Obstetrik ve Jinekoloji Zirvesi

"Tartışmalı Konular"

2-6 Ekim 2019, Antalya

www.obstetrijinekolojizirvesi.org

Bilimsel Program ve Bildiri Özetleri Kitabı

Değerli katılımcılarımız; kongre süresince gerçekleşecek tüm panellerde oylamalarda kullanılmak üzere telefonunuza Kahoot! uygulamasını panellere katılım sağlamadan önce indirmenizi önemle rica ediyoruz.

Kahoot!

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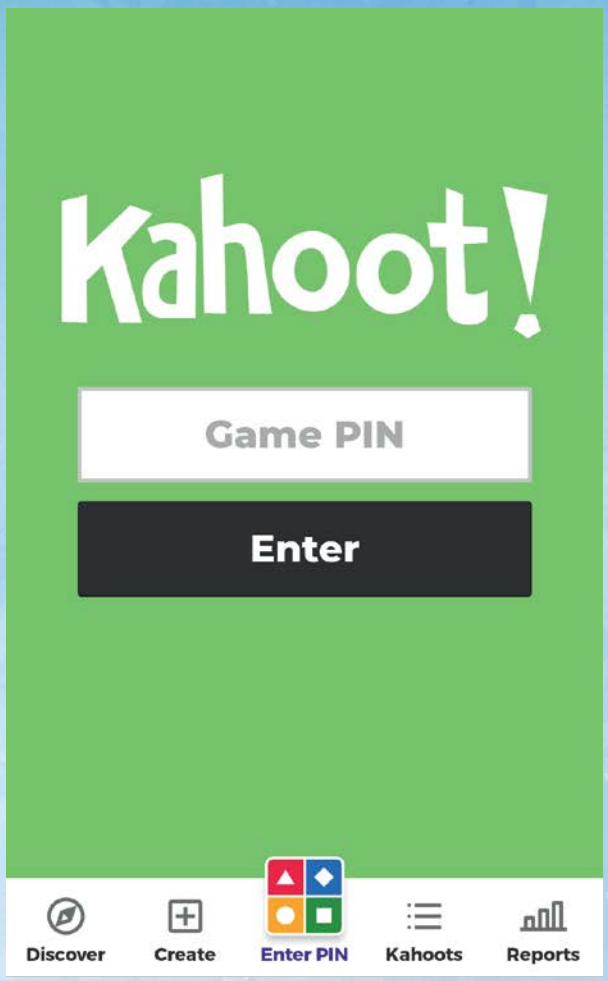

İÇİNDEKİLER

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ÖNSÖZ

Obstetrik ve Jinekoloji Zirvesi "Tartışmalı Konular", Kadın Sağlığı alanındaki en güncel tartışmalı konularla ilgilenen, konuşmacılarla katılımcıların birbiri ile etkileşimi ve yüzyüze görüşebilmesini önemseyen ve buna çok zaman ayrılmasını sağlayan, liyakata dayalı, kaliteyi ön planda tutan bir kongre olacaktır.

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

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

Obstetrik ve Jinekoloji Zirvesine katılın ve şunları yapın:

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

Bu toplantı Obstetrik ve Jinekolojide çığır açacak görüldüğü gibi birçok dernek ve fikir liderinin oluşturduğu birleştirici unsurları yüksek bir toplantı olacaktır. Tüm yan dallarla ilgili bilimsel kurullarımız ilgili derneklerimizin yönetimlerinin kararlarıyla oluşturulacaktır. Biz fikir liderleri sadece aracıyız. Tüm derneklerimizin yönetim ve üyeleri ise asıl gücümüz. Bu derneklere ek katılmak isteyen her dernek veya alanımızdaki kuruluşa da kapımız daima açıktır.

Saygılarımızla,

Başkan
M. Faruk Köse

Bilimsel Program Sorumlusu
Mete Güngör

Koordinatörler
Ali Ayhan, Fuat Demirci, L. Cem Demirel, İlkkan Dünder, Erdoğan Ertüngealp, Davut Güven, Ahmet Zeki Işık, Yücel Karaman, Cem Keçe, Yakup Kumtepe, Engin Oral, Sinan Özalp, Gürkan Uncu, Bülent Urman, Kunter Yüce, Atıl Yüksel

Sekreterler
Nejat Özgül, M. Murat Naki

**Soyadı alfabetik olarak sıralanmıştır.*

KURULLAR

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M. Faruk Köse
Kongre Başkanı

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Bülent Urman
Minimal İnvaziv Jinekoloji Derneği

L. Cem Demirel
TAJEV Vakfı

Ahmet Zeki Işık
TSRM Derneği

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Ürojinekoloji Derneği

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Cem Keçe
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Maternal Fetal Tıp ve Perinatoloji Derneği

MİNİMAL İNVAZİV CERRAHİ PROGRAM KOORDİNATÖRLERİ

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Robotik Jinekolojik Cerrahi Derneği

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Gürkan Uncu
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Yakup Kumtepe
Minimal İnvaziv Ürojinekoloji Derneği

KURULLAR

PELVİK AĞRI VE ENDOMETRİOZİS PROGRAM KOORDİNATÖRÜ

Engin Oral
Endometriozis ve Adenomyozis Derneği

JİNEKOLOJİK ONKOLOJİ PROGRAM KOORDİNATÖRLERİ

Ali Ayhan
TRSGO Derneği

Sinan Özalp
Trofoblastik Hastalıklar Derneği

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BİLİMSEL PROGRAM KOORDİNATÖRÜ

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Nejat Özgül

M. Murat Naki

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FİGÜR
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Ercan Baştu
Kutay Biberoğlu
Gürkan Bozdağ
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Suat Dede
Fulya Dökmeci
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Yavuz Ceylan
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Feride Söylemez
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Fehmi Yazıcıoğlu
Gökhan Yıldırım

Soyadı alfabetik olarak sıralanmıştır.

BİLİMSEL KURULLAR

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Özcan Balat
Ergin Bengisu
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Baki Erdem
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Mehmet Gökçü
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Müge Harma
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Volkan Ülker
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Taylan Yüksel

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Selçuk Ayas
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Hüsnü Çelik
Murat Dede
Nasuh Utku Doğan
Evrim Erdemoğlu
Ahmet Göçmen
Fatih Güçer
Onur Karabacak
Özay Oral
Kemal Özerkan
Erhan Şimşek
Tayyup Şimşek
Ömer Lütfi Tapısız
Salih Taşkın
Çağatay Taşkıran
Müfit C. Yenen
Tevfik Yoldemir

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Ayşe Seyhan Ata
Erkut Attar
Banu Kumbak Aygün
Ercan Baştu
Fatih Durmuşoğlu
Özgüç Takmaz
Onur Topçu

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BİLİMSEL PROGRAM

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2 Ekim 2019, Çarşamba				
SALON A	**SALON B**	**SALON C**	**SALON D**	**SALON E**
KURS 1	KURS 2	KURS 3	KURS 4	KURS 5
13:00-18:40	13:00-17:30	13:00-18:00	13:00-18:15	13:00-18:00
Olgu Sunumlarıyla Obstetrik Ultrasonografi Kursu	Laparoskopik Sütur Teknikleri ve Ofis Histereskopi Kursu	Reprodüktif Endokrinoloji ve İnfertilite Kursu	Jinekolojik Ultrason Kursu	Kadın Hastalıkları ve Doğum Uzmanlari İçin Temel Genetik Kursu

3 Ekim 2019, Perşembe				
08:15-08:30	Açılış Oturumu (Salon 1)			
	SALON 1	**SALON 2**	**SALON 3**	**SALON 4**
08:30-10:30	Oturum 1 Onkoloji 1	Oturum 2 Genital Estetik 1	LIVE Oturum 3 Endometriozis 1	
10:30-10:45	Kahve Arası			
10:45-11:15	LIVE Keynote (Salon 1)  ***Evelyn Telfer***			
11:15-12:00	Uydu Sempozyumu (Salon 1) QIAGEN			
12:00-13:30	Öğle Yemeği			
13:30-15:00	Oturum 4 Perinatoloji 1	Oturum 5 Genel Jinekoloji 1	Oturum 6 Cinsel Sağlık 1	Sözel Sunumlar-1
15:00-15:30	Kahve Arası			
15:30-17:30	Oturum 7 Minimal İnvaziv Cerrahi 1	Oturum 8 Ürojinekoloji 1	Oturum 9 Perinatoloji 2	

4 Ekim 2019, Cuma				
	SALON 1	**SALON 2**	**SALON 3**	**SALON 4**
08:30-10:30	Oturum 10 İnfertilite 1	Oturum 11 Perinatoloji 3	Oturum 12 Genel Jinekoloji 2	Sözel Sunumlar-2
10:30-10:45	Kahve Arası			
10:45-11:15	Keynote (Salon 1)  ***Karen Sermon***			
11:15-12:00	Uydu Sempozyumu (Salon 1) astellas			
12:00-13:30	Öğle Yemeği			
13:30-15:30	Oturum 13 İnfertilite 2	Oturum 14 Minimal İnvaziv Cerrahi 2	Oturum 15 Postpartum Kanama 1	
15:30-16:00	Kahve Arası			
16:00-18:00	Oturum 16 Menopoz	Oturum 17 Ürojinekoloji 2	Oturum 18 İnfertilite 3	Sözel Sunumlar-3

5 Ekim 2019, Cumartesi				
	SALON 1	**SALON 2**	**SALON 3**	**SALON 4**
09:00-11:00	Oturum 19 Onkoloji 2	Oturum 20 Endometriozis 2	Oturum 21 Perinatoloji 4	
11:00-11:15	Kahve Arası			
11:15-12:00	Uydu Sempozyumu (Salon 1) Abbott			
12:00-13:00	Öğle Yemeği			
13:00-13:45	Uydu Sempozyumu (Salon 1) MSD INVENTING FOR LIFE			
13:45-15:45	Oturum 22 IVF'de Tartışmalı Konular	Oturum 23 Perinatoloji 5	Oturum 24 Onkoloji 3	Sözel Sunumlar-4
15:45-16:00	Kahve Arası			
16:00-17:30	Oturum 25 Onkoloji 4	Oturum 26 İnfertilite 4	Oturum 27 Miyom	Sözel Sunumlar-5

6 Ekim 2019, Pazar			
	SALON 1	**SALON 2**	**SALON 3**
09:00-11:00	Oturum 28 Perinatoloji 6	Oturum 29 Genel Jinekoloji 3	Oturum 30 Genel Jinekoloji 4
11:00-12:00	Kapanış (Salon 1)		

2 Ekim 2019, Çarşamba

KURS 1 (Salon A)
Olgu Sunumlarıyla Obstetrik Ultrasonografi Kursu
Kurs Başkanı: *Atıl Yüksel*

Oturum Başkanları: *Recep Has, Talat Umut Kutlu Dilek*

13:00 - 13:20	11-14 Hafta Ultrasonografisi: Nasıl Ölçelim? Nerelere Bakalım?	*Ebru Çelik*
13:20 - 13:40	11-14 Hafta Ultrasonografisi: Olgu Sunumları ile Anomaliler	*İbrahim Kalelioğlu*
13:40 - 14:00	Olgu sunumlarıyla Skar Gebeliği ve Plasenta İnsersiyon Sorunları	*Halil Aslan*
14:00 - 14:20	Örnek Olgularla Obstetrik Doppler Uygulamalarının Klinikte Kullanımı	*Acar Koç*
14:20-14:40	Tartışma	
14:40-15:00	Kahve Arası	

Oturum Başkanları: *Rıza Madazlı, Ahmet Gül*

15:00 - 15:20	Olgularla Fetal Merkezi Sinir Sistemi Anomalileri	*Atıl Yüksel*
15:20 - 15:40	Olgu sunumlarıyla Fetal Vertebral Anomaliler	*Zeki Şahinoğlu*
15:40 - 16:00	Olgu sunumlarıyla Yüz, Boyun, kalvariyum ve Saçlı deri Anomalileri	*İnanç Mendilcioğlu*
16:00-16:20	Olgularla Fetal Toraks Anomalileri	*Nuri Danışman*
16:20 - 16:40	Tartışma	
16:40 - 17:00	Kahve Arası	

Oturum Başkanları: *Acar Koç, İnanç Medilcioğlu*

17:00-17:20	Olgularla Fetal Kardiyak Anomaliler	*Ahmet Gül*
17:20 - 17:40	Olgularla Fetal Üriner Sistem Anomalileri	*Recep Has*
17:40 - 18:00	Olgularla Fetal İskelet Sistemi Anomalileri	*Rıza Madazlı*
18:00 - 18:20	Olgu sunumlarıyla Fetal Gastrointestinal Sistem Anomalileri	*Şevki Çelen*
18:20 - 18:40	Tartışma	

2 Ekim 2019, Çarşamba

KURS 2 (Salon B)
Laparoskopik Sütur Teknikleri ve Ofis Histereskopi Kursu
Kurs Başkanları: ***Onur Karabacak, L. Cem Demirel***

13:00	Açılış ve Kursun Amacı ile Bilgilendirme	
13:15-13:45	Laparoskopik Sütür Teknikleri	*Serkan Erkanlı*
13:45-14:15	Ofis Histeroskopide Kullanılan Aletler ve Kullanım Prensipleri	*Onur Karabacak*
14:15 -14:30	Kahve Arası	
14:30-17:00	Kişiye Özel Sütür Kursu ve Histeroskopi Maket çalışması	

6 İSTASYON

1.İstasyon	
Görüntüleme Sistemi ile Sütür Eğitimi	*M. Murat Naki, Salih Taşkın*
2.İstasyon	
Görüntüleme Sistemi ile Sütür Eğitimi	*Onur Karabacak, Onur Topçu*
3.İstasyon	
Makettte Sütür Eğitimi	*Serkan Erkanlı, Üzeyir Kalkan*
4.İstasyon	
Makette Sütür Eğitimi	*Murat Api, Şevki Göksun Gökulu*
5.İstasyon	
Histeroskopik Sistem Eğitimi ve Maket Çalışması	*L. Cem Demirel, Erhan Şimsek*
6.İstasyon	
Histeroskopik Sistem Eğitimi ve Maket Çalışması	*Barış Ata, Ercan Baştu*

17:00 – 17:30 Tartışma ve Kapanış

** Kurs kontenjanı her istasyonda 2 kursiyer olmak üzere 12 kişi ile sınırlıdır.*

2 Ekim 2019, Çarşamba

KURS 3 (Salon C)
Reprodüktif Endokrinoloji ve İnfertilite Kursu
Temel Bilgilerimizi Kliniğe Nasıl Yansıtalım?
Kurs Başkanları: *Kutay Biberoğlu, Faruk Buyru*

13:00-13:10	Açılış ve Kursun Amacı ile Bigilendirme	*Kutay Biberoğlu*
13:10-13:30	Kurs Öncesi Değerlendirme	*Faruk Buyru*
13:30-13:50	Mensturasyon ve Over Yaşam Siklusu	*Özgür Öktem*
13:50-14:10	Over Rezerv Belirteçleri-Menopoz Yaşının Belirlenmesi, İnfertilite ve IVF Danışmanlığındaki Önemi	*Sezcan Mümüşoğlu*
14:10-14:30	Anovulasyon ve Oligoovulasyon-Patofizyoloji ve Tedavi	*Barış Ata*
14:30-14:45	Kahve Arası	
14:45-15:15	İmplantasyon Fizyolojisi ve Endometrium	*Sezcan Mümüşoğlu*
15:15-15:45	Amenore ve Puberte	*Engin Oral*
15:45-16:15	Üreme Cerrahisinin Güncel Durumu	*Ercan Baştu*
16:15-16:30	Kahve Arası	
16:30-17:00	Erkek İnfertilitesine Güncel Yaklaşım	*Tansu Küçük*
17:00-17:45	HSG Maratonu	*Bülent Urman*
17:45-18:00	Kurs Sonu Değerlendirme ve Sertifikaların Dağıtımı	

2 Ekim 2019, Çarşamba

KURS 4 (Salon D)
Jinekolojik Ultrason Kursu
Jinekologlar Ultrasonu daha etkin nasıl kullanabilirler?
Kurs Başkanları: ***Ayşe Seyhan, Ayşen Boza***

13:00-13:10	**Açılış ve Kursun Amacı ile Bigilendirme**	*Ayşe Seyhan*
13:10-13:30	**Kurs Öncesi Değerlendirme**	*Ayşe Seyhan*
13:30-14:30	**İnfertilite ve Konjenital Uterus Anomalileri**	
	İnfertil Çiftin Değerlendirilmesinde Ultrason	*Ayşen Boza*
	3 Boyutlu Ultrason Uterus Anomalilerinin Tanısı	*Ayşen Boza*
	Tartışma	
14:30-14:45	**Kahve Arası**	
14:45-15:45	**Myom, Adenomyosis ve Sarkom**	
	Myom ile Adenomyozisin Ayırıcı Tanısında Ultrason	*Ayşe Seyhan*
	Myom ile Sarkomun Ayrıcı Tanısında Ultrason?	*Ayşe Seyhan*
	Tartışma	
15:45-16:45	**Endometriosis**	
	Endometriosis Ultrasonu ve Preoperatif Haritalandırma	*Ayse Seyhan*
	Endometriosisde MR-Jinekeologlar ne Bilmeli?	*Cemil Gürses*
	Tartışma	
16:45-17:00	**Kahve Arası**	
17:00-18:00	**Anormal Uterus Kanamalari ve Adneks Kitleleri**	
	Anormal Uterine Kanamalı Hastada Ultrason ile Patolojiyi Öngörebilir miyiz ? IETA	*Doğan Vatansever*
	Adeneksiyal Kitlelerin Ultrason Bulgularına Göre Yönetimi Nasıl Olmalı?	*Doğan Vatansever*
	Tartışma	
18:00-18:15	**Kurs Sonu Değerlendirme ve Sertifikaların Dağıtımı**	

2 Ekim 2019, Çarşamba

KURS 5 (Salon E)
Kadın Hastalıkları ve Doğum Uzmanlari İçin Temel Genetik Kursu
Kurs Başkanları: ***Nejat Özgül, Dilek Aktaş***

13:00-13:10	**Açılış ve Kursun Amacı ile Bigilendirme**	
13:10-13:30	**Kurs Öncesi Değerlendirme**	
13:30-15:00	**Jinekolojik Onkolojide Genetik**	
	Klinik Yaklaşım	*Nejat Özgül*
	Jinekolojide Genetik Testler ve Uygulamalar	*Dilek Aktaş*
	Risk Azaltıcı Prosedürler	*Müfit C. Yenen*
	Tartışma	
15:00-15:30	**Kahve Arası**	
15:30-16:50	**Üreme Genetiği**	
	Erkek ve Kadın İnfertilitesinde Genetik ve Danışmanlık Tekrarlayan Gebelik Kayıplarında Genetik	*Oğuz Çilingir*
	Preimplantasyon Genetik Tanı ve Uygulamalar	*Muhterem Bahçe*
	Tartışma	
16:50-17:10	**Kahve Arası**	
17:10-18:00	**Prenatal Tanıda Genetik**	*Sevilhan Artan*
	Genel Değerlendirme ve Tartışma	*Dilek Aktaş*

Değerli katılımcılarımız;
kongre süresince gerçekleşecek tüm panellerde oylamalarda kullanılmak üzere telefonunuza Kahoot! uygulamasını panellere katılım sağlamadan önce indirmenizi önemle rica ediyoruz.

Kahoot!

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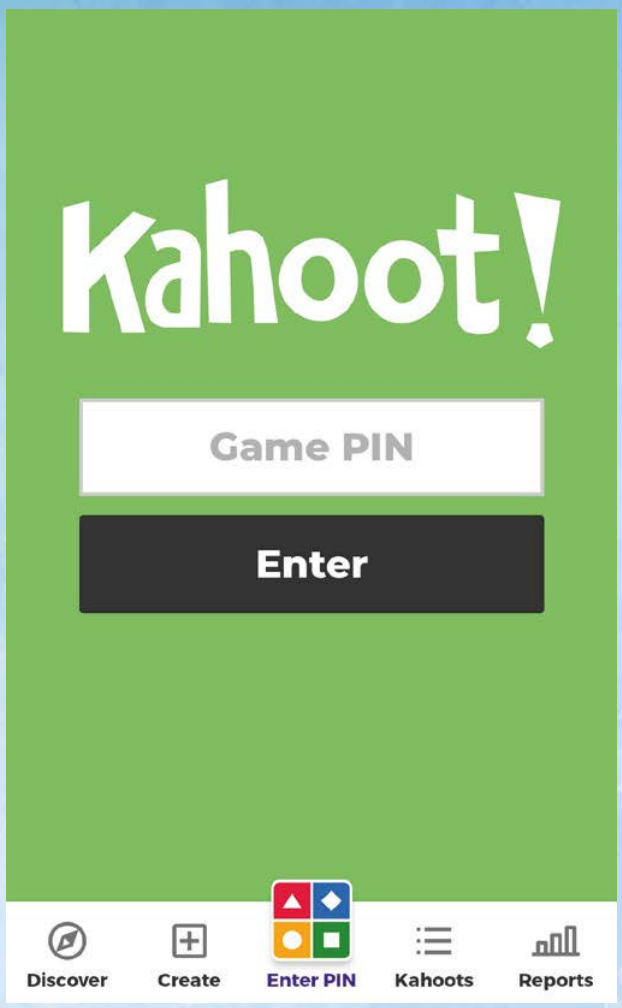

3 Ekim 2019, Perşembe

SALON 1

08:15-08:30 AÇILIŞ OTURUMU

08:30-10:30

OTURUM 1 - ONKOLOJİ 1

Panel: Servikal Preinvaziv lezyonlar
Panel Başkanı: *Kunter Yüce*

Panelistler: *U. Fırat Ortaç, M. Faruk Köse, Müfit C. Yenen, Coşkun Salman, Fulya Kayıkçıoğlu*

Panel Konuları:
Serviks Kanseri Taramasında HPV Primer Taramasının Önemi
Anormal Smear Sonuçlarının Yorumlanması
Anormal Smearde Yönetim
Anormal Servikal Histopatolojilerde Yönetim
HPV DNA Pozitifliğinde Ek Tedaviler

10:30-10:45 KAHVE ARASI

10:45-11:15

KEYNOTE
Başkanlar: *Necati Fındıklı, Evrim Ünsal*
Kök hücre teknolojisi IVF hastalarına ne sunabilir?

Evelyn Telfer

LIVE

11:15-12:00

UYDU SEMPOZYUMU
Türkiye ve Dünyada Servikal Kanser Taramaları
Konuşmacı: *Nejat Özgül*

QIAGEN

12:00-13:30 ÖĞLE YEMEĞİ

13:30-15:00

OTURUM 4 - PERİNATOLOJİ 1

Oturum Başkanları: *Sinan Beksaç, Özlem Pata*

MTHFR Polimorfizmleri ve Gebelik Komplikasyonları
Sinan Beksaç

Fetal Büyüme Kısıtlılığı: İzlem ve Doğumun Zamanlaması
Acar Koç

cfdna ile Kromozom Anomalilerinin Taranması
Atil Yüksel

Güven Vermeyen Trase Değişiklikleri
Özgür Deren

Tartışma

15:00-15:30 KAHVE ARASI

15:30-17:30

OTURUM 7 - MİNİMAL İNVAZİV CERRAHİ 1

Panel: Güvenli Laparoskopi Teknikleri ve Komplikasyonlar
Panel Başkanı: *Mete Güngör*

Panelistler: *Onur Karabacak, Çağatay Taşkıran, Hüsnü Görgen, Kemal Özerkan, Evrim Erdemoğlu*

Pro-Con: Benign Jinekolojik Cerrahide Robot vs Laparoskopi
Oturum Başkanı: *Gürkan Uncu, Tayup Şimşek*

Pro: Benign Jinekolojik Cerrahide Robot Avantajlıdır
Ahmet Göçmen

Con: Benign Jinekolojik Cerrahide Laparoskopi Avantajlıdır
Suat Dede

3 Ekim 2019, Perşembe

SALON 2

08:30-10:30

OTURUM 2 - GENİTAL ESTETİK 1

Panel: Kozmetik Jinekolojik Cerrahi
Panel Başkanı: ***Akın Sivaslıoğlu***

Panelistler: *Tansu Küçük, Özgür Leylek, Eren Akbaba, Murat Emanetoğlu, Ozan Doğan*

Panel Konuları:
Kaç Tip Hymenoplasti Vardır? Kime Hangisi Yapılmalıdır?

