rate, Population Policy, World Population Policy

PS-32 [Obstetri Genel]

Intrahepatic Cholestasis of Pregnancy Complicated by Hepatitis A Infection: A Case Report

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OBJECTIVE: Acute viral hepatitis can lead to various complications during pregnancy. While hepatitis A is common in the general population, it is rare among pregnant women. The progression of the disease is similar to that in non-pregnant individuals, but it may lead to complications such as premature contractions, placental separation, premature membrane rupture, and vaginal bleeding. This report aims to highlight intrahepatic cholestasis of pregnancy (ICP) in the context of hepatitis A infection, a rare complication in pregnancy.

METHOD: A 37-year-old pregnant patient underwent physical examination, obstetric evaluation, and laboratory tests.

FINDINGS: The patient was a 37-year-old gravida 2 woman with one elective abortion in her history. She was a strict vegetarian with a diagnosis of vitiligo and a penicillin allergy. Her medical history was otherwise unremarkable. During routine prenatal visits, she presented with generalized pruritus at 22 weeks and 6 days of pregnancy, which led to a referral to our center due to elevated ALT and AST levels. On physical examination, scleral icterus was observed. Ultrasonography revealed no additional pathology. Laboratory tests showed ALT: 1856 IU/L, AST: 2552 IU/L, direct bilirubin: 2.45 mg/dL, indirect bilirubin: 1.09 mg/dL, and total bilirubin: 3.54 mg/dL. Hepatitis A markers revealed Anti-HAV IgM: 15.38 and Anti-HAV IgG: 2.5, indicating acute hepatitis A infection. Also the patient underwent a full abdominal USG and no additional pathology was detected. Due to persistent itching, fasting serum bile acids were measured and found to be 34 mmol/L, confirming ICP. Following consultation with infectious disease specialists, the patient was treated with ursodeoxycholic acid and hydration. ALT, AST and bilirubin levels were monitored daily. After 14 days of follow-up, the patient's liver enzymes and bilirubin levels normalized, and her symptoms improved. The patient was discharged after her laboratory tests returned to normal. She delivered via normal vaginal delivery at 37 weeks of gestation. No increase in AST, ALT, or bilirubin levels was observed during the week leading up to and following delivery.

CONCLUSION: Intrahepatic cholestasis of pregnancy is the primary diagnosis in pregnant women presenting with widespread itching and elevated liver enzymes. However, as shown in this case, rare infections like hepatitis A can complicate the clinical picture. Therefore, a comprehensive approach that includes a detailed patient history and a multidisciplinary team is essential for accurate diagnosis and effective treatment. This case emphasizes the importance of considering rare infections in the differential diagnosis of ICP and the value of holistic patient care.

Keywords: risky pregnancy, intrahepatic pregnancy cholestasis, hepatitis A infection.

PS-33 [Obstetri Genel]

Management of Recurrent Cesarean Scar Pregnancy After IVF-Embryo Transfer Procedure: Case Report

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AIM: Cesarean scar pregnancy (CSP) is the rarest form of ectopic pregnancy, and it develops depending on the implantion of the pregnancy sac to the previous cesarean scar. With the increasing rates of cesarean section and improvement in sonographic diagnosis, CSP has seen more common. The recurrence of ceserean scar CSP is even rarer, prior CSP may increase rate of recurrence CSP. We report a recurrent ceserean scar ectopic pregnancy (RCSP) after embryo transfer with vaginal spotting complain. If CSP is not diagnosed in time and inadequately managed, it can cause serious maternal and fetal morbidity and mortality. Its crucial early diagnosis and treatment in CSP.

METHODS: A case report.

CASE: A 31 year-old female patient with one previous live birth with cesarean section and 2 consecutive cesarean scar pregnancies was admitted to our hospital with vaginal spotting complain in her fourth pregnancy after 6 weeks of gestational amenorhea. The pregnancy was conceived through IVF in external center. The patient was hemodinamicaly stable and vaginal spotting minimally on pelvic exam. A single intrauterine gestational sac was seen eccentrically near the cesarean section scar site in the lower anterior uterine segment on initial transvaginal sacanning (TVS).Cervix appeared normal and closed. The fetal pole was identified in the sac with crown-rump length (CRL) of 5,8 mm, corresponding to 6 weeks 2 days. Cardiac activity was noted and normal yolk sac was seen.Anterior myometrium between the gestational sac and the posterior wall of the urinary bladder was measuring 4.8 mm.The endometrial cavity in the upper-uterine segment was empty. The patient was initially managed medically due to fertilty preservetion request. Locally intracaviter Methotrexate (MTX) injection with simultaneus aspiration of gestational tissue under TVS guidance was aplied. Plasma betahcg level decreased from 47.000 to 9149 in two weeks.
RESULT: Cesarean scar pregnancy (CSP) is a rare but serious form of ectopic pregnancy.The incidence of CSP has increased in parallel with the rising global cesarean delivery rates. Recurrent CSP, as observed in our case, is even more uncommon and poses significant risks, including uterine rupture, severe hemorrhage, and loss of future fertility.In this case, the patient presented with a third CSP following in vitro fertilization (IVF), highlighting the potential association between assisted reproductive techniques and abnormal implantation in a scarred uterus. Studies suggest that IVF may increase the risk of CSP due to altered embryo transfer techniques and endometrial receptivity, although the exact mechanisms remain unclear. Treatment options include systemic or local methotrexate administration, uterine artery embolization, suction curettage, hysteroscopic or laparoscopic resection, and in some cases, hysterectomy. Given the recurrent nature of CSP in our patient and the associated high-risk profile, a multidisciplinary approach was essential for optimal management and prevention of severe complications.. Further research is needed to elucidate the pathophysiology of CSP in IVF pregnancies and to develop standardized preventive and management protocols.

Keywords: scar pregnancy,ectopic pregnancy, recurrent CSP, methotrexate(MTX),ultrasound

PS-34 [Obstetri Genel]

Postpartum Uterine Rupture and Complicated Infected Hematoma Following Cesarean Section: Clinical Challenges and Management

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Akdeniz University, Faculty of Medicine

INTRODUCTION: To present a rare case of delayed postpartum hemorrhage and uterine rupture complicated by intra-abdominal sepsis following cesarean section in a woman.

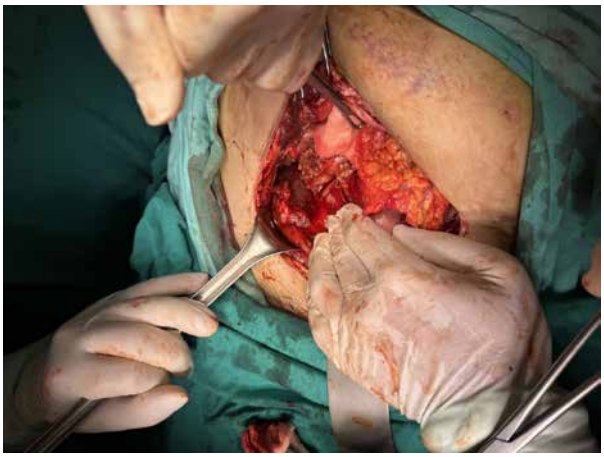
CASE: A 25-year-old, G3P3Y2 c/s; woman underwent cesarean delivery at 37 weeks due to intrauterine fetal demise on February 23, 2025, at an external center. Two weeks later, on March 8, 2025, she was transferred to our emergency service via ambulance due to vaginal bleeding and suspected pelvic hematoma or abscess. She had received 2 units of erythrocyte suspension due to a hemoglobin level of 4.7 g/dL at the referring center, but was referred due to repeated cross-match subgroup incompatibility. Her blood type was O Rh(+).

RESULTS: Upon admission, the patient was alert and oriented, with a heart rate of 112 bpm, blood pressure of 100/60 mmHg, and oxygen saturation of 99%. Laboratory findings included: Hb 5.3 g/dL, PLT 830,000/mm³, CRP 266 mg/L, INR 1.26. She reported 3 days of fever and abdominal pain. Transvaginal ultrasonography showed minimal intrauterine fluid, suspected dehiscence at the cesarean scar, and a 12 cm hematoma in the left adnexal region. CT imaging from the referring center revealed a 14x8 cm hematoma extending from the left psoas to the pelvic region adjacent to the uterus, and a 6 cm loculated fluid collection in the right parauterine area. Broad-spectrum IV antibiotics (ceftriaxone and metronidazole) were initiated empirically. Blood cultures showed no growth. Hematology consultation advised the use of crossmatch-negative blood and preparation of sufficient units for the planned surgery. On March 9, the patient underwent laparotomy. Intraoperatively, anterior and posterior ruptures of the left lateral uterine wall were detected, with widespread adhesions and multiple hematoma collections, including a 7 cm hematoma in the pouch of Douglas. Purulent material was aspirated for culture. Uterine adhesions were lysed, ruptured areas were repaired with 1.0 Vicryl sutures, and two drains were placed. She received 2 units ES and 1 unit FFP intraoperatively. Pre-op Hb: 8.4 g/dL, post-op: 9.7 g/dL. Due to a fever of 39°C and signs of intra-abdominal infection, antibiotics were escalated to piperacillin–tazobactam (3x4.5 g). On March 11, intraoperative cultures grew E. coli. Therapy was continued. Enterococcus species were later added to the culture report. Infectious diseases specialists were consulted, and the significance of this finding was discussed. Despite recommendations for further treatment, the patient refused continued care and left the hospital on March 20. The patient received 10 days of piperacillin–tazobactam and a single dose of rifampin. CRP decreased from 266 to 22 mg/L. She started low molecular weight heparin on March 13. Despite Enterococcus being deemed clinically significant, the patient refused further treatment and was discharged with a hemoglobin level of 9.1 g/dL after receiving a total of 6 units ES and 3 units FFP.

CONCLUSION: This case highlights the importance of close postpartum monitoring following cesarean section. Delayed recognition of uterine rupture and intra-abdominal sepsis can lead to life-threatening complications. Multidisciplinary management and timely surgical intervention were critical in this case, despite the patient's refusal to complete antibiotic therapy.

Keywords: Postpartum Hemorrhage, Caesarean section, Postpartum Uterine Rupture

INTRA ABDOMINAL INFECTION



INTRA ABDOMINAL INFECTION

INTRA ABDONMINAL HEMATOMA AND SEPSIS

INTRA ABDONMINAL HEMATOMA AND SEPSIS

UTERINE RUPTURE

UTERINE RUPTURE

PS-35 [Obstetri Genel]

Unexpected Intrapartum Diagnosis of Uterus Didelphys in an Unsupervised Pregnancy: A Case Report Unexpected Intrapartum Diagnosis of Uterus Didelphys in an Unsupervised Pregnancy: A Case Report and Review of Obstetric Implications

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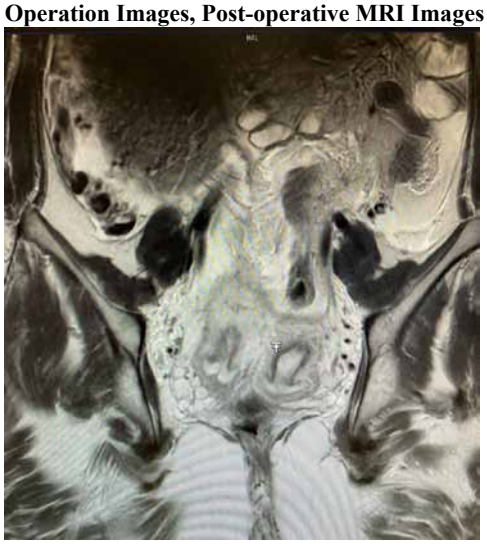
INTRODUCTION: Uterus didelphys is a rare müllerian anomaly characterized by incomplete fusion of the müllerian ducts during embryogenesis, resulting in two separate uterine cavities, duplicated cervices, and often a vaginal septum. Although frequently asymptomatic, it is associated with obstetric complications such as recurrent pregnancy loss, preterm birth, malpresentation, and increased cesarean delivery rates.Diagnosis is typically established via transvaginal ultrasonography or magnetic resonance imaging (MRI) in early pregnancy or preconception. However, in unsupervised pregnancies, the diagnosis may remain unnoticed until labor or during surgical intervention. This report presents the obstetric and surgical management of an undiagnosed uterus didelphys discovered intrapartum. CASE: A 31-year-old gravida 4, para 3 woman with no antenatal follow-up presented in active labor. She had a history of three previous cesarean deliveries. Vaginal examination revealed 1 cm cervical dilation and 60% effacement, with a structure suggestive of a vaginal septum or double cervix.Transabdominal ultrasonography showed a live singleton fetus in cephalic presentation within the right uterine cavity. Fetal biometry was consistent with term gestation. The amniotic fluid index was 40 mm, with an anteriorly located placenta. Due to significant thinning of the uterine scar, an emergency cesarean was performed. During laparotomy, uterus didelphys was identified. A live female infant, weighing 3400 grams with a 1-minute Apgar score of 8, was delivered from the right uterine cavity in cephalic presentation. No pregnancy was present in the left cavity. The postoperative course was uneventful. MRI confirmed uterus didelphys and an old cesarean scar on the left side. Renal ultrasound revealed no abnormalities. DISCUSSION: Uterus didelphys limits intrauterine space, predisposing to malpresentation, which is reported in 43-62% of cases, commonly breech. Consequently, cesarean delivery rates exceed 80% in these patients. In this case, cephalic presentation facilitated controlled delivery, although the anomaly remained undiagnosed antenatally. The restricted growth restriction (IUGR), with rates reported at 15-25%. Although fetal biometry was normal here, close surveillance is advised in future cases. Placental implantation abnormalities, such as placenta previa and accreta spectrum disorders, are more frequent in müllerian anomalies, with placenta previa rates reaching up to 20%, increasing the risk of hemorrhage and surgical difficulty. Renal anomalies co-exist in approximately 20-30% of uterus didelphys cases due to the developmental link between the urinary and reproductive systems. No renal anomalies were identified in this patient. Failure to diagnose müllerian anomalies prenatally can lead to unexpected findings and management challenges during labor, especially in unsupervised pregnancies. Early imaging to assess uterine morphology is critical, particularly in multiparous women with a prior cesarean history. CONCLUSION: This case highlights the importance of early recognition of müllerian anomalies. Identifying uterus didelphys prenatally allows better obstetric planning and minimizes complications. A multidisciplinary approach remains essential to optimize maternal and neonatal outcomes.

Keywords: Uterus Didelphys, Pregnancy Complications, Cesarean Section, Müllerian Duct Anomalies

Operation Images, Post-operative MRI Images



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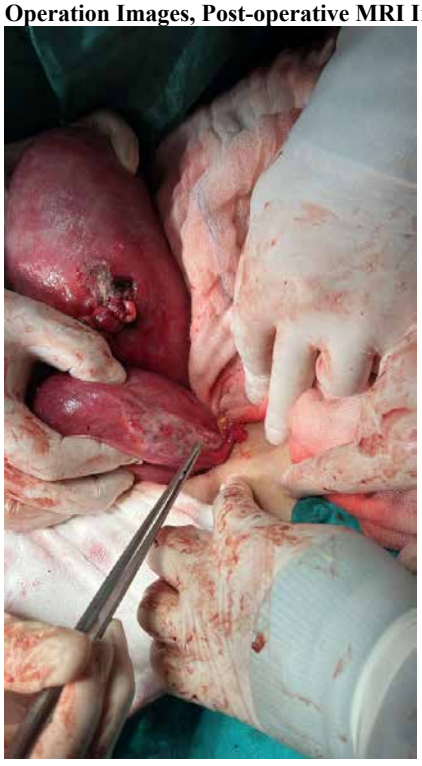

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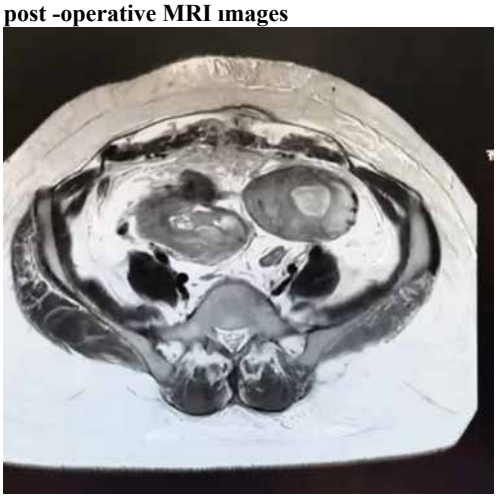

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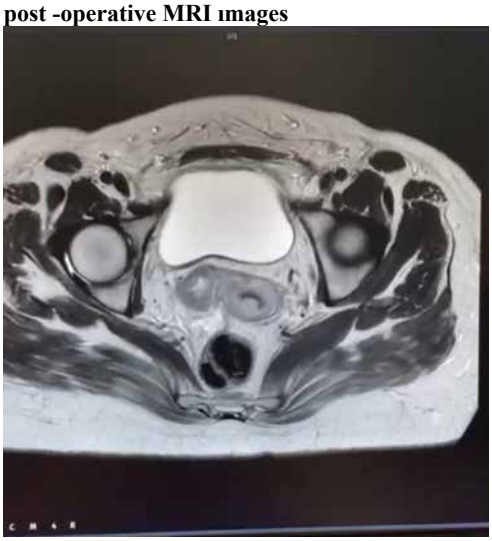

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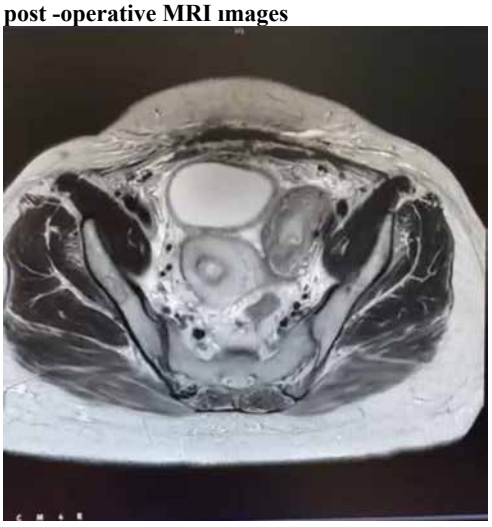

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PS-36 [Obstetri Genel]

Isolated Fetal Megacystis with Spontaneous Regression

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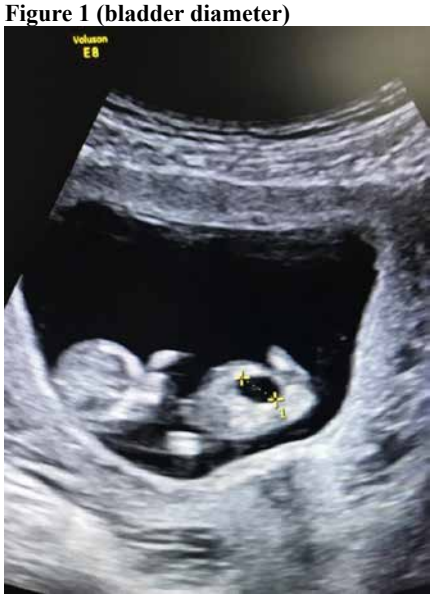
Keywords: Fetal megacystic, intraabdominal cyst, lower urinary tract obstruction, bladder diameter

INTRODUCTION: Fetal urine production begins in the fetus approximately at the 10th week of pregnancy. The bladder is observed between the two umbilical arteries in the pelvis during abdominal evaluation of the fetus.[1] Fetal megacystis can be diagnosed when the longitudinal diameter of the bladder is >7 mm and the bladder diameter does not decrease during 45 minutes of observation[1-2]. It is seen in approximately 1/1660 of pregnancies.[2-3] The fetal bladder can be observed to be wide due to obstructive and non-obstructive causes.[1-7] Megacystis does not always continue during pregnancy and may undergo spontaneous resolution.[1-6-7]. In our case, an isolated megacystis case detected in the first trimester and spontaneously regressed in the prenatal period is discussed. CASE: The patient, 38 years old, Gravida 3, parity 2, known to have had two vaginal deliveries before, and 11 weeks pregnant according to the last menstrual period, applied to our outpatient clinic for first trimester screening. It was learned that the patient had no known additional disease, medication use or allergy. No pathology or disease was observed in her previous pregnancies, pregnancy follow-ups and postpartum period. There is no known feature in the patient's family history.

The fetal heart rate was observed in the ultrasonographic evaluation. The head-butt distance measurement was compatible with the week of the fetus, and the bladder size was observed as 8.3 mm in the abdominal evaluation. (Figure 1) Double umbilical artery was observed in the pelvis Doppler ultrasonography of the fetus. (Figure 2) The nuchal translucency of the fetus was measured as 1.0 mm and was found to be normal. The fetal nasal bone was observed. The fetus, whose kidney sizes were normal, was diagnosed with fetal megacystis because the bladder was measured as 8.3 mm. The patient was offered chorionic villus sampling. Upon her refusal, the patient was offered a follow-up examination and taken under follow-up. The patient underwent a double screening test, the results of which were deemed low risk.

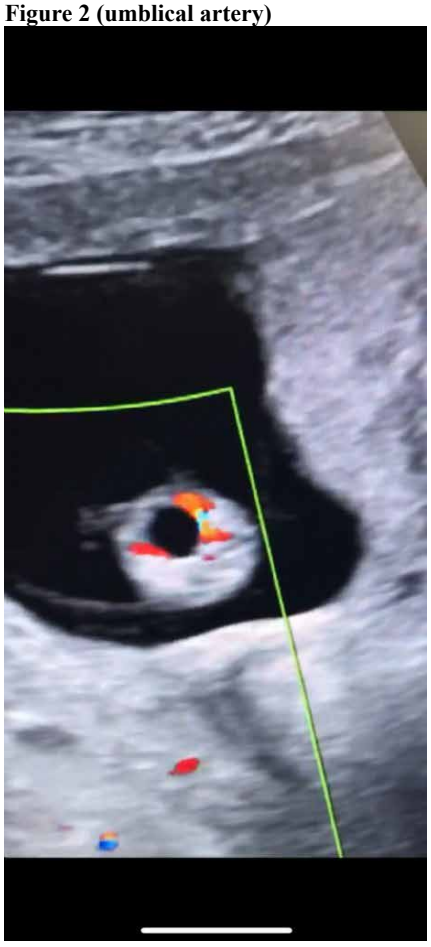
The patient's ultrasonographic evaluation at the 16th week of pregnancy showed that her measurements were consistent with her week. The pelvic examination of the fetus revealed that the fetal megacystis, which was observed at 11 weeks of pregnancy, had regressed. The patient underwent an amniocentesis procedure in the following weeks, the results of which were normal. A detailed ultrasound was performed at 20 weeks, and no megacystis or other fetal anomalies were observed in the patient. The patient's oral glucose tolerance test results at 25 weeks of pregnancy were found to be within normal values. The patient gave birth to a healthy baby by normal vaginal delivery at 39 weeks. No pathology was detected during the 2-year follow-up of the baby. CONCLUSION: Fetal megacystis can be an indicator of some syndromes and anomalies, and can also be observed in isolation. In isolated fetal megacystis cases, as in our case, prenatal spontaneous regression can also be observed. However, when this pathology is encountered, it is very important to perform all additional evaluations and closely follow the patient.

Figure 1 (bladder diameter)



The bladder size was observed as 8.3 mm in the abdominal evaluation. (Figure 1)

Figure 2 (umblical artery)



Double umbilical artery was observed in fetal pelvis doppler ultrasonography.

PS-37 [Obstetri Genel]

Management of HIV-positive pregnancies: A case report

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INTRODUCTION: Human Immunodeficiency Virus (HIV) has been a global health challenge since its identification in 1981, causing millions of deaths worldwide. Significant advancements in antiretroviral therapy (ART) have improved mortality rates and life expectancy for individuals living with HIV. As a result, an increasing number of HIV-positive pregnancies are being encountered in clinical practice. I This case report presents the management of a pregnant woman with HIV and outlines the prophylaxis recommendations for her newborn, emphasizing the importance of a multidisciplinary approach to optimize outcomes.

CASE REPORT: A 24-year-old primigravida at 31+6 weeks of gestation, based on her last menstrual period, presented to our clinic with a known history of HIV positivity. The patient had been diagnosed with HIV four years prior, with an unknown source of transmission. The patient had been on continuous Triumeq (abacavir/dolutegravir/lamivudine) therapy since her diagnosis, except for a brief discontinuation between the 16th and 21st weeks of pregnancy due to non-adherence. At 34 weeks of gestation, her HIV RNA test was negative; however, a repeat test at 38 weeks showed detectable viral load. To minimize the risk of vertical transmission, an elective cesarean section was planned at 39+2 weeks of gestation. Intravenous zidovudine was administered three hours before the procedure, with a loading dose of 2 mg/kg over one hour, followed by a maintenance dose of 1 mg/kg/hour, which was continued until two hours postpartum. The patient was discharged 48 hours postoperatively with appropriate follow-up recommendations. For the newborn, zidovudine prophylaxis was initiated under pediatric consultation. The infant was bathed immediately after birth, and breastfeeding was strictly prohibited. HIV RNA testing was performed at one week, four weeks, and six months postpartum, with all results confirming the absence of HIV infection.

DISCUSSION: Vertical transmission of HIV from mother to child most commonly occurs during the intrapartum period. To mitigate this risk, cesarean delivery at 39 weeks of gestation is recommended for HIV-positive pregnant women, particularly those with detectable viral loads. The administration of intravenous zidovudine three hours before cesarean delivery has been shown to significantly reduce transmission rates. Initiating ART during pregnancy, ideally before 28 weeks of gestation, is crucial. Preferred antiretroviral regimens in pregnancy include nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs), protease inhibitors (PIs),integrase inhibitors. Breastfeeding is another potential route of transmission and is therefore contraindicated in HIV-positive mothers in resource-rich settings. Newborns should receive six weeks of oral zidovudine prophylaxis. HIV RNA testing is recommended at 14–21 days, 1–2 months, and 4–6 months of age. Two separate negative HIV RNA tests after six months of age effectively rule out HIV infection in the newborn.

In the presented case, the patient and newborn was managed with some basic attitudes. Consequently vertical transmission wasn' t detected during follow-up.

CONCLUSION: Key strategies include early initiation of ART, elective cesarean delivery for women with detectable viral loads, and strict adherence to newborn prophylaxis protocols. With appropriate antenatal, intrapartum, and postnatal management, the risk of vertical HIV transmission can be significantly reduced.

Keywords: antiretroviral therapy,HIV, pregnancy

PS-38 [Obstetri Genel]

Management of the labour process in a pregnant woman with multiple drug hypersensitivity syndrome

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OBJECTIVE: Drug hypersensitivity is a common public health problem. Hypersensitivity to more than one drug is common. The term of multiple drug hypersensitivity syndrome (MDHS) is used to describe situations where the patients are hypersensitive to two or more chemically different drugs and are positive for one or more immunological or allergic tests. This case describes the management of the labour process in a pregnant woman with multidrug allergy.

CASE: A 29 years old primigravida patient with a gestation of 40 weeks and 2 days had been referred from a secondary care unit because the patient was in active labour, had multi-drug allergy and might need intensive care unit. Ultrasonography revealed head presentation alive singleton fetus with estimated fetal weight of 3600 g, compatible with 38- 39 weeks. Vaginal examination revealed a cervical dilatation of 9 cm and 90% effacement. The pouch was opened during the examination and the amniotic fluid was clear. The previous medical history of the patient includes positive angioedema test against arveles, midazolam, propofol, bupivacaine, ketamine drugs. All possible risks including the need for intensive care were explained to the patient and her relatives. Anaesthesiologist was consulted and normal vaginal delivery was planned in the operating room. A rapid skin prick test for lidocaine and oxytocin was performed before delivery. No allergy was noticed. A mediolateral episiotomy was opened and alive singleton baby girl weighing 3630 g with an APGAR of 9-10 was delivered with a head presentation. Placenta was completely separated spontaneously. Episiotomy was repaired. Uterus was contracted, rectal examination and anal sphincter tone were normal. No additional medical treatment other than oxytocin was administered in the postpartum period. The patient who had no problems in postpartum follow-up was discharged with the recommendations.

DISCUSSION: MDHS, referred to as multidrug allergy syndrome in the literature, is defined as allergic reactions to 2 or more unrelated drugs by immune-mediated mechanisms. MDHS is caused by immune-mediated mechanisms. The most common drug group causing MDHS is antibiotics, followed by non-steroidal anti-inflammatory drugs. It is also seen in therapeutically used drugs that have effects on respiratory, gastrointestinal, nervous and cardiovascular systems, corticosteroids,

local and general anaesthetics, iodinated contrast agents and vitamins. In this case, analgesics and anaesthetics were predominant. In order to identify the culprit drug, a detailed drug history and questioning of the associated symptoms are necessary. This should also be recorded for future follow-up. Offending drugs should be avoided. After a successful tolerance test, alternative medication should be prescribed. Drug testing under close medical supervision in an emergency setting is essential. These drug tolerance tests help with immediate intervention in emergency situations.

CONCLUSION: Drug allergy is common in the community, although it is not common as MDHS. Management of labour in these individuals, considering the possible need for emergency caesarean section, in tertiary hospitals with intensive care facilities, with the least possible medical agents minimises possible side effects.

Keywords: Angioedema,labor, multiple drug hypersensitivity syndrome

PS-39 [Obstetri Genel]

Non-Infectious Acute Parotitis After Spinal Anesthesia: A Rare Pathology

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Introduction: Anesthesia mumps refers to the temporary inflammation and swelling observed in the salivary glands, particularly the parotid glands. The prevalence of anesthesia mumps is reported to be 0.02% to 0.04% of postoperative cases, and it is typically a unilateral, benign, and non-infectious complication. However, it is crucial to recognize that the swelling of the parotid glands can theoretically lead to serious consequences, including respiratory distress, which may require surgical intervention. In this study, we report a case of postoperative parotitis that developed within the first 24 hours following a cesarean section under spinal anesthesia and spontaneously resolved by the 48th postoperative hour.

Case: A 34-year-old multiparous patient with no history of systemic diseases or allergies was admitted for an elective cesarean section at 39 weeks of gestation due to a previous cesarean delivery. The patient had no history of any complications following her prior cesarean section. Under spinal anesthesia, a 3250 g female baby was delivered. During the 7th postoperative hour visit, the patient complained of painful swelling on the right side of her face. Palpation revealed a swelling consistent with the right parotid gland (Figure 1) (Figure 2). No heat or redness was noted at the swollen site. Ultrasonography showed no evidence of stones or sludge in the parotid gland to suggest obstruction. Laboratory markers indicated no infection. After the application of warm compresses and IV paracetamol, facial swelling resolved with no sequelae by the 36th hour.