Labioplasti Tipleri

Hudoplastinin Endikasyonları

Dolgu Maddeleri: Avantaj ve Dezavantajları

Laser/Radyofrekans ile Yapılan Vajinal Rejuvenasyonun Etkisi ve Etkinliği

10:30-10:45 — **KAHVE ARASI**

12:00-13:30 — **ÖĞLE YEMEĞİ**

13:30-15:00

OTURUM 5 - GENEL JİNEKOLOJİ 1

Panel: Oral Kontraseptifler
Panel Başkanı: ***Cihat Ünlü***

Panelistler: *Faruk Buyru, Yeşim Bayoğlu Tekin, Funda Güngör Uğurlucan, M. Murat Naki*

Panel Konuları:
Oral Kontraseptiflerde Mitler ve Gerçekler

Şiddetli Uterin Kanama için Güncel Tanımlar

Şiddetli Uterin Kanamalarda Medikal Tedavi Seçenekleri

Oral Kontraseptifler ve Kanserle İlişkisi

15:00-15:30 — **KAHVE ARASI**

15:30-17:30

OTURUM 8 - ÜROJİNEKOLOJİ 1

Pro-Con: Stres İnkontinans Cerrahisinde Meş Kullanımı
Oturum Başkanları: ***Fuat Demirci, Orhan Ünal***

Pro: Meş Kullanılmalıdır
Fulya Dökmeci

Con: Meş Kullanılmamalıdır
Adnan Orhan

Pro-Con: Apikal Prolapsus Cerrahisinde;
Oturum Başkanları: ***Fuat Demirci, Orhan Ünal***

Pro: Vaginal Yaklaşım Tercih Edilmeli
Fuat Demirci

Con: Abdominal Yaklaşım Tercih Edilmeli
Yakup Kumtepe

3 Ekim 2019, Perşembe

SALON 3

08:30-10:30

OTURUM 3 - ENDOMETRİOZİS 1

Pro-Con: Derin İnfiltratif Endometriozis / Adenomiyozise Bağlı İnfertilitede;
Oturum Başkanları: ***Bülent Urman, Mete Işıkoğlu***

Pro: IVF Yapılmalıdır
Engin Oral

Con: Cerrahi Tedavi Uygulanmalıdır LIVE
Horace Roman

Pro-Con: Endometriozise Bağlı Ağrıda Tedavi
Oturum Başkanları: ***Gürkan Uncu, Servet Özden Hacıvelioğlu***

Pro: Medikal Tedavi Uygulanmalıdır
Kutay Biberoğlu

Con: Cerrahi Tedavi Uygulanmalıdır LIVE
Vito Chiantera

10:30-10:45 KAHVE ARASI

12:00-13:30 ÖĞLE YEMEĞİ

13:30-15:00

OTURUM 6 - CİNSEL SAĞLIK 1

Panel: Jineseksoloji
Panel Başkanı: ***Cem Keçe***

Panelistler: *Selcen Bahadır, Şule Kıray, Ali Ata Özdemir, Fatma Çoşar*

Panel Konuları:
Jineseksoloji bakış Açısıyla Pelvik Ağrı ve Penetrasyon Bozukluğu ve Tedavisi

Jineseksoloji Bakış Açısıyla Kadın Cinsel İlgi ve Uyarılma Bozukluğu ve Tedavisi

Jineseksoloji Bakış Açısıyla Kadın Orgazm Bozukluğu ve Tedavisi

15:00-15:30 KAHVE ARASI

15:30-17:30

OTURUM 9 - PERİNATOLOJİ 2

Panel: Doğum Zamanlaması
Panel Başkanı: ***Recep Has***

Panelistler: *Halil Aslan, İnanç Mendilcioğlu, Ali Ergün, Cem Batukan*

Panel Konuları:
Term Gebelikte Vaginal Doğum ve Sezaryen Zamanlaması

Akciğer Maturite Testlerinde Güncel Durum

Yüksek Riskli Gebeliklerde Doğum Zamanlaması

Doğum Öncesi Son Dokunuşlar

A. Steroid Ne Zaman ve Kaç Kere Yapılmalı?

B. Nöroproteksiyon Amaçlı Mgso4 En Son Kaçıncı Haftada Yapılmalıdır?

3 Ekim 2019, Perşembe

SALON 4

13:30-15:00

Sözel Sunumlar- 1
Oturum Başkanları: *Salih Taşkın, Esra Özbaşlı*

SS-01
Mechanic colonic obstruction caused by endometritis after curettage
Uğur Yaşar, Ebru İnci Coşkun

SS-02
Port-site metastasis after laparoscopic surgery for early-stage, low-risk endometrioid type endometrial adenocarcinoma: Case report
Halise Meltem Batur, Utku Akgör, Nejat Özgül, Mehmet Coşkun Salman

SS-03
Paraurethral transobturator tape to treat stress urinary incontinence
Ozan Doğan, Sadık Gündüz, Ulaş Çoban, Çiğdem Pulatoğlu, Gürsoy Burak Kurt

SS-04
Granular cell tumor of the vulva:A rare entity
Nermin Cansu Uçkan, Sinem Ayşe Duru Çöteli, Fulya Kayıkçıoğlu

SS-05
Evaluation and management of patients with hematoma after gynecologic and obstetric surgery
Bekir Kahveci, Sertaç Ayçiçek

SS-06
Sacrouterine ligament plication for surgically treatment of voiding dysfunctions
Ozan Doğan, Gül Özel Doğan, Murat Yassa, Meriç Kabakçı, Üzeyir Kalkan

SS-07
The role of systemic inflammatory response markers' change during neoadjuvant chemotherapy in predicting suboptimal surgery in ovarian cancer
Varol Gülseren, İlker Çakır, İsa Aykut Özdemir, Muzaffer Sancı, Mehmet Gökçü, Kemal

SS-08
Treatment of labial fusion in a reproductive age patient-surgical seperation: a case report
Rüya Coşar, Utku Akgör, Esra Karataş, Z.selçuk Tuncer

SS-09
Laparoscopic cornual resection in ectopic pregnancy
Pınar Kadiroğulları

SS-10
Retrospective Analysis Of Gestational Trophoblastic Diseases In Our Clinic
Gülden Gök, Nazlı Aylin Vural, Nayif Çiçekli, Gürkan Kıran

4 Ekim 2019, Cuma

SALON 1

08:30-10:30

OTURUM 10 - İNFERTİLİTE 1

Oturum Başkanları: *Gürkan Uncu, Şafak Olgan*

Tekrarlayan Gebelik Kaybı, Süperfertilite ve Obezite
Siobhan Guenby

Tekrarlayan Gebelik Kaybı İçin Progesteron
Siobhan Quenby

Panel: Tekrarlayan Gebelik Kaybının Kanıta Dayalı Araştırma ve Tedavisi: Üreme Endokrinologları, Genetikçiler ve Hematologların Bakış Açısı
Panel Başkanı: *Gürkan Uncu*

Panelistler: *Sedat Kadanalı, Kayhan Yakın, Mustafa Çetiner, Yasemin Alanay, Siobhan Quenby*

10:30-10:45 KAHVE ARASI

10:45-11:15

KEYNOTE

Başkanlar: *Bülent Urman, Başak Balaban*

Yardımla Üreme ve Üreme Genetiği Arasındaki Evlilik-Ebedi Mutluluk ya da Bekleyen Boşanma

Karen Sermon

11:15-12:00

UYDU SEMPOZYUMU

Aşırı Aktif Mesane Tedavisinde Betmiga

Oturum Başkanı: *Ali Fuat Demirci*

Konuşmacı: *Funda Güngör Uğurlucan*

astellas

12:00-13:30 ÖĞLE YEMEĞİ

13:30-15:30

OTURUM 13 - İNFERTİLİTE 2

Oturum Başkanları: *Serhan Cevrioğlu, Yılmaz Güzel*

PKOS, Metabolik Sendrom ve Obezite
Kutay Biberoğlu

PKOS İçin ilk Basamak Ovulasyon İndüksiyonu Tedavisi: Son Söz Söylendi mi?
Gürkan Bozdağ

PKOS'nun Uzun Dönemli Yan Etkileri: Ne Kadar Endişeli Olmalıyız?
Turgut Aydın

Pro-Con: İlk Basamak Ovulasyon İndüksiyonu Tedavileri Başarısız Olduğunda ne Yapılmalı?
Oturum Başkanları: *Ahmet Zeki Işık, Serkan Kahyaoğlu*

Pro: Gonadotropin +/- IUI
Semra Kayataş Eser

Con: IVF
Mehtap Polat

15:30-16:00 KAHVE ARASI

16:00-18:00

OTURUM 16 - MENOPOZ

Panel: Menopoz Panel 1
Panel Başkanı: *Hakan Seyisoğlu*

Panelistler: *Erdoğan Ertüngealp, Fatih Durmuşoğlu, Levent Şentürk, Ümit Sungurtekin İnceboz*

Cerrahi Menopozda Tedavi Seçenekleri
Fatih Durmuşoğlu

Erken Over Yetmezliği Olgusu. Nasıl Tanımlayalım? Krioprezervasyon Endikasyonları? Tedavi Protokolleri
Levent Şentürk

Endometriozisli Olguda Postmenopozal Hormon Tedavisi
Ümit Sungurtekin İnceboz

Panel: Menopoz Panel 2
Panel Başkanı: *Sezai Şahmay*

Panelistler: *Hasan Serdaroğlu, Hakan Seyisoğlu, C.Tamer Erel, Tevfik Yoldemir*

Genito Üriner Sistem Yakınmalarında Tedavi Seçenekleri
C. Tamer Erel

4 Ekim 2019, Cuma

SALON 2

08:30-10:30

OTURUM 11 - PERİNATOLOJİ 3

Oturum Başkanları: *Füsun Varol, Yaprak Üstün*

Preterm Doğum: Öngörü ve Riskli Gebeye Yaklaşım (Progesteron,Serklaj, Pesser)
Yalçın Kimya

Preeklampside Öngörü ve Korunma
İskender Başer

Maternal Mortalite
Yaprak Üstün

Gebelikte nefrolojik komplikasyonlar
İbrahim Kalelioğlu

Gebelik Kolestazı
Talat Umut Kutlu Dilek

10:30-10:45 KAHVE ARASI

12:00-13:30 ÖĞLE YEMEĞİ

13:30-15:30

OTURUM 14 - MİNİMAL İNVAZİV CERRAHİ 2

Pro-Con: Laparoskopik histerektomide
Oturum Başkanları: *U. Fırat Ortaç, Müfit C. Yenen*

Pro: Retroperitona Girilmelidir
Hüsnü Çelik

Con: Retroperitona Girmeye Gerek Yoktur
Mete Güngör

Panel: Robotik Cerrahi: Güvenlik, Teknik ve Komplikasyonlar
Panel Başkanı: *İlkkan Dünder*

Panelistler: *Mete Güngör, Cem İyibozkurt, Fatih Güçer, M. Murat Naki, Gürkan Kıran*

15:30-16:00 KAHVE ARASI

16:00-18:00

OTURUM 17 - ÜROJİNEKOLOJİ 2

Panel: Aşırı Aktif Mesanede Tedavi Modaliteleri
Panel Başkanı: *Vedat Atay*

Panelistler: *Süleyman Akhan, İsmet Gün, Petek Balkanlı, Yusuf Üstün, Ömer Tarık Yılçın*

Pro-Con: Prolapsus Cerrahisine Histerektomi veya İnkontinans Cerrahisi;
Oturum Başkanları: *Ömer Tarık Yalçın, Mehmet Yılmazer*

Eklenmelidir
Funda Güngör Uğurlucan

Eklenmemelidir
Selçuk Ayas

4 Ekim 2019, Cuma

SALON 3

08:30-10:30

OTURUM 12 - GENEL JİNEKOLOJİ 2

Pro-Con: ERAS
Oturum Başkanları: *M. Mutlu Meydanlı, Çağatay Taşkıran*

Pro: Uygulanmalıdır
Haldun Gündoğdu

Con: Uygulamaya Gerek Yoktur
Hüsnü Çelik

Panel: Vulvovajinitler
Panel Başkanı: *Aykut Barut*

Panelistler: *Mert Turğal, Kemal Özerkan, Serdar Yalvaç, Esra Özbaşlı*

Panel Konuları:
Bakteriyel Vajinoziste en Uygun Tedavi
Dirençli Vulvovaginal Kandidiyaziste Tedavi Yaklaşımları
Gebelerde Vulvovaginal Enfeksiyonlara Yaklaşım
Kronik Vulvovajinit

10:30-10:45 KAHVE ARASI

12:00-13:30 ÖĞLE YEMEĞİ

13:30-15:30

OTURUM 15 - POSTPARTUM KANAMA 1

Oturum Başkanı: *Demir Özbaşar, Faik Mümtaz Koyuncu*

Postpartum Kanamalarda Kabus Nasıl Önlenir?
Nuri Danışman

Postpartum Kanamada Proaktif ve Etkin Medikal Yönetim
M. Mutlu Meydanlı

Postpartum Kanamanın Cerrahi Tedavisi
Şevki Çelen

Jinekolog Onkolog Perspektifi
Murat Öz

Postpartum Kanama: Yoğun Bakım Ünitesi Açısından
Ender Gedik

15:30-16:00 KAHVE ARASI

16:00-18:00

OTURUM 18 - İNFERTİLİTE 3

Panel: İnfertilitenin Değerlendirilmesinde ve Tedavisinde ve IVF Olacak Çiftlerde Histeroskopinin Yeri: Liberal mi? Seçici mi?
Panel Başkanı: *Cem Atabekoğlu*

Panelistler: *Erbil Doğan, Tayfun Bağış, Berfu Demir, Erhan Şimşek, Şadıman Altınbaş*

Oturum Başkanları: *Cemal Posacı, Volkan Turan*

Çoğu Histeroskopik Müdahale ne Yazık ki Kanıttan Yoksundur
Tarek El Thoukhy

Mekanik Morselatörler-Histeroskopik Myomektomi için Rezektoskopun Yerini Alacak mı?
Mustafa Bahçeci

4 Ekim 2019, Cuma

SALON 4

08:30-10:30

Sözel Sunumlar- 2
Oturum Başkanları: ***Selçuk Ayas, Emine Karabük***

SS-11
Fetal Aorta Larger Than the Main Pulmonary Artery on the Three-Vessel View: Perinatal outcomes
Şafak Yılmaz Baran, Alev Arslan, Gülşen Doğan Durdağ, Hakan Kalaycı, Seda Yüksel Şimşek, Songül Alemdaroğlu

SS-12
Hysteroscopy of a patient with hyperplastic endometrial polyp, endometrial intraepithelial neoplasia and atypical endometrial hyperplasia
Hasan Aykut Tuncer, Serap Firtina Tuncer

SS-13
Low grade endometrioid stromal sarcoma of the ovary: two cases and review of the literature
Gülşen Doğan Durdağ, Songül Alemdaroğlu, Seda Yüksel Şimşek, Şafak Yılmaz Baran, Hüsnü Çelik, Filiz Aka Bolat, Özlem Özen, Hüseyin Mertsoylu

SS-14
Lymphoma mimicking adnexal mass and presenting as lumbosacral radiculopathy: a case report
Gülşen Doğan Durdağ, Seda Yüksel Şimşek, Songül Alemdaroğlu, Hüsnü Çelik, Filiz Aka Bolat, Emre Durdağ, Ali Ayberk Beşen

SS-15
Use of pelvic floor sonography in the early diagnosis and management of obstetric anal sphincter injuries
Murat Yassa, Ozan Doğan, Çiğdem Pulatoğlu

SS-16
Clinicopathological findings and treatment and short-term fertility outcomes in patients with myoma prolapsed into vagina
Eda Adeviye Şahin

SS-17
Monochorionic monoamniotic twins; experience of a tertiary center
Emre Ekmekci, Servet Gençdal

SS-18
Uterus preserving Laparoscopic Lateral Suspension: Modifications to the original approach
Murat Yassa, Ozan Doğan, Çiğdem Pulatoğlu, Niyazi Tuğ

SS-19
Points to be considered during the total laparoscopic hysterectomy of a patient with uterus bicornis unicollis: a case report
Ozan Doğan, Gül Özel Doğan, Aylin Güneş Gülcan, Ulaş Çoban, Meriç Kabakçı

SS-20
Risk factors for the development of recurrence at early stage pure serous type endometrial adenocarcinoma
Hamdullah Sozen

SS-21
Surgically management of enterocele with transvaginal bridge technique
Ozan Doğan, Aylin Güneş Gülcan, Çiğdem Pulatoğlu, Murat Yassa, Gül Özel Doğan

SS-22
The investigation of toxoplasma and rubella seroprevalancies in pregnant women in a private university hospital
Umut Sarı

SS-23
Postpartum posterior reversible encephalopathy syndrome that presented with visual loss in a normotensive woman without preeclampsia
Murat Yassa, Özge Yağcıoğlu Yassa, Sevinç Rabia Serindağ, Ozan Doğan

SS-24
A different approach to anterior colporrhaphy with using vaginal mucosa as a native prosthesis in cystocele repair: Deepithelialized vaginal flap
Ozan Doğan, Ulaş Çoban, Murat Yassa, Sadık Gündüz, Çiğdem Pulatoğlu

4 Ekim 2019, Cuma

SALON 4

16:00-18:00

Sözel Sunumlar- 3
Oturum Başkanları: *Murat Api, Özgüç Takmaz*

SS-26
Prognostic factors in uterine serous carcinoma
Zeliha Fırat Cüylan

SS-27
A novel combination to treat rectocele in conjunction with urgency: Rectovaginal fascia repair and sacrouterine ligament plication
Ozan Doğan, Meriç Kabakçı, Sadık Gündüz, Aylin Güneş Gülcan, Gürsoy Burak Kurt

SS-28
Parasitic fibroids: four case reports
Didem Alkaş Yağınç, Selçuk Yetkinel, Hakan Kalaycı, Erhan Şimşek, Hüsnü Çelik

SS-29
Evaluation of 217 Cases Undergoing Amniocentesis
Erdal Şeker, Evindar Elçi

SS-30
A Ruptured Cesarean Scar Pregnancy While Beta Hcg Level Was Decreasing: Case Report
Emine Arslan, Fikriye Karanfil Yaman

SS-31
Laparoscopy should be the preferable route in the morbidly obese endometrial cancer
Mehmet Ali Vardar, Ahmet Barış Güzel, Ümran Küçükgöz Güleç, Ghanim Khatib

SS-32
A case of gastrointestinal stromal tumor with preoperative diagnosis of suspicious adnexal mass, rarely seen tumor histology
Alper Seyhan, Ayşegül Bestel, Merve Begüm Osmanlıoğlu

SS-33
Uterine didelphys with bilateral cervical cancer involvement in a woman and review of the literature
Esra Isci Bostanci, Ayse Sinem Duru Çöteli, Yasin Durmus, Nurettin Boran

SS-34
Rare cause of maternal death: the rupture of iliac artery aneurysm
Can Türkler, Nahit Ata

SS-36
Assosiation between male-female infertility and obesity
Osman Ergün

SS-37
Women's knowledge and beliefs towards vaccination for influenza during pregnancy in Turkey and underlying factors of misinformation: A single-center cross-sectional study
Çiğdem Pulatoğlu, Murat Yassa, Ozan Doğan, Gökçe Turan, Mete Çağlar

SS-38
Posterior Reversible Encephalopathy Syndrome With Global Amnesia: A Rare Case Report
Elif Nazlı Çetindağ, Ayşegül Alkılıç, Sinem Ertaş

SS-39
Clinical outcomes of pregnancies with amniotic fluid sludge
Safak Yılmaz Baran, Hakan Kalaycı, Gülşen Doğan Durdağ

5 Ekim 2019, Cuma

SALON 1

09:00-11:00 — OTURUM 19 - ONKOLOJİ 2

Panel: Serviks Kanserinde Tarama ve HPV Aşıları
Panel Başkanı: *Ali Ayhan*

Panelistler: *Ali Haberal, Sinan Özalp, M. Faruk Köse, Nejat Özgül, H. Gökhan Tulunay*

Panel Konuları:
HPV - Serviks Kanseri İlişkisi
Serviks Kanserinin HPV ile Primer Taraması
HPV Aşıları
Türkiye Servikal Kanser Tarama Programının Sonuçları

11:00-11:15 — KAHVE ARASI

11:15-12:00 — UYDU SEMPOZYUMU
Her Yönü ile Digrogesteron
Oturum Başkanı: *Ahmet Zeki Işık*
Konuşmacılar: *Barış Ata, Erbil Doğan*
Abbott

12:00-13:00 — ÖĞLE YEMEĞİ

13:00-13:45 — UYDU SEMPOZYUMU
Ülkemizde HPV'nin yükü ve HPV Aşılarının Önemi
Oturum Başkanı: *Nejat Özgül*
Konuşmacılar: *M. Faruk Köse, Nejat Özgül*
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13:45-15:45 — OTURUM 22 - IVF'DE TARTIŞMALI KONULAR

Oturum Başkanları: *Başak Balaban, Berrin Avcı*

Oositin Gelişim Potansiyeli Nasıl Tanımlanır?
Genler, Morfokinetik, Blastulasyon ve Öploidi
Danilo Cimadomo

Time-Lapse: Faydalı Bir Araç mı, Eğlenceli Bir Oyuncak mı?
Laura Rienzi

Embriyoların Çözme Sonrası Gelişimi ve İmplantasyon Potansiyeli Üzerine Blastokist Morfolojisi, Trofoektoderm Biyopsisi ve Diğer Laboratuvar Uygulamalarının Etkisi
Danilo Cimadomo

Pro-Con: Hepsini Donduralım
Oturum Başkanları: *Serdar Günalp, Turgut Aydın*

Pro: Hepsini
Kemal Özgür

Con: Seçerek
Abha Maheshwari

15:45-16:00 — KAHVE ARASI

16:00-17:30 — OTURUM 25 - ONKOLOJİ 4

Panel: Adneksiyel Kitleler
Panel Başkanı: *Çağatay Taşkıran*

Panelistler: *Tayup Şimşek, Özcan Balat, Çetin Çelik, Serkan Erkanlı, Hamdullah Sözen*

5 Ekim 2019, Cuma

SALON 2

09:00-11:00

OTURUM 20 - ENDOMETRİOZİS 2

Panel: Endometriozis Yönetimi-Katılımcılarla Birlikte 6 Olgunun Tartışılması
Panel Başkanı: *Bülent Urman*

Panelistler: *Gürkan Uncu, Yücel Karaman, L. Cem Demirel, Ercan Baştu, Onur Topçu*

11:00-11:15 KAHVE ARASI

12:00-13:00 ÖĞLE YEMEĞİ

13:45-15:45

OTURUM 23 - PERİNATOLOJİ 5

Pro-Con: Anne isteği ile sezaryen
Oturum Başkanları: *Atıl Yüksel, Yavuz Ceylan*

Pro: Evet
Metin İngeç

Con: Hayır
Tamer Mungan

Pro-Con: Kötü Obstetrik Öykü ve Tekrarlayan Gebelik Kayıplarında Edinsel ve Kalıtsal Trombofili
Oturum Başkanları: *Atıl Yüksel, Yavuz Ceylan*

Pro: Tarayalım
Mustafa Başbuğ

Con: Taramayalım
Ahmet Gül

15:45-16:00 KAHVE ARASI

16:00-17:30

OTURUM 26 - İNFERTİLİTE 4

Oturum Başkanları: *Faruk Buyru, Ahmet Demir*

Klinisyenlerin IVF'nin Başarısını Arttırmak İçin Kullandıkları Ek Tedaviler (Add-Ons): Kullanımlarını Mazur Gösterecek Kanıt Var mı?
Tarek El Thoukhy

Luteal Faz-IVF Tedavisinin İhmal Edilmiş Bir Parçası mı?
Tayfun Bağış

Pro-Con: Over Uyarılmasına Zayıf Yanıt Veren Olgularda Adjuvanlar
Oturum Başkanları: *Esra Bulgan Kılıçdağ, Ülkü Özmen*

Yararlı Olabilecek Adjuvanlar Var
Ahmet Zeki Işık

Adjuvanların Etkinliklerinin Kanıtlanması Gerekir
Barış Ata

Tartışma

5 Ekim 2019, Cuma

SALON 3

09:00-11:00

OTURUM 21 - PERİNATOLOJİ 4

Panel: Obstetrikte Sık Rastlanan Medikolegal Sorunlar
Panel Başkanı: *Rıza Madazlı*

Panelistler: *Sabahattin Altınyurt, Gökhan Yıldırım, Turgut Bozkurt, İbrahim Üzün*

Fetal Tarama Testleri ile İlgili Mediko-Legal Çatışmalar

Ultrasonda Yakalanamayan Anomalilerle İlgili Mediko-Legal Çatışmalar

Serabral Palsi ile İlgili Mediko-Legal Çatışmalar

Omuz Takılması ile İlgili Mediko-Legal Çatışmalar

11:00-11:15 KAHVE ARASI

12:00-13:00 ÖĞLE YEMEĞİ

13:45-15:45

OTURUM 24 - ONKOLOJİ 3

Panel: Jinekolojik Kanserlerde Sentinel Lenf Nodu
Panel Başkanı: *U. Fırat Ortaç*

Panelistler: *Alessandro Buda, Tugan Beşe, Samet Topuz, Nurettin Boran, Salih Taşkın*

Panel Konuları:
Sentinel Lenf Nodu Konsepti Nedir?

Boyalar, Enjeksiyon Tekniği ve Başarıyı Etkileyen Faktörler

ICG / NIR Görüntüleme Sistemlerinin Farklılıkları

Endometrium Kanserinde SLN

Serviks Kanserinde SLN

15:45-16:00 KAHVE ARASI

16:00-17:30

OTURUM 27 - MİYOM

Panel: Miyomlarda Tartışmalı Konular
Panel Başkanı: *Kubilay Ertan*

Panelistler: *Tansu Küçük, Nuray Bozkurt, Mete Çağlar, Ömer Lütfü Tapısız, Burak Karadağ*

Panel Konuları:
Miyomların Tanısı ve Haritalandırılması

Miyomlarda Tıbbi Tedavinin Güncel Durumu

Miyomektomi: Laparotomi vs Laparoskopi

Miyomların Karın Dışına Alınması-Morselasyon ve Alternatifleri

Miyom Tedavisinde Histeroskopinin Yeri

5 Ekim 2019, Cuma

SALON 4

13:45-15:45

Sözel Sunumlar- 4
Oturum Başkanları: *Ali Sami Gürbüz, Mehmet Ali Narin*

SS-41
Correlation of ultrasonographic fetal biometric parameters with birth weight
Hasan Aykut Tuncer

SS-42
Neuroendocrine carcinoma of the uterine cervix: two cases and review of the literature
Gülşen Doğan Durdağ, Seda Yüksel Şimşek, Songül Alemdaroğlu, Selçuk Yetkinel, Hüsnü Çelik, Filiz Aka Bolat, Özlem Özen, Fatih Köse

SS-43
Evaluation of atypical glandular cells in cervico-vaginal cytology in a single tertiary center
Sevki Göksun Gökulu, Nuri Yıldırım

SS-44
Risk factors for ovarian metastasis in patients with endometroid type endometrial cancer
Koray Aslan

SS-45
Can we manage adnexal masses in pregnancy expectantly; a case report of yolk sac tumor of the ovary
Sinem Ayşe Duru Çöteli, Nurettin Boran

SS-46
Prenatal findings in sirenomelia: Report of three cases and literature review
Seçil Karaca Kurtulmuş

SS-47
The effects of Pilates during pregnancy
Halil İbrahim Bulguroğlu, Merve Bulguroğlu, Arzu Güçlü Gündüz

SS-48
A case of primer peritoneal carcinoma with preoperative diagnosis of suspicious adnexal cystic mass in douglas space
Ayşegül Bestel, Alper Seyhan, Melih Bestel

SS-49
Prevention of preterm delivery by cervical cerclage: A comparison of prophylactic and emergent procedures
Seda Yüksel Şimşek, Erhan Şimşek, Gülsen Dogan Durdag, Songül Alemdaroğlu, Şafak Baran, Hakan Kalaycı

SS-50
The expressions of Oct-4 CD44 and E-cadherin in eutopic and ectopic endometrial tissues in women with endometriosis
Ceyda Sancakli Usta, Gülay Turan, Cagla Bulbul Hanedar, Akin Usta, Ertan Adali

5 Ekim 2019, Cuma

SALON 4

16:00-17:30

Sözel Sunumlar- 5
Oturum Başkanları: *Ercan Baştu, Hanifi Şahin*

SS-51
Operating room nursing in gynecologic oncology surgeries: Our one-year, single-center experience
Nuray Ekici, Nazan Çelik, Hilal Otlu, Eda Adeviye Şahin, Hanifi Şahin

SS-52
The mobility of bladder neck in patients with stress incontinence
Elif Meseci

SS-53
Endometrial polyps and concomitant uterine pathologies in hysterectomy specimens
Latife Atasoy Karakaş, Emre Gunakan, Alev Ok Atılgan, Ali Haberal, Ali Ayhan

SS-54
Prognostic factors associated with Hipec in Recurrent epithelial ovarian cancer
Hüseyin Akıllı

SS-55
Hymen Protecting Hysteroscopy: Case Series
Hasan Sarp Özcan

SS-56
Outcomes of patients with krukenberg tumors from gastric, colorectal and appendix cancer
Tevfik Avcı, Ali Ayhan

SS-57
Müllerian Anomaly Associated with Chronic Pelvic Pain: A Case of Non-Communicating Rudimentary Horn
Gürhan Güney, Mine Islimye Taskin, Ezgi Tolu

SS-58
Delivery methods and cesarean indications in immigrant pregnant women
Serap Fırtına Tuncer

6 Ekim 2019, Cumartesi

SALON 1

09:00-11:00

OTURUM 28 - PERİNATOLOJİ 6

Pro-Con: Gebelikte Rutin Sitomegalovirüs, Toksoplazma ve Rubella Taraması
Oturum Başkanları: *Feride Söylemez, Bilge Çetinkaya Demir*

Yapalım
Namık Demir

Yapmayalım
Özlem Pata

Pro-Con: Gebelikte Diyabet Taraması
Oturum Başkanları: *Feride Söylemez, Bilge Çetinkaya Demir*

Genel Populasyon Taraması Yapalım
Zeki Şahinoğlu

Riskli Gebeleri Tarayalım
Fehmi Yazıcıoğlu

75 gr ile Tarayalım
Zeki Şahinoğlu

50 gr ile Tarayalım
Fehmi Yazıcıoğlu

11:00-12:00 KAPANIŞ

SALON 2

09:00-11:00

OTURUM 29 - GENEL JİNEKOLOJİ 3

Panel: Fertilite Koruyucu Yaklaşımlar
Panel Başkanı: *Ali Ayhan*

Panelistler: *Yakup Kumtepe, Mehmet Gökçü, Ali Küçükmetin, Nasuh Utku Doğan, Özgür Öktem*

Panel Konuları:
Fertilite Koruyucu Teknikler

Jinekolojik Kanserlerde Fertilite Koruyucu Teknikler

Non-Jinekolojik Kanserlerde Fertilite Koruyucu Teknikler

Uterus Transplantasyonu

Uterus ve Over Transpozisyonları

SALON 3

09:00-11:00

OTURUM 30 - GENEL JİNEKOLOJİ 4

Panel: Anormal Uterin Kanamalar
Panel Başkanı: *Mehmet Ali Vardar*

Panelistler: *Ruşen Aytaç, Vedat Atay, Aydın Özsaran, Anıl Onan, Davut Güven*

Oturum: Akılcı İlaç Kullanımı
Özgüç Takmaz

Obstetrik ve Jinekoloji Zirvesi
"Tartışmalı Konular"
2-6 Ekim 2019, Antalya

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SS-01

Mechanic colonic obstruction caused by endometritis after curettage

Uğur Yaşar[1], Ebru İnci Coşkun[2]

[1]Özel EGM Hayat Hastanesi Malatya

[2]İnönü Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı

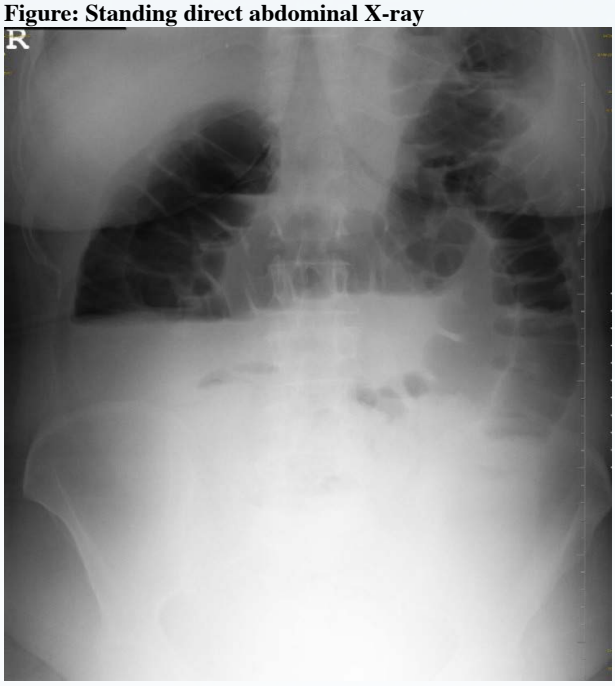
INTRODUCTION: Malignancies are the most common cause of the colonic obstruction. In cases of anorectal obstructions, fetal impactions and foreign bodies should be considered besides malignancies. Short segment disease - Hirschprung Disease and endometriosis are the rare causes told in literature. However, malignancies should be considered as the first mentioned cause in patients applied with mechanic ileus, in patients which have an history of endometrial curettage recently, extrinsic compression related to endometritis, should be considered as a rare cause. Besides the fact that the most common cause of colonic obstruction is malignancy, mechanic ileus which requires surgery is a common seen complication related to surgeries done before. The incidence after colectomy is 11 %.
Mechanic obstructions are seen in small intestines four times common than seen in colon. Ileus of small intestine usually origins from preceding surgeries (65 %) and hernia (15 %). However, ileus of colon, generally related to malignancy (70 %), adhesions and stenosis (10 %) and rarely related to volvulus (5 %) and hernia (2.5 %). Usually it has been represented as swelling (80 %), cramps (60 %) and absence of gas decharge or defecation (50 %).

CASE: 45 years old female patient arrived to emergency service with the complaints of difficulty of defecation and gas decharge, high tempreture, and vomiting of fecaloid. In her history there has been an umblical hernia repair 5 years ago and a dilatation and curettage for endometrial biopsy one week ago. There was no chronical disease. In her physical examination there was distention and 8 cm scar of the incision for umblical hernia repair.There were sensitivity and defense in all abdominal spaces and the intestinal sounds were as metallic echo. In rectal touche, rectum was empty and there was no sign of palpable mass lesion. In standing direct abdominal graphy wide colonic gas shadows and the level of air-liquid levels were seen. There were no gas shadow in rectum.It has been decided to make surgical exploration. It has been seen that there has been omentum in the incarserious hernia pouch and there was no finding of strangulation. By the exploration, it has been detected that whole intestinal and colonic regions were dilated and full of intestinal ingredients. There has been no more further findings of mass lesion, brid or herniation. In the pelvic region, uterus has been seen bigger than the normal, eodematous and erythematous and in retrovertio position which causes a external pressure to the colon in the pelvic entrance and causing totally obstruction. 36 French tube has been applied by the rectal way the colonic ingredients have been discharged. The intestinal area has been discharged by the nasogastric tube aspiration by suction towards the gastric way. The patient has been externed on the 3 th day of surgery.

CONCLUSION: Functional obstruction and ileus caused by colonoscopy and colonic biopsy related edema and spasm have been also reported. That's why rare causes should also be examined by the anamnesis.

Keywords: Colon, ileus, endometritis, endometrial curettage

Figure: Standing direct abdominal X-ray



Obstruction and dilatation of colon

SS-02

Port-site metastasis after laparoscopic surgery for early-stage, low-risk endometrioid type endometrial adenocarcinoma: Case report

Halise Meltem Batur, Utku Akgör, Nejat Özgül, Mehmet Coşkun Salman

Department of Obstetrics and Gynecology, Division of Gyneclogic Oncology, Hacettepe University Faculty of Medicine, Ankara, Turkey

AIM: Endometrial adenocarcinoma (EC) is the most common gynecologic malignancy in developed countries and 75% of patients present with stage 1 disease (1). Standard treatment includes total hysterectomy with bilateral salpingo-oophorectomy, and lymphadenectomy when necessary (2). Laparoscopy is minimal invasive alternative to laparotomy especially in early stage disease with shorter recovery time, shorter hospitalization, and decreased risk of adhesions (3). However, port-site metastasis (PSM) as an early recurrent lesion developing in the abdominal wall is a novel complication of laparoscopy (4,5). Although overall incidence of PSM in gynecologic malignancies has been estimated to be 1-2% and most reported cases have advanced ovarian cancer with malignant ascites, it has been rarely reported in women with EC (6).
Here, we report two cases with stage Ia EC who presented with PSM 5 and 31 months after laparoscopic surgery who underwent surgery

followed by chemotherapy and radiotherapy.

CASE REPORT 1: A 51-year-old patient with a history laparoscopic staging for EC 31 months ago was referred to our clinic. Her final pathology revealed FIGO stage 1a, grade 1 endometrioid EC with a 1.3 cm tumor showing superficial myometrial invasion. Her recent computerized tomography showed a solid mass with a diameter of 2.9 cm adjacent to umblical port site. Another mass was also reported in the left obturator fossa. Biopsy from the umblical tumor was reported as adenocarcinoma. Surgical exploration was performed. Port site mass was infiltrating the fascia and rectus muscle and 3 cm mass in left obturator fossa were removed.

CASE REPORT 2: A 50-year-old patient with a history of laparosopic hysterectomy and bilateral salpingo-oophorectomy 5 months ago for grade 1 EC with a small tumor superficially invading myometrium was referred to our clinic. Her PET-CT revealed recurrent masses located in the Douglas pouch and between intestinal loops with the largest one measuring 2.5 cm and another mass located adjacent to left lower quadrant trocar site with a diameter of 1 cm. All masses including the one in the trocar site was surgically removed. Microscopic examination confirmed recurrent disease.

DISCUSSION: The etiology of PSM remains unknown, but may be multifactorial including exfoliation and spread of tumor cells by laparoscopic instruments, direct implantation at the trocar site during instrument changes and specimen passage, and chimney effect of pneumoperitoneum that causes the passage of tumor cells at port-sites. Also, laparoscopic port sites have cellular turnover which may provide fertile ground for tumor cells. Ascites and advanced stage disease are other risk factors (7). Although rare, women with early-stage and low-risk EC are also at-risk (5,6). Preventive measures such as reduction in tissue trauma and in the number of transferred instruments, abundant washing of scars, suturing of peritoneum of large trocar entry sites, use of protective bags, resection of port-site scars should be considered since the treatment of PSM after laparoscopic EC approach necessitates surgical excision followed by chemotherapy with or without raditherapy (5,8).

Keywords: Port-site metastasis, laparoscopic surgery, endometrial adenocarcinoma

SS-03

Paraurethral transobturator tape to treat stress urinary incontinence

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[2]Department of Obstetrics and Gynecology, Istinye University Hospital Gaziosmanpaşa Medical Park, Istanbul, Turkey

Introduction: Urinary incontinence in women is a health problem that negatively affects the quality of life in terms of psychological, social and sexual life. Urinary incontinence was found to be between 8% and 52% in women (1). In a study conducted in our country, this rate was found to be 48.3% (2). The most common type of urinary incontinence is stress urinary incontinence (SUI). The treatment of SUI includes lifestyle changes, exercises aimed at strengthening the pelvic floor muscles, as well as bladder training and medical treatment. However, the most commonly used treatment method is trans-obturator tape (TOT) surgery, which is a minimally invasive option (3). TOT surgery is a sling operation for making fibrosis below the midurethra by incision and placing a polypropylene mesh in this region. Differences have been observed in the application of this surgery over the years considering the morbidity and ease of application. These can be listed under 4 different headings; midline vaginal approach, suprapubic approach, transobturator and paraurethral approaches. (4). Although the paraurethral approach is not a new approach, it has been used for the first time since 1910 (5). DeLancey emphasized the importance of the midurethral vaginal hammock structure in the urethral closure mechanism (6). In the paraurethral approach, since the vaginal tissue under the midurethra is protected, both the vaginal hammock is protected and the risk of mesh erosion is reduced. Another benefit of the paraurethral approach is the safety feeling it gives for the direct upward application of the surgical instrument.

Case: A 45-year-old patient with G4P4L4 (NSD4) presented to our outpatient clinic with urinary incontinence when she coughed and laughed. On physical examination, standing and supine stress tests were positive. Ultrasonography measurements are bladder neck descent: 41 mm, Urethral rotation> 45 °, Pubourethral distance: 16 mm, no pathological findings were detected in uterus and ovaries. The patient was diagnosed as stress urinary incontinence and operation was scheduled.

Conclusion: Paraurethral TOT is a promising method that has similarities with the classical methods in terms of surgical technique while it carries potential of avoiding dissecting the mid-urethral area. Randomized controlled trials that compares paraurethral TOT with the standard methods are needed to assess its safety and efficacy.

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Keywords: Midurethra, paraurethral transobturator tape, stress urinary incontinence,

SS-04

Granular cell tumor of the vulva:A rare entity

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Granuler cell tumor of the vulva: A rare entity

AIM: To present a case managed in our institution.

Case presentation: A 61-year-old postmenopausal woman with a three months history of a palpabl mass in her vulva attended in gynaecology department. In her gynaecologic examination revealed a soft, mobile, unpigmented, nontender mass measuring 1*1.5 cm on the left labium majus near the clitoris extanding to the superficial dermis. She underwent wide local excision of the mass with local anesthesia. According to the pathological report it is associated with granuler cell tumor. In immunohistochemical analyses; S100, CD58 and vimentin positivity and SMA (smooth muscle actin) negativity were detected. Surgical margines were negative and 1 mm to surgical border. In her follow-up, no recurrence or abnormality was found.

CONCLUSION: Granuler cell tumors (GCT) are usually benign and only 1-3% shows malignant potential. They mostly occur in 4th -6th decades. Poor prognostic factors for GCT are advanced age, rapid growth of tumor, masses larger than 4cm at the initial diagnosis, local recurrens and depth of invasion. Malignant features are spindle like cells, large nucleolus, vesicular nucleus, increased mitous, and increased nucles/cytoplasm ratio. If there are three or more features positivity, it supports malignant GCT diagnosis. In our case any of the featers were positive.
To our knowledge, there are limited case reports about GCT in the literature. The diagnosis and treatment process for malignant GCT is not clear yet. After initial surgical treatment close follow-up with physical examination is very important. In case of local recurrensi re-excision is recommended. These tumors do not respond to radiation or chemotheraphy. Since GTC is very rare, the information about diagnosis and treatment is not clear.

Keywords: Granular cell tumor,vulvar tumor,vulvar mass

SS-05

Evaluation and management of patients with hematoma after gynecologic and obstetric surgery

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OBJECTIVE: Postoperative hematoma (PH) following abdominal surgery is relatively rare and mainly depends on the type of surgery. Although hematoma usually resolves by simple local treatment of symptoms, specific treatment including surgery or interventional radiology is sometimes necessary. The aim of this study is to evaluate the cases of PH after gynecologic and obstetric surgery.

MATERIAL-METHODS: This is a retrospective study of 30 patients with hematoma developed after gynecologic and obstetric surgery. We included the patients who hospitalized with the diagnosis of PH between June 2017 and April 2019 at Gazi Yasargil Training and Research Hospital of Health Sciences University. Hematomas occurring after endoscopic surgery and episiotomy were not included. The diagnosed cases were divided into three groups as WH (wound hematoma), RSH (rectus sheath hematoma) and intra-abdominal hematoma (intraperitoneal and retroperitoneal). RSH was divided into three subgroups as type I, II, III. All cases were assessed by patient demographics and clinical findings, hematoma of characteristics, treatment methods and results.

RESULTS: A total of 30 patients were included in the study with a mean age of 33.0±8.6 years. The mean CRP was 37.9±47.4 mg/dL at admission, and 14.6±25.8 mg/dL at discharge, respectively. The decrease was statistically significant ($p < 0.001$). The mean Hb was 10.6±2.1 g/dL at admission, and 10.7±1.5 g/dL at discharge. Fever was detected in 7 (23.3%) patients. The mean WBC was determined as 13.5±3.8, the mean INR as 1.2±0.3, aPTT as 33.9±8.4, and the platelet count as 289.7±117.1 (count*109/L) (Table 1). Only 12 patients (40%) were followed up by observation and symptom management. In 10 (33.3%) patients, antibiotics were included in the treatment due to infection. In addition, 4 patients (13.3%) had relaparotomy, 5 patients (16.7%) underwent percutaneous radiological drainage and 8 patients (26.7%) received blood transfusion. The mean time of resorption of the hematoma was 4.6±2.0 days (Table 2). The evaluation of the hematoma locations revealed that 14 patients (46.7%) had wound hematoma, 7 patients (23.3%) had RSH (Type I: 2 cases, type II: 3 cases, type III: 2 cases), 8 patients (26.7%) had pelvic hematoma and 2 patients (6.7%) had retroperitoneal hematoma. The mean hematoma size was 68.1±15.18 mm (Table 3).

CONCLUSIONS: Postoperative abdominal hemorrhage is a rare but potentially severe complication with hematoma. Early diagnosis is essential in order to avoid morbidity or unnecessary surgery. In cases of hematoma resistant to antibiotic treatment and non-resorbable hematoma, we can consider percutaneous catheter drainage as an alternative to surgical intervention.

Keywords: Gynecologic and obstetric surgery, percutaneous catheter drainage, postoperative hematoma.

Table 1. Patient Demographics and Clinical Characteristics

Patient Characteristic	Value*
Age	33.0±8.6
Gravida	3.2±1.8
Parity	2.5±1.2
Abortus	0.7±0.8
HT	5 (16.7)
DM	5 (16.7)
CRP mg/dl admission	37.9±47.4
CRP mg/dl discharge	14.6±25.8
Hb g/dl admission	10.6±2.1
Hb g/dl discharge	10.7±1.5
Fever	7(23.3)
WBC	13.5±3.8
INR	1.2±0.3
aPTT	33.9±8.4
Platelet count, *109/L	289.7±117.1

*Abbreviations: aPTT = Activated partial thromboplastin time; INR = International normalized ratio; CRP=C-reactive protein; Hb=Hemoglobin; WBC= White blood count HT=Hypertension DM=Diabetes mellitus *No. of patients (%) or mean ± SD.*

Table 2. Treatment and Outcomes

Treatment or Outcome	Value*
Observation and symptom management alone	12 (40)
Antibiotic treatment	10 (33.3)
Blood transfusion	8 (26.7)
Percutaneous radiological drainage treatment	5 (16.7)
Relaparotomy	4 (13.3)
Time to hematoma resorbed (day)	4.6±2.0

**No. of patients (%) or mean ± SD.*

Table 3. Hematoma of Characteristics

Location and size	Value*
WH	14(46.7)
RSH Type I Type II Type III	7(23.3) 2 (6.6) 3 (10) 2 (6.6)
Intraperitoneal hematoma (Pelvic)	8(26.7)
Retroperitoneal hematoma	2(6.7)
Hematoma size (mm)	68.1±15.18
After Caesarean	18(60.0)
After gynecologic surgery	12(40.0)

*Abbreviations: WH= Wound hematoma; RSH = Rectus sheath hematoma. *No. of patients (%) or mean ± SD.*

SS-06

Sacrouterine ligament plication for surgically treatment of voiding dysfunctions

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[1]Department of Obstetrics and Gynaecology, Istanbul Sisli Hamidiye Etfal Training and Research Hospital, Istanbul, Turkey.

[2]Clinics of Obstetrics and Gynaecology, Private Egemed Hospital, Aydın, Turkey.

Introduction: Main types of voiding dysfunctions are stress and urge incontinence,overactive bladder(OAB), frequency and nocturia. While stress urinary incontinence is a surgically cured entity, medical treatment step forward for urge incontinence.For now, anticholinergics are known to be the leading type of oral therapy for urgency,OAB nocturia.

However,more evidence are currently emerging that favour surgical treatment for urgency,OAB and nocturia. Supporting the cardinal and uterosacral ligament with mesh has shown to improve the voiding dysfunctions including urge, urge incontinence, nocturia, frequency,fecal incontinence and pelvic pain(1).Similarly,a trend in ameliorating of OAB symptoms regardless of the prolapse stage was reported by a abdominal prolapse surgery that mimic cardinal and partly sacrouterin ligaments(2).Reinforcement of main pelvic ligaments and particularly adding modified McCall culdoplasty that includes sacrouterine plication also have shown to improve urgency and nocturia(3).Herein, we present our experience with a commonly used technique for a novel purpose.We have hypothesized that sacrouterine ligament plication(SLP) may improve urgency,nocturia and OAB symptoms in patients without stress urinary incontinence.
Case1: 36 years-old,parity-3 woman underwent to laparoscopic sacrouterine ligament plication operation.She was suffering from significant nocturia and urgency.Laparoscopic SLP procedure was performed as follows(Video 1):Under general anaesthesia, after pneumoperitoneum has been created,a 10mm 0° laparoscope is introduced at the umbilical site.Under direct visualization three 5mm ancillary trocars are inserted, one suprapubically and two laterally to the epigastric arteries.The uterus is lifted into an anteverted position with an intrauterine manipulator(RUMI System®).The sacrouterine ligament laxity was identified and two helical sutures placed in the right and left sacrouterine ligaments respectively with the last one approximately 1cm beneath the cervix using a 0 non-absorbable Ethibond suture.The ends of the suture are tied down with an extra-corporeal knot-tying technique,thus shortening the ligament.The course of the pelvic ureters is identifed and if necessary,mobilized from the pelvic peritoneum to avoid ureteral kinking or obstruction. There was minimal(<10 ml) blood loss and the total operative time was 19min. There were no intra-operative or post-operative complications.

Case2: 44 years-old,parity-2 woman underwent to SLP operation for significantly reduced quality of life due to urgency,OAB symptoms and three episodes of nocturia per night. Transvaginal SLP procedure was performed as follows(Video 2):The patient was placed in dorsal

lithotomy position under spinal anesthesia. Cervix was hold and pulled by a tenaculum to determine the sacrouterine ligaments. Performing a 2cm vertical insicion from 3cm inferoposterior of the cervix and after a sharp and blunt dissection sacrouterine ligaments were reached. Finally SLP was performed by using 2-0 prolene or etibond suture on right and left side respectively. There was minimal(<10 ml) blood loss and the operative time was 12min. There were no intra-operative or post-operative complications.

Conclusion: Plicating sacrouterine ligaments either both with abdominal or transvaginal routes significantly improve urgency,OAB and nocturia.This technique regardless of the route has the advantage of being minimally invasive.In addition, this technique can be accounted among natural tissue procedures with avoiding use of mesh. More specifically,laparoscopic SLP can be easily integrated to any other laparoscopic procedure such as prolapse surgeries.A prospective study is now underway to prove efficacy in a longitudinal fashion.

Keywords: Urgency, sacrouterine ligament plication, voiding dysfunctions

SS-07

The role of systemic inflammatory response markers' change during neoadjuvant chemotherapy in predicting suboptimal surgery in ovarian cancer

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PURPOSE: The aim of this study investigate the possibility of neutrophil to lymphocyte ratio (NLR), platelet to lymphocyte ratio (PLR) and platelet counts predicting suboptimal surgery at interval debulking surgery (IDS) in stage IIIC-IVA serous ovarian cancer.

METHOD: Patients who underwent interval cytoreduction after neo-adjuvant chemotherapy (NAC) for stage IIIC-IVA serous ovarian cancer, at three centers between January 2008– March 2018, were analyzed retrospectively. Age, type of operation performed, histological type, grade, stage, complete blood counts and CA125 level of the patients were analyzed from patient files. All women with stage III or IV serous ovarian carcinoma with both a complete blood counts at diagnosis (T0) and after the completion of NAC but prior to IDS (T1) were included. If more than one complete blood count result was present, the result which between 7-14th days before NAC was used at statistical analysis as T0. The result which between 7-14th days after last NAC cure was used at statistical analysis as T1. There was an average of 3 weeks between IDS and last NAC cure.

FINDINGS: A total of 193 patients were found suitable for the study. Suboptimal surgery was performed in 43 (22.3%) patients and optimal surgery was performed in 150 (77.7%) patients. The NLR and PLR values both of T0 and T1 were significantly higher in the suboptimal surgery group. Rate of difference of NLR was calculating as: [(NLR T0 - NLR T1) / NLR T0]*100. Rate of difference of PLR calculating as: [(PLR T0 - PLR T1) / PLR T0]*100. Both of higher rate of difference of NLR and PLR was calculated in optimal surgery group. Rate of difference of NLR of 17% (cut-off) and above were found as 75.3% sensitivity and 88.4% specificity for suboptimal surgery (area under curve (AUC)=0.868; P< 0.001). Rate of difference of PLR of 16% (cut-off) and above were found as 52.1% sensitivity and 70.0% specificity for suboptimal surgery (AUC= 0.641; P= 0.005). Recovery of thrombocytosis (When platelet before NAC was >400000/mm3, defination of recovery of thrombocytosis was as ≤400000/mm3 after NAC) was found to have 85.0% sensitivity and 63.3% specificity to predicting suboptimal surgery (P<0.001). According to both multivariate and univariate regression analysis, it was found that high NLR difference (Odds ratio (OR)=0.1, 95% confidence interval (CI)=0.1-0.2 for univariate analysis; OR=0.1, 95% CI=0.1-0.2 for multivariate analysis) and recovery of thrombocytosis (OR=0.1, 95% CI=0.1-0.4 for univariate analysis; OR=0.2, 95% CI=0.1-0.6 for multivariate analysis) detected significantly suboptimal surgery.

CONCLUSION: In order to identify candidates for suboptimal surgery in advanced stage ovarian cancer patients who underwent IDS after NAC, the dynamic difference between NLR values can be examined. Patients with low difference NLR can be given more cycles of NAC or new treatment modalities may be considered rather than standard NAC treatment.

Keywords: neoadjuvant chemotherapy, ovarian cancer, suboptimal surgery, systemic inflammatory response markers'

SS-08

Treatment of labial fusion in a reproductive age patient-surgical seperation: a case report

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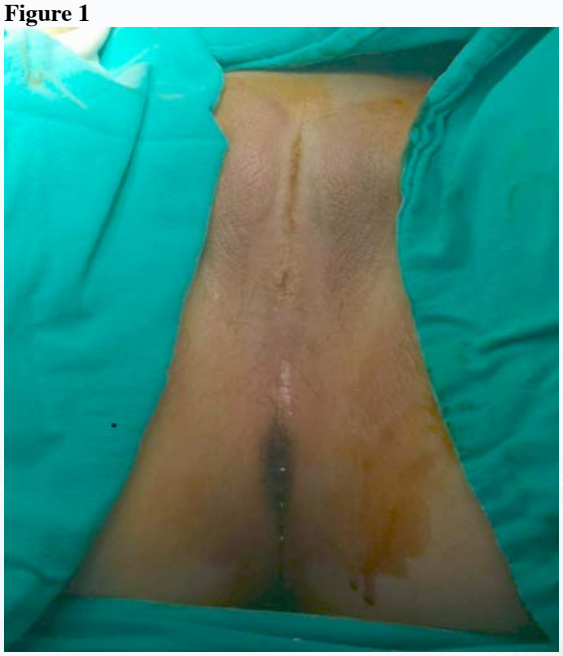
Introduction: Labial fusion is defined as full or partial adherence of the labia minora in the midline. It is a common problem of childhood. The most common age is 13-23 months. It is extremely rare in the reproductive population. Low estrogen of prepubertal period and inflammation of the labia minora play a role in the pathogenesis. In particular, poor perineal hygiene, trauma, vaginal infection or lichen sclerosis factors trigger the inflammation process of the labia minora. Labial adhesions may be asymptomatic or cause difficulty in urination, vaginal pain, recurrent urinary tract infections or recurrent vaginal infections.
The management of labial adhesions is determined by the presence and degree of symptoms; Treatment options include manual or surgical

seperation or topical estradiol,topical betamethasone medications.