Discussion: Postoperative parotitis is a non-infectious condition of unknown etiology. While many cases of postoperative parotitis are associated with prolonged procedures performed under general anesthesia, more recent publications have documented its occurrence following shorter surgeries, such as cesarean sections. The most widely accepted hypothesis is dehydration and prolonged fasting. Dehydration is thought to cause thickened salivary gland secretions, which may temporarily obstruct the duct. In our case, we cannot speak of severe dehydration. Despite the patient undergoing surgery after an 8-hour fasting period, sufficient IV hydration was administered during and after the procedure, resulting in urine output levels exceeding 50 mL/h. Although anemia could be considered a potential contributor to dehydration, we know that the patient had similar hemoglobin levels during her previous surgery without subsequent parotitis. Sympathetic stimulation caused by the use of vasopressors can contribute to the development of postoperative parotitis. The stimulatory effect of a 48-52 mg dose of ephedrine administered during surgery could lead to parotitis. In our case, the patient received 20 mg of ephedrine during the perioperative period, and we believe that this dose is unlikely to have caused significant sympathetic stimulation sufficient to affect the parotid gland. Epidural anesthesia induces peripheral vasodilation in the affected regions. This vasodilation could trigger compensatory vasoconstriction in unaffected areas, potentially leading to obstruction of the parotid gland. In our case, after ruling out nearly all other potential etiological factors contributing to parotitis, compensatory vasoconstriction can be considered a plausible cause. However, it remains unclear why this phenomenon did not occur during the patient's previous cesarean section.

Keywords: obstetrics, anesthesia mumps, postoperative parotitis

Figure 1

Front view of the patient's parotid swelling

Figure 2

Lateral view of the patient's parotid swelling

PS-41 [Obstetri Genel]

Investigation of Podocalyxin Expression as an Immunohistochemical Marker in Placenta Accreta Spectrum

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Placenta accreta spectrum (PAS), which develops as a result of abnormal invasion of the placenta into the myometrium instead of the decidua basalis, is associated with serious maternal morbidity and mortality that can range from massive hemorrhage to death due to placental failure to separate at birth. Although the role of uterine scar in the pathophysiology of PAS is known, the fact that it can also be seen in nulliparous women or women who have not undergone uterine surgery indicates that the development of PAS is not only due to anatomical defects but may also be associated with immunohistological changes. Vascular endothelial growth factor (VEGF) and Ki-67 play an important role in the process of placental angiogenesis and trophoblast invasion. Overexpression of podocalyxin (PXC) has effects that promote cancer cell migration and invasion. In our study, we planned to investigate PXC immunoreactivity in pathology samples of cases diagnosed with PAS. As a result of the examination of hysterectomy specimens of cases that underwent cesarean hysterectomy with a clinical diagnosis of PAS, we compared the cases with histopathologically confirmed PAS and the cases where the diagnosis of PAS was ruled out as two groups. We showed that VEGF and Ki-67 immunoreactivity, as well as PXC immunoreactivity, increased significantly in PAS cases. The increase in PXC immunoreactivity in PAS cases suggests that it may offer a therapeutic solution worth investigating as an immunohistochemical marker for the early diagnosis of PAS.

Keywords: placenta accreta, VEGF, Ki-67, podocalyxin, biomarker

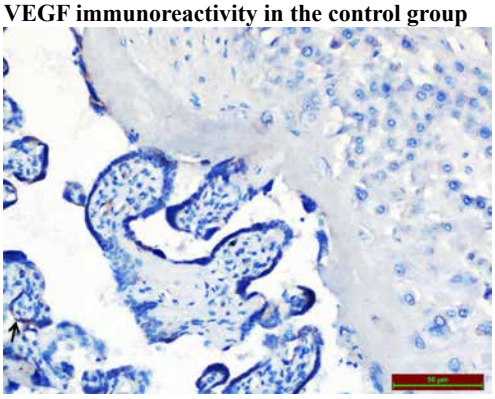
Table 1. Comparison of Demographic and Clinical Characteristics Between PAS and Control Groups

Table 1. Comparison of Demographic and Clinical Characteristics Between PAS and Control Groups

Parameter	PAS Group (n=44)	Control Group (n=16)	*p*-value
Age (years, mean ± SD)	33.75 ± 5.37	33.14 ± 5.15	0.681
Gestational age at delivery (weeks)	36.5 ± 1.73	34.48 ± 3.87	0.072
Previous uterine surgery, n (%)	42 (95.5%)	13 (81.3%)	0.201[1]
No prior uterine surgery, n (%)	2 (4.5%)	3 (18.7%)	

[1]Fisher's Exact Test or Chi-Square Test was used where appropriate. Mann–Whitney U Test was used for continuous variables. A *p*-value of <0.05 was considered statistically significant.

VEGF immunoreactivity in the control group



VEGF immunoreactivity in the PAS group

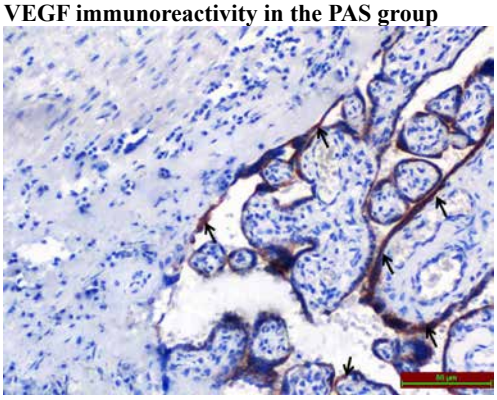


Table 2.Comparative VEGF immunoreactivity scores between the PAS and control groups

Table 2. Comparison of VEGF Immunoreactivity Histoscores Between PAS and Control Groups

Group	Median (Min–Max) Histoscore
Control	0.40 (0.30–0.45)
PAS	1.80 (1.20–2.70)*
p Value	<0.001*

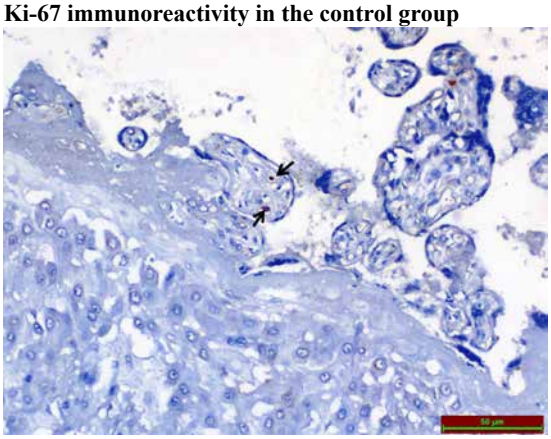
Note:

Values are presented as median (minimum–maximum).

- *Mann–Whitney U test.*

* Statistically significant compared to the control group ($p<0.05$).

Ki-67 immunoreactivity in the control group



Ki-67 immunoreactivity in the PAS group

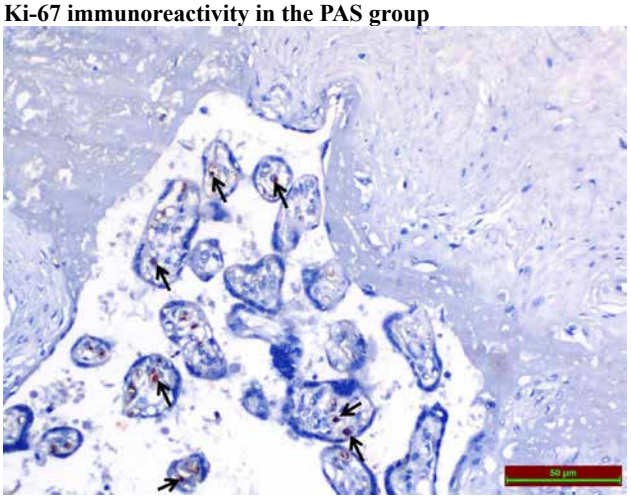


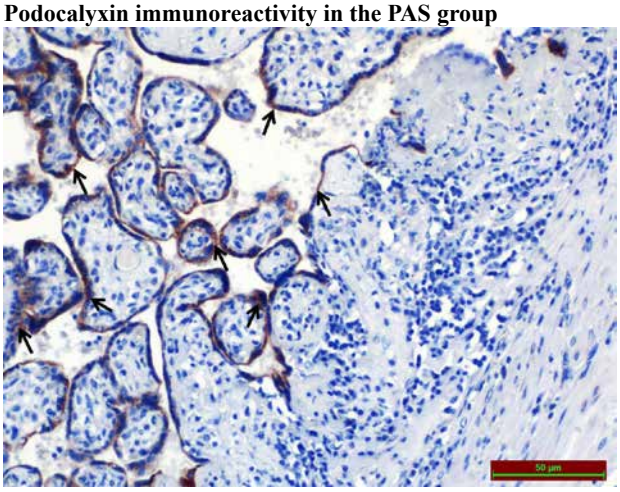
Table 3.Comparative Ki-67 immunoreactivity scores between the PAS and control groups

Table 3. Comparison of Ki-67 Immunoreactivity Histoscores Between PAS and Control Groups

Group	Median (Min–Max) Histoscore
Control	0.40 (0.20–0.60)
PAS	1.20 (0.90–2.70)*
p Value	<0.001*

Note:
Values are presented as median (minimum–maximum).
- *Mann–Whitney U test.*
* Statistically significant compared to the control group ($p<0.05$).

Podocalyxin immunoreactivity in the PAS group



Podocalyxin immunoreactivity in the control group

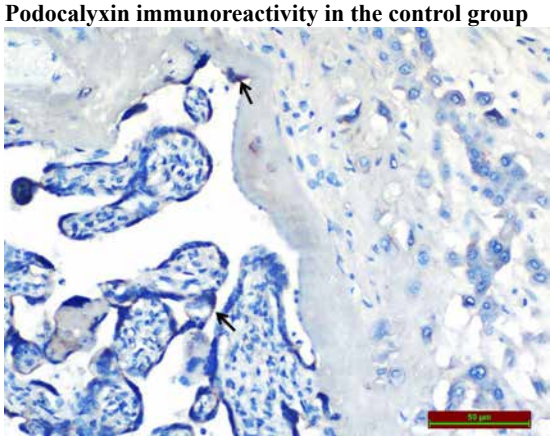


Table 4. Comparative PXC immunoreactivity scores between the PAS and control groups

Table 4. Comparison of Podocalyxin (PXC) Immunoreactivity Histoscores Between PAS and Control Groups

Group	Median (Min–Max) Histoscore
Control	0.40 (0.30–0.60)
PAS	1.50 (1.20–1.80)*
p Value	<0.001*

Note:
Values are presented as median (minimum–maximum).
- *Mann–Whitney U test.*
* Statistically significant compared to the control group ($p<0.05$).

PS-43 [Perinatoloji]

Pregnancy in Takayasu Arteritis: A Case Report

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Takayasu arteritis is a rare vasculitis that primarily affects large vessels such as the aorta and its branches, predominantly in young women. The disease progresses through inflammatory and stenotic phases. Initial symptoms include fatigue, mild fever, weight loss, and anemia, often leading to delayed diagnosis. The stenotic phase is characterized by reduced blood flow, causing headaches, dizziness, syncope, hypertension, and cardiovascular complications. Clinical examination may reveal pulse and blood pressure differences between the arms, along with carotid and renal bruits. Angiography remains the gold standard for diagnosis. As Takayasu arteritis affects women of reproductive age, pregnancy management is crucial. While data are limited, studies have documented successful pregnancies and healthy deliveries. Pregnancy does not alter disease progression, though activation is more frequent in the second and third trimesters. Hypertension is the most common complication, contributing to fetal growth restriction and increased fetal mortality rates. Pregnancy is not contraindicated in patients not receiving cytotoxic therapy, but close prenatal monitoring is essential.

CASE: A 23-year-old woman, with a history of three pregnancies, presented at eight weeks of gestation with nausea and vomiting. She had been diagnosed with Takayasu arteritis four years prior and had experienced right-sided hemiplegia three and a half years ago. Her current medications included immunosuppressive and anti-inflammatory agents. She had not attended follow-ups for the past year and had undergone a cesarean section nine months earlier. Examination confirmed fetal heart activity. Previous imaging revealed subacute total thrombosis of the left common carotid artery and total occlusion of the left subclavian artery. Rheumatologic evaluation found mild upper extremity weakness but no additional abnormalities. She was informed about the effects of her medications on pregnancy and was discharged following treatment for hyperemesis gravidarum.

DISCUSSION: Takayasu arteritis is a chronic vasculitis affecting the aorta in reproductive-age women, associated with increased risks of preeclampsia, preterm birth, fetal growth restriction, and fetal mortality. Abdominal aortic involvement correlates with adverse perinatal outcomes. Preconception and antenatal follow-up are crucial, with management strategies including medication adjustments and discontinuation of cytotoxic agents. Regular blood pressure monitoring, fetal well-being assessments, and maternal hemodynamic surveillance are essential throughout pregnancy. While vaginal delivery is preferred, epidural anesthesia is recommended. A 2019 Turkish Takayasu Study Group study analyzing 112 patients and 296 pregnancies reported high hypertension and preeclampsia rates but lacked specific data on uncomplicated deliveries. Similarly, a 2015 single-center study produced comparable results. Further research is needed to determine healthy birth rates in Takayasu arteritis.

CONCLUSION: This case report examines the impact of Takayasu arteritis on pregnancy in a patient with one successful delivery and two miscarriages. Due to the disease's rarity, pregnancy-related data remain limited. However, successful pregnancies are feasible when the disease is well-controlled, despite existing sequelae and medication use. Patient education and strict monitoring for hypertensive and vascular complications are essential. A well-managed pregnancy and delivery can be achieved through medication adherence, fetal well-being assessments, and biophysical profile monitoring.

Keywords: Recurrent Abortion,Pregnancy,Takayasu Arteritis

PS-44 [Perinatoloji]

Methotrexate and wedge resection for cesarean scar pregnancy

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BACKGROUND: One of the worst cesarean complications is cesarean scar pregnancy (CSP). CSP is the abnormal implantation of the gestational sac (GS) near the cesarean scar area, which can cause serious hemorrhage, uterine rupture, or placenta accreta spectrum illnesses. Since cesarean rates are rising, CSP is increasing by 1 in 600. CSP management is unstandardized. Active heartbeat, residual myometrial thickness, peritrophoblastic vascularity, type of CSP, and gestational age at presentation can affect CSP prognosis. CASE: We presented a 28-year-old G3P2 multiparous patient with CSP. Her initial beta-hCG level was 6675 IU/mL. Ultrasonography showed an anembriyonic GS in the niche at 6+3 weeks gestation (Figure 1). Type-2 CSP resulted in the GS protruding from the uterine cavity and serosal layer. The patient received 90 mg of intramuscular methotrexate (MTX) and was performed laparotomic wedge excision of the scar after 48 hours. We avoided dilatation curettage (D&C) due to rupture and hemorrhage from the retroverted uterus. Figure 2-A shows bladder dissection from the uterus, while Figure 2-B shows wedge resection with GS. After plastic canule replacement into the servical canal (Figure 2-C), the uterus closed one layer (Figure 2-D). Pre- and post-op hemoglobin values were 11.3 and 10.8 gr/dL. The patient was discharged without complications. The blood beta-hCG level dropped to 87.4 IU/mL and ultrasonography showed no niche or defect in the scar area of the uterus after 1 week (Figure 3). There are two primary CPS types. Type 1 is endogenous implantation, while Type 2 is niche pregnancy. MTX injection, gestational sac MTX/potassium chloride (KCl) injection, and, less often, oral mifepristone are used to treat CSPs. D&C, hysteroscopic, laparoscopic CSP excision, and hysterectomy are surgical treatments that may be combined with medical therapy. Additionally, uterine artery chemoembolization (UAE), a conservative CSP treatment that combines embolization and local chemotherapy, is frequently done before D&C and other surgical therapies or with medical treatment. Our treatment reduces the danger of uterine artery damage, preserving fertility and reducing embolization consequences. Inability to undertake laparoscopic surgery due to lack of experience with dissection and resection hemorrhage is the weakness of this case. Following MTX, laparoscopic minimally invasive surgery is planned in next cases.