Case Presentation: A 24-year-old virgin patient was admitted to our clinic with complaints of difficulty in urination and low menstrual bleeding. The patient has a normal internal genitalia. The external genital examination revealed that the orifice was completely closed from the clitoris to the perineum. (Figure 1)The patient was then scheduled for surgery. Labial adhesions were separated by sharp and blunt dissection. The urethra and vaginal orifice are fully visible. (Figure 2) The patient received postoperative estriol treatment.
Unlike most cases of labial adhesion, which usually resolved spontaneously by the effect of estrogen in the pubertal period, this case remained symptomatic until 24 years of age but was not intervened. The patient benefited from the operation and was supported by postoperative estrogen therapy.
Discussion: Labial fusion usually affects prepubertal girls and postmenopausal women, it may rarely occurs in reproductive years in the absence of predisposing factors such as vulvar infections, dermatitis, trauma and lichen sclerosis.
The management depends on the age of the patient and whether it is symptomatic or not. Symptomatic labial adhesions can be treated with topical drugs or surgery.
In this case report, we discussed the management of a virgin patient presenting with difficulty in urination and low menstrual bleeding consequently diagnosed with labial fusion. After surgical seperation, patient's menstrual cycles become regular and her urination problems are resolved. Since the patient is in reproductive age, her introitus is surgically opened for normal sexual functions. In conclusion, labial adhesion cases especially in reproductive age have successful outcomes after surgical treatment.

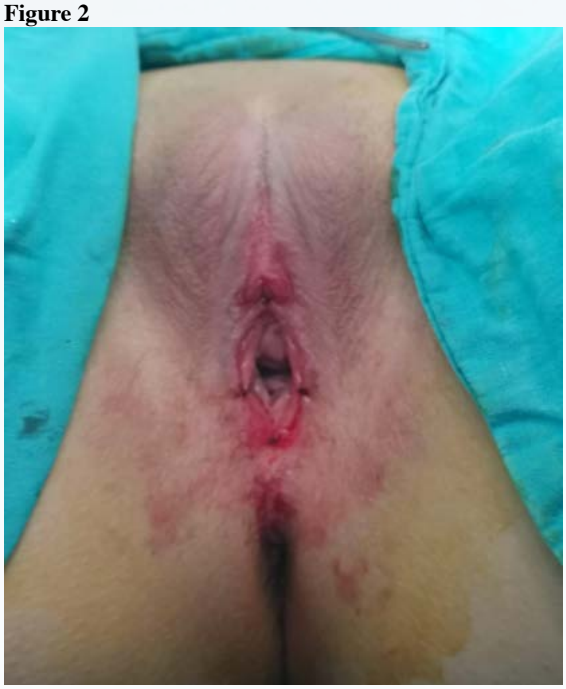
Keywords: labial adhesion, labial fusion, surgical seperation, reproductive age

Figure 1



the orifice was completely closed from the clitoris to the perineum.

Figure 2



Labial adhesions were separated by sharp and blunt dissection. The urethra and vaginal orifice are fully visible.

SS-09

Laparoscopic cornual resection in ectopic pregnancy

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OBJECTIVE: Cornual pregnancy is a rare form of ectopic pregnancy that accounts for 2% to 4% of ectopic pregnancies, with a mortality rate of 2.0% to 2.5%, accounting for 20% of all ectopic pregnancies. Until recent years, interstitial pregnancies were treated by laparotomy, cornual resection or hysterectomy until recent years. However, laparoscopic cornual resection has increasingly applied in interstitial pregnancies. In this technique, the main concern about surgery is hemorrhage. Laparoscopic cornual pregnancy operation, therefore, requires advanced skills and techniques. In this video, we want to describe the procedure for laparoscopic treatment of cornual ectopic pregnancy.

METHODS and RESULT: In this context; We present a 32-year-old woman with a G4p2y2 pelvic ultrasound with seven weeks and six days gestation of cornual ectopic pregnancy. The patient complained of inguinal pain and had a BhCG level of 5417. After consulting the treatment options, it was decided to perform laparoscopic cornual resection. The operation was uneventful,and the patient was discharged one day after the surgery. Serial serum HCG levels were followed for several weeks until complete consideration.

CONCLUSION: Laparoscopic cornual resection is a safe and effective procedure for the management of cornual ectopic pregnancy. The use of hemostatic agents and sutures can help to prevent bleeding and allows safe removal of ectopic pregnancy and repair of the uterine defect.

Keywords: cornual pregnancy, cornual resection, interstitial pregnancy, laparoscopy

SS-10

Retrospective Analysis Of Gestational Trophoblastic Diseases In Our Clinic

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OBJECTIVE: The purpose of this study is to present the retrospective clinical results of 79 patients, who applied to Ümraniye Training and Research Hospital, Obstetrics and Gynecology Clinic between 2007-2016, and whose gestational trophoblastic disease diagnosis has been performed and monitored.

METHOD: The following information have been recorded in the hospital archive files and electronic database: Demographic information, patient age, obstetric history, blood type, application complaints, clinician's clinical suspicion, gestational trophoblastic disease histological sub type, β-hCG levels during application and after one week and β-hCG reset time. Hemogram measurements and β-hCG values of patients during application and after treatment have been recorded.

RESULT: When compared to demographic data according to complete and partial molar patients, parity and hospitalization β-hCG values have been identified to be higher in complete molar group ($p<0.05$). Most frequent blood type was A Rh positive (31 patients, %39.2) and 0 Rh positive (25 patients, %31.6). As a result of the analysis, it is determined that the hospitalization β- hCG value was the best parameter that predicts the pathology result ($p=0.032$). Screening of persistence development factors reveal that β- hCG values of the persistent ones in the next 1 week were significantly higher than those with the non-persistent ($p=0.009$).

CONCLUSIONS: This study shows that gestational trophoblastic disease and gestational trophoblastic neoplasia have positive progress, requires multidiscipline approach and must be monitored at referred centers. It is very important for the treatment that the patients are informed about follow up monitoring. Since the β- hCG value that is measured at the time of hospitalization for the first time is a very important parameter, β-hCG levels must be monitored.

Keywords: β- hCG, follow up, gestational trophoblastic disease

Characteristics of women with molar pregnancy

	Complete Molar Pregnancy			Partial Molar Pregnancy			
	Median	Minimum	Maximum	Median	Minimum	Maximum	p
Age	27	15	55	28	18	42	0.787
Gravida	3	1	9	2	1	6	0.262
Parity	1	0	5	1	0	4	0.035
Abortus	0	0	3	0	0	4	0.490
Hospitalization β- hCG value	134109	1273	500000	10800	15	96048	<0.001
Gestational age	8.2	5.2	20.0	7.4	5.1	21.1	0.918

SS-11

Fetal Aorta Larger Than the Main Pulmonary Artery on the Three-Vessel View: Perinatal outcomes

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AIM: To evaluate the diagnostic accuracy of ascending aorta (AA)/main pulmonary artery (MPA) ratio for identifying fetal cardiac anomalies

METHODS: This cross-sectional study is designed with twenty-one pregnant women who had diagnosed as fetal cardiac anomaly in second-trimester screening with AA diameter larger than MPA diameter on the three-vessel view (3VV) at Adana Baskent University Department of Perinatalogy between 2015-2019. Cardiac anomalies were revealed with postnatal echocardiography.

RESULTS: The mean maternal age was 30 (range, 23-38), median gravidity was 2 and median parity was 1. Four of the cases were multiple pregnancies and 7 pregnancies were conceived by in vitro fertilization. The mean age of fetuses at diagnosis was 20.2 gestational weeks (range, 17-23.1).
The mean diameter of AA was 3.6 mm (range, 2.3-6.5 mm), the mean diameter of MPA was 3.1 mm (range, 2.1-5.9 mm) and the mean AA/MPA ratio was 1.2 (range, 1.1-1.4). Types of cardiac anomalies related with fetal aorta larger than main pulmonary artery in three-vessel view were demonstrated in Table 1. The highest rate of AA/MPA was 1.4 in a fetus with a large muscular ventricular septal

defect. Features of cardiac anomalies with fetal aorta larger than main pulmonary artery in three- vessel view were summarized in Table 2. Cesarean delivery was performed in 18 cases. The mean birth weight was 2638 g and the mean gestational age at delivery was 36.6 weeks. APGAR score at the first minute was smaller than 7 in 5 cases. Eleven neonates were followed up in Neonatal Intensive Care Unit.

CONCLUSIONS: Fetal AA diameter was larger than MPA diameter on the 3VV in some cases with fetal cardiac anomalies. The AA/MPA ratio should be useful for first fetal cardiac abnormally screening in some major heart anomalies. Although this ratio does not usually indicate severe congenital heart disease, careful prenatal and postnatal advanced echocardiographic examinations are mandatory to determine the presence of congenital heart disease.

Keywords: congenital heart disease, echocardiography, fetal heart, three-vessel view

Table 1

- 6 Muscular ventricular septal defect (VSD), - 3 Malalignment VSD, - 3 Perimembranous VSD (range, 1.6-2.8 mm)
- 2 Total anomalous pulmonary venous connection
- 2 Pulmonary valve stenosis
- 2 Double inlet left ventricle
- 1 Double outlet right ventricle
- 1 Tetralogy of Fallot
- 1 Tricuspid regurgitation

Table 1. Types of cardiac anomalies related with fetal aorta larger than main pulmonary artery in three- vessel view

Table 2

Major cardiac anomalies	7/21
Cyanotic cardiac anomalies	2/21
Operations -Tetralogy of Fallot, - Total anomalous pulmonary venous connection	2/21
Multiple anomalies	4/21
Chromosomal anomalies - Trisomy 21 - Translocation carrier	2/21
Neonatal exitus	2/21

Table 2. Features of cardiac anomalies with fetal aorta larger than main pulmonary artery in three- vessel view

SS-12

Hysteroscopy of a patient with hyperplastic endometrial polyp, endometrial intraepithelial neoplasia and atypical endometrial hyperplasia

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AIM: Hysteroscopy is the gold standard method for the diagnosis of endometrial premalignant diseases. Diagnosis of macroscopic pathologies such as polyps and fibroids can be easily detected by hysteroscopy. However, pathologies such as endometrial hyperplasia and endometrial intraepithelial hyperplasia (EIN) can be missed in hysteroscopy. Moreover, most clinicians have little experience on hysteroscopy of these premalignant lesions as pathology outcomes are learned later. In this educational video, we will present the hysteroscopy of a patient with hyperplastic endometrial polyp, EIN and atypical endometrial hyperplasia.

METHOD: A 32-year-old infertile woman was presented with abnormal uterine bleeding. Her Hb level was 7,8 g/dl. Ultrasonography revealed 30 mm endometrial thickness. She had a history of intrauterine insemination and in vitro fertilization. Hysteroscopy was performed.

RESULTS: Irregular, thickened and indented endometrium with polipoid structures were observed. Entire endometrium layer and polipoid structures were resected.

CONCLUSION: Identifying abnormal structures in hysteroscopy will lead to surgical effort to remove those abnormal structures. Consequently, this will improve the accuracy of pathological diagnosis.

Keywords: Hysteroscopy, endometrial intraepithelial neoplasia, endometrial hyperplasia, polyp, endometrial cancer.

SS-13

Low grade endometrioid stromal sarcoma of the ovary: two cases and review of the literature

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AIM: Endometrial stromal sarcomas which constitute 0.2% of gynecological malignancies may rarely rise from extrauterin sites, and they are called as endometrioid stromal sarcomas in this condition. Most common sites of origin are ovaries, peritoneum, bowels, stomach and lungs. In half of the cases that originate from ovaries, tumor is reported to be associated with endometriosis. Sex cord stromal tumors, smooth muscle tumor, leiomyosarcoma, granulosa cell tumor, and adenosarcoma must be considered in differential diagnosis, and immunohistochemical markers are helpful. While surgical resection is the main treatment, there is not a consensus for optimal therapy. Adjuvant radiotherapy, chemotherapy or hormonal therapy can all be used for treatment. Low grade endometrioid stromal sarcoma in particular is considered as a hormone dependent malignancy and high dose oral progestins, Gonadotropin Releasing Hormone analogs and aromatase inhibitors are used for treatment. Aim of this study is to describe two rare cases with endometrioid stromal sarcoma of the ovary.

METHOD: Two cases of ovarian endometrioid stromal sarcoma are presented in this report.

RESULTS: Case 1: A 43 year-old women was referred to our center due to ovarian cyst, her CA125 value was 211. Unilateral salphingo-oopherectomy, contrlateral cyst excision and peritoneal biopsy was performed and intraoperative frozen-section was reported as benign. However final pathology was low grade endometrial stromal sarcoma developing on endometriotic cyst, omental implant, and tumor on pelvic peritoneum. Vimentin, CD10, WT-1, ER, and PR were positive on immunohistochemical examination. Cytoreductive surgery was applied, and megestrol acetate was given, she is still being followed up. Case 2: A 71 year-old women was referred to our center for ovarian mass. She was operated and the pathology was low grade endometrial stromal sarcoma, with omental invasion. Vimentin, CD10, WT-1, ER, and calponin were positive on immunohistochemical examination. Letrozol was used for treatment and she is still being followed up.

CONCLUSION: Primary ovarian endometrioid stromal sarcoma is a rare tumor. While prognosis is poor in high grade type, low grade tumors progress slowly, and resemble uterin endometrial stromal sarcomas clinically and pathologically. Follow up and treatment of our cases are consistent with the literature. However, long term follow up is needed due to risk of late recurrences.

Keywords: endometrioid stromal sarcoma, endometriosis, ovary, uterus

SS-14

Lymphoma mimicking adnexal mass and presenting as lumbosacral radiculopathy: a case report

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AIM: To describe a different presentation of lymphoma is aimed in this study.

METHOD: A case of lymhoma mimicking adnexal mass and presenting as lumbosacral radiculopathy is reported.

RESULTS: A 62 year-old women was referred with a two-month history of right leg pain and progressive weakness at right foot. In her pelvic magnetic resonance imaging an adnexal mass suggestive of ovarian tumor or leiomyoma adjacent to right uterine corn and bilateral parailiac lympadenopathy were found. An operation of total abdominal hysterectomy, bilateral salpingo-oopherectomy and bilateral pelvic and paraaortic lymph node dissection was performed. The lesion described on imaging was found to be a leiomyoma. However, on the right side, a palpable lymph node on sciatic nerve was excised, and sciatic nerve was found to be healthy throughout its line until sciatic canal. Frozen section was reported as lymphoma. Final patology was diffuse large B cell lymphoma (CD20+), stage 3 with extranodal presentation (tumor was found on cervix uteri, endometrium, leiomyoma, right ovary, left tuba uterina and right pelvic lymph nodes). Chemotherapy (R-CHOP)(rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) and intratecal methotrexate (MTX) were given for treatment. As there was partial relief in right leg pain, analgesic and pregabalin were added to the therapy.

CONCLUSION: This case emphasizes that pelvic lesions can cause radiculopathy. Although a rare clinical presentation, lymphoma should be kept in mind in differential diagnosis. Previous reports in literature suggest significant improvement at neurological findings with appropriate treatment, however, sensory deficits continue at follow up.

Keywords: adnexal mass, lumbosacral radiculopathy, lymphoma

SS-15

Use of pelvic floor sonography in the early diagnosis and management of obstetric anal sphincter injuries

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Introduction: The overall incidence of obstetric anal sphincter injuries (OASI) are reported to be %2.9 and range between %0 and %8 (1). Only %60-80 of the women are known to be asymptomatic after the repair. Fecal urgency is seen at around %21-40 in the follow-up. Several risk factors are defined for OASI including nulliparity, use of forceps or ventouse, occiputo-posterior position, prolonged second stage, should dystocia, Asian ethnicity and giving birth for over 4 kg. Immediate use of postpartum pelvic floor sonography may be beneficial in terms of early recognizing such defects and therefore may affect the management. Occult tears were considered as those cases not detected clinically but detected by sonography. It was reported to account for %11.5 of all cases (2). Herein we present our experience on pelvic floor sonography below

Cases:
Video 1. Grade 3-C tear.
Figure 1. View on transvers plane. Rectum is intact.
Video 2. Grade 3-C tear.
Video 3. Sagittal view at postoperative 1st week. Repaired with overlap technique.
Video 4. Grade 3-B tear at 10-11'o clock.
Figure 2. A normal sagittal view.
Figure 3. Occult OASI at 11-12'o clock.
Figure 4. Multiple occult OASIs indicated by red arrows.
Figure 5. Oedema in early period indicated by red arrows.

Discussion: %7 of women who had a clinical diagnosis of OASI were known to be wrongly diagnosed as they only had a second-degree tear (3). Use of immediate postpartum pelvic floor sonography may aid clinicians in reducing over- or underdiagnosis. Occult OASI lesions can be accurately diagnosed. It can also help precise decision of repair technique either end-to-end or overlap. Sonography may overcome the inaccurate determination of rectal digital tonus when patient is on regional anaesthesia. Confirming the absence of minor tears can be protective in terms of medico-legal issues.

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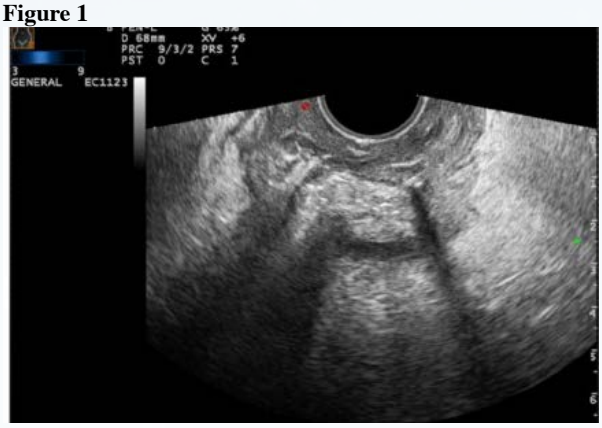
2) Ozyurt, S., Aksoy, H., Gedikbasi, A., Yildirim, G., Aksoy, U., Acmaz, G., & Ark, C. (2015). Screening occult anal sphincter injuries in primigravid women after vaginal delivery with transperineal use of vaginal probe: a prospective, randomized controlled trial. Archives of gynecology and obstetrics, 292(4), 853-859.

3) Sioutis, D., Thakar, R., & Sultan, A. H. (2017). Overdiagnosis and rising rate of obstetric anal sphincter injuries (OASIS): time for reappraisal. Ultrasound in Obstetrics & Gynecology, 50(5), 642-647.

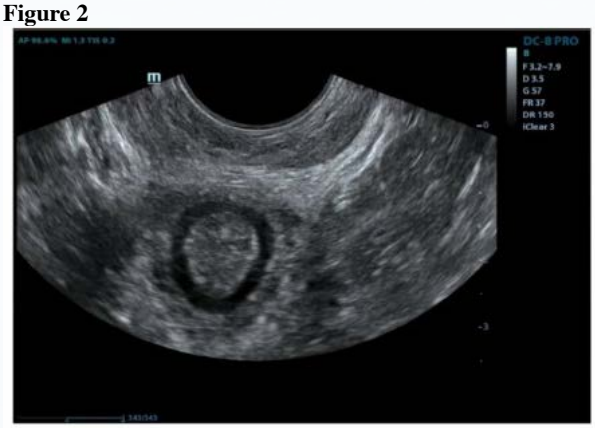
Keywords: Perineal tear, Obstetric anal sphincter injury, Transperineal ultrasound, Shoulder dystocia

Figure 1



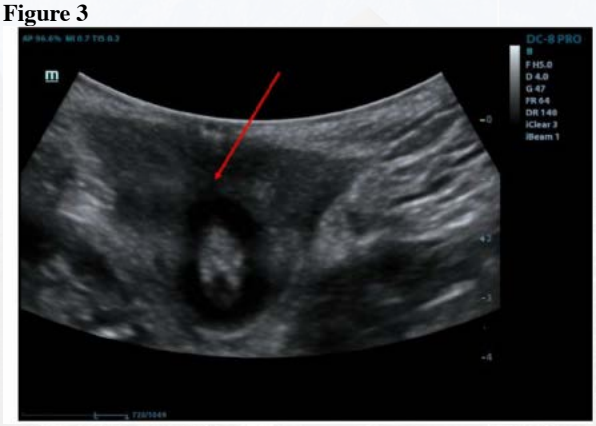
View on transvers plane. Rectum is intact.

Figure 2



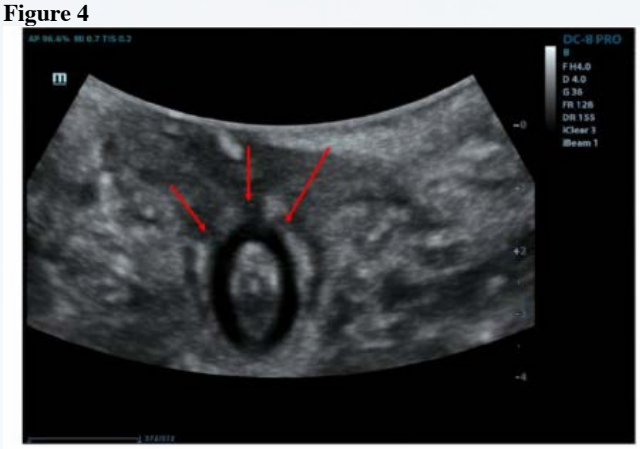
A normal sagittal view.

Figure 3



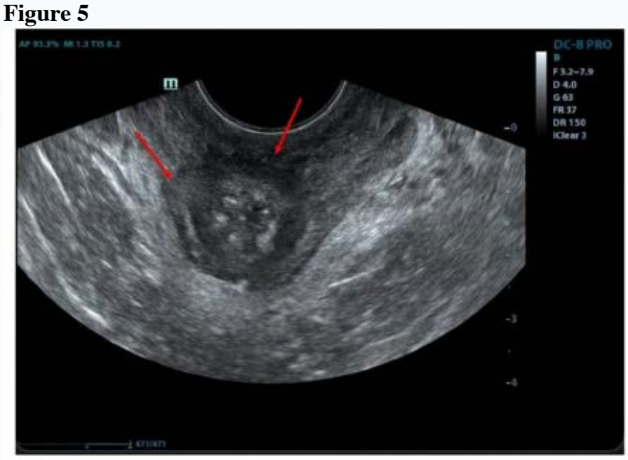
Occult OASI at 11-12'o clock

Figure 4



Multiple occult OASIs indicated by red arrows.

Figure 5



Oedema in early period indicated by red arrows

SS-16

Clinicopathological findings and treatment and short-term fertility outcomes in patients with myoma prolapsed into vagina

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OBJECTIVE: This study aims to evaluate clinicopathological findings and treatment and short-term fertility outcomes in patients with a myoma prolapsed into the vagina.

MATERIALS-METHOD: A total of 17 patients who were diagnosed with a myoma prolapsed into the vagina at Malatya Training and Research Hospital, Obstetrics and Gynecology outpatient clinic between June 2018 and July 2019 were retrospectively analyzed. Demographic and clinicopathological data of the patients were recorded. Statistical analysis was performed using the SPSS version 23 software.

RESULTS: The median age was 36 (range, 27 to 49) years. The main complaint was severe menstrual bleeding in nine, irregular menstruation in seven, and foul-smelling vaginal discharge in one patient. The median tumor size was 6.5 (range, 2.5 to 12) cm. The median parity was 2 (range, 1 to 8). Vaginal myomectomy was performed under spinal anesthesia in 11 (64.7%) patients and in the outpatient setting without using anesthesia in six (35.3%) patients. Histopathological results were compatible with a myoma in 16 patients and an endometrial stromal sarcoma (ESS) in one patient. The patient with ESS was 42 years old and underwent staging surgery through total abdominal hysterectomy, salpingo-oophorectomy, infracolic omentectomy, and pelvic and paraortic lymph node dissection. Seven patients had a childbearing desire. During follow-up, two patients became pregnant. At the time of admission, the median hemoglobin level was 9.3 (range, 5.6 to 11.2) g/dL. Two patients required blood transfusion due to symptomatic anemia.

CONCLUSION: Our study results suggest that vaginal myomectomy is a minimally invasive definitive, and fertility-sparing surgical approach with a low morbidity rate in patients with a myoma prolapsed into the vagina. It can be performed either in the outpatient setting or under local anesthesia. All patients with a mass prolapsed into the vagina must undergo histopathological examination to confirm the diagnosis.

Keywords: Vaginal myomectomy, Myoma prolapse, Fertility

SS-17

Monochorionic monoamniotic twins; experience of a tertiary center

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INTRODUCTION: Monoamniotic twins are rare and comprise about 1- 2% of monozygotic twins. The risk of unique and serious complications place these pregnancies at the highest risk of perinatal mortality of all twin gestations. Perinatal mortality rates are reported as 46%, before the 1990s. Adverse perinatal prognosis in monoamniotic twins is related to umbilical cord entanglement, congenital malformation, preterm birth, fetal growth restriction, and complications such as twin–twin transfusion syndrome(TTTS) and twin reversed arterial perfusion sequence(TRAP). In this retrospective case series study, we aimed to report perinatal outcomes of monoamniotic twin pregnancies that we have managed in our center during two years period.

METHODS: We have retrospectively evaluated monochorionic monoamniotic (MCMA) twin pregnancies that were managed in Sanliurfa Education and Research Hospital, Perinatology Unit between June 2017 and August 2019. The diagnosis monoamnionicity have been made with the absence of separating amniotic membranes between two fetuses in a monochorionic pregnancy. All cases have

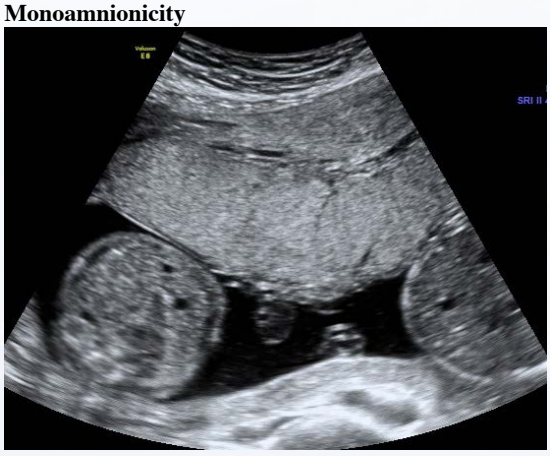
been examined weekly after the diagnosis of monoamnionicity. Patients have been informed about the complications and risks of a monoamniotic pregnancy and we have recommended cesarean delivery at 32th week of pregnancy. Antenatal corticosteroid therapy for fetal pulmonary maturation have been made with betametasone at the 28th week with full dose and 31st week of pregnancy with half dose. Cases that have been reached to 31st week with two fetuses have been hospitalized at 31st week and delivery have been made by cesarean section on the 32nd week. Gestational ages at delivery, perinatal outcomes and complications are reported.

RESULTS: In this 2 years period total 9 MCMA pregnancies have been diagnosed and managed in our clinic. Five cases have been diagnosed in the first trimester (8 - 13 weeks), three cases were diagnosed in the early second trimester (15-21 weeks) and one case have been diagnosed in the 35th week of pregnancy. Except the case diagnosed at 35th week, all cases have been planned to follow up to 32nd week of pregnancies. Death of co-twin have benn occured at two cases. One of them was at 21st week of pregnancy and the other was at the 29th week of pregnancy. The other six cases have been followed up to 32nd week and have undergone to cesarean section. The case that have been diagnosed at the 35th week have beeen delivered after the diagnosis. One of the cases with death of co-twin have been delivered electively at 32nd week and the other have been delivered electively at 34th week. We have not experienced any monochorionicity specific complication(selective IUGR, TTTS, TRAP) at MCMA pregnancies under follow-up. All newborns have been discharged from hospital after adequate follow at newborn intensive care unit. Neonatal neurologic morbidity have not been diagnosed at cases with death of co-twin.

CONCLUSION: MCMA pregnancies are rare but they are one of the most complex and controversial issues in perinatal medicine. How to manage and when to delivery are not clarified certainly yet. We reported our experience with our management protocol in our center

Keywords: monochorionicity, monoamniotic, twins, monozigosity

Monoamnionicity



Diagnosis of monoamnionicity

Umbilical cord entanglement

Umbilical cord entanglement is common at MCMA pregnancies

SS-18

Uterus preserving Laparoscopic Lateral Suspension: Modifications to the original approach

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Introduction: Laparoscopic lateral suspension with mesh(LLSM) is a promising novel technique that was originally introduced by Dubuisson et al(1). The technique has been improved since the first presentation(2). Currently, LLSM has the potential to function as an alternative to sacropexy.
The method consisted of laparascopic fixation of the lateral vaginal fornices to the lateral abdominal wall through subperitoneal tunnels parallel to the ovarian vessels using a T-shaped polypropylene mesh. This not only suspends the prolapsed pelvic organs but also reinforces the pubocervical fascia at the apex.
We have improved the surgical technique and contributed with modifications(3). Herein, we present the follow-up of three years of a young lady that has been suffering from uterine prolapse. This presentation contains a 4-minutes video of the technique.

Case: A 32-year-old woman with prior four vaginal birth has been referred for significantly reduced quality of life due to uterine prolapse. On her POP-Q examination; she had grade4 apical, grade3 anterior and grade1 posterior prolapse. Her stress test was negative. She was additionally complaining of nocturia with five episodes per night and urgency. Uterus-preserving LLMS was performed appropriately. Surgical technique was as follow: The vesicouterine fold was incised laparoscopically and the bladder was dissected to expose the vaginal wall. As described previously(3), a V-shaped 2-cm wide strip was prepared by cutting two edges off a 30×30cm polypropylene macropore mesh (Parietene™ , France) with scissors. We individualized the

corner of the V-mesh by adding a 2×2cm diamond-shaped extension to treat accompanying anterior wall defects. The bottom corner of the diamond-shaped extension of the V-mesh was fixed on the anterior part of the cervix with a delayed absorbable tacker device (Absorba Tack™ Covidien, USA). The anterior corner of the "V" was laid over the vaginal fascia under the bladder without fixation. The 2-cm skin incisions were made on either of the abdomen, about 3–4 cm superior and lateral to the anterior-superior iliac spine. The abdominal muscles were perforated with laparoscopic grasper and the subperitoneal space was entered without perforating visceral peritoneum. Subperitoneal tunnels were created by pushing the grasper caudally just above and parallel to the ovarian vessels. After passing the ovaries, the grasper was directed towards the midline and advanced through the leaflets of the broad ligament to reach the prepared vesicouterine space. The arms of the mesh were pulled throughout the tunnels symmetrically until the external cervical ostium was suspended just above the level of the ischial spines. The mesh was then fixed to the fascia of the external oblique muscles with 3.0 propylene(Prolene®, Belgium).
On the 33th week of follow-up, no recurrence was observed. She was completely symptom-free for urgency and very satisfied of having the operation. Postoperative POP-Q measurements on her last follow-up were as follows; C:-50mm, Ba:-25mm, Bp:-15mm. Her nocturia episodes were reduced from five to one episode.

Conclusion: Uterus-preserving LLMS(abdominocervicopexy) is safe and effective with high patient satisfaction rates and simultaneous correction of apical and anterior prolapse. Significant improvements in patients' quality of life, frequency of nocturia and urge symptoms were observed.

Keywords: Apical prolapse, Uterus preserving, Lateral suspension, Mesh

SS-19

Points to be considered during the total laparoscopic hysterectomy of a patient with uterus bicornis unicollis: a case report

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While the occurrance of mullerian duct anomalies are reported at varying rates(0.1-3.8%), uterus bicornis unicollis accounts for 10% among those(1). Fusion anomalies of the mullerian ducts during the embryologic period and/or the inefficient fusion of the septa can result in differing degrees of congenital malformations(2). In these patients, concurrent renal anomalies are reported at 20% (3). This case report presents the pre-, peri- and postoperative management of a patient with uterus bicornis unicollis who underwent to total laparoscopic hysterectomy due to menometrorrhagia.

Case: A 50 years-old parity-3 woman in her menopause was referred for genital prolapsus and postmenopausal bleeding.On clinical examination she was found to have stage-3 apical defect, stage-1 rectocele and stage-1 cystocele.A two-dimensional transvaginal ultrasonography revealed a double cavity of uterus. The endometrial thicknesses of those cavities were 9-mm and 7-mm, respectively.
Both ovaries were consistent with her age. Transperineal sonographic measurements were as follows: Bladder neck descent: 23-mm Pubourethral distance: 14-mm Rectocele descent: 10-mm, Apical descent: 34 mm, Cystocele descent: 10-mm.The radiological evaluation of urinary system was asked from radiologist due to the frequent co-occurrance of urogenital and mullerian duct anomalies. It was reported that both kidneys were normally located and both pelvicaliceal systems were unremarkable. A suspicion of uterus didelphys was reported on subsequent MRI imaging.No urinary system malformation was seen. Endometrial sampling from both cavities was reported normal with benign endometrial polyps.Laparoscopic hysterectomy with bilateral salpingo-oopherectomy and sacrouterine plication was scheduled. The diagnosis of uterus bicornus was confirmed laparoscopically
The bladder was found to be laid between the two cornu, elongated medially to the posterior and adhered to the sigmoid mesocolon. Both ovaries and tubes were normal.After dissecting the bladder and colon, hysterectomy was initiated. The ureter line trace was attempted to be visualized retroperitoneally. Upon failure of uretheral visualization, an urological evaluation was called.Initial cystoscopy revealed no pathology in the trigon and the bladder wall. Both ureter orifices and jet-stream were seen normally. Double J catheters were placed and clear urine flow was observed.However, catheters could not be observed laparoscopically. Therefore, both ureters were believed to be deeperly localized than the dissected tissues. The areas where the catheters could not be seen were considered to be safe.The operation was completed without complications.(figure 1)
In the patient's postoperational management;24-hour drain follow-up was normal. Urinary ultrasound re-confirmed a normal urinary anatomy.Intravenous pyelography was performed at the postoperative 2nd week and the results were found as follows: 1st min: Bilateral secretion and excretion started at the expected time.Opaque substance concentration was equal. 5th min: Renal parenchyme and pelvicaliceal system were natural, bilaterally.
15th min: Ureters were visualized towards to the bladder.Ureter diameters were found normal and the trace of the ureters were normal. 30 min: Bladder was in normal formation.45 min: No residue was observed on post-mictional graphy(Figure 2-3).Pathological examination confirmed uterus bicornis unicollis.

Conclusion: Asymptomatic mullerian duct anomalies can be detected postmenopausally. Urinary anomalies should be detected in the pre-, intra- and postoperative period in patients diagnosied with a mullerian duct anomaly that can cause significant complications.

Keywords: Uterus bicornis, mullerian malformation, mesocolon, hysterectomy, urogenital malformation

Figure 1

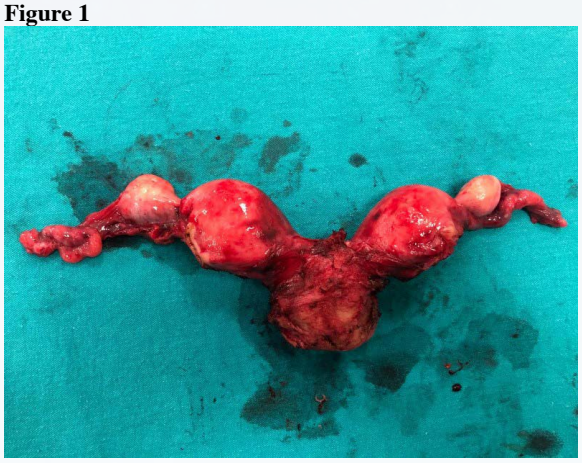


Figure 2

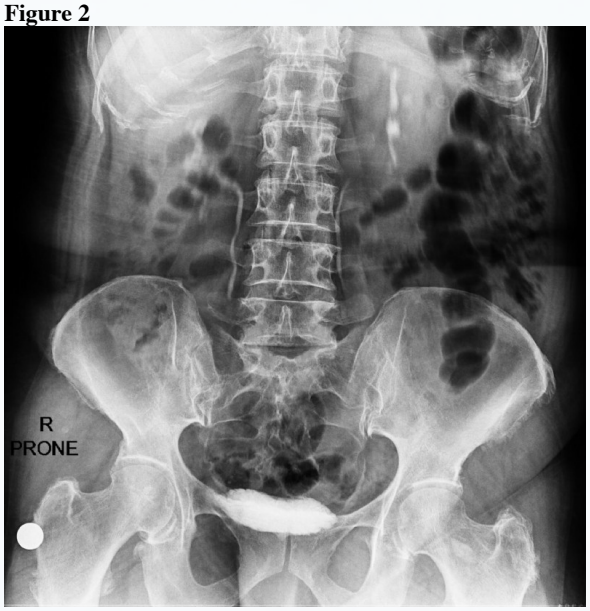
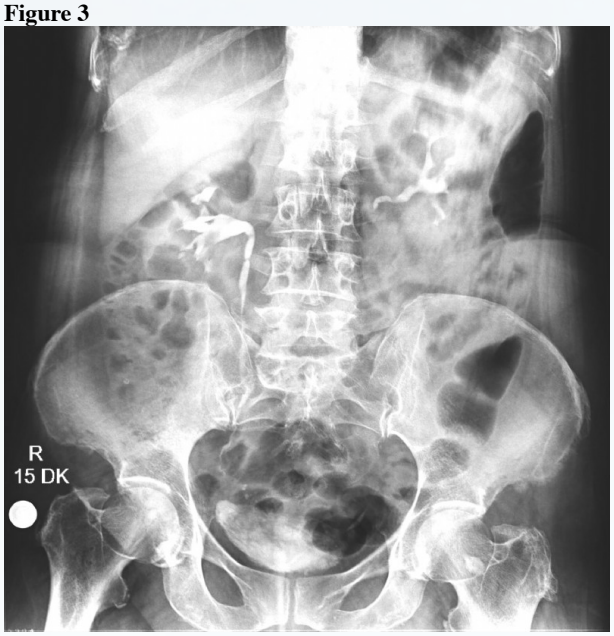


Figure 3



SS-20

Rısk factors for the development of recurrence at early stage pure serous type endometrial adenocarcinoma

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AIM: To determine the risk factors on recurrence among the patients diagnosed as early stage pure serous type endometrial adenocarcinoma (Stage I-II).

MATERIAL-METHODS: Nineteen patients who were operated in our clinic between 2006-2013 and diagnosed as early stage pure serous endometrial adenocarcinoma were retrospectively investigated (Stage I-II). In the postoperative period, all patients' follow up were performed at our clinic

RESULTS: Median follow up time was calculated as 47 months. Among the patients cohort median age is found 69. Recurrence rate is determined as 26%. Myometrial invasion rate more than 50% was found at 12 patients whereas seven patients had myometrial invasion less than 50%. Presence of lymphovascular invasion (LVI) in uterus was seen in 9 patients. Of the five patients (26%) among the cohort had tumoural invasion in cervical stroma. Even though no recurrence have been seen in the group of patients who had myometrial invasion less than 50% recurrence rate was found as 71% in the group of patients who had myometrial invasion more than 50% ($p<0.05$). Incidence of recurrence is found as 44% in patients who had lymphovascular invasion in uterus whereas at the counter group (no lymphovascular invasion) recurrence rate is 10%. Age above 70 is determined as another risk factor for development of recurrence (9% vs 50%).

CONCLUSION: Unlike to the other hystological type of endometrial cancer, pure serous type endometrial adenocarcinoma is accepted

as highly recurrent endometrial cancer. In our cohort frequency of recurrence is calculated as 26%. Myometrial invasion more than 50%, presence of LVI, age above 70 are determined as risk factors for the development of recurrence among the patients diagnosed as pure serous type endometrial adenocarcinoma.

Keywords: serous endometrial cancer, endometrial cancer, uterus

SS-21

Surgically management of enterocele with transvaginal bridge technique

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Introduction: Enterocele was oftenly characterized with posterior vaginal wall prolapse with peritoneum that is directly in relation with the vagina.The hernia sac is mainly filled with the intestines due to posterior fascial defect.The feeling of vaginal bulge, defacation dysfunctions are commonly associated with enterocele.Enterocele oftenly accompany to uterine or cuff prolapse. Major risk factors were found to be birth route and age.Other factors include increased intraabdominal and body-mass index, collagen tissue disorders(1).
Several surgical techniques from abdominal or transvaginal routes either with using natural tissue or mesh are currently available(2).The proper repair of pubocervical and rectovaginal fascia defect, removal of the hernial sac and support of apex are essential fragments in the surgical management of enterocele(3,4).
To be noted, fascial parts are significantly damaged in the majority of genital prolapses.That actually is the main motivator of the increasing use of mesh when compared to native tissue repair.On the other hand, transvaginally use of mesh for genital prolapses are strongly recommended to be avoided by FDA(5).
The novel technique presented in this case become prominent with its nature of being native tissue repair although it mimics mesh-kind layer.This technique has been firstly described by Caliskan et al.(6).
No other study assessing the outcomes of this method are found in the literature search.
Herein, we present one of our case-series that include 12 patients so far.

Case: 62-years-old, parity-3 with 39 kg/m2 BMI woman was referred with vaginal bulging, defecation problems, dyspareunia and vaginal relaxation. In her urogynaecological examination, grade-2 anterior prolapse, grade-1 apical prolapse, grade-3 posterior compartment prolapse with significant enterocele were observed.Transperineal sonography confirmed the enterocele with active intestinal segment motility towards vagina in the hernia sac (Video 1).The pelvic floor biometry were as follows: bladder descent:7mm, apical descent:9mm and rectal descent:11mm. Vaginal enterocele repair with vaginal bridge technique was performed without any complication.

Surgical tecnique: The patient received spinal anesthesia and was placed in the lithotomy position.The limits of the enterocele sac was identified in the posterior vagina wall. Allis clamps were positioned on the apexes of pubocervical and rectovaginal fascias to delimitate good exposition of the enterocele. An ellipsoid vertical incision about 1x3 cm was made. Sharp and blunt dissection has been performed extending to the vaginal side walls, perineal body and sacrouterine ligaments.The ellipsoid vaginal superficial epitelium was destroyed by using the electrocoagulation. Posterior of the cervix were sutured with 2-0 etibond to the deep levator muscles. Therefore douglas sac is obliterated by fixing deepithelised tissue on the enterocele sac. Rectovaginal fascia was supported with deepithelised tissue and united tension free. Remaining vaginal tissue was continously sutured. No complication was occured. Total operation time was 32 minutes.(Video 2)

Conclusion: Vaginal bridge technique to repair enterocele transvaginally enables surgically management of enterocele without using a prosthesis material. The novelty underlying this native tissue repair technique is to use de-epithelized excessive vaginal wall which is a stronger structure than defective rectovaginal fascia. A better pelvic floor support with avoiding shortening vagina can be obtained.

Keywords: Enterocele, Pelvic organ prolapse, native tissue repair, deepithelization

SS-22

The investigation of toxoplasma and rubella seroprevalancies in pregnant women in a private university hospital

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OBJECTIVE: Toxoplasmosis and rubella can cause high risks in pregnancy such as severe intrauterine infections, congenital malformations and abortion. The aim of this study was to determine the investigation of IgM and IgG type antibodies against toxoplasmosis and rubella infections among pregnant women who admitted to a private university hospital department of Gynecology and Obstetrics.

METHODS: Between January 2017 and December 2018, 2511 pregnant women were investigated for toxoplasma,2511 pregnant women for rubella.Toxoplasma IgM and IgG, rubella IgM and IgG antibodies were detected by ELISA system.

RESULTS: Seropositivites of IgM for toxoplasmosis (n=11),rubella (n=9) were found as 0.004 % and 0.003 %.Seropositivities of IgG for toxoplasmosis was 24.6% and for rubella was 98.7%.

CONCLUSION: In our study we found toxoplasmosis and rubella seroprevalance were similar to those found in other regions of Turkey. Although the population of our hospital and the demographic characters are different than the state hospitals and other regions of Turkey, highly educate,high welfare, we saw the public awareness are same and the vaccination policy is succesfull.In the light of our

findings and in accordance with previous research, we believe that the scanning program for toxoplasmosis and rubella is unnecessary for the general public.

Keywords: toxoplasmosis,rubella,torch

Table 1

	Negative n	Negative %	Positive n	Positive %	Total
Anti-Toxoplasma IgM	2500	99.5	11	0.004	2511
Anti-Toxoplasma IgG	1891	75.3	620	24.6	2511
Anti-Rubella IgM	2502	99.6	9	0.003	2511
Anti-Rubella IgG	32	1.2	2426	98.7	2458

Findings

SS-23

Postpartum posterior reversible encephalopathy syndrome that presented with visual loss in a normotensive woman without preeclampsia

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Introduction: Postpartum posterior reversible encephalopathy syndrome (PPRES) is a life-threatening condition that can lead to significant indirect unfavourable consequences. Herein, we discuss an atypical presentation of PPRES without a known precipitating cause.

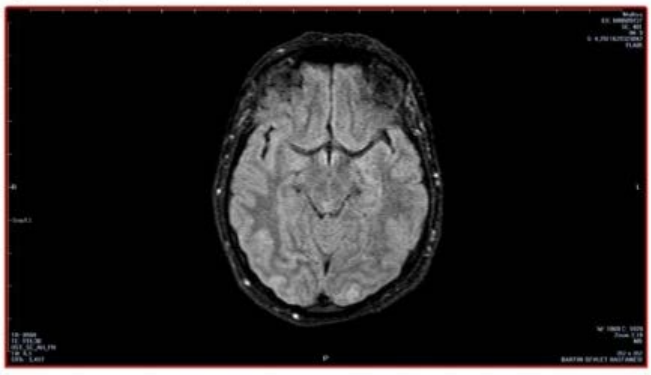
Case: A 30-year-old normal-weighted woman with a prior cesarean section was seen in the postnatal ward grand visit on the second day of her birth in a secondary hospital. She has received 48 hours of tocolysis with ritodrin and full dose of antenatal corticosteroid. Her obstetric and family history was unremarkable. The urinalysis, full blood count and biochemical analysis was within normal ranges. Her blood pressure during the pregnancy until birth were seen to be stable except one solely mild hypertension measurement with 140/85 mmHg during tocolysis with ritodrine. On postnatal ward visit, it was noticed that her eyes were partly closed in order to see more clearly. Later, she unveiled that the oedema has started right after the ritodrine regimen and her eyesight has reduced at immediate postpartum period. Our tragic experience that was characterized with photophobia, partial visual loss and resulted with maternal mortality has led us the suspicion of PPRES in this case (1). Continuous intravenous magnesium sulfate infusion and oral amlodipin have been started. Cranial and diffusion MRI confirmed the diagnosis of PPRES upon specific characteristics that include vasogenic oedema within the frontal, parietal and occipital regions in the cranial MRI and lesions that was reported as PRES located at right occipitalis and bilateral parietal lobes in the diffusion MRI. Intravenous 10%-mannitol as anti-oedema and enoxaparin sodium for thromboprophylaxis were added to the treatment protocol. In the same day she had a generalised tonic clonic seizure that has lasted for 2-3 minutes. Diazepam 10mg has been administered. An additional dose was given after a second seizure has occured. Phenytoin bolus and maintenance dose have been initiated due to prolonged post-ictal state with dilate pupils and positive Babinski sign. The seizure has been successfully controlled. Electroencephalography was found as normal at her third day of the combined treatment. Control MRI on the 4th and 10th days of the treatment were found to be normal; brain oedema has been disappeared. She was seizure-free without any neurological symptom during the six months of follow-up.

Discussion: The present patient was one of the rare examples of this type of case that had PRES in the postpartum period without having preeclampsia or chronic hypertension. She was normotensive throughout her pregnancy without any known risk factor for preeclampsia. She had no proteinuria and headache. She did not have any autoimmune disorders or symptoms for vasculitis. The prominent symptoms that raise suspicion was visual loss only.

Conclusion: This case highlights the difficult diagnosis of PPRES, and visual disturbances should be considered as an early-warning sign of PPRES. Clinicians should bear in mind that PPRES can occur in normotensive women even though preeclampsia and hypertensive conditions constitute major causes. We underline a possible association with use of ritodrine and PPRES

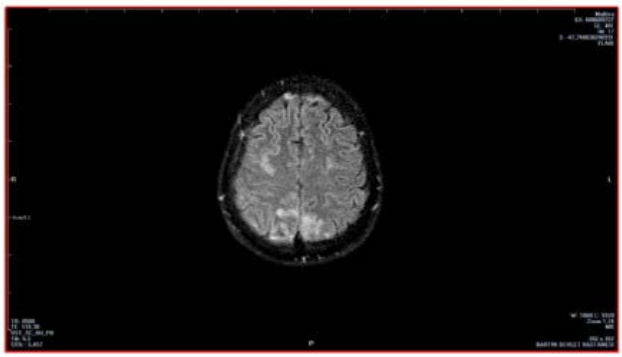
Keywords: Posterior reversible encefalopathy syndrome, Eclampsia, Hypertension, Preeclampsia, Postpartum

Figure 1



Vasogenic oedema in occipital areas.

Figure



Vasogenic oedema in frontoparietal cortical areas.

SS-24

A different approach to anterior colporrhaphy with using vaginal mucosa as a native prosthesis in cystocele repair: Deepithelialized vaginal flap

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Introduction: Anterior colporrhaphy(AC) is the most commonly used procedure to treat anterior compartment prolapse and is performed all over the world approximetely for 150 years. Athough it is a universal procedure, it is not clearly standardized and varies among the surgeons(1).

The use of mesh in the management of cystocele transvaginally is gradually decreasing. This trend became apparent particularly after the warning by FDA due to discouraging complications in the long-term follow-up(2). However, the debate in choosing the apropppriate technique continues because of higher recurrence in AC. The latest evidence reveals that recurrent vaginal bulging symptoms vary between 10% to 20% and the reoperation rate was found to be up to 10%(3). Those unfavourable failures are attributed to already-impaired fascial structure possibly due to collagen defects(4)

Therefore, we hypothesized that an additional layer that originated from otologous native tissue over the cite-specifically repaired fascia would be beneficial. Hence, we used deepithelialized vaginal mucosa as a prosthesis secondarily over the repaired fascia to strengthen vesicovaginal fascia and reduce the recurrence of anterior compartment prolapse.

Herein, we present the description of a novel technique to treat cystocele.

Surgical technique: A vertical incision was made below 2cm down from external os of urethra, through the cystocele defect on anterior vagina wall. The bladder is spared with sharp and blunt dissections. Vesico vaginal fascia is repaired with purse sutures. The lambda parts created from the mucosa of anterior vaginal wall and the one on the left side was de-epithelised with electro coterisation. The de-epithelised area is laid flat on the vesico vaginal fascia and the vaginal wall lambda on the right side sutured on the de-epithelised area. (Video 1).

Discussion: Deepithelialized vaginal flap technique is a novel method to treat anterior compartment prolapse which belongs to native-tissue-repair methods along with mimicking a prosthesis. It seems a promising modification to classical colporrhaphy anterior. We are keen to share our prospective results to assess the safety and effectiveness of this technique.

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Keywords: Anterior colporrhaphy, cystocele, anterior prolapse, de-epithelialization

SS-25

A case of a Galen's vein aneurysm with early antenatal diagnosis

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Galen's vein is a midline structure that provides blood flow from the inferior sagittal sinus to the sinus rectus. In fact, the term Galen's vein aneurysm is not a real aneurysm, but it involves a group of vascular anomalies characterized by the dilatation of Galen's vein. It occurs with one or more formations of the arteriovenous shunt with Galen's vein in the middle brain by the arteries originating from the carotid or the vertebrobasilar artery. It is a rare anomaly with a birth incidence of approximately 1/25000.

Although the postnatal diagnosis is made in most cases, diagnosis can be made in the 3rd trimester with the in utero recognition of possible complications such as heart failure. Before the signs of heart failure develop, Galen's aneurysm is recognized in very rare cases. The earliest diagnosis reported in the literature is in the 25th gestational week. Our patient is the first in the literature because of being diagnosed during detailed ultrasonography examination in the 20th gestational week.