CONCLUSION: Primary laparotomy is recommended for patients who do not respond to D&C or endoscopic therapy. Combining medicaal and surgical procedures may increase success and reduce bleeding.

References:
1- Timor-Tritsch IE, Kaelin Agten A, Monteagudo A. et al. The use of pressure balloons in the treatment of first trimester cesarean scar pregnancy. Best Pract Res Clin Obstet Gynaecol. 2023 Dec;91:102409.
2-BafferoGM,BusnelliA,RonchiA,et.al.Differentmanagementstrategies for cesarean scar pregnancy: Short-term outcomes and reproductive prognosis. J Gynecol Obstet Hum Reprod. 2023 Sep;52(7):102607.
3- Noël L, Chantraine F. Methotrexate for CSPs. Best Pract Res Clin Obstet Gynaecol. 2023 Jul;89:102364. doi: 10.1016/j.bpobgyn.2023.102364. Epub 2023 Jun 1. PMID: 37354647.
4- Lin R, DiCenzo N, Rosen T. Cesarean scar ectopic pregnancy: nuances in diagnosis and treatment. Fertil Steril. 2023 Sep;120(3 Pt 2):563-572.

Keywords: Cesarean scar pregnancy, methotrexate, wedge resection

Figure 1

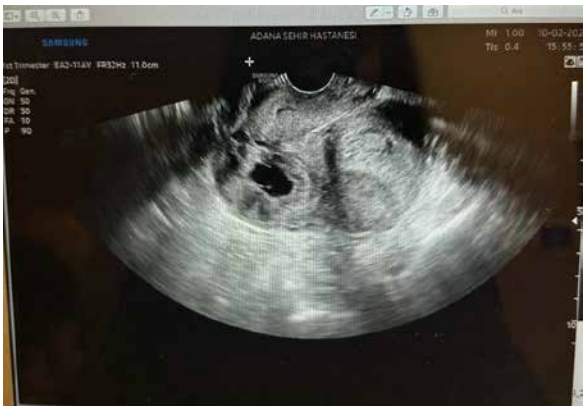


Figure 1 showed an anembriyonic gestational sac in the niche.

Figure 2

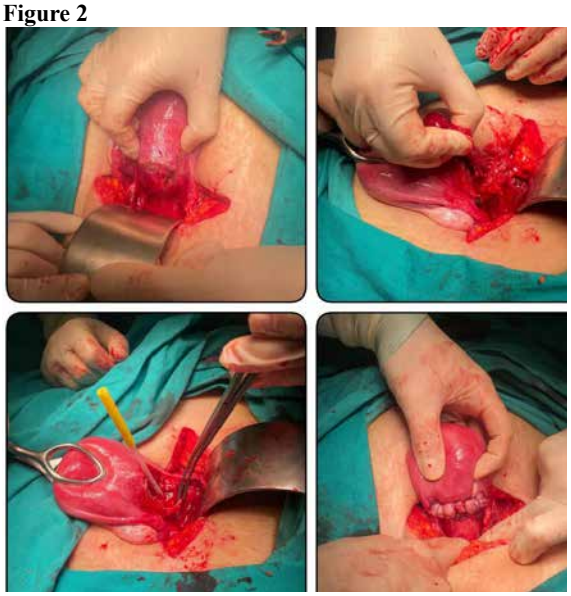
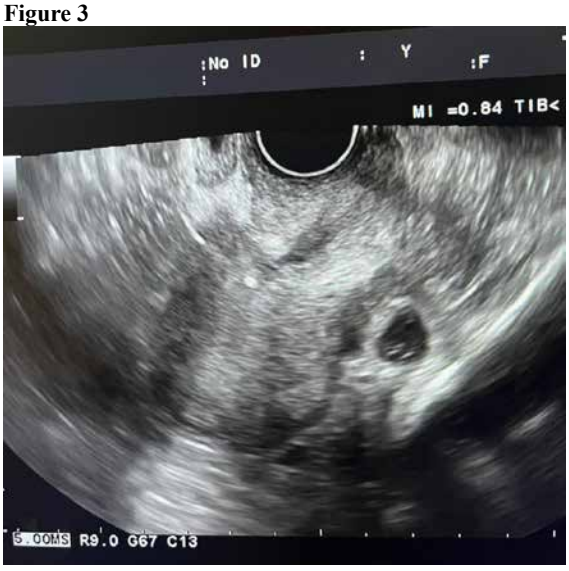


Figure 2-A shows bladder dissection from the uterus, while Figure 2-B shows wedge resection with GS. After plastic canule replacement into the servical canal (Figure 2-C), the uterus was closed one layer (Figure 2-D).

Figure 3



In Figure 3, there was no niche or defect in the scar area of the uterus after 1 week.

PS-46 [Perinatoloji]

Cord Compression of the Extremity in the Intrauterine Period: Case Presentation

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OBJECTIVE: In the intrauterine period, it should be kept in mind that the cord may be entangled in different parts of the baby and this may disrupt circulation in the organ depending on the duration and compression effect.

METHOD: A patient came to the emergency department, complaining of labour pain and not feeling fetal movements for two days. There was 4 cm cervical opening on examination. According to the last menstrual period, she was 35+1 days old, and her measurements were compatible with 34 weeks. Patient was taken to emergency caesarean section with the diagnosis of fetal distress due to variable decelerations on NST (non stress test). Regular follow-up, detailed ultrasonography, and pregnancy scans were not performed throughout the pregnancy. Head presentation, 1935 g male baby was delivered with 5th minute APGAR score of 7.8/10. Placenta was sent to pathology (calcification was observed). The patient was discharged on the 2nd postoperative day without any surgical problems. The baby was followed up in the neonatal unit without intervention.

RESULTS: In the first examination performed by paediatrics in the operating theatre, the left arm was mildly cyanosed from below the biceps level to the distal part of the arm. The shoulder and elbow range of motion were open despite tourniquet-induced compression at the left mid humerus. Capillary refill time was 9 seconds. The radial nerve and ulnar nerve was less functional compared to the right arm. The shoulder joint, humerus and clavicle were normal on x-ray. Venous Doppler examination of the left upper extremity showed normal calibre and tracing of the veins and regular vein walls. The venous structures examined were compressible in all segments and no thrombus was observed in the lumen. The blood flow was normal and respiratory phasicity was not observed. Cranial ultrasonography was normal. Arterial colour doppler examination of the left arm showed subclavia and axillarybrachial artery in normal tracing and calibration. Stenotic segment or plaque formation in the lumen was not observed. Bilateral flow direction, velocity and spectra were normal. Cyanotic colour of the arm lightened 24 hours after birth. Within 3 days, the cyanotic appearance disappeared and the compressible appearance on venous Doppler ultrasound also disappeared.

CONCLUSION: Cord entanglement may occur not only in the neck of the foetus but also in a different limb. As this period prolongs, circulatory disturbance may be observed in the baby.

Keywords: cord compression, disrupt circulation, newborn

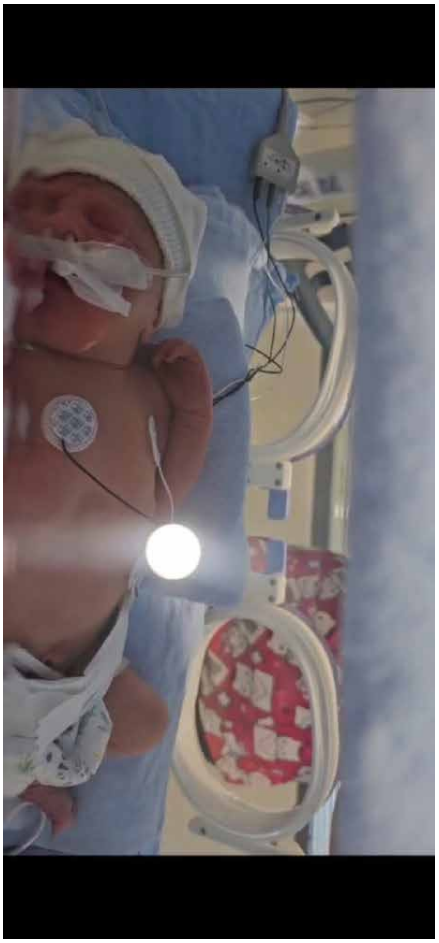
Picture 1

Newborn first hour

Picture 2

X Ray

Picture 3



3 affter day

PS-47 [Perinatoloji]

Tuberosclerosis: Rare Case Report

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OBJECTIVES: We aimed to present a patient who was referred to perinatology because of a hyperechogenic cardiac focus detected in the foetus, cardiac rhabdomyoma in the following gestational weeks and genetic diagnosis of tuberous sclerosis.

INTRODUCTION: Tuberous sclerosis is a genetic disorder that causes tumour formation in the foetus by autosomal dominant inheritance. When these benign tumours reach large sizes, they may cause dangerous conditions. They usually occur in the lung, eye, kidney, brain, skin and heart organs. Clinical course and mobility vary from case to case. The main marker of the disease is the location of the tumours and if the vital functions are affected, fetal loss may develop.

METHOD-FINDINGS: A 29-year-old primigravid patient was referred to perinatology after detection of a hyperechogenic cardiac focus in anomaly screening performed at 25 weeks of gestation. Fetal MRI

and genetic diagnostic test were recommended with a prediagnosis of cardiac rhabdomyoma upon detection of 4x4mm, 4x7mm and 9x16mm enlargement in the echogenic focus measurements in the fetal heart during repeated follow-ups (Figure 1-2-3-4-5-6-7). No additional pathological ultrasonographic findings were detected. Fetal biometry measurements were compatible with the week of gestational age. Fetal MRI could not be imaged 2 times due to incompatibility of fetal position. Amniocentesis QF-PCR result showed maternal contamination (Figure-8). A/S Tuberosclerosis (TSC1-TSC2 gene sequence analysis) culture result showed pathogenic sequence in TSC2 gene (Figure-9-10). In the genetic interpretation, it was predicted that this pathogenic sequence would lead to harmful changes in the protein structure sequence in the baby. No possible pathogenic change was found in the genetic investigation performed in maternal peripheral blood. Paternal genetic testing was recommended. The patient was informed about the termination option and she wanted to continue the pregnancy. The patient completed her routine pregnancy follow-up with a live birth at 38 weeks.

In postnatal follow-up; Fetal Echo: cardiac rhabdomyoma and atrial premature beats and WPW pattern were observed. No pathology was detected in whole abdomen USG. Fetal Brain MRI: Millimetric subependymal nodule and appearance compatible with tuberosclerosis in bilateral frontal white matter. On neurological examination, focal beats in the left eye were compatible with epileptic activity. CONCLUSIONS: Tuberous sclerosis may be of maternal or paternal genetic origin. If the disease is present in one of the couple, the foetus is potentially at risk. However, since the disease is inherited in an autosomal dominant manner, the child may have this disorder even if the parents are not ill. The disease is thought to be caused by a mutation in one of two genes known as TSC1 and TSC2. A defect in these genes can trigger an uncontrolled process of cell proliferation. Genetic changes or mutations can occur completely randomly in an individual and are inherited. If a fetal cardiac echogenic focus is observed in obstetric anomaly screening, the patient should be followed up carefully. Although this soft marker is frequently encountered in trisomies, it may also be a warning sign for rare diseases such as tuberous sclerosis.

Keywords: Cardiac Echogenic Focus, Rhabdomyoma, Tuberosclerosis,

Figure-1. Fetal Cardiac Echogenic Focus

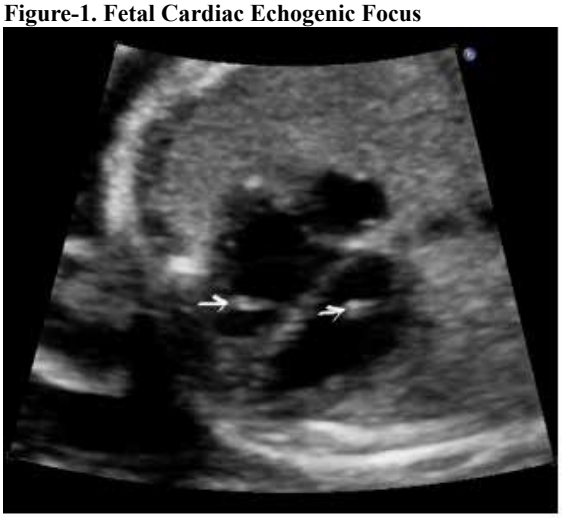
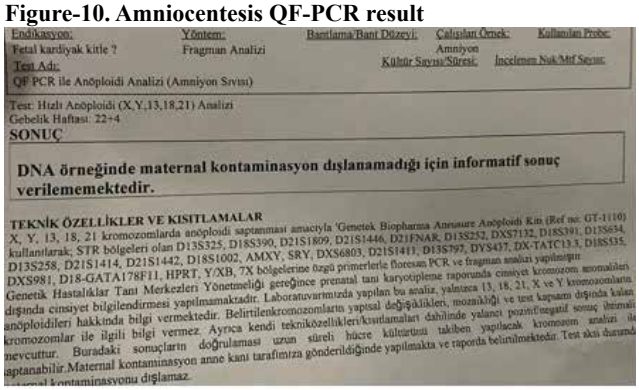


Figure-10. Amniocentesis QF-PCR result



Endikasyon: Fetal kardiyak kitle ?
Yöntem: Fragman Analizi
Bantlama/Bant Düzeyi:
Çalışılan Örnek: Amniyon
Kültür Sayısı/Süresi:
Kullanılan Prob:
İncelenen Nuk/Mtf Sayısı:
Test Adı: QF PCR ile Anöploidi Analizi (Amniyon Sıvısı)

Test: Hızlı Anöploidi (X,Y,13,18,21) Analizi
Gebelik Haftası: 22+4

SONUÇ

DNA örneğinde maternal kontaminasyon dışlanamadığı için informatif sonuç verilememektedir.