CASE: An x-year-old GxPx patient in the 20th gestational week was admitted to our hospital for 2nd level ultrasonography. A 12x7 mm hypo echoic area at the x level in the midline cranium on the transverse plane attracted attention during the sonographic examination. In the color Doppler examination, the turbulent flow with significant aliasing within the hypo echoic area was observed. No signs of structural and functional cardiac failure were found in the fetal echocardiographic examination. No accompanying anomaly was found in ultrasonography. The family was informed about prognosis and offered a pregnancy termination option. The family preferred the continuation of pregnancy. Although no disproportionate change in the size of the lesion with the growth of fetus was observed in monthly follow-ups, the size of the lesion was 29x22 mm on the transverse plane in the 22nd gestational week. The signs of tricuspid regurgitation and right heart dominance began in the 25th gestational week. An increase in tricuspid regurgitation and additionally pericardial effusion were observed in the 27th gestational week. The patient continued her follow-up in a tertiary center due to the possibility of postpartum microsurgery. She gave birth through x due to the development of non-immune hydrops fetalis in week x. The newborn died without being operated on postpartum day x.

CONCLUSION: Galen's vein aneurysm is a malformation with a rare diagnosis, and its antenatal diagnosis is difficult unless the signs of heart failure develop. If a suspected lesion is observed in the midline during the 2nd trimester cranial examination, the examination of the lesion by color Doppler ultrasonography will provide the opportunity for early diagnosis without the development of the signs of heart failure, will allow for early termination if the termination option is preferred by providing appropriate consulting, and will make it possible to refer the patient to a suitable center for surgery in the antenatal period for postpartum intervention if the continuation of pregnancy is preferred.

Keywords: Galen's vein aneurysm, Early Prenatal Diagnosis, Heart Failure

Figure 1

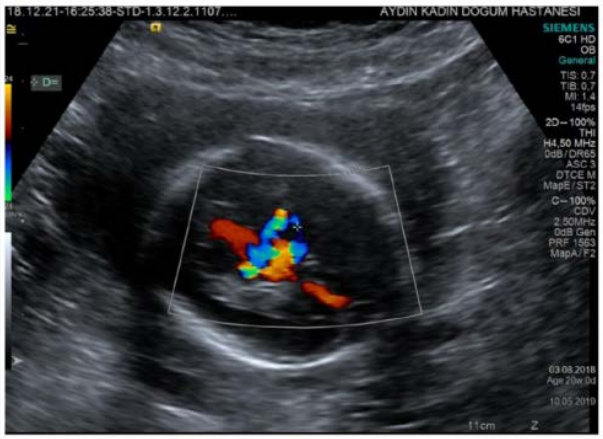
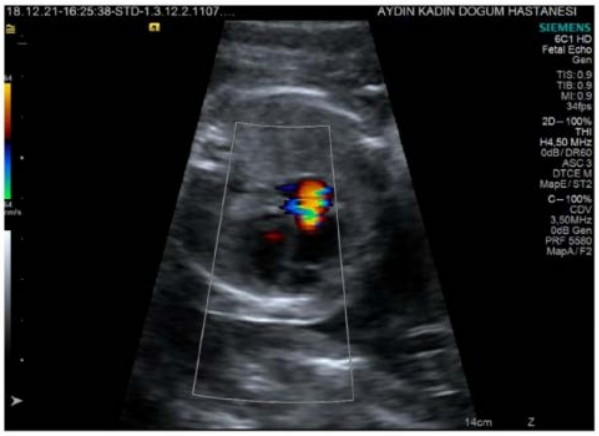


Figure 10



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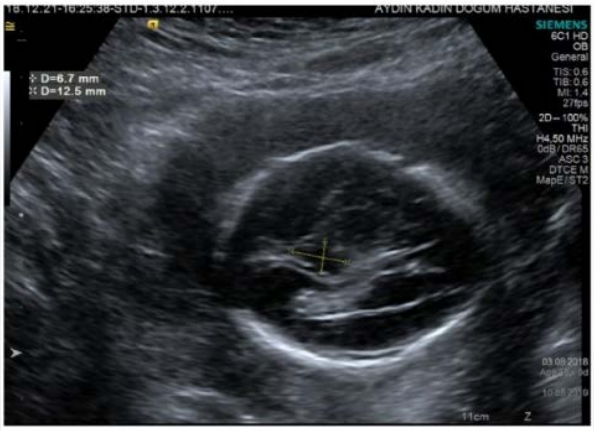

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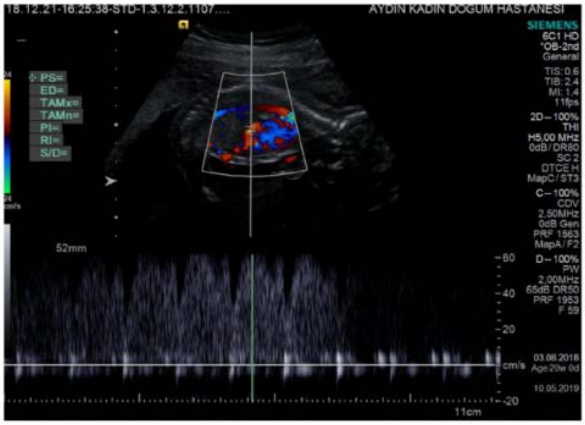
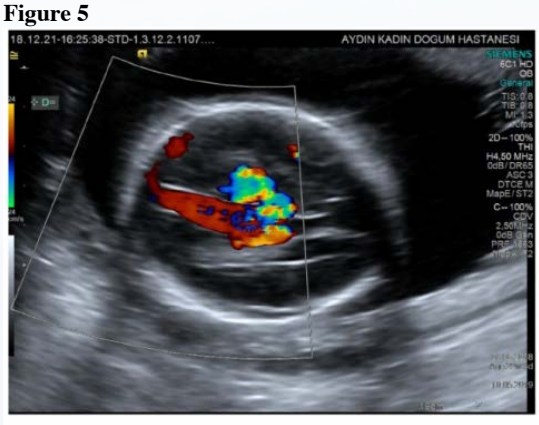


Figure 4

Figure 5



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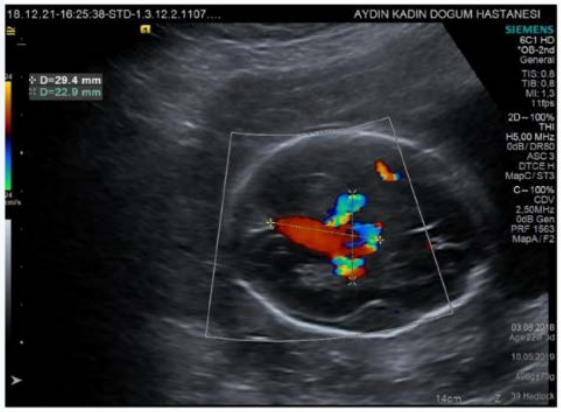

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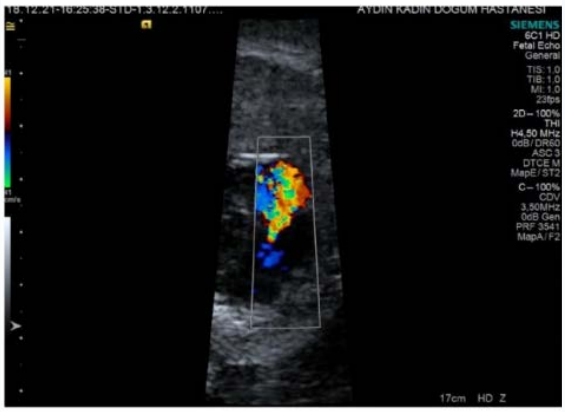
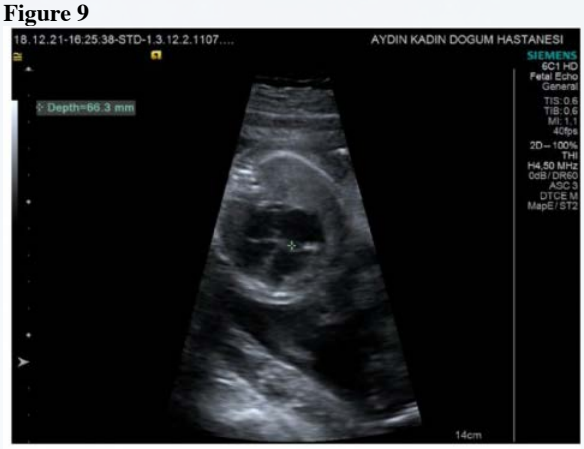


Figure 8

Figure 9



SS-26

Prognostic factors in uterine serous carcinoma

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INTRODUCTION: Uterine serous carcinoma is a rare but aggressive histologic type of endometrial cancers and responsible for nearly 40% of endometrial cancer deaths. There is no consensus on prognostic factors affecting survival due to its rarity. In this study, we aimed to investigate the prognostic factors associated with survivals of patients.

MATERIALS-METHODS: In this retrospective study, demographic, clinicopathological and survival data of the patients diagnosed with uterine serous carcinoma were collected. Survival curves were generated using the Kaplan-Meier plots, and the differences between survival curves were calculated using the log-rank test. In order to evaluate the prognostic factors for disease free survival (DFS) and overall survival (OS), a univariate Cox-regression model was used. Any p-value of less than 0.05 in the univariate analyses was subjected to multivariate analysis. A p-value <0.05 was considered to indicate statistical significance.

RESULTS: We identified 71 women with uterine serous carcinoma who were diagnosed by surgical staging and pathologic evaluation. The median age at diagnosis was 65 and the median duration of follow-up was 43 months. The 5-year DFS and OS rates of patients were 61% and 68.7%, respectively. Univariate analysis revealed that DFS was significantly decreased in the patients with stage III-IV disease (p=0.02), tumor diameter >3.5 cm (p=0.03), positive peritoneal cytology (p<0.001), presence of omental metastasis (p=0.01) and adnexal involvement (p=0.002). In the multivariate analysis, only positive peritoneal cytology (HR 6.89, 95% CI 2.48-19.12; p<0.001) remained as an independent prognostic factor for decreased DFS. Univariate analyses revealed that OS was significantly decreased in the patients with stage III-IV disease (0.01), tumor diameter >3.5 cm (0.03), positive peritoneal cytology (p<0.001), omental metastasis (p=0.007) and adnexal involvement (p<0.001). Positive peritoneal cytology (HR 4.32, 95% CI 1.39-13.41); p=0.01) remained as an independent prognostic factor for decreased OS in the multivariate analysis.

CONCLUSION: Although peritoneal cytology is no longer required for staging of endometrial cancers, we found that positive peritoneal cytology is an independent prognostic factor for both disease free and overall survivals of patients.

Keywords: uterine serous carcinoma, prognostic factor, disease free survival, overall survival

SS-27

A novel combination to treat rectocele in conjunction with urgency: Rectovaginal fascia repair and sacrouterine ligament plication

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INTRODUCTION: Rectocele is defined as the herniation of anterior rectal wall in to the posterior vagina.1Isolated rectocele constitutes a minor portion of pelvic organ prolapse cases with about 5.8%.2 Rectocele occurs when rectovaginal fascia weakens through three different mechanisms: (1) Rectovaginal fascia weakening may be due to site-specific defects, (2) may be caused by its detachment from perineal body,3morefrequently, (3) may be accompanying cardinal-sacrouterine ligament complex defects.3Posterior compartment prolapse can be presented with lower back pain, incomplete defecation, constipation, bowel incontinence, pelvic pressure sensation or vaginal loosening.4It is not suprising that these symptoms indicated in the literature are also commonly observed in apical prolapses. Rectovaginal fascia is almost always detached from the apex in those cases. Urgency and/or urge incontinence can be observed due to accompanying apical weakness. The surgical treatment of urge incontinence is possible according to the Integral Theory with enforcing the uterosacral ligaments and thus, restoration of trampoline membrane tension.5 Surgical treatment aims restoring the anatomy, treating the symptoms, obtaining proper bowel movement and sexual function. Standard surgical techniques include posterior colporrhaphy, site-specific defect repair, and repair using graft. The most commonly used surgical method is colporrhaphy posterior. Unfortunately, resection of vaginal tissue is oftenly accompanied in this technique and attention to direct repair of rectovaginal fascia is oft-neglected. Therefore, recurrence and dyspareunia are frequently encountered.6After the current warnings from FDA, the trend of use of transvaginal graft/mesh techniques declined gradually. Thus, a different surgical technique with a satisfying restore of the anatomy without the use of prosthesis is required. In this technique, rectovaginal fascia which is detached from the damaged servical ring is sutured to posterior cervix. Thus, integrity of cervical ring and rectovaginal fascia is accomplished without any tissue excision. Urgency/urge incontinence problem is majorly solved by reinforcing the ligaments through sacrouterine ligament plication. We aim to report our experience of this novel technique.

CASE REPORT: A 49-year-old patient parity-4 wasreferred with complaints of urinary incontinence when coughing and laughing,

loose vagina and vaginal gas extraction. Stress-test was negative, grade-3 rectocele and urge/urgency were diagnosed.
Inpelvic-floor-sonography, bladder neck descent and urethral rotation were found as 21mm and 20 degrees respectively.

SURGICAL TECHNIQUE: Posterior vagina was transversely dissected from the loose drugae, rectovaginal fascia was fixated to posterior cervix at two different points with 2.0 Ethibond polyester suture, and thus the cervical integrity was provided. Bilateral sacrouterine ligaments were plicated, vaginal mucosa was closed with2.0-Vicryl suture (Video-1).

CONCLUSION: Repairing the rectovaginal fascia using this technique to treat posterior compartment prolapse is efficent with regard to not excising vaginal tissue and restoration of anatomy properly. With the addition of sacrouterine plication procedure, voiding disfunctions can be surgically treated in patients with urgency/urge incontinence and nocturia symptoms.

Keywords: posterior colporrhaphy, rectocele, rectovaginal fascia, sacrouterine ligament plication, voiding disfunctions

SS-28

Parasitic fibroids: four case reports

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AIM: Parasitic fibroids are nourished outside the uterus and are rarely seen among female tumors. Separation of subserosal fibroids from the uterus feeding by other tissues, peritoneal metaplasia, hormonal factors and laparoscopic morselation are among the causes of etiology. The aim of this study was to present four cases of parasitic fibroids followed in our clinic.

METHOD: Four cases of parasitic fibroids are presented in this report.

RESULTS: Case 1 A 45-year-old patient underwent laparoscopic surgery in 2013 for a 12 cm uterine fibroid. Morselator used. The patient presented with menstrual irregularity in 2019 and it was determined that she had fibroids. Pelvic imaging revealed, 28 × 26 mm on the left ovarian edge, 96 ×95 ×76 mm from the uterus superior to the outside of the pelvic region, 10-18 mm in the uterine corpus, 73 ×59 ×63 mm exophytic other fibroids extending from the posterior of the uterus to the presacral region. Total abdominal hysterectomy and bilateral salphingo-oforectomy and appendectomy was performed in 2019.

Case 2 In 2012, a 40-year-old patient underwent first surgery for a 5-6 cm degenerated fibroid in the uterus fundus. Morselator used. In the controls in 2016 and 2017, magnetic resonance imaging showed multiple fibroids, the largest being 86 × 80 mm. The patient underwent diagnostic laparoscopy in 2017 and multiple biopsies were taken and sent for frozen examination. Malignancy could not be ruled out and final pathology was expected. The patient was operated for the third time in 2017 when the pathology result was leiomyoma. Total abdominal hysterectomy and bilateral salphingo-oforectomy, appendectomy and myomectomy was performed. The patient was operated for the fourth time in 2017 because of the right inguinal canal onset, umbilicus level and in the right rectus muscle lesions. The tumor markers were normal during this period and a GnRH analogue (Lucrin Depot 11.25 mg) was performed in every three months. The patient is still under follow-up because of a complicated cyst in the left ovary.

Case 3 A 44-year-old patient was operated in 2017 for fibroids with right adnexial subserosal, left lateral wall of the bladder and posterior uterus. The old caesarean section incision was opened up to 2 cm and fibroids were removed. No morselatör used. Abdominal tomography taken in 2019 showed 10 × 12 × 14 cm left subdiaphragmatic, 10 × 7 × 11 cm fibroids in the right lower quadrant. Ca 125 level of the patient was 81. Secondary surgery was not performed.

Case 4 A 26 year-old patient was operated in 2014 for 7.5×6.5 cm fibroid. Morselator used. In the control performed in 2016, 8 cm fibroids from the omentum were removed by laparoscopy using a safe bag.

CONCLUSION: Parasitic fibroids are rare tumors of gynecology. The incidence has increased with increasing laparoscopy and morselator use. During the removal of uterine fibroids, it should be ensured that there is no intraabdominal spread and safe compartment technique should be applied.

Keywords: laparoscopic myomectomy, morcellation, parasitic fibroids, parasitic myoma

SS-29

Evaluation of 217 Cases Undergoing Amniocentesis

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OBJECTIVE: The aim of this study is to evaluate the success rate, complications, effect on pregnancy and the results obtained after karyotyping in amniocentesis (AS) cases.

MATERIAL-METHODS: 217 patients who underwent AS in our clinic between September 2011 and July 2013 were included in the study. Detailed ultrasound (USG) examination was performed before AS. Age, gravida, parity, abortion, number of living children, gestational week, screening tests and anomalies detected in USG were recorded. The indications for AS were positive screening test, advanced maternal age, maternal anxiety, a history of baby with chromosomal anomaly and findings suggesting fetal anomaly on USG. 1 ml amniotic fluid was taken with 20 ml sterile syringe for each gestational week. 20 ml fluid was taken for those whose gestational week was over 20 weeks.

Pregnant women with Rh incompatibility were given 300 micrograms of anti-D immunoglobulin immediately after the procedure to avoid the risk of immunization.

RESULTS: The mean age of the pregnant women was 32.37 ± 6.20 (18-47), gravida 2.59 ± 1.91 (0-11), parity 1.14 ± 1.41 (0-8), abortion 0.51 ± 0.91 (0-5), the number of children 1.09 ± 1.03(0-8), gestational week 17.58 ± 1.86 (13-20). The mean of amniotic fluid obtained from the pregnant women was 17.9 ± 1.86 (13-20) ml. 3 cases were diamniotic twins, each was treated separately. All other cases underwent single needle entry.
The indications of AS, positive triple test was the first with 24.9%, followed by cases with more than one indication with 22% and positive USG findings with 21.7%. Karyotype was abnormal in 18 (8%) patients. Six of these were life-compatible abnormalities. From 12 cases with abnormal karyotype, 4 cases were Trisomy 21 (Down syndrome), 2 cases Trisomy 18 (Edward syndrome), 2 cases Turner syndrome, 1 case Trisomy 13 (Patau syndrome), 1 case Trisomy 10, 1 case Triploidy and 1 case Partial Thyrisomy 10 (Pallister-Killian syndrome). No chromosomal anomaly was detected in 22 patients who underwent AS because of isolated advanced maternal age. Trisomy 10 was detected in 1 (11%) of 9 patients with positive family history. Chromosomal abnormality was detected in 8 (17%) of 47 patients who underwent AS because of fetal anomaly detection on USG.
None of the cases had abortion in the first three weeks after the procedure. 6(2.76%) of the patients had preterm labor. Mort fetus was detected in 3 (1.30%) cases. Two of them had multiple anomalies and the other had trisomy 18 on karyotype analysis.
There was no maternal complication after the procedure.

CONCLUSION: Chromosomal anomalies were mostly detected in the patient who had fetal anomaly on USG and underwent AS with multiple indications. This shows that it is more beneficial to perform anomaly screening for prenatal diagnosis by experts. However, we think that advanced maternal age does not increase the chance of catching chromosomal anomaly.

Keywords: Prenatal diagnosis, amniocentesis, karyotype, chromosomal anomaly

SS-30

A Ruptured Cesarean Scar Pregnancy While Beta Hcg Level Was Decreasing: Case Report

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Ectopic pregnancy in a previous cesarean scar is called as ceserean scar pregnancy. It occurs in about 1 in 2000 pregnancies. In symptomatic patients, the clinical presentation ranges from vaginal bleeding with / without pain to uterine rupture and hypovolemic shock. The diagnosis is made by ultrasonography. Magnetic resonance imaging and hysteroscopy have been used to further evaluate pregnancy location

We aimed to present a case of ceserean scar pregnancy that was firstly treated by dilatation and curettage and systemic methotrexate but laparoscopic surgery was performed because of rupture during follow up.
A 40-year-old patient (G2P1) presented with 20 days of menstrual delay. At the time of admission her beta HCG level was 416 mIU / ml. Beta HCG follow up in 48 hours period was: 1111 mIU / ml, 3300 mIU / ml, 6029 mIU / ml and 9781mIU / ml. In the pelvic USG there was a 14x10 mm cystic appearance mimicking a gestational sac in the lower segment of the cavity. When the beta HCG level was 9781mIU / ml, the patient admitted with the complaint of vaginal bleeding and there was no fetal pole at this beta HCG level. So a dilatation and curettage was performed with the diagnosis of abortus incepiens. 25 days after this intervention, the patient presented with bleeding. The patient had a beta-HCG of 12560 mIU / ml and a 20x20 mm cystic structure like a gestational sac in lower segment of the uterine cavity. The thickness of the myometrium between the gestational sac and the bladder was 3 mm. The patient was hospitalized with the diagnosis of cesarean scar pregnancy and she was treated with systemic methotrexate (Mtx). On the fourth day of treatment, beta HCG value was 6154 mIU / ml and on the seventh day, beta HCG value was 3526 mIU / ml and the patient was discharged.T he gestational sac was still present in the scar of caesarean section while the beta HCG levels continued to decline. Weekly follow up continued and one week after discharge from hospital, beta HCG level was 1075 mIU / ml. On the day when beta HCG was 1075 mIU / ml she had a laparoscopic excision in the hospital where she admitted with the complaint of severe abdominal pain and bleeding because of uterine rupture.

Cesarean scar pregnancy is a rare form of ectopic pregnancy. If a patient with a history of previous cesarean section appears to have a gestational sac in the lower uterine segment, cesarean scar pregnancy should be considered. Medical treatment is also a suitable option in hemodynamically stable patients. However, the most important disadvantage of medical treatment is the fact that pregnancy resorption takes months despite the decrease in beta HCG. So the risk of rupture and hemorrhage persists for a very long time. Therefore, follow-up of the patient and not delaying the intervention is as life saving as early diagnosis and treatment of cesarean scar pregnancies.

Keywords: Cesarean scar, dilatation and curettage, methotrexate, pregnancy, ectopic

SS-31

Laparoscopy should be the preferable route in the morbidly obese endometrial cancer

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OBJECTIVE: The risk of endometrial cancer is known to be increased with the increasing body mass index (BMI). Patients with BMI more than 40 kg/m2 are identified as morbid obese according to the World Health Organization. Morbidly obese patients are an enormous problem regarding all of their health procedures including

examination, evaluation with imaging methods, surgery, increased per-operative and postoperative morbidity and complications. The laparoscopic approach had been validated for the endometrial cancer surgery in many studies. The present study aimed to investigate the adequacy and oncological safety of laparoscopy compared to laparotomy in the surgery of the morbid obese women with endometrial cancer.

METHODS: Archival records and pathological reports of the endometrial cancer cases who were operated and followed up in Çukurova University Gynecologic Oncology Center between January 2008 and December 2018 were retrospectively reviewed. Patients with BMI ≥40 were divided into laparoscopy and laparotomy groups. Groups were compared concerning cases' clinic, surgical and pathological features. In addition, survival analysis of the groups were performed using Kaplan-Meier and compared with the Log-rank method.

RESULTS: A total of 146 morbidly obese endometrial cancer cases with sufficient data were determined during the study period. Laparoscopic surgery was performed in 65 (44.5%) and laparotomy in 81 (55.5%) of them. Mean age was 58 years for both groups. Mean BMI of the laparoscopy and laparotomy groups was 46.1 kg/m2 and 44.3 kg/m2, respectively. No difference between groups according to the main clinical, surgical and pathological characteristics. Five-year overall survival rates were 86.6% and 83.9% in the laparoscopy and laparotomy groups (p=0.571), respectively. No difference between groups concerning to the disease free survival was noted (p=0.184).

CONCLUSION: Laparoscopic surgery do not harm the long-term oncologic outcomes of the morbidly obese endometrial cancer patients, while its short-term advantages in this special population are undeniable.

Keywords: Laparoscopic surgery, morbid obesity, endometrial cancer, oncologic outcomes.

SS-32

A case of gastrointestinal stromal tumor with preoperative diagnosis of suspicious adnexal mass, rarely seen tumor histology

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INTRODUCTION: Most common group in mesenchymal neoplasms through the gastrointestinal tract is gastrointestinal stromal tumors. Generally GISTs are located subepithelial region in stomach and upper small intestines. GISTs are mainly identified with KIT and PDGFRA mutations and specific overexpression and immunstaining for CD117. The incidance is reported 0.68 per 100.000 in SEER data. (10) GISTs occur mainly in middle age and older individuals. %5 of cases have familiar GIST who have different syndromes and mutations. Clinical and pathological behavior of GISTs are variable. Tumor size, mitotic rate and tumor location are main prognostic determinants. AFIP (Armed Forces Institute of Pathology) prognostic model can predict the risk of agressive behavior

CASE: 74 years old patient was referred with abdominal distension and pain. In transvaginally ultrasound examination, uterus and endometrial thickness is normal, right adnexea was seen atrophic. Probably in left adnexea; cystic mass with 12*12 cm size, regular shape and border, heterogenic content was seen. Suspicious mass was mobile with palpation. In colour doppler examination torsion of mass was excluded. Tumor markers CA125:27, CA15.3: 12, CA19.9: 18. In MRI; in left side of abdomen,10*12 cm mass with regular border was seen which has intensive content. Patient was prepared for laparatomy. In operation, mass was seen related with ileum and its mesentery. Mass was removed with surgically clear border. Final pathology was reported as GIST with spindle cell type, grade-1 histology, expansile growth pattern, surgical borders negative for tumor and abdominal washing fluid is negative. In this case diffuse CD117 staining was important diagnostic marker for GIST.

CONCLUSION: GISTs are rarely seen neoplasms in clinical practice. Incidance is reported 6.8/100.000 in SEER data. This rare tumors which have malign potential can be misdiagnosed as an adnexal mass in different image studies.

Keywords: AFID prognostic model, gastrointestinal stromal tumor, mesenchymal tumor

SS-33

Uterine didelphys with bilateral cervical cancer involvement in a woman and review of the literature

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OBJECTIVE: Gynaecologic carcinomas that coexist with uterine malformations are rare. So diagnosis and treatment have great importance in the management of these cases. We aimed to report a case of cervical adenocarcinoma occurred with uterine didelphys and a review of the literature.

CASE PRESENTATION: A 41-year-old woman; gravidity 6, parity 2, who complained about postcoital bleeding, has been referred to our center with the finding of cervical heterogeneous mass in the gynaecologic examination and ultrasound on January 16, 2019. There was no remarkable history in her family history.
She had no previous abdominal surgery. No renal or any other abnormalities were present. Endocervical adenocarcinoma was confirmed from the cervix biopsy. According to her gynaecologic examination under anaesthesia in our department, a normal vulva, vagina had been found. A 4 cm exophytic mass was detected all around the uterin cervix and no suspected parametrial invasion.
Positron emission tomography-computed tomography (PET-CT)

of the head to the pelvis, and magnetic resonance imaging (MRI) were performed. These showed an antero-posterior diameter of 35 mm tumoral lesion with any lymph node enlargement. Duo to this findings, it is accepted stage IB2 according to the International Federation of Gynecology and Obstetrics (FIGO) classification 2018.
Patient was informed about surgical treatment or chemoradiation and about the possible risks and benefits of either approach. She had choosed the surgery option. So she underwent laparotomy and uterin didelphys with normal adnexa on both sides were discovered in the exploration. Nerve-sparing radical hysterectomy and bilateral pelvic and paraaortic lymph node dissection was performed to lower bladder dysfunction and to protect the autonomic pelvic nervous system. There was no complication related to surgery. Final pathology was reported as endocervical adenocarcinoma of cervix with a total diameter of 35 mm tumor that circumscribes both two cervices (22 mm in the right cervix, 15 mm in the left side occurred elong the endocervical canal). Parametrial involvement was negative and there were no lymph node meatastasis in total of 44 lymph nodes. She was informed about the pathology results and three months intervals follow-up was recommended for first two years without adjuvant treatment. Short-term (8 months) follow-up visits were normal without any treatment related complications or signs of recurrence.

CONCLUSION: As a result of a search of historical and recent literature, we reported a literature review about cervical cancer and uterine didelphys co-occurrence (Table-1). As it mentioned, to the best of our knowledge, in total there were only nineteen cases of cervical cancer in uterus didelphys reported until now. We aimed to mention clinical and technical controversia at the phase of diagnosis and treatment in an unusual anatomy of uterus. It is hard to determine the uterine anomaly in a fully involved cervix with a tumor. Gynaecologists should be aware of Mullerian malformations by which to determine early diagnosis and optimal treatment way of a genital tract cancer.

Keywords: cervical cancer, uterus didelphys, nerve - sparing radical hysterectomy

Figure 1

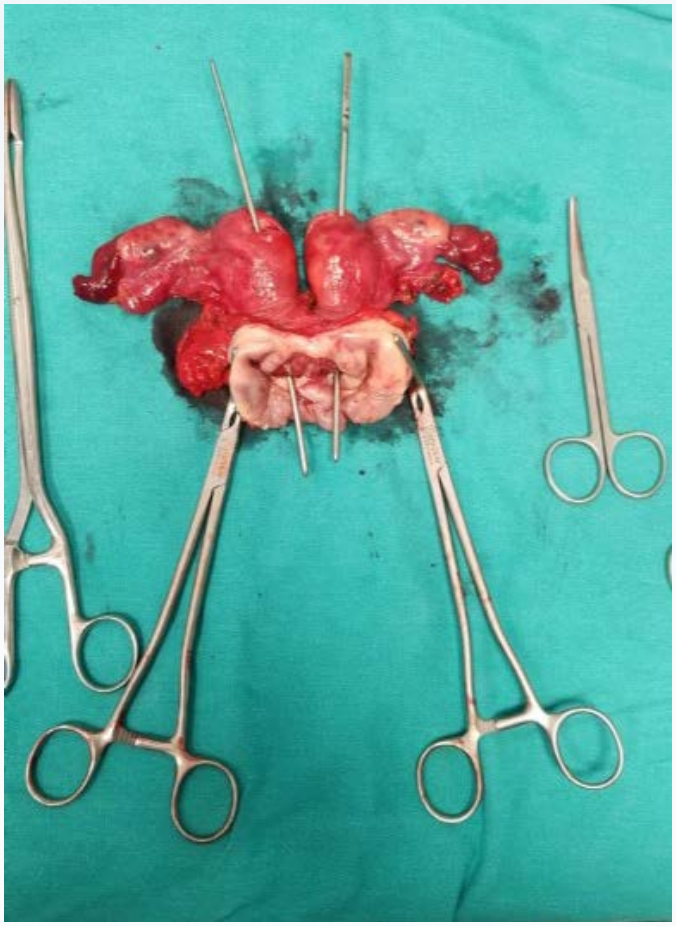

Table 1

No	Age	Site&Stage	Histology	Treatment	DFS (month)	Author
1	34	IIB	SCC	EBRT+BT	12	Gauwerky, 1955
2	34	IIA	CCA	RH+PLA	288	Nordqvist, 1976
3	27	IB	SCC	RH+BT+EBRT	192	Nordqvist, 1976
4	56	Right cervix,IB1	SCC	RT+Hysterectomy+PLA	24	Corbett, 1982
5	30	Two cervices, IA	SCC	Hysterectomy	NA	Fox, 1986
6	69	Two cervices, IB1	SCC	RH+RT	NA	Tam, 1988
7	44	Two cervices, IIB	AC	RH+PLA+RT	NA	Sugimori, 1990
8	44	Left cervix, IB	ASC	RH+BSO+PPLA+CCRT	26	GomezIrizarry, 1996
9	45	Two cervices, IIA	SCC	CCRT	36	Lee, 2000
10	49	Right cervix, IB1	EAC	RH+PPLA	15	Kaba, 2015
11	37	Left cervix, IIIA	AC	Paraaortic LA+CCRT	30	Cordoba, 2017
12	65	Right cervix, IB2	CCA	RH	NA	Kusunoki, 2018
13	61	Two cervices, IIB	SCC	CCRT	80	Kaneyasu, 2019
14	36	IIB	AC	RT+TAH+ BSO+CT	84	Zong, 2019
15	31	Two cervices, IIA	CCA	TLH+BSO+ PPLA+CCRT	18	Zong, 2019
16	38	Cervix,IIA	AC	RH+BSO+ PPLA+RT	24	Zong, 2019
17	26	Two cervices, IVA	CCA	LSO+CCRT	12	Zong, 2019
18	61	Cervix, IA1	SCC	LH+BSO	18	Zong, 2019
19	43	Cervix, IB1	SCC	LH+BSO+ PLN+CCRT	120	Zong, 2019
20	41	Two cervices, IB2	AC	Nerve sparing RH+BSO+ PPLND	8	Present case

Case reports of patients with uterine didelphys and cervical cancer concomitancy

SS-34

Rare cause of maternal death: the rupture of iliac artery aneurysm

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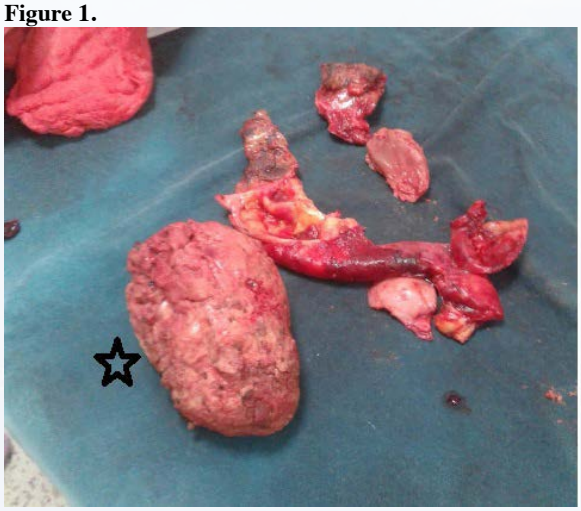
OBJECTIVE: Maternal deaths are defined as deaths that occur during pregnancy or within 42 days of the end of pregnancy. According to the literature, the most common cause of maternal death was cardiac pathology after which pulmonary emboly and infection followed with decreasing frequencies. The aim of this case report is to present a rare cause of maternal death.

CASE: A 37-year-old woman suddenly faints at home while she was pregnant at 27th gestational week (G6P4Y4A1). The patient is immediately brought to the emergency room by ambulance. When the patient is brought to the emergency room, intubated and cardiopulmonary resuscitation is performed. When fetus was evaluated by ultrasonography, fetal heart rate was 30 / min. An urgent cesarean section and laparotomy was performed. The maternal abdomen was full with blood and 1420 g male baby was delivered with zero Apgar. During exploration, we revealed the rupture of left external iliac artery aneurysm (Figure 1). Despite surgical repair of vascular surgeons and all medical treatments, the mother could not be saved. According to the retrospective anamnesis, we have learned that the patient had persistent left leg pain for the last 3 years and applied to orthopedics, neurosurgery and neurology outpatient clinics repeatedly.

CONCLUSION: Since considerable amount of maternal deaths have preventable causes; determining all aspects of risk factors which may cause death and increasing follow quality before and after labour will be efficient in order to decrease the number of maternal deaths.

Keywords: Maternal death, iliac artery aneurysm, rupture.

Figure 1.



The rupture of left external iliac artery aneurysm. (⁎thrombus)

SS-36

Assosiation between male-female infertility and obesity

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AIM: Studies have shown that there is a relationship between obesity and infertility in females, but this is not clear in males. In this study, we investigated the relationship between spermiogram parameters and obesity in men.
METHODS: A 286 male patients with infertility complaint was included the study. Selected participants were grouped according to their body mass index (BMI): normal BMI (18.5-24.9 kg/m2) and elevated BMI (≥25 kg/m2). The effect of weight on semen quality was assessed based on sperm count, percentage motility, and morphology. Patients' spouses data were also screened from patient file and with face-to-face interviews. If there was a detected cause that led to female infertility, it was recorded. Female participants were divided into 2 groups according to BMI as mentioned above. Statistical analysis was performed with the SPSS-15 package program.
RESULTS: In 183 of the male patients wife, the female factor that could cause infertility was determined. Therefore, 64% of the patients had male and female factors together. The causes of infertility in women were menstrual disorders 61.7% (113), ovulation dysfunction 49.7% (91) and, utero-tubal causes 19.1% (35). The number of female participants with normal BMI was 41.3% (118/286) while those with elevated BMI were 58.7% (168/286). A statistically significant difference was found between Group A and Group B in terms of infertility status in women ($p = 0.0253$). 153 (53.5%) men have normal and 133 (46.5%) has elevated BMI. Of 133 elevated BMI group, 72 (25.2%) were overweight and 61 (21.3%) were obese. Comparison of semen parameters of the study population with BMI, showed that there was no statistically significant difference in the semen parameters (sperm count, motility and morphology) of the study population with normal and elevated BMI ($p>0.05$ - Table 1).
CONCLUSION: Elevated BMI did not significantly influence semen quality. Male partners of infertile couples with elevated BMI seeking treatment can be reassured that their BMI may not adversely affect their semen quality as well as their quest for conception but overall obesity is discouraged for healthy living.

Keywords: Body mass index, infertility, obesity

Table 1

Semen parameters	Body mass index	Body mass index	Body mass index	Relative risk	Confidence interval	p-value
	Normal	Overweight	Obesity			
Sperm count						
Normozoospermia	92 (60,1)	38 (52,8)	28 (45,9)	1.841	0.889-3.645	0.152
Oligozoospermia	52 (34)	29 (40,3)	31 (50,8)	0.628	0.260-1.073	0.271
Azoospermia	9 (5,9)	5 (6,9)	2 (3,3)	1.264	0.235-6.245	0.609
Motility						
Normal	35 (22,8)	12 (16,7)	10 (16,4)	1.455	0.618-3.912	0.357
Asthenozoospermia	108 (70,6)	55 (76,4)	47 (77)	0.575	0.282-1.521	0.285
Azoospermia	10 (6,5)	5 (6,9)	4 (6,6)	1.271	0.235-6.245	0.789
Morphology						
Normal	126 (82,4)	62 (86,1)	53 (86,9)	0.904	0.297-2.190	0.464
Teratozoospermia	17 (11,1)	4 (5,6)	5 (8,2)	1.312	0.373-4.024	0.829
Azoospermia	10 (6,5)	6 (8,3)	3 (4,9)	1.264	0.235-6.245	0.647
Body mass index	Normal: 18.5-24.9 kg/m2	Overweight: 25-29.99 kg/m2	Obesity: ≥30 kg/m2			

Comparison of semen parameters of the study population with BMI

SS-37

Women's knowledge and beliefs towards vaccination for influenza during pregnancy in Turkey and underlying factors of misinformation: A single-center cross-sectional study

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OBJECTIVE: The aim of the present study was to evaluate the knowledge and perceptions of the pregnant women presenting to our hospital for seasonal vaccination for influenza and to determine the factors associated with it.

MATERIAL-METHOD: In this cross-sectional study, the first 268 pregnant woman presenting to our hospital between October 2018 and March 2019 were evaluated. A non-validated, well-detailed questionnaire addressing the vaccination rates, participants' perceptions about the facts behind the vaccination for influenza and the factors associated with refusal of vaccination was performed. Women's knowledge level provided by their healthcare providers was also questioned.

RESULTS: The average age of the patients was 28.85±5.42 (18-43); and the average pregnancy week was 19±9.75. It was determined that 98% (n:245) of the participants did not have any vaccinations in pregnancy before, and 98.8% (n:247) did not have any vaccination during their current pregnancy. A total of 65.2% (n:163) of the participants did not know that the vaccination for influenza was safe in pregnancy; and 64% (n:160) did not know that the vaccination for influenza was recommended and was necessary in pregnancy. The most frequent responses given by the participants to justify their refusal for the vaccination was "my doctor was against" and "it can be harmful to my baby" (25.6% and 24%, respectively). It was determined that a total of 98.4% (n:246) of the participants were not recommended about the vaccination for influenza by any healthcare centers; and 92.8% (n:232) did not receive any information on vaccination for influenza.
CONCLUSION: The knowledge of the participants on vaccination for influenza was inadequate and had misconceptions. The inadequacy of healthcare employees, government institutions and the media may have played roles in this outcome. The reasons underlying the inadequacy of the healthcare providers on vaccination for influenza may be questioned.

Keywords: Seasonal Influenza, Vaccination, Influenza, Pregnancy, Maternal immunization

Table 1: The Demographical Data of the Pregnant Women

		Mean ± SD	Std. Error	Median (IQR)	Min-Max
Age		28.85±5.42	0.34	28.5 (8)	18-43
Gravida		2.16±1.28	0.08	2 (2)	1-7
Parity		0.89±0.91	0.06	1 (1)	0-4
Gestational week		19±9.75	0.62	18 (18)	4-39
			% (n)		
Education	None		1.6 (4)		
	Primary		16.4 (41)		
	Middle		16 (40)		
	High		26 (65)		
	University		34.4 (86)		
	Master's degree		5.6 (14)		
Profession	Housewife		59.2 (148)		
	Unemployed		3.6 (9)		
	Worker		5.6 (14)		
	Teacher		10 (25)		
	Other		10.8 (54)		
Income	Subsistence wage		29.2 (73)		
	Middle		42.4 (106)		
	High		28.4 (71)		

Table 2: History of Having Vaccination for influenza in the Current and Prior Pregnancie

		n (%)
Have you been vaccinated during your previous pregnancy	Yes	5 (2)
	No	245 (98)
Did you get vaccinated during your current pregnancy	Yes	3 (1.2)
	No	247 (98.8)
Did your primary healthcare provider (doctor or nurse) recommend getting vaccinated for influenza during your pregnancy?	Yes	4 (1.6)
	No	246 (98.4)

Table 3: Opinions on Vaccination for influenza*

Would you like to get vaccinated for influenza and why?			
	n (%)		n (%)
I have no idea	23 (9.2)		
No; I do not have risk for it	45 (18)	Yes, I belong to the risk group	13 (5.2)
No, it can be harmful for my health	37 (14.8)	Yes, it is not harmful to my health	7 (2.8)
No, it can be harmful to the health of my baby	60 (24)	Yes, it is not harmful to the health of my baby	10 (4)
No, it does not have any benefit	42 (16.8)	Yes, it is advantageous	10 (4)
No, my doctor was against	64 (25.6)	Yes, my doctor particularly recommended	1 (0.4)
No, other	5 (2)	Yes, other	0 (0)

*More than one response was chosen.

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Table 4: Knowledge Level on the Influenza and Vaccination for Influenza

		N	%
Influenza is more dangerous during pregnancy	Yes	114	45.6
	No	29	11.6
	I do not know	107	42.8
Vaccination can protect pregnant women against influenza	Yes	92	36.8
	No	42	16.8
	I do not know	116	46.4
Influenza vaccination is recommended for pregnant women	Yes	37	14.8
	No	53	21.2
	I do not know	160	64
It is recommended during the first trimester	Yes	14	5.6
	No	45	18
	I do not know	191	76.4
It is recommended during the second trimester	Yes	17	6.8
	No	30	12
	I do not know	203	81.2
It is recommended during the third trimester	Yes	11	4.4
	No	33	13.2
	I do not know	206	82.4
Influenza vaccination is safe during pregnancy	Yes	50	20
	No	37	14.8
	I do not know	163	65.2

Table 5: Providing Information on the Flu and Vaccination for Influenza in Pregnancy

		n (%)
Were you informed about influenza during your pregnancy?	No	230 (92)
	Yes, doctor/nurse	11 (4.4)
	Yes, media	9 (3.6)
	Yes, friend	0 (0)
	Yes, family	0 (0)
	Other	0 (0)
Were you informed about Vaccination for influenza during your pregnancy?	No	232 (92.8)
	Yes, doctor/nurse	10 (4)
	Yes, media	5 (2)
	Yes, friend	2 (0.8)
	Yes, family	1 (0.4)
	Other	0 (0)
Do you think that you need more information about influenza during pregnancy?	Yes	134 (53.6)
	No	116 (46.4)
Do you think that you need more information about Vaccination for influenza during pregnancy?	Yes	139 (55.6)
	No	111 (44.4)

SS-38

Posterior Reversible Encephalopathy Syndrome With Global Amnesia: A Rare Case Report

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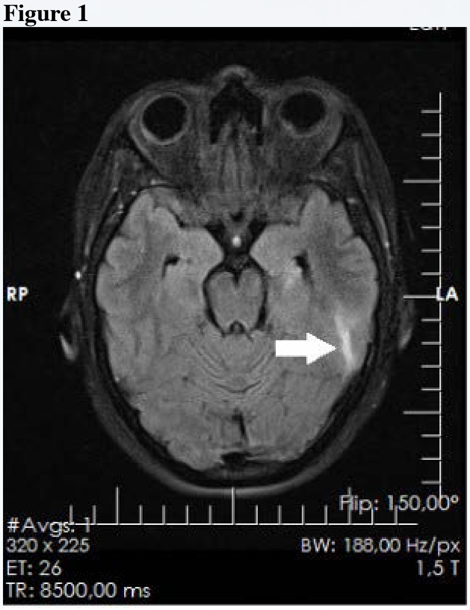
Posterior reversible encephalopathy syndrome (PRES), also termed reversible posterior leukoencephalopathy syndrome, is a recognised syndrome affecting predominantly the white matter of the posterior cerebral hemispheres and characterised by visual disturbances, headache, nausea, change in mental status and seizure. Preeclampsia and eclampsia are among the most common causes of PRES.
However treatment of the underlying reason provides clinical and radiological healing, a delay in the diagnosis and treatment can result in permanent brain damage and death. Here, we report a case of 39-weeks-pregnant woman who developed eclampsia and PRES.
A 35-year-old primiparous woman in the 39th week of gestation who did not come regularly for routine antenatal examinations presented to the emergency department with an episode of generalized tonic clonic seizure. The seizure had kept going approximately 20 minutes and stopped at the 5th minute of the emergency presentation. Her blood pressure on admission was 180/110 mmHg. The laboratory studies disclosed leukocyte 14,1x103/μL (reference 4-10x103/μL), creatinin 1,24 mg/dL (reference 0,42-1,06 mg/dL), uric acid 9,37 mg/dL (reference 2,6-6 mg/dL), alanine aminotransferase (ALT) 96,7 IU/L (reference 0-35 IU/L), aspartate aminotransferase (AST) 206,3 IU/L (reference 0-35 IU/L) and lactate dehydrogenase (LDH) 960,1 IU/L (reference 125-248 IU/L). Clotting tests showed elevated levels of plasma D-dimer 18,3 mg/L (0-0,55 mg/L), fibrinogen 669,2 mg/dL (reference 60-420 mg/dL). The patient was transferred to the operating room for an emergent cesarean section. A baby girl with 1 and 5 minute APGAR scores of 1 and 3, weighing 2650 gr was delivered. Then the patient was treated in the clinical context of HELLP syndrome within the intensive care unit (ICU) since blood analysis revealed elevated liver enzymes and a low platelet count of 115x103/μL (reference 142-424x103/μL). On hospital day (HD) 1, the patient displayed neuropsychiatric symptoms of confusion, agitation and anxiety with a global memory loss which was an unexpected finding. Cranial non-contrast computed tomography (CT) revealed brain edema. Cranial magnetic resonance imaging (MRI) showed multipl areas of high signals on T2-weighted and FLAIR sequences, involving left halves of pons and mesencephalon, the bilateral parietooccipital and the left temporal regions (Figure 1). In addition, there are focal cortical acute ischemia areas in bilateral parietooccipital lobes (Figure 2). Treatment with intavenous (IV) 20% mannitol 4x100 cc/day, intramuscular dexamethasone 4x2 mg/day, IV valproic acid 3x400 mg/day and subcutaneous low molecular weight heparin 2x0,4 cc/day were started. On HD 3, blood pressure values were around 140/80 mmHg and platelets increased; ALT, AST, LDH and fibrinogen values decreased. Two weeks after delivery she was discharged with acetylsalicylic acid 300 mg daily. On neurological examination four weeks after delivery, she had neither motor nor sensory deficit but complained of intermittent amnesia and black spots on the visual area. The physician should be aware of PRES in the postpartum period of a preeclamptic woman with neurological signs and symptoms, delayed treatment may cause permanent brain damage.

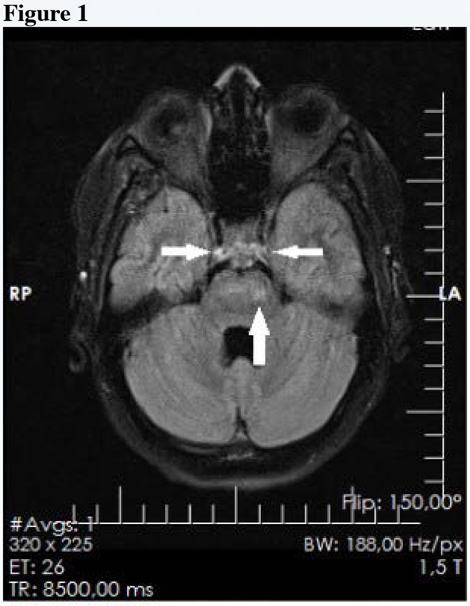
Keywords: Eclampsia, posterior reversible encephalopathy syndrome, pregnancy

Figure 1



IntheT2Aexamination,hyperintenselesionswereobservedinthebilateralparieto-occipital region and the left halves of pons, mesencephalon and temporal regions.

Figure 1



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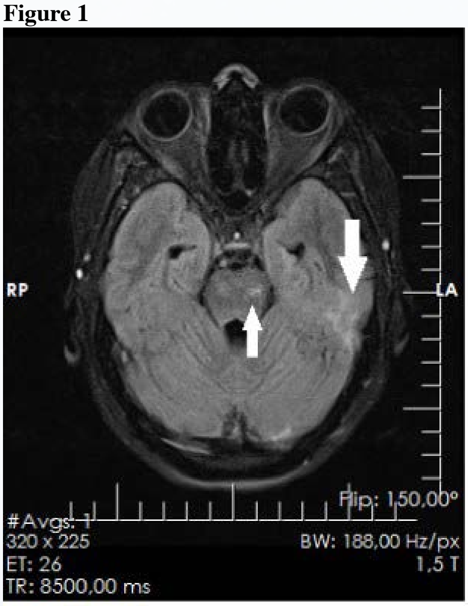
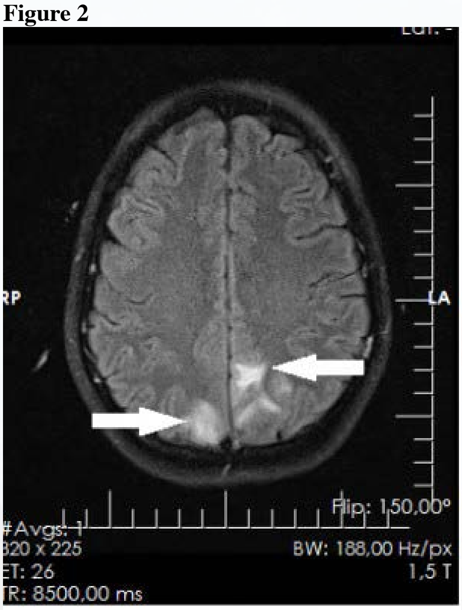


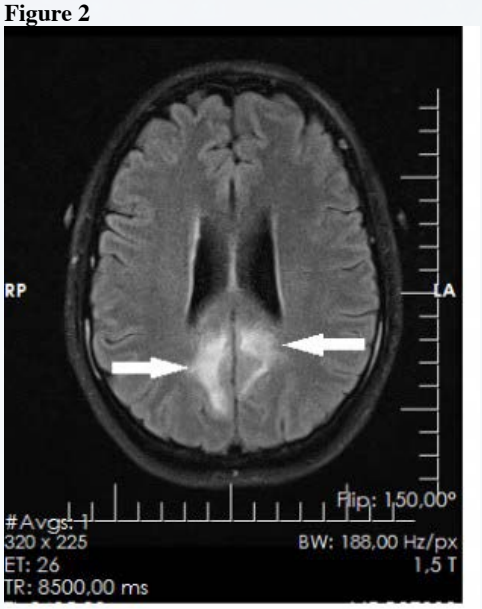
IntheT2Aexamination,hyperintenselesionswereobservedinthebilateralparieto-occipital region and the left halves of pons, mesencephalon and temporal regions.

Figure 2



Focal cortical acute ischemia areas were observed in the bilateral parietooccipital lobes.

Figure 2



Focal cortical acute ischemia areas were observed in the bilateral parietooccipital lobes.

SS-39

Clinical outcomes of pregnancies with amniotic fluid sludge

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AIM: To evaluate the clinical significance and pregnancy outcomes of amniotic fluid sludge.

METHODS: Sixteen singleton pregnancies with amniotic fluid sludge were included in the study. All patients were followed at Baskent University Adana Research Hospital in between 2014-2018. Amniotic fluid sludge view is demonstrated in Figure 1. Maternal characteristics, perinatal and neonatal outcomes of these pregnancies were examined. The interval between the first occurrence of amniotic fluid sludge and the termination of pregnancy was evaluated. Diagnostic tests (infection parameters such as leukocytosis and c-reactive protein (CRP), microbiological assessment of blood and vaginal discharge, amniocentesis for evaluation of glucose content and infection, pathological examination) were recorded.