TEKNİK ÖZELLİKLER VE KISITLAMALAR

X, Y, 13, 18, 21 kromozomlarda anöploidi saptanması amacıyla 'Genetek Biopharma Annesure Anöploidi Kit (Ref no: GT-1110) kullanılarak; STR bölgeleri olan D13S325, D18S390, D21S1809, D21S1446, D21FNAR, D13S252, DXS7132, D18S391, D13S634, D13S258, D21S1414, D21S1442, D18S1002, AMXY, SRY, DXS6803, D21S1411, D13S797, DYS437, DX-TATC13.3, D18S535, DXS981, D18-GATA178F11, HPRT, Y/XB, 7X bölgelerine özgü primerlerle floresan PCR ve fragman analizi yapılmıştır. Genetik Hastalıklar Tanı Merkezleri Yönetmeliği gereğince prenatal tanı karyotipleme raporunda cinsiyet kromozom anomalileri dışında cinsiyet bilgilendirmesi yapılmamaktadır. Laboratuvarımızda yapılan bu analiz, yalnızca 13, 18, 21, X ve Y kromozomlarını anöploidileri hakkında bilgi vermektedir. Belirtilenkromozomların yapısal değişiklikleri, mozaikliği ve test kapsamı dışında kalan kromozomlar ile ilgili bilgi vermez. Ayrıca kendi tekniközellikleri/kısıtlamaları dahilinde yalancı pozitif/negatif sonuç üretmeli nevcuttur. Buradaki sonuçların doğrulaması uzun süreli hücre kültürünü takiben yapılacak kromozom analizi ile saptanabilir.Maternal kontaminasyon anne kanı tarafımıza gönderildiğinde yapılmakta ve raporda belirtilmektedir. Test aksi durumda maternal kontaminasyonu dışlamaz.

Figure-2. Rhabdomyoma

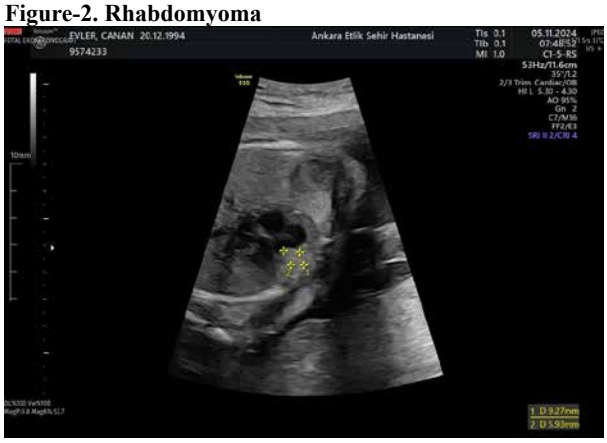


Figure-3. Rhabdomyoma

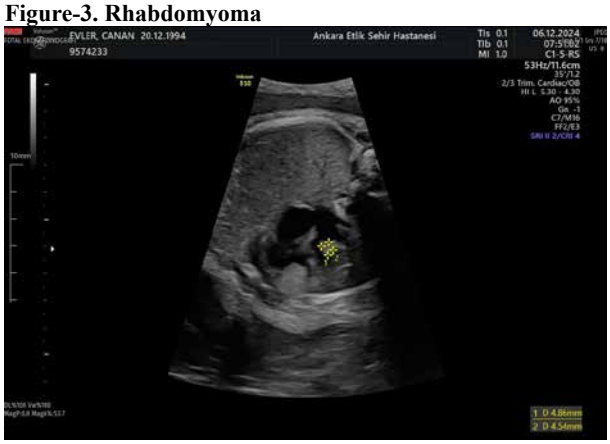


Figure-4. Rhabdomyoma

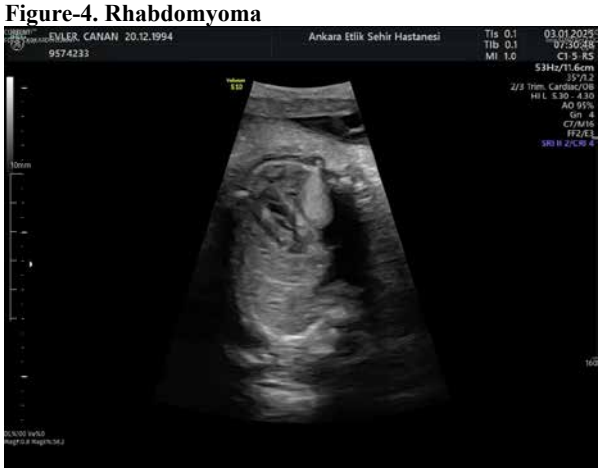


Figure-5. Rhabdomyoma

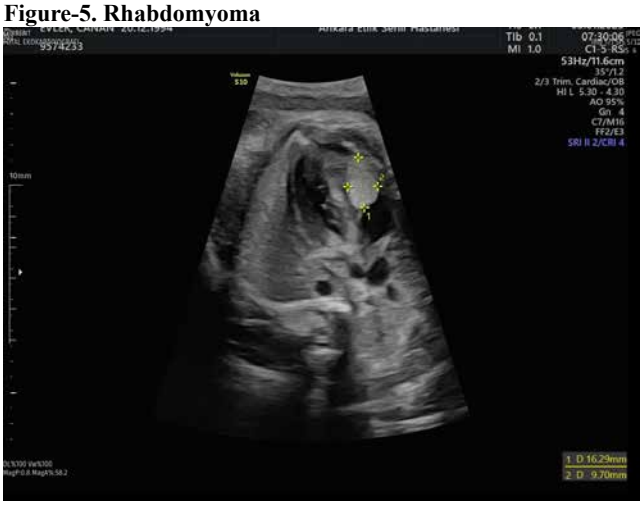
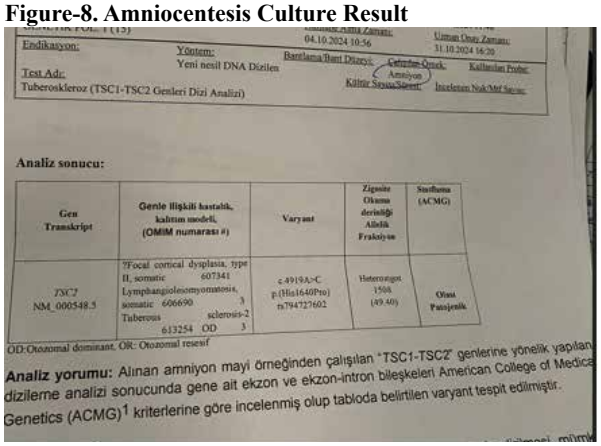


Figure-6. Rhabdomyoma

Figure-7. 3D Render Rhabdomyoma

Figure-8. Amniocentesis Culture Result



Endikasyon: | Yöntem: Yeni nesil DNA Dizileri | Bantlama/Bant Düzeyi: | Çalışılan Örnek: Amniyon | Kullanılan Probe:

Test Adı: Tuberoskleroz (TSC1-TSC2 Genleri Dizi Analizi)

Kültür Sayısı/Süresi: | İncelenen Nuk/Mtf Sayısı:

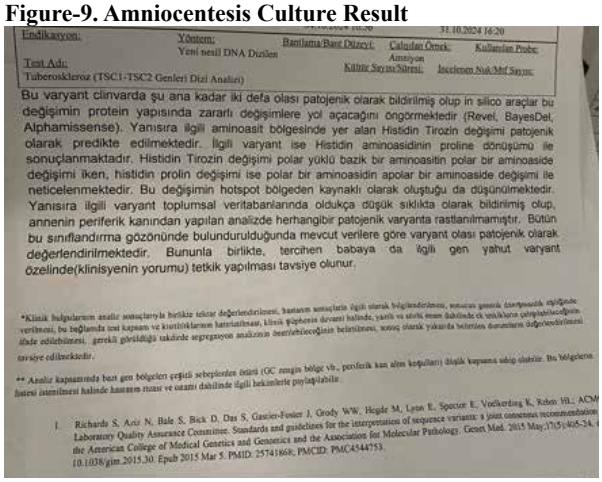
Analiz sonucu:

Gen Transkript	Genle ilişkili hastalık, kalıtım modeli, (OMIM numarası #)	Varyant	Zigosite Okuma derinliği/ Allelik Frakisyon	Sınıflama (ACMG)
TSC2 NM_000548.5	?Focal cortical dysplasia, type II, somatic 607341 Lymphangioleiomyomatosis, somatic 606690 3 Tuberous sclerosis-2 613254 OD 3	c.4919A>C p.(His1640Pro) rs794727602	Heterozigot 1508 (49.40)	Olası Patojenik

OD:Otozomal dominant, OR: Otozomal resesif

Analiz yorumu: Alınan amniyon mayi örneğinden çalışılan 'TSC1-TSC2' genlerine yönelik yapılan dizileme analizi sonucunda gene ait ekzon ve ekzon-intron bileşkeleri American College of Medical Genetics (ACMG)[1] kriterlerine göre incelenmiş olup tabloda belirtilen varyant tespit edilmiştir.

Figure-9. Amniocentesis Culture Result



Endikasyon: | Yöntem: Yeni nesil DNA Dizileri | Bantlama/Bant Düzeyi: | Çalışılan Örnek: Amniyon | Kullanılan Probe:

Test Adı: Tuberoskleroz (TSC1-TSC2 Genleri Dizi Analizi)

Kültür Sayısı/Süresi: | İncelenen Nuk/Mtf Sayısı:

Bu varyant clinvarda şu ana kadar iki defa olası patojenik olarak bildirilmiş olup in silico araçlar bu değişimin protein yapısında zararlı değişimlere yol açacağını öngörmektedir (Revel, BayesDel, Alphamissense). Yanısıra ilgili aminoasit bölgesinde yer alan Histidin Tirozin değişimi patojenik olarak predikte edilmektedir. İlgili varyant ise Histidin aminoasidinin proline dönüşümü ile sonuçlanmaktadır. Histidin Tirozin değişimi polar yüklü bazik bir aminoasitin polar bir aminoaside değişimi iken, histidin prolin değişimi ise polar bir aminoasidin apolar bir aminoaside değişimi ile neticelenmektedir. Bu değişimin hotspot bölgeden kaynaklı olarak oluştuğu da düşünülmektedir. Yanısıra ilgili varyant toplumsal veritabanlarında oldukça düşük sıklıkta olarak bildirilmiş olup, annenin periferik kanından yapılan analizde herhangibir patojenik varyanta rastlanılmamıştır. Bütün bu sınıflandırma gözönünde bulundurulduğunda mevcut verilere göre varyant olası patojenik olarak değerlendirilmektedir. Bununla birlikte, tercihen babaya da ilgili gen yahut varyant özelinde(klinisyenin yorumu) tetkik yapılması tavsiye olunur.

*Klinik bulgularının analiz sonuçlarıyla birlikte ielicar değerlendirilmesi, bantanın sonuçlarla ilgili olarak bilgilendirilmesi, sonuçun genetik danışmanlık eşliğinde verilmesi, bu bağlamda test kapsamı ve kısıtlılıklarının hatırlatılması, klinik şüphenin devamı halinde, yanlış ve sınırlı sonuç dahilinde ek testlerin çalışılabileceğinin ifade edilebilmesi, gerekli görüldüğü takdirde segregasyon analizinin önerilebileceğinin belirtilmesi, sonuç olarak yukarıda belirtilen durumların değerlendirilmesi tavsiye edilmektedir.

** Analiz kapsamında bazı gen bölgeleri çeşitli sebeplerden ötürü (GC zengin bölge vb., periferik kan alım koşulları) düşük kapsama sahip olabilir. Bu bölgelerin önemi istenilmesi halinde hastanın rızası ve onamı dahilinde ilgili birimlerle paylaşılabilir.

1. Richards S, Aziz N, Bale S, Bick D, Das S, Gastier-Foster J, Grody WW, Hegde M, Lyon E, Spector E, Voelkerding K, Rehm HL; ACMG Laboratory Quality Assurance Committee. Standards and guidelines for the interpretation of sequence variants: a joint consensus recommendation of the American College of Medical Genetics and Genomics and the Association for Molecular Pathology. Genet Med. 2015 May;17(5):405-24. doi: 10.1038/gim.2015.30. Epub 2015 Mar 5. PMID: 25741868; PMCID: PMC4544753.

PS-48 [Perinatoloji]

Intrauterine Volvulus in Late Gestation: A Multidisciplinary Management Perspective

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BACKGROUND: Fetal volvulus is a rare but potentially life-threatening condition caused by the twisting of intestinal loops around the mesenteric axis, leading to bowel obstruction, ischemia, or necrosis. Prenatal diagnosis is challenging but critical for optimizing neonatal outcomes through timely surgical intervention.

CASE PRESENTATION: We present the case of a 19-year-old pregnant woman at 34 weeks of gestation (G1) who was referred to our center due to suspected fetal bowel abnormality. Ultrasonography revealed fetal midgut volvulus. Biometric measurements were consistent with gestational age, with adequate amniotic fluid and positive fetal cardiac activity. An emergency cesarean section was performed. The neonate underwent immediate laparotomy by the pediatric surgery team, during

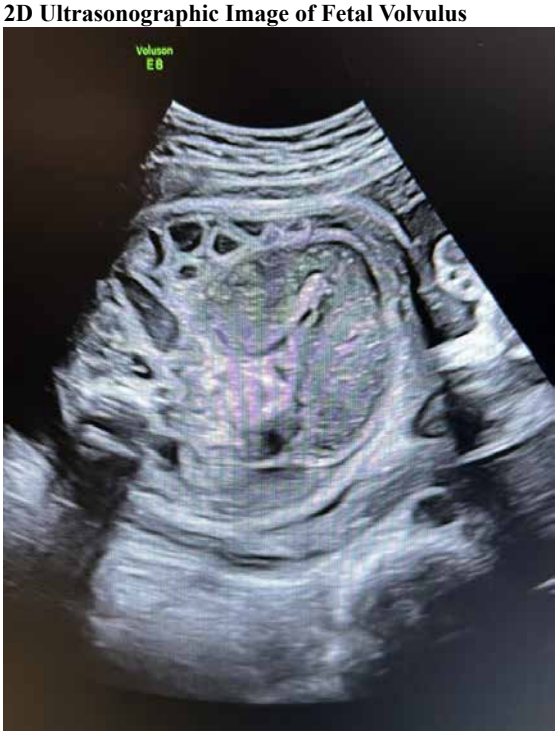
which intestinal necrosis was confirmed and bowel resection with primary anastomosis was performed. Following surgical intervention and neonatal intensive care, the infant recovered well and was discharged on postoperative day 30 in stable condition.

DISCUSSION: This case highlights the importance of prenatal recognition of volvulus-specific sonographic findings, including bowel dilatation and the whirlpool sign. Differential diagnoses include intestinal atresia, meconium ileus, and Hirschsprung's disease. Management requires a multidisciplinary approach involving maternal-fetal medicine, neonatology, and pediatric surgery. While early diagnosis and intervention can improve survival, outcomes remain guarded in cases of extensive necrosis.

CONCLUSION: Fetal volvulus, though rare, should be considered in fetuses presenting with abnormal bowel patterns on ultrasound in the third trimester. Early diagnosis and coordinated perinatal management are essential to reduce morbidity and mortality.

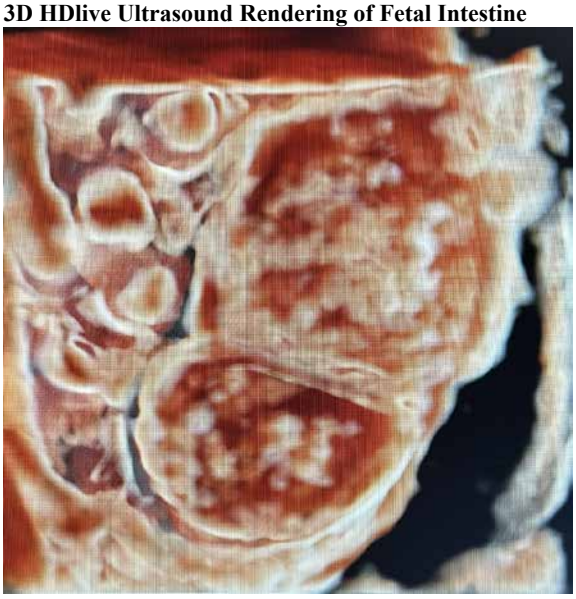
Keywords: Fetal volvulus, Intestinal malrotation, Ultrasonography

2D Ultrasonographic Image of Fetal Volvulus



Description: Axial grayscale image showing dilated, twisted bowel loops suggestive of volvulus.

3D HDlive Ultrasound Rendering of Fetal Intestine



3D silhouette mode highlighting abnormal bowel configuration consistent with volvulus.

Intraoperative Image Following Emergency Neonatal Laparotomy

Visualization of necrotic bowel segment and viable small intestine during surgical correction of volvulus.

PS-49 [Perinatoloji]

Meconium Ileus with Fetal Anemia: Prenatal Management and Favorable Outcome

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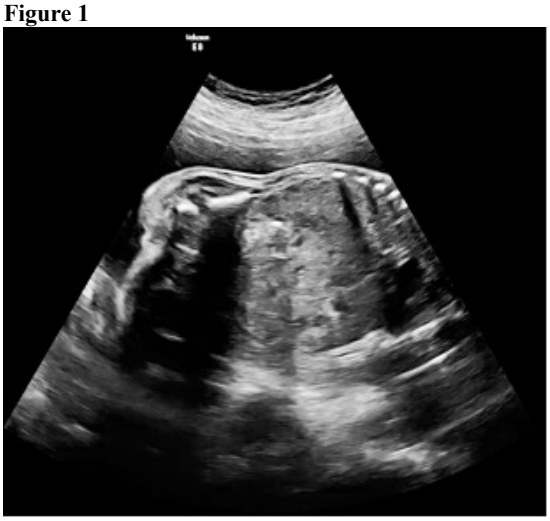
OBJECTIVE: Meconium ileus (MI) is a common cause of intestinal obstruction in newborns, accounting for 9–33% of cases. It is often the earliest sign of cystic fibrosis (CF), occurring in about 16% of CF patients. However, MI can also occur without CF. Prenatal ultrasound findings include dilated, hyperechogenic bowel, and rarely, in utero perforation leading to peritoneal calcifications, ascites, or absent bowel dilation. In the literature, there are rare cases of fetal anemia in patients with meconium ileus in association with perforation and most likely intestinal bleeding in patients with cystic fibrosis. We present a case of MI with fetal anemia in a non-CF patient, highlighting its management and outcome. CASE: A 36-year-old woman (gravida 2, parity 1) presented at 22 weeks and 6 days of gestation. Second-trimester screening and cell-free DNA results were normal. Ultrasound revealed polyhydramnios (Maximum vertical pocket: 9 cm), hepatic calcifications, and hyperechogenic, honeycomb-patterned intestines, suggesting MI. Doppler showed elevated MCA PSV (42 cm/s, 1.44 MoM), indicating fetal anemia (figure 1). TORCH, parvovirus, and indirect Coombs tests were negative. At 24 weeks, cordocentesis revealed fetal hemoglobin of 10.3 g/dL (<2 SD) and hematocrit of 31.4%. Genetic testing (karyotype, array, HBA1/HBA2, CFTR) was normal. By 26 weeks, ascites developed (figure 2), and MCA PSV rose to 54 cm/s (1.58 MoM). Intrauterine transfusion (24 cc erythrocytes) improved hemoglobin to 11.4 g/dL and hematocrit to 34.9%. Follow-up showed regression of ascites and improved intestinal findings. At 35 weeks and 4 days of gestation, the patient presented with active labor and delivered a 2565-gram female infant via uncomplicated vaginal delivery, with APGAR scores of 8 and 9 at 1 and 5 minutes, respectively. Postnatal imaging confirmed intestinal transition. The baby tolerated feeding and passed stool by day 1, discharging on day 4. Pediatric surgery concluded that intrauterine MI caused microperforation and anemia, which resolved post-transfusion, avoiding neonatal surgery. RESULT: MI can be diagnosed prenatally with favorable outcomes. Early detection does not necessitate termination. Resolution of bowel dilation and polyhydramnios predicts low postnatal surgical need. This case underscores successful management of non-CF MI with fetal anemia, emphasizing close monitoring and timely intervention.

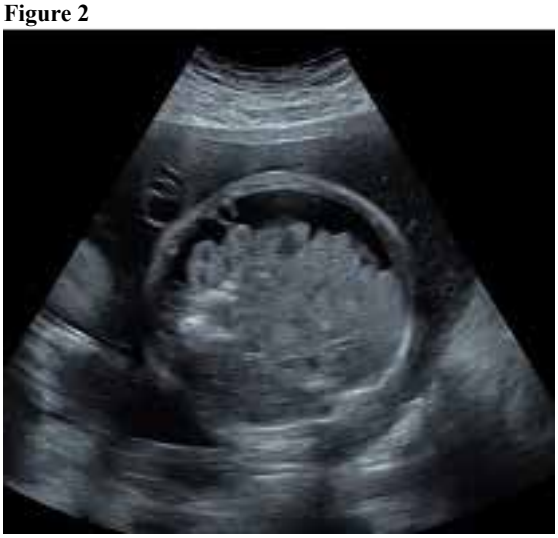
Keywords: Fetal anemia,Intrauterine transfusion, Meconium ileus

Figure 1



Hypercogenic, dilated bowel bowel image

Figure 2



Ultrasound at 26 weeks of gestation showing ascites

PS-50 [Perinatoloji]

Renal Tubular Dysgenesis: A Case Report of a Lethal Fetal Disorder with Prenatal Diagnostic Challenges

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OBJECTIVE: Renal tubular dysgenesis (RTD) is a rare and lethal fetal disorder characterized by the absence or poor development of proximal renal tubules, leading to oligohydramnios, pulmonary hypoplasia, and neonatal death. It is often associated with genetic mutations (e.g., REN, AGT, ACE, AGTR1) or secondary causes like maternal ACE inhibitor use. Ultrasonography demonstrated normal or mildly hyperechoic kidneys, with absent bladder visualization supporting the diagnosis. Early diagnosis is critical for genetic counseling and management.

CASE REPORT: A 23-year-old gravida 2, para 0 woman presented at 22 weeks of gestation with severe oligohydramnios and a single umbilical artery. Her first pregnancy was terminated due to anhydramnios and a single umbilical artery, with a normal karyotype reported (array not performed). On detailed ultrasonography, there was no bladder image and renal corticomedullary structures were poorly differentiated. Bilateral renal structures were seen in normal anatomical position (figure 1). Amniocentesis and 300 cc amnioinfusion were performed concurrently. Genetic analysis showed normal karyotype and normal array. The patient was closely monitored with ultrasound because of oligohydramnios and the amnioinfusion procedure was repeated several times. Fetal MRI confirmed bilateral kidneys but no bladder or fluid-filled calyces, suggesting dysfunctional urine production (figure 2). Considering the present findings, renal tubular dysgenesis was considered. At 27 weeks, the patient delivered a 1100-gram male neonate (APGAR 3/4/6/7) who died 8 hours postpartum. Autopsy results are pending to confirm RTD.

RESULT: This case highlights the diagnostic challenges of RTD, particularly in distinguishing it from other renal pathologies. Despite normal genetic testing, RTD remains probable due to clinical and imaging findings. Early suspicion, genetic testing for RTD-associated mutations, and multidisciplinary care are essential.

Keywords: Amnioinfusion, Oligohydramnios, Renal Tubular Dysgenesis

Figure 1

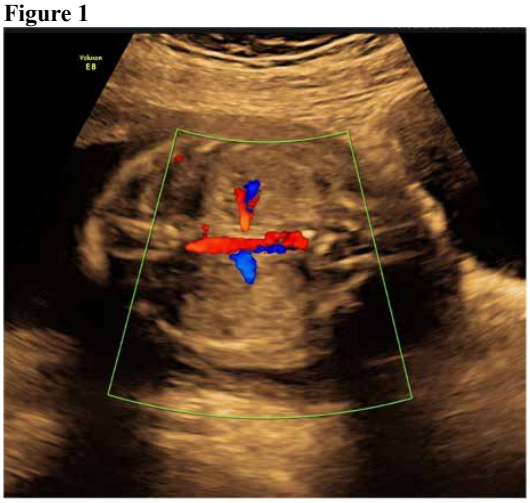
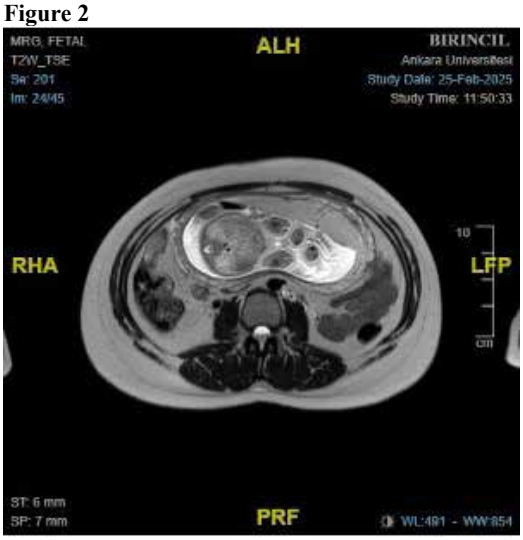


Figure 2



PS-51 [Onkoloji]

A 20-year-delayed case of endometrial cancer; Diagnosis, follow-up and treatment management

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INTRODUCTION: Endometrial cancer is the most common gynecological malignancy in developed countries. However, 5-29% of patients are young women under the age of 45. A significant proportion of patients are detected at an early stage and a long survival is observed with effective treatment. Currently, the 5-year survival rate for stage 1 is over 90%. Early-stage endometrial cancer is the most controversial group of gynecological cancer. In particular, it is still not clear to which patients surgical staging and lymphadenectomy will be performed and

which patients will not be performed. The basic treatment approach in endometrial cancers is shaped according to the patient's age, fertility desire, and histology of the tumor.

CASE: A 54-year-old patient, G0P0, married, was followed up for infertility. 20 years ago, when he was a 34-year-old newlywed, our patient was diagnosed with endometrioid adenocarcinoma (histological and nuclear grade 2). The patient was presented with treatment options for endometrial cancer and informed about fertility-preserving surgical approaches. However, our patient absolutely refused treatment during those years and stated that she had received many fertility treatments, including assisted reproductive techniques. No imaging method is available after the initial diagnosis. Approximately 20 years after the initial diagnosis, our patient gave endometrial sampling again and the diagnosis of adenocarcinoma was confirmed again. Intense FDG uptake of 53*48*39mm in the uterus in PET-CT performed for the whole body (SUVmax: 30.62) and lymph nodes with increased FDG uptake (SUVmax:2.61) in the pelvic-paraaortic areas, the largest of which was approximately 10mm. Then, the patient underwent the necessary surgical staging. Total hysterectomy, bilateral salpingoophorectomy, bilateral pelvic lymphadenectomy, and excision of lymph nodes in the paraaortic area up to the level of the inferior mesenteric artery were performed laparoscopically. Endometrioid type endometrial cancer, grade 2, full-thickness myometrial involvement, LVSI (-), stromal involvement, 16 pelvic paraaortic lymph nodes were reported as negative. Stage 2 was evaluated as a high intermediate risk group. According to the NCCN 2022 version 1 guideline, EBRT+/- vaginal brachytherapy +/- systemic CT recommendation EBRT+/-vaginal brachytherapy was decided to refer her to radiation oncology for evaluation of systemic CT and then referred to medical oncology for evaluation. (Figure 1)

CONCLUSION: A tragic situation occurs when a young woman who has never experienced a pregnancy in her life comes with a diagnosis of endometrial cancer. Our patient had a fertility desire and therefore opposed standard destructive treatment modalities. Since there are case reports, case series and very few prospective studies in the literature for endometrial cancer patients diagnosed at a young age, the standard treatment approach is not clear. Recurrence occurs in approximately one-third of young endometrial cancer patients undergoing fertility-preserving treatment. When pregnancy is achieved, the family is completed or the possibility of pregnancy is removed, standard treatment surgery is required. In our case, our patient could have received standard treatment in the early stages and reduced recurrence rates. In addition, he may not have needed to receive postoperative adjuvant therapies.

Keywords: Adjuvant therapy, Endometrial cancer, Fertility preservation therapy

Figure 1:

Full-thickness invasion of the myometrium and cervical involvement of endometrial tumor observed in frozen examination

PS-52 [Onkoloji]

Gigantic clear cell carcinoma arising from abdominal wall endometriosis in a postmenopausal woman

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Etlik Şehir Hastanesi

AIM: Endometriosis-associated clear cell carcinoma (CCC) of the anterior abdominal wall is a very rare disease with an aggressive course, usually occurring after previous surgery. Herein, we report a 60-year-old postmenopausal woman with endometriosis-associated clear cell carcinoma of the anterior abdominal wall arising from a caesarean section scar and metastases at other sites, and the treatment of the CCC.

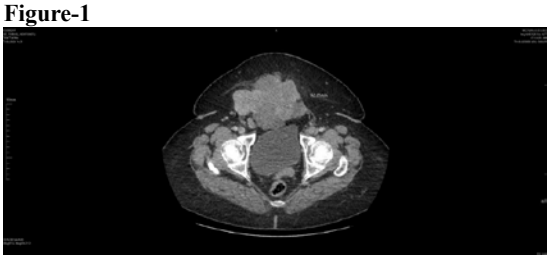
METHOD: A 60-year-old postmenopausal woman with no history of endometriosis that presented with abdominal pain and a mass at the level of the caesarean scar was presented.

RESULTS: Her physical examination revealed a solid mass approximately 20 cm in size on the anterior abdominal wall at the level of the cesarean scar line. CA 125, one of the tumour markers, was found to be high. CT showed an irregularly circumscribed mass within the muscle planes in the anterior abdominal wall and a mass in the right lower quadrant in close contact with the ovary and showing continuity with the other lesion (Figure-1). In addition, lesions were observed in the right rectus muscle, both lungs and kidneys, and lymph nodes in the paravertebral, external iliac and femoral regions. Histopathological and immunohistochemical evaluation of the tissue sample from the patient who underwent chemotherapy and debulking surgery showed that the lesion was compatible with clear cell carcinoma secondary to endometriosis developing in the caesarean scar (Figure-2). A whole-body FDG PET scan was performed during follow-up and showed metastases in the lungs, right paravertebral area, anterior left acetabulum, left and right inguinal regions. Control ultrasound and tumour markers showed no abnormalities and the patient is being followed up with chemotherapy.

CONCLUSION: Patients presenting with non-specific complaints such as abdominal pain or a mass should be questioned about their history of previous gynaecological or obstetric procedures. Endometriosis-related malignancies should be kept in mind in the differential diagnosis, especially in patients with a history of surgery, but it should not be forgotten that they may also be present in patients without a history of surgery. Although there is no definitive consensus on treatment, most authors have emphasised that removal of the mass is the best approach.

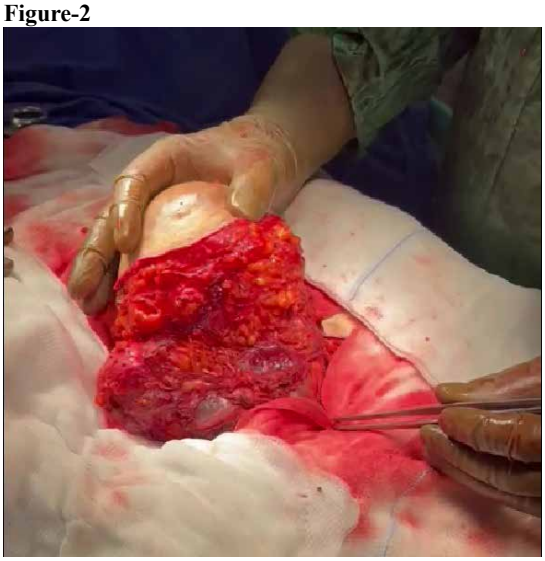
Keywords: Clear cell carcinoma, endometriosis, abdominal wall, postmenopausal, caesarean section scar

Figure-1



Computer Tomography showed an irregularly circumscribed mass

Figure-2



Intraoperative mass excision

PS-53 [Onkoloji]

Pelvic hydatid cyst with concurrent endometrial cancer

Belma Gözde Özdemir, Elif Ceren Sislituna, Rabia Nur Sağlam, Ahmet Bilgi, Çetin Çelik
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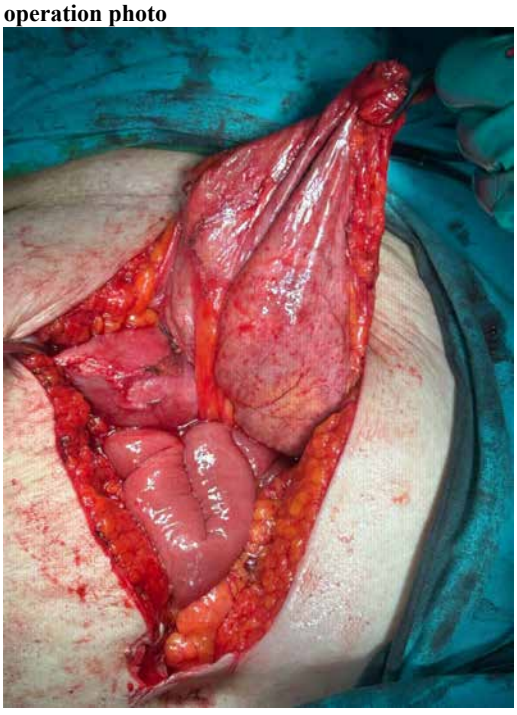
BACKGROUND-AIM: Hydatid cyst is a pathology caused by Echinococcus granulosus. This disease, which usually affects the lungs and liver, is sporadic in the pelvic region. We aimed to present a case of pelvic hydatid cyst detected at the abdominal entrance in a patient who was scheduled for surgery due to endometrial cancer in our clinic.

CASE: A 69-year-old patient with three regular deliveries applied for postmenopausal bleeding. The patient, who had hypertension and a history of orthopedic surgery, was prepared for surgery after a diagnostic endometrial biopsy diagnosed endometrial serous carcinoma. A peritoneal pouch was observed between the uterus and bladder on the anterior surface of the intraoperative incision line. It was dissected and sent to pathology. Radiologically, a sac with contrast enhancement was observed in contrast-enhanced MRI images. Pathology result was compatible with hydatid cyst, and the patient was consulted with relevant departments for infectious diseases and treatment of primary pathology. Long-term Albendazole treatment was planned for hydatid cysts. DISCUSSION: In the pelvis and thigh region, giant cyst formations are extremely rare and can lead to severe functional loss and surgical difficulties. Since such atypically located cysts usually present with non-specific symptoms, diagnosis may be delayed, and the risk of complications increases. Attention should be paid to endemic regions. It may present itself as multilocular. First-line for detecting characteristic "daughter cysts," septations, "honeycomb," or "wheel spoke" patterns. Anthelmintic treatments and percutaneous drainages may be considered. It may cause symptoms depending on the region where the mass is located due to pressure. Close follow-up should be planned in terms of recurrences. CONCLUSION: Hydatid cysts should be considered in cases of tuba ovarian abscess, bladder diverticulum, mass, and urachal cysts in pelvic masses, especially in patients dealing with animal husbandry or in patients with a history of hydatid cyst. Preoperative treatment is valuable in terms of prophylaxis, mass mobilization, and prevention of spread.

Keywords: hydatid cyst, endometrium cancer, pelvic

operation photo



Pelvic hydatid cyst with concurrent endometrial cancer

PS-54 [Onkoloji]

A rare case: HPV negative cervical cancer

Gamze Karababa[1], Erbil Karaman[2], Onur Karaaslan[2]
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Cervical cancer (CC) is the fourth most common malignancy among women worldwide, accounting for approximately 4% of all cancer cases in women(1). Human Papilloma Virus (HPV) has been largely associated with CC, especially in high-risk groups(2). However, approximately 5.5-11% of CC cases have been reported as HPV-negative. These cases include true negatives and false negatives (3). False negatives may be due to latent HPV infection, testing methods or histologic misclassification(4,5).

Keywords: cervical cancer, mass, vaginal bleeding

figure 1

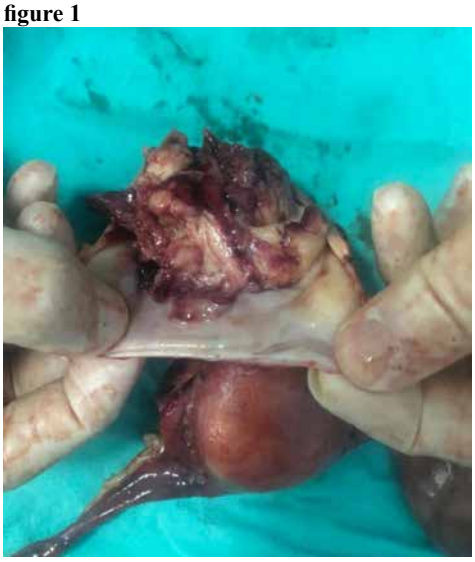


figure 1

figure 2

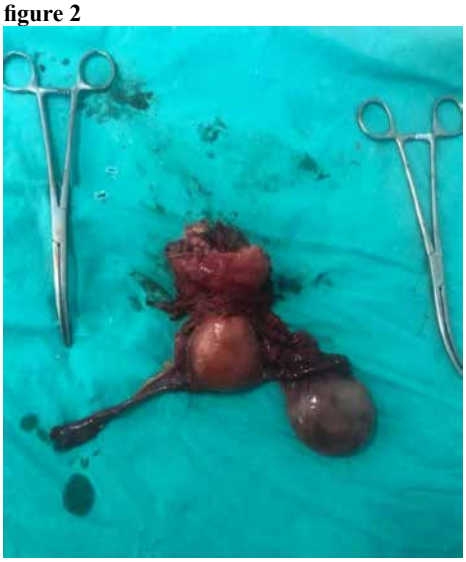


figure 2

PS-55 [Onkoloji]

The Case Report of Papillary Thyroid Cancer Developing From Thyroid Component of Dermoid Cyst

Zübeyde Aytufan, Tolga Taşçı
Bahçeşehir Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı

OBJECTIVE: Mature cystic teratomas (dermoid cysts) are among the most common benign ovarian tumors, accounting for approximately 10-20% of all ovarian neoplasms.They originate from totipotent germ cells and contain tissues derived from all three germ layers. Although the majority of dermoid cysts remain benign, malignant transformation is a rare phenomenon, occurring in approximately 1-2% of cases. The most frequently observed malignancy in these cysts is squamous cell carcinoma, followed by adenocarcinoma and sarcoma.Papillary thyroid carcinoma (PTC) arising within an ovarian dermoid cyst is an exceptionally rare occurrence.PTC typically originates from the thyroid gland;however,ectopic thyroid tissue can be present in ovarian teratomas,known as struma ovarii.In rare instances,this ectopic thyroid tissue may undergo malignant transformation.Given the rarity of this condition, it is often challenging to diagnose preoperatively. In this case report,we present a postmenopausal patient diagnosed with PTC within a mature cystic teratoma of the ovary.

CASE: A 57-year-old postmenopausal woman (G3P3 Nsd) with no significant past surgical history presented to our clinic with complaints of lower abdominal pain and progressive abdominal swelling over the past three months.The patient's medical history is unremarkable Her family history was notable for colorectal cancer in a maternal uncle.On gynecological examination,a mobile, non-tender, solid-cystic mass was palpated in the left adnexal region.

Transvaginal ultrasonography (TVUSG) revealed a well-defined,10×10 cm solid-cystic mass with acoustic shadowing in the left ovary, suggestive of a mature cystic teratoma.The myometrium was normal and endometrium was irregular, and the right ovary was atrophic. Laboratory tests showed an elevated CA-125 level (64 U/mL) and an increased anti-thyroglobulin level (14.03 ng/mL). Tumor markers CA 19-9 and AFP were within normal limits.Thyroid function tests, including TSH and free T4, were also within the reference range. A laparoscopic hysterectomy with bilateral salpingo-oophorectomy was performed.During the procedure, the left adnexal mass was carefully excised using an endobag to prevent intra-abdominal rupture.The specimen was sent for frozen section analysis, which did not indicate malignancy.However, definitive histopathological evaluation revealed a mature cystic teratoma containing ectopic thyroid tissue with foci of papillary thyroid carcinoma.

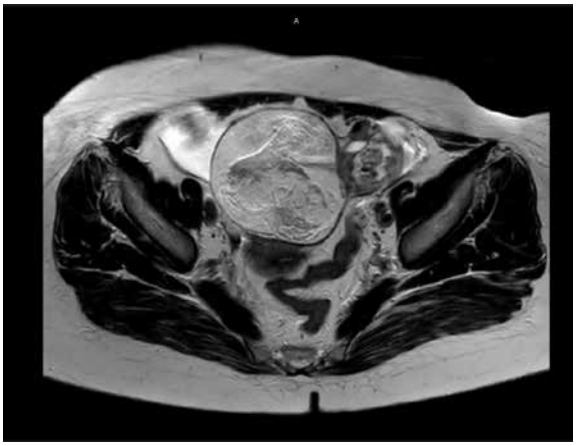
The patient's postoperative course was uneventful.Multidisciplinary consultation with endocrinology and oncology specialists was conducted. No pathological condition was detected in the postoperative thyroid nodule biopsy of the patient.No further treatment was planned since the dermoid cyst was removed from the endobag without completely bursting.The patient was placed on routine follow-up with periodic imaging and thyroid function tests.

CONCLUSION: Although dermoid cysts are common ovarian tumours, malignant transformation in these cysts is rare.Development of papillary thyroid carcinoma in an ovarian teratoma is extremely rare and very few

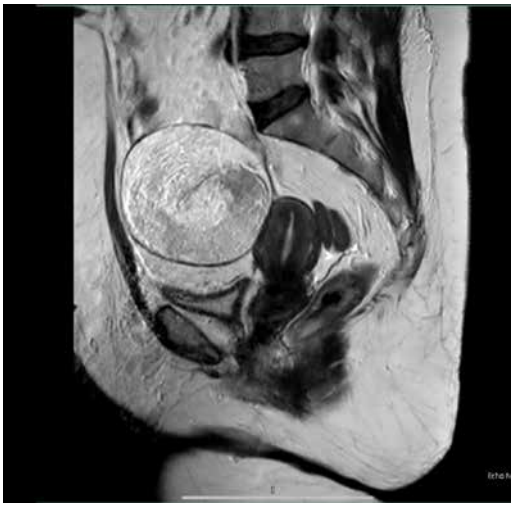
cases have been reported in the literature.Because of the non-specific clinical presentation and imaging findings, preoperative diagnosis remains challenging.Malignancy should be considered when the ovarian mass is larger than 10 cm, contains solid components or is associated with elevated tumour markers. Careful surgical removal without cyst rupture is very important to prevent peritoneal dissemination.This case highlights the importance of detailed histopathological evaluation of dermoid cysts and the necessity of a multidisciplinary approach in the diagnosis and management of such rare malignancies.

Keywords: Ovarian dermoid cyst, Papillary thyroid carcinoma, Malignant transformation, Struma ovarii, Laparoscopic surgery, Germ cell tumor

MR GÖRÜNTÜSÜ



MR GÖRÜNTÜSÜ 2



PATOLOJİ RAPORU

UYGULANAN ÖZEL YÖNTEMLER (Özel boyalar, IHK, moleküler yöntemler, EM)	Yapılan immünohistokimyasal çalışmada papiller tiroid karsinomu odağında CK19 ve Galaktin 3 ile yaygın ve kuvvetli boyanma izlenmiştir. HBME1 ile fokal zayıf boyanmalar mevcuttur. Kromogranin, sinaptofizin ve kalsitonin negatiftir. Kalsitonin, kromogranin, sinaptofizin negatiftir.
TANI	1) Sol salpingooferektomi: Matür kistik teratom zemininde gelişmiş papiller tiroid karsinomu, lütfen açıklamayı okuyunuz - Teratom deri ve deri ekleri, kas dokusu, adipöz doku, silyalı solunum yolu epiteli, kıkırdak dokusu ve tiroid dokusu komponentlerinde oluşmaktadır. - Tiroid dokusu 3x3 cm boyutunda olup, tiroid dokusu içinde en büyüğü 0,7 cm çapında dağınık halde papiller tiroid karsinomu odakları izlenmiştir. - Tümör odakları çevresinde enkapsülasyon mevcut değildir. - Tümör fokal bir alanda over kapsülünü invaze etmiş, fakat aşmamıştır. - Lenfovasküler invazyon izlenmemiştir. - Perinöral invazyon izlenmemiştir. - Sol tuba kesitlerinde reaktif hiperplazi bulguları izlenmiştir. 2) TAH + Sağ SO: - Serviks: Kronik servisit, Naboth kistleri - Endometrium: Fokal atipili endometrial hiperplazi - Sağ over: Korpus albikanslar - Sağ tüp: Reaktif hiperplazi 3) Sağ parametrium: Kongestyone fibroadipöz dokular
EPİKRİZ-YORUM	İmmünohistokimyasal boyamalar; Dako Autostainer Link 48 cihazı ve kitleri kullanılarak otomatize olarak çalışılmıştır.

PS-56 [Onkoloji]

Assessment of the the effect of sarcopenia on perioperative complications in patients with endometrial cancer

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OBJECTIVE: Sarcopenia refers to a decrease in muscle mass, muscle strength, and physical performance. Obesity and advanced age are risk factors for sarcopenia and endometrial cancer. This study examined the rate of sarcopenia in patients diagnosed with endometrial cancer and its effects on perioperative complications.

METHODS: In this study, 455 patients who visited the Tepecik Education and Research Hospital Gynecology and Obstetrics Clinic between 2014 and 2023 were examined. Ethical approval for this study was obtained from the hospital ethics committee. The inclusion criteria for the study were as follows: having undergone surgery with the diagnosis of endometrial cancer, having their follow-up and treatments performed in our hospital, and having complete file and pathology information. The exclusion criteria were having undergone surgery outside our hospital, having more than one cancer diagnosis, and not having access to medical records. A total of 230 patients who met these criteria were included in this study. The skeletal muscle area (SMA) was obtained with CT in a single axial slice passing through the L3 intervertebral disc level and approximately at the umbilical level. Sarcopenia value was calculated by dividing the obtained data by the square of the height. If sarcopenia was 41<SMA/m2, the patient was evaluated as sarcopenic. Complication types and rates were recorded in patients with sarcopenia. Data were evaluated using SPSS.

RESULTS: The mean values of physical demographic characteristics such as height, age, BMI, Body Surface Area (BSA) and Sarcopenia were 158.30±5.11, 72.15±11.35, 33.75±5.91, 2.51±0.16, and 43.53±9.78, respectively. 95(41%) patients were evaluated as sarcopenic and 101(43%) patients were evaluated as obese. The intraoperative complication rate was 25(10.9%). The most common complications were vascular injuries in 9(3.9%), followed by bowel serosa in 7(3%), bladder in 4(1.7%), ureter in 4(1.7%), and nerve injury in 1(0.4%). The mean BMI in sarcopenic and non-sarcopenic patients was 32.21±5.97 and 34.86±5.63, respectively. There was a statistically significant difference between the two groups in terms of BMI (p=0.001). Although sarcopenic patients were obese, their BMI was lower than that of non-sarcopenic patients. This is because adipose tissue is lower than muscle tissue. There was a statistically significant difference between the two groups in terms of sarcopenia value (p=0.001). The BSA was 2.55±0.17 in sarcopenic patients and 2.48±0.15 in non-sarcopenic patients. Accordingly, the BSA of non-sarcopenic patients was smaller (p=0.001). The calculated sarcopenia measurement value was 35.36±13.66 in the complication group and 42.82±15.89 in the non-complication group. Patients with complications were classified as

sarcopenic. The relationship between the presence of sarcopenia and the presence of complications was statistically significant (p<0.047). CONCLUSION: The sarcopenia rate in the patient group was 41%. The complication rate was high in patients with sarcopenia. Imaging tests, such as computed tomography (CT) and magnetic resonance imaging (MRI), are performed in patients scheduled for surgery for endometrial cancer. Sarcopenia can be easily diagnosed with CT. Implementing rehabilitation to improve the quality of life of these patients and increase functional muscle mass before surgery is important to reduce complications that may arise due to sarcopenia.

Keywords: Sarcopenia, endometrial cancer, perioperative complication

Figure

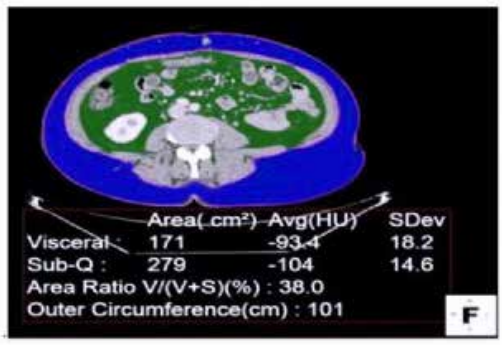

Table1: Comparison of demographic and measured parameters according to sarcopenic status of patients

Parameters	Sarcopenia (+), Mean± SD	Sarcopenia (-), Mean± SD	P value
Height (cm)	159.6±5.35	157.36±4.74	0.001
Age (year)	73.35±11.25	71±13.45	0.115
BMI (kg/m2)	32.21±5.97	34.86±5.63	0.001
Sarcopenia (SMA/m2)	35.234±11.04	44.593.±16.597	<0.001
BSA (m2)	2.55±0.17	2.48±0.15	0.001
Sarcopenia density	24.93±7.78	30.67±12.79	<0.001

SD: Standart Deviation, BSA: Body Surface Area, BMI: Body Mass Index, SMA: Skeletal Muscle Area

Table2: Comparison of sarcopenic measurement parameters between patients with and without complications

	Complication (+), Mean± SD	Complication (-), Mean± SD	P value
Height (cm)	158.60±4.35	158.26±5.211	0.487
BMI (kg/m2)	33.65±6.58	33.76±5.84	0.838
Sarcopenia(SMA/m2)	35.36±13.66	42.82±15.77	0.047
BSA (m2)	2.52±0.14	2.51±0.171	0.487
Sarcopenia density	25.92±8.04	28.59±11.681	0.440

SD: Standart Deviation, BSA: Body Surface Area

PS-57 [İnfertilite]

Management of Severe Ovarian Hyperstimulation Syndrome: A Case Report

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OBJECTIVE: Ovarian hyperstimulation syndrome (OHSS) is a serious complication of controlled ovarian stimulation, particularly in high-risk patients such as those with polycystic ovary syndrome (PCOS). Severe OHSS occurs in 0.1-2% of cycles and is characterized by ovarian enlargement, third-space fluid shifts, and potential thromboembolic events. This case report presents the clinical course of a 30-year-old PCOS patient who developed severe OHSS following IVF, highlighting the importance of early recognition and multidisciplinary management to prevent morbidity.

CASE REPORT: A 30-year-old woman with PCOS (AMH 46 ng/ml) and primary infertility underwent ovarian stimulation using a total of 1050 IU HMG and 750 IU recombinant FSH in combination with a GnRH antagonist. Triggering with GnRH agonist resulted in retrieval of 84 oocytes. As a result, 36 embryos were obtained. A totally of 10 embryos were frozen by performing PGT on grade 1 embryos. Within 8 hours post-retrieval, she developed severe abdominal pain, nausea, and oliguria. Ultrasound demonstrated 10 cm ovaries with marked ascites. Laboratory findings revealed acute kidney injury (creatinine 0.79 → 2.29 mg/dl). The patient was managed in a multidisciplinary manner in consultation with nephrology. Postrenal causes of acute renal failure were excluded. Acute renal failure was considered to be due to OHSS. Management included cabergoline (0.5 mg BID), LMWH for thromboprophylaxis, letrozole, and GnRH antagonist. Supportive care involved strict fluid balance monitoring, albumin infusions, and diuretics. Two therapeutic paracenteses drained 6000 ml ascitic fluid, resolving respiratory symptoms. Renal function normalized by day 6 (creatinine 1.07 mg/dl), and the patient was discharged in stable condition. Three-month follow-up confirmed complete resolution without sequelae.

DISCUSSION: This case illustrates several critical aspects of severe OHSS management. First, despite preventive measures (GnRH agonist trigger and freeze-all strategy), high-risk patients remain vulnerable, emphasizing the need for careful monitoring. Second, the rapid development of oliguria and acute kidney injury underscores the importance of early nephrology consultation and prompt albumin replacement. Third, therapeutic paracentesis proved essential for managing respiratory compromise. Current evidence supports the use of dopamine agonists like cabergoline to reduce vascular permeability, while LMWH remains crucial for thromboembolism prevention in hemoconcentrated patients. The freeze-all strategy likely mitigated further OHSS exacerbation from pregnancy-related hCG. This case reinforces that severe OHSS requires a coordinated approach combining pharmacological interventions, supportive care, and procedural management. Future research should focus on better risk prediction models and novel targeted therapies to improve outcomes in this potentially life-threatening condition.

Keywords: Acute Kidney Injury, In Vitro Fertilization (IVF), Ovarian Hyperstimulation Syndrome (OHSS)

PS-58 [Endoskopi]

The role of laparoscopy in the diagnosis and treatment of the ectopic pregnancy in the tubal remnant stump

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AIM We would like to present an unusual case of a ectopic pregnancy (EP) in the stump of remnant Fallopian tube after assisted reproductive technology IVF/ET.

METHOD A 30-years-old woman (gravida-2,para0) was followed in our hospital after she underwent assisted reproductive technology IVF/ET to see success of the treatment. She had medical history with experienced of two ectopic pregnancies. The first one was 4 years ago, on the right Fallopian tube (FT) after intrauterine insemination (IUI) and the treatment was incision right tube and expression ovum by laparoscopy. The second EP was located in the left FT, one year later, again after IUI. We performed left salpingectomy by laparoscopy. Between this two EP she had conization of cervix uteri because of cervical intraepithelial neoplasia III and the third laparoscopy because of hydrosalpinx on right FT and we performed right salpingectomy. One year later she underwent IVF/ET. RESULTS The serum level of human chorionic gonadotropin (beta HCG) was 8,0 IU/ml 24th days of embryotranfer (ET), 32 IU /ml 26th days of ET, 130 IU /ml 30th days, 923 IU/ml 33rd days and 1500 IU/ml 40th days of ET. Transvaginal ultrasound (TVS) examination revealed no sign of intrauterine pregnancy without free fluid in the sac of Douglas. The endometrium was thick and patients had no vaginal bleeding and abdominal pain. The full blood count and vital signs were normal. We suspected on cornual pregnancy and performed laparoscopy which showed intact EP on the left side in the tubal remnant stump. We removed residual stump with ectopic pregnancy and removed right FT. Pathologic confirmed present of trophoblastic tissue.

CONCLUSIONS The prevalence of EU ranges from 6 to 16% in general population. Most of them are in FT (95%). All medical assisted procreations techniques increased risk for EU. Thus, the possibility of EU should be considered even after bilateral salpingectomy. Through this rare case we can see the big role of laparoscopy as the most effective treatment for this patients who unfortunately had 3 EU. First advantage of laparoscopy is fast recovery with minimal scarves of operations.

Nowadays, we know that this patient gave birth to a healthy male newborn after the eight attempt IVF/ET by a Caesarean Section. Thanks to the laparoscopy, it was much easier and safer to perform a Caesarean Section than if she, previously, had three open surgery.

Keywords: ectopic pregnancy, tubal remnant stump, laparoscopy

PS-59 [Endoskopi]

Risks of late complication of laparoscopic surgery for patients and surgeons: A case report of port site herniation of the small bowel following laparoscopic-myomectomy

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BACKGROUND We would like to present an unusual case of a port site herniation of the small bowel as a late complication of laparoscopic myomectomy and to show how it impact on patients and surgeons.

METHOD 41year old women (gravida-0, para-0) admitted in our hospital for myomectomy by laparoscopy. She had medical history with primary infertility and experienced myomectomy by open laparotomy 10 years ago. We did myomectomy and removed specimens of myomas which was 5 cm in diameter on the fundus of the uterus through right site trocar after morcellation. We sutured both port sites and umbilical port. Patient left hospital after one day.

RESULTS 14 days after operation she came to hospital with the history of abdominal pain and vomiting. The serum of all parameter in blood and habits of bowel were normal. Her abdomen was soft without tenderness. X ray was done and was normal, so we treated her conservatively for the next 3 days. At fourth day she had excessive vomiting and epigastric pain. We repeated X ray and it showed us multiple air fluid levels. We performed open laparotomy and found multiple distended jejunal loops and one was retracted in right port without ischemia, so we released jejunal loops and sutured fascial defects on port site.

CONCLUSION Port site herniation of the small bowel is a very rare complication, but it could be very dangerous for patients because of potential necrosis and ischemia of the small bowel and for physicians, surgeon laparoscopists, too. The level of stress is high. We can not sleep, eat and it damage our health, especially if it is been long time before discovered complications. Primary prevention of this is good closure of fascial defects on port sites and secondary prevention is immediate diagnosis and management.

Keywords: Laparoscopy, complications, bowel herniation

PS-60 [Endoskopi]

Ruptured Unilateral Tubal Twin Ectopic Pregnancy with IUD

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Twin ectopic pregnancy is a rare condition with an estimated incidence of 1 in 20,000 in spontaneous pregnancies. In this case, a 25-year-old G2P2Y2 patient presented with severe groin pain, vaginal bleeding and delayed menstruation. Serum β-human chorionic gonadotropin level was above 10000 IU/mL. Trans-vaginal ultrasound showed diffuse hemorrhagic fluid in the abdomen and a focus of twin ectopic pregnancy in the left tuba. Laparoscopy revealed a ruptured ectopic focus in the left tuba. This patient underwent laparoscopic left salpingectomy.

Keywords: Rupture, Tubal Twin Ectopic Pregnancy, Laparoscopy

PS-62 [Endoskopi]

Laparoscopic posterior colpotomy: a safe and reproducible technique for myomectomy specimen removal

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AIM: to review the benefits of posterior colpotomy for myomectomy specimen removal and to show reproducible technique for performing posterior colpotomy for multiple specimens.

METHOD: 37 years old, gravida 0, parity 0, patient referred to gynecological oncology by the infertility department. Imaging revealed a myomatous uterus, there are multiple myomas, the largest of which is 65x51 mm in the left posterolateral part. The patient has complaints of long-term menometrorrhagia and pain.

RESULTS: the patient underwent laparoscopic myomectomy. Monopolar and bipolar energy was used in dissection. Surgical specimens were removed vaginally by opening a posterior colpotomy. The colpotomy incision was repaired primarily with 2.0 V-Loc™ wound closure device. A vasoconstrictor agent was administered (0.2 mg methylergonovine maleate) to reduce the amount of intraoperative bleeding. Total surgery time was 1.5 hours and total bleeding amount was 150 cc. The patient was discharged on the 2nd postoperative day. Pathology result was reported as leiomyoma

CONCLUSION: in gynecologic laparoscopic procedures, 5 mm and 10 mm trocars are generally used, so the skin and fascia incisions are quite small compared to laparoscopic operations. Posterior colpotomy is a safe way to remove specimens without requiring a larger skin incision and may reduce the risk of surgical spillage. in addition, reducing the need for larger incisions can lead to less postoperative pain, faster recovery and better cosmetic results

Keywords: colpotomy, laparoscopy, myomectomy,

PS-63 [Endoskopi]

Laparoscopic Approach to a 30 cm Benign Ovarian Cyst: Challenges and Surgical Management

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INTRODUCTION: Giant ovarian cysts are rare but pose significant diagnostic and surgical challenges. Traditionally, large cysts were managed via laparotomy due to concerns over rupture, peritoneal contamination, and limited intra-abdominal space. However, advances in laparoscopic techniques have allowed for minimally invasive management, even in cases of massive ovarian cysts.

This case presents a 28-year-old single female who complained of progressive abdominal bloating and distension. Clinical examination and imaging identified a 30 cm simple cystic mass arising from the right ovary. Pelvic MRI confirmed benign characteristics, and tumor markers were within normal limits, ruling out malignancy.

Case Presentation & Surgical Approach:

Despite its large size, a laparoscopic approach was chosen to minimize morbidity, enhance recovery, and preserve fertility. Key challenges included:

• Safe cyst decompression without spillage

• Maintaining adequate visualization in limited space

• Minimizing peritoneal contamination

• Preventing adhesion formation

To ensure a contamination-free procedure, the cyst was exteriorized through the umbilicus before decompression. It was then aspirated outside the abdominal cavity, and the cyst wall was secured with sutures before being placed back into the abdomen for removal. This technique completely prevented intra-abdominal spillage, reducing the risk of peritoneal contamination and adhesion formation.

CONCLUSION: This case demonstrates that laparoscopic surgery is a safe and effective alternative to laparotomy for large ovarian cysts when performed with proper technique. The patient had an uneventful recovery with no postoperative complications. With advancements in minimally invasive gynecologic surgery, fertility-preserving laparoscopic management should be considered even for giant ovarian cysts, provided that benign criteria are met on imaging and tumor markers.

Keywords: Giant ovarian cyst, laparoscopic surgery, ovarian cystectomy, benign ovarian cyst, minimally invasive gynecologic surgery

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