RESULTS: Mean maternal age was 32.7± 6 (25-40), median gravidity, parity and previous miscarriage were 2 (1-5), 1 (1-2) and 1 (0-3), respectively. Mean gestational week at which sludge was first detected was 23± 4.3 (14.2-29) week, mean end of the pregnancy week was 24.1± 4 (15.3-29.3) and mean time from detection of sludge to delivery was 9.3± 7 (2-25) days. Five patients (31.3%) had history of preterm delivery and 4 (25%) patients had cervical cerclage. Eleven cases (68.8%) had short cervix, and preterm premature rupture of membranes (PPROM) occurred at 4 (25%) patients. Amniocentesis was performed at 4 cases, and all of them demonstrated infection of amniotic fluid. Table 1 demonstrates laboratory findings of pregnancies with amniotic fluid sludge. Nine pregnancies (56.3%) were terminated before 24 weeks. Seven (%43.8) live births developed and neonatal death was occurred in 4 cases with three (18.9%) healthy neonates in total. Cesarean section was performed in 2 patients (12.5%). Postpartum mortality occurred in 1 pregnant patient due to sepsis and disseminated intravascular coagulation three days after termination.

CONCLUSION: Close follow-up is important for chorioamnionitis and preterm delivery in pregnancies with amniotic sludge. As seen in our study, the amniotic sludge detected in the clinical evaluation of pregnant women may help the diagnosis before the laboratory results.

Keywords: amniotic sludge, chorioamnionitis, ultrasonography

Figure-1

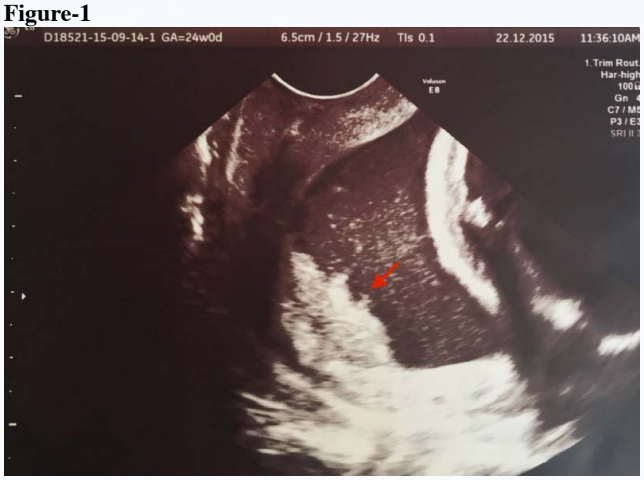

Figure 1. Amniotic fluid sludge view

Table 1

Laboratory findings	N
Leukocytosis	15
Elevated CRP	14
Culture test +	Vaginal culture 8, blood culture 4, amniotic fluid culture 4
Detected bacterial species	7 (enterococcus, escherichia coli, klebsiella pneumoniae)
Positive amniocentesis findings	4
Chorioamnionitis	15
Antibiotherapy	Administered to all cases

Table 1. Laboratory results of pregnancies with amniotic sludge

SS-41

Correlation of ultrasonographic fetal biometric parameters with birth weight

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Background and AIM: Accurate estimation of fetal weight during the antenatal period is crucial for deciding the delivery method (cesarean or vaginal birth). Deciding the best delivery method minimalizes the birth dependent adverse outcomes of fetal macrosomia and low birth weight. In the present study we aim to compare frequently used fetal biometry parameters (BPD, HC, AC, FL, HL), fetal mid-arm subcutaneous tissue thickness and clinical characteristics on estimation of neonatal weight.

METHODS: 72 term healthy singleton pregnants were prospectively evaluated. Ultrasonographic measurements were done at the the day of delivery. Routine sonographic biometric parameters included bilateral parietal diameter (BPD), head circumference (HC), abdominal circumference (AC), femur length (FL), humerus length (HL) and mid-arm subcutaneous tissue thickness between skin and triceps muscle. We also compared the effect Hadlock formula, maternal weight at the beginning of pregnancy, maternal weight at the day of birth, maternal body weight increase during pregnancy, maternal age and fetal gender on the accurate estimation of neonatal weight. Neonatal weight was taken based on the measurement just after the delivery. Student T test and paired samples test were used together with descriptive statistical methods for the analysis of parameters. Pearson correlation (r) was used for the correlation of parameters with neonatal weight. (r) <0.2: no correlation, (r)=0.2-0.4: poor correlation, (r)=0.4-0.6: moderate correlation, (r)=0.6-0.8, high correlation, (r) >0.8: very high correlation descriptions were used.

RESULTS: Mean neonatal weight was 3367 +/- 406.2 SD gram. Neonatal weight was highly correlated with Hadlock formula (r: 0.829) and AC (r: 0.826), moderately correlated with BPD (r: 0.561), FL (r: 0.552), mid-arm subcutaneous tissue thickness (r:0.535) and HL (r: 0.501), poorly correleted with maternal body weight increase during pregnancy (r: 0.479) and maternal body weight at the day of birth (r: 0.339). There were no correlation of maternal age, fetal gender, maternal body weight at the beginning of pregnancy.

CONCLUSION: For the best estimation of neonatal weight we need formulas including AC, BPD, FL, mid-arm subcutaneous tissue thickness, HL, maternal body weight increase during pregnancy and maternal body weight at the day of birth.

Keywords: Birth weight, fetal weight, ultrasonography

SS-42

Neuroendocrine carcinoma of the uterine cervix: two cases and review of the literature

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AIM: Neuroendocrine carcinoma of uterin cervix constitutes 1% of cervical cancers. These rare tumors have small cell, large cell and carcinoid subtypes, and immunohistochemical markers which indicate neuroendocrin differentiation such as synaptophysin, chromogranin A, and CD56 are helpful for accurate diagnosis. Small cell neuroendocrin carsinoma, of which the prognosis is worse, is shown to be related to HPV 16/18 types. Treatment is mostly regulated due to the suggestions of gynecologic oncology societies based on the few literature data owing to the rarity of these tumors. Aim of this study is to describe two cases with neoroendocrine carcinoma of the uterine cervix.

METHOD: Two cases of neuroendocrine carsinoma of uterine cervix are presented in this report.

RESULTS: Case 1 was diagnosed at March 2017. A 33 year-old woman applied with postcoital and interval vaginal bleeding. A fragile ectocervical mass was found on examination. Cervical biopsy was performed and pathology was reported as high grade neuroendocrin carcinoma, small cell type, grade 3, with 35% of cervix being infiltrated, and lymphovascular invasion. Laparoscopic type 3 hysterectomy, bilateral salpingo-oopherectomy and lymph node dissection was performed. Keratin, chromogranin, synaptophisin, and TTF-1 were positive on immunohystochemistry. Adjuvant chemotherapy (cysplatin-etoposide) was applied. The patient was controlled with cuff smear and imaging methods by regular intervals, and the examination findings were normal. She is still being followed up. Case 2 was diagnosed at December 2018. A 37 year-old woman applied with continious vaginal bleeding. Pathology was reported as high grade neuroendocrin carcinoma, large cell type. Laparoscopic type 3 hysterectomy, bilateral salpingo-oopherectomy and lymph node dissection was performed. Less than 5% of cervical infiltration was found, and lymphovascular invasion was not seen, however, there was perineural invasion. Keratin, chromogranin, p16, mCEA and NSE were positive on immunohystochemistry. CD56 was negative. Adjuvant chemotherapy (cysplatin-etoposide) was applied. She has been controlled every three months, with normal physical examination and imaging. ASC-H was found on cuff smear, though colposcopic findings were normal. (July 2019) The patients is still

being followed up.

CONCLUSION: Servical neuroendocrine tumors, particularly small cell type, cause early hematogeneous metastasis and have poor prognosis, however, size of the servical lesion and tumor stage are shown to be important prognostic factors. Radical surgery and adjuvant chemotherapy are the main treatment in early stage disease. Treatment and follow up of our patients are consistent with the literature. Early and accurate diagnosis affect treatment success.

Keywords: Neuroendocrine carcinoma, cervical cancer, small cell cancer, large cell cancer, radical surgery, chemotherapy

SS-43

Evaluation of atypical glandular cells in cervico-vaginal cytology in a single tertiary center

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INTRODUCTION: Glandular cell abnormalities in cervical cytology are relatively rare compared with squamous cell abnormalities. The purpose of this study is to analyse the pathological outcomes of patients with atypical glandular cells (AGC) in cervicovaginal cytology examinations.

MATERIAL-METHODS: Patients with abnormal cervico-vaginal cytology or Human papilloma virus (HPV) positivity (n: 894) referred to colposcopy between 2008 and 2017 were included in this study and AGC cytology results were evaluated. Patient data were collected retrospectively from all colposcopic biopsy results.

RESULTS: Atypical glandular cells was found 0.89 % (8/ 894) in the abnormal cervico-vaginal cytology cohort. Median age of the patients was 46 years (36-61 years), median parity was 2 (0-3), 25 % of patients were infertile, 87,5% of patients were married, 37,5 % of patients were smokers, 37,5 % of patients (n=3) were postmenopausal. Human papilloma virus (HPV) screening test was performed in 3 patients, one of them was HPV 16 others were HPV 82 and HPV 31,39 positive. Colposcopy, cervical, endocervical canal and endometrial cavity biopsy was performed for all patients. High grade cervical dysplasia(HSIL) was detected in 75 % of cervical biopsies and 50 % underwent cervical conisation,all of them were margin negative. One patient had HSIL and ovarian and breast cancer coexistence by this reason staging procedure was performed. Endometrial cavity biopsy results showed %25 benign endometrial polyp, only 12,5 % of patients had endocervical glandular hyperplasia. Eighty seven percent (n:7) patients pathological follow –up were available and median follow up time was 24 mounts (5-42). Twenty- five percent of patients underwent hysterectomy and final result were HSIL. In this study subgroup %75 of the patients fınal results were HSIL, no cervical or endometrial cancer was detected.

CONCLUSION:Glandular cell abnormalities in cervical cytology are relatively rare. These lesions originate from the glandular epithelium of the cervix. High grade cervical dysplasia or malignancy probability of AGC cytology is more commonly associated with malignancy in the postmenopausal group. Due to their appearance and abnormal colposcopic findings, diagnosis is difficult. Pathologic examinations for endometrium, endocervical canal and cervix are recommended in these patients with AGC smears because of the high malignancy risk.

Keywords: Cervical cancer, atypical glandular cells, high grade cervical dysplasia

SS-44

Risk factors for ovarian metastasis in patients with endometroid type endometrial cancer

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BACKGROUND: The standard surgical treatment of endometrial cancer includes total hysterectomy and bilateral salpingo-oophorectomy with or without pelvic and para-aortic lymphadenectomy. The BSO procedure is routinely performed in the surgical management of endometrial cancer to decrease estrogen production and to detect occult ovarian metastasis. However, BSO results in surgical menopause in premenopasal patients which will cause long term sequelae of estrogen deprivation including an increased risk of cardiovascular disease, osteoporosis, hip fracture, and cognitive dysfunction. Therefore, this study aims to define the risk factors for ovarian metastasis and to determine the candidate population for ovarian preservation in women with endometrial cancer.

METHODS: The women with endometrioid endometrial cancer who underwent surgery as a primary treatment were included in this retrospective study. The information including patient age at diagnosis, LVSI status, tumor grade, primary tumor diameter, depth of myometrial invasion, cervical stromal invasion, lymph node metastasis, and intra-abdominal metastasis were extracted from the database of the hospital. The patients were grouped as ovarian metastasis positive and ovarian metastasis negative. The differences between groups were evaluated using the Chisquare test or Fisher's exact test for categorical variables. Multivariate regression models were developed to identify the risk factors for predicting ovarian metastasis.

RESULTS: A total of 725 women with endometroid type endometrial cancer were included in final analyses. Ovarian metastasis was detected in 34 (4.7%) cases according to final pathology report. The patients with positive LVSI ($p<0.0001$), grade 3 tumor ($p<0.0001$), primary tumor diameter ≥ 3 cm ($p<0.0001$), myometrial invasion ≥ 50 % ($p<0.0001$), cervical stromal invasion ($p<0.0001$), lymph node metastasis ($p<0.0001$), intra-abdominal metastasis ($p<0.0001$) were more common in ovarian metastasis group. Multivariate analyses revealed that positive LVSI [hazard ratio (HR) = 3.55; 95% confidence interval (CI), (1.11-11.40); $p=0.033$] and presence of intraabdominal

metastasis [HR = 12.91; CI, (3.96-42.10); <0.0001] were independent risk factors for ovarian metastasis. In the case of positive LVSI and/or intra-abdominal metastasis, ovarian involvement was detected in 17.6% (24/112) of patients. However, the ovarian metastasis was detected only 1.7% (10/579) of patients if none of these risk factors was present.

CONCLUSION: In conclusion, the identification of risk factors associated with ovarian metastasis can facilitate the decision of patient selection for ovarian preservation in young patients with endometrial cancer. The current study suggests that the ovarian metastasis risk was lower in cases without positive LVSI and intraabdominal metastasis. However, the decision for preserving ovaries must be discussed with the patients.

Keywords: Endometrial cancer,LVSI, ovarian involvement

Table 1. Clinical and pathological characteristics

	Ovarian metastasis Positive	Ovarian metastasis Negative	p
Age, years <60 ≥60	23 (67.6%) 11(32.4%)	418(60.5%) 273(39.5%)	0.513
LVSI Absent Present	10(29.4%) 24(70.6%)	581(84.1%) 110(15.9%)	<0.0001
Grade I-II III	23(67.6%) 11(32.4%)	643(93.1%) 15(2.2%)	<0.0001
Primary tumor diameter (cm) <3 ≥3	5(14.7%) 316(45.7%)	29(85.3%) 375(54.3%)	0.0001
Depth of myometrial invasion (%) < 50 ≥50	12(35.3%) 22(64.7%)	525(76.0%) 166(24.0%)	<0.0001
Cervical stromal invasion Absent Present	22(63.7%) 12(35.3%)	620(89.7%) 71(10.3%)	<0.0001
Lymph node metastasis Absent Present	21(61.8%) 13(38.2%)	647(93.6%) 44(6.4%)	<0.0001
İntra-abdominal metastasis Absent Present	24(70.6%) 10(29.4%)	685(99.1%) 6(0.9%)	<0.0001

Table 2. Multivariate analysis of risk factors for ovarian metastasis

Variable	OR (CI %95)	p
LVSI Absent Present	Reference 3.55 (1.11-11.40)	0.033
Grade I-II III	Reference 1.76(0.68-4.55)	0.242
Primary tumor diameter (cm) <3 ≥3	Reference 1.52(0.51-4.54)	0.447
Depth of myometrial invasion (%) < 50 ≥50	Reference 1.39(0.52-3.75)	0.506
Cervical stromal invasion Absent Present	Reference 1.49(0.59-3.71)	0.391
Lymph node metastasis Absent Present	Reference 1.75(0.65-4.71)	0.268
İntra-abdominal metastasis Absent Present	Reference 12.91(3.96-42.10)	<0.0001

Tablo 3. Predictive value of different risk factors for ovarian metastasis

Risk group	Ovarian metastasis positive	Ovarian metastasis negative	p
Low-risk LVSI (-), İntra-abdominal metastasis (-)	10(1.7%)	569(98.3%)	<0.0001
High-risk LVSI (+) and/or İntra-abdominal metastasis (+)	24(17.6%)	88(82.4%)	

SS-45

Can we manage adnexal masses in pregnancy expectantly; a case report of yolk sac tumor of the ovary

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AIM: To present a case managed in our institution.

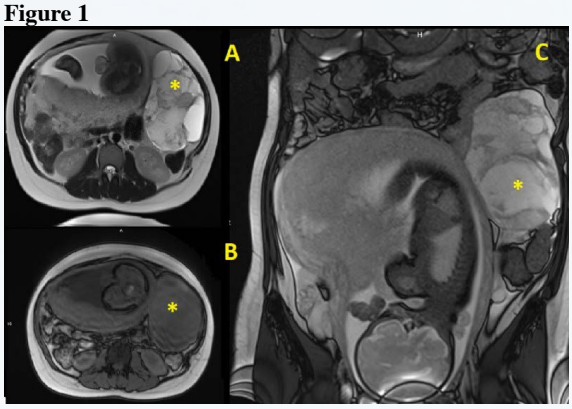
METHODS: This is a case report.

RESULTS: A 19 year old primigravid woman, 33 weeks of pregnant according to her last date of menstrual period, presented to our clinic with preterm contractions and an adnexal mass. Her antenatal records were normal and the mass was detected in the 20 th week of her pregnancy. In her first examination the fetal development was normal for gestational age and a 155*83 mm sized, multi septated left adnexal mass with solid projections was detected. She was hospitalized, tocolytics were administered and was given two doses of betamethasone for lung maturation. Tumor markers of Ca125 and AFP were resulted as; 133 U/mL, AFP:5293 ng/mL, respectively. For the further evaluation of the mass magnetic resonance imaging (MRI) was done. The mass was characterised as 95*135*200 mm sized, with solid and hemorrhagic components, and hyperintense on the T2 weighted images and hypointense on T1 weighted images (Figure 1). The mass was suspected of high possibility of malignancy. The delivery was postponed until term due to patient choice. After consulting the perinatology department a labor induction was done after completing 37 weeks of pregnancy. The patient gave birth to a healty infant with vajinal delivery. 2 weeks after the birth a laparotomy was done, the frozen section was reported as an germ cell tumor of the ovary and fertility sparing surgery was made (Left unilateral salpingo-oophorectomy + bilateral pelvic and para aortic lymphadenectomy + peritoneal biopsy). The pathology specimen was reported to be yolk sac tumor of the ovary, the surgical stage was 3A1 (with involvement of one para aortic lymph node). Chemotherapy protocol of BEP (bleomycin, etoposide, cisplatin) is planned for adjuvant therapy.

CONCLUSION: The malignancy risk of an adnexal mass detected in pregnancy is 2-3% and germ cell tumors make up the majority. A pregnancy with malignancy is struggling because of the balance between the optimal therapy for the mother and the fetal well being. A surgical intervention is required during the second trimester when there is a suspicion of malignancy. The route of delivery is usually cesarean section; for the exploration of the mass and the abdomen, to prevent the rupture of the mass during delivery and to prevent dystocia. Here in our case we show that with a high suspicion of a malignancy, the patient may choose to delay the delivery until term. This decision should be made with the perinatologist, oncologists and the family. Also the route of the delivery can be chosen as vaginal delivery. With this management the laparotomy was safer (less bleeding) and we had a better exposure (smaller uterus postpartum).

Keywords: adnexal mass, pregnancy, yolk sac tumor

Figure 1



*Abdomen MRI, 95*135*200mm left adnexal mass shown by asterisks A- T2 weighted transverse view B- T1 weighted transverse view C- T2 weighted coronal view*

SS-46

Prenatal findings in sirenomelia: Report of three cases and literature review

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OBJECTIVE: Sirenomelia is a rare congenital malformation characterized by varying degrees of fusion of the lower extremities. Urogenital, gastrointestinal, neural tube and vertebral anomalies are found in most cases. Its prognosis is very poor due to pulmonary hypoplasia that is caused by severe oligohydramnios. Ultrasonography is an optimal method for prenatal screening and diagnosis of sirenomelia. The incidence of sirenomelia in the twin pregnancy is extremely low.

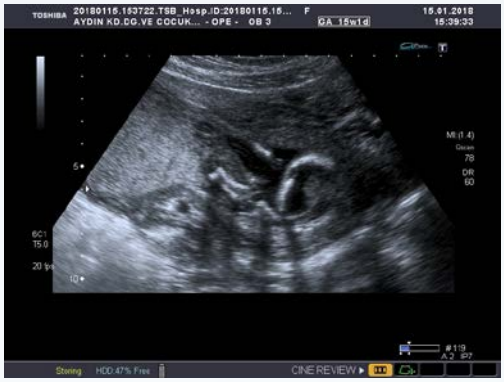
METHODS: We present three cases of sirenomelia two of them diagnosed in early second trimester and one diagnosed in first trimester in a conjoined twin pair.

RESULTS: The first case was presented with oligohydramnios at 15th gestational week, after sonographic evaluation symelia apus with bilateral renal agenesis and single umblical artery was diagnosed. The patient refused the option of pregnancy termination. The second case presented at 15th gestational week, with oligohydramnios and symelia monopus with bilateral renal agenesis was diagnosed. The patient accepted the option of pregnancy termination. The third case was a symelia dipus diagnosed at 12th gestational week of pregnancy in a twin pair of a cephalopagus conjoined twin. The pregnancy was terminated at 23rd gestational week of pregnancy due to patient's desire.

CONCLUSION: Sirenomelia is a lethal condition in the perinatal period. Early antenatal diagnosis is very important and gives the parents the option of early pregnancy termination.

Keywords: early diagnosis, sirenomelia, sonography

Case 1

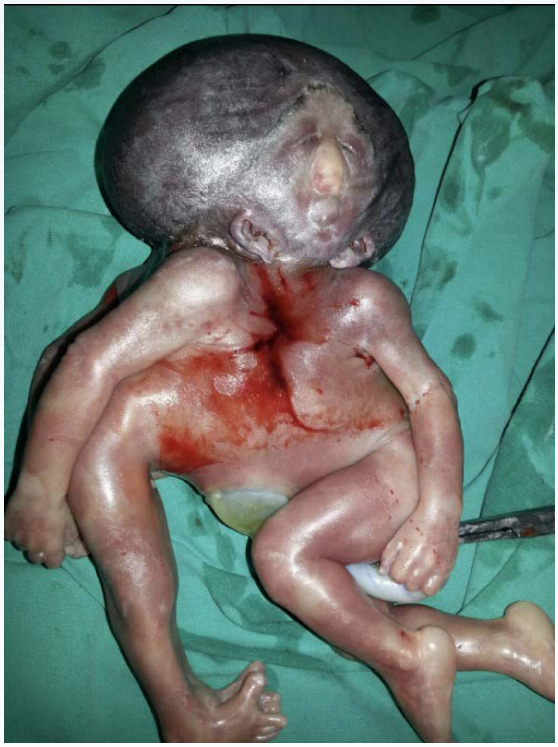


Sonography of sirenomelia

Case 2

Macroscopy of fetus

Case 3



Sirenomelia in a cephalopagus conjoined twin pair

SS-47

The effects of Pilates during pregnancy

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OBJECTIVE: Pilates is an exercise method which increases the stability and endurance of the core muscles and improves mood and balance. To analyze effects of Pilates methods during pregnancy.

METHODS: Fifty-eight pregnants were included in the study. Participants were randomly divided into 2 groups as Pilates and control groups. The subjects in the Pilates group did Pilates for 8 weeks, 2 days a week. The control group did breathing and relaxation exercises at home. Core stability, Core endurance, balance, risk of depression and fear of birth were evaluated. Core stability was evaluated by Sahrmann Core stability test and Core endurance tests. Among the core endurance tests; trunk flexion test, right-left side bridge test and prone bridge test were used. Balance was evaluated using the Biodex-BioSway ™ (Biodex Medical Systems, Shirley, NY, USA) Portable Balance System, an objective measurement method. Depression was evaluated by Edinburgh Postnatal Depression Scale. Fear of birth was evaluated by The Wijma Delivery Expectancy/Experience Scale- A version.

RESULTS: As a result of Pilates training, it was seen that core stability, core endurance and balance levels increased in pregnant women ($p < 0.05$), risk of depression and fear of birth decreased ($p < 0.05$). No change was observed in control group ($p > 0.05$).

CONCLUSIONS: As a result, applied 2 times a week for 8 weeks Pilates in pregnancy; to be effective in core stability, core endurance, balance and mood.

Keywords: Pilates, pregnant, core, balance, depression.

SS-48

A case of primer peritoneal carcinoma with preoperative diagnosis of suspicious adnexal cystic mass in douglas space

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INTRODUCTION: Papillary serous carcinoma of the peritoneum (PSCP) has been recognized for almost 5 decades, but little is known about the etiology or pathogenesis of this uncommon malignancy. The clinical presentation of peritoneal carsinoma may be either acute or subacute. Women who present in an acute fashion are typically those with advanced disease who present with a condition that requires urgent care and evaluation (eg, pleural effusion, bowel obstruction). More commonly, disease presents in a subacute fashion (eg, pelvic or abdominal pain, bloating, gastrointestinal symptoms) in women with either early or advanced disease. These conditions are usually evaluated in an outpatient setting. Alternatively, an adnexal mass may be discovered incidentally at the time of imaging performed for another indication.

CASE: A 50-year old woman referred to our clinic with a complaint of pelvic pain. The patient was diagnosed as ovarian tumor with pelvic examination before the operation. Serum tumor markers were significantly elevated. Ultrasonography showed that endometrial thickness was 8mm and left ovarian solid tumor was examined 85mm*60mm.
At the end of the examination we composed the differential diagnoses as a epithelial tumor, granulosa tumor and krukenberg tumor of ovarii. Gastrocolonoscopy and endometrial biopsy procedures were performed. In endometrial biopsy, atrophic epitelium was seen, while endoscopy was normal.
Magnetic Resonans also identified an solid ovarian tumor (10 cm) with pathologic contrast fixation.
Debulking surgery was performed after the frozen section of left pelvic mass which was reported as a malign epithelial tumor. We explorated that abdomen and pelvic region, solid mass was related with left distal tuba uterina and bilateral ovaries were seen normally.
The surgen was performed as total hysterectomy with bilateral salpingo-oophorectomy, pelvic and paraaortic lymph node dissection, and infragastric omentectomy.
The histomorphological features from the pathology examination concluded peritoneal serous carcinoma with uninvolved ovaries. Immunohistochemical examination showed that Ki-67 (>20%), ER(–), Desmin(–), WT-1(+), HMWK(+), CK7(+), Pan CK(+), Progesteron(+), EMA:Luminal(+), P53(+), BerEP4(+),

CONCLUSİON: Women with peritoneal carcinoma may present either with or without an adnexal mass. For these women, the decision to proceed with surgery is based upon either the combination of epitelial ovarian carsinoma-associated symptoms and an elevated tumor marker or upon imaging findings consistent with peritoneal carcinomatosis.

Keywords: adnexal tumor, cystic tumor, peritoneal carcinoma,

SS-49

Prevention of preterm delivery by cervical cerclage: A comparison of prophylactic and emergent procedures

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INTRODUCTION: Cervical insufficiency is an important cause of preterm delivery and pregnancy loss in obstetrical population. Incidence is around 8 % in high risk population who had second trimester loss in previous pregnancies. Cervical cerclage which is placed prophylactic or as an emergency procedure according to patient history or presentation respectively is a surgical treatment option in cervical insufficiency. Aim of the study is to overview and compare the outcomes of these cerclage types and delineate the factors that may effect on outcomes.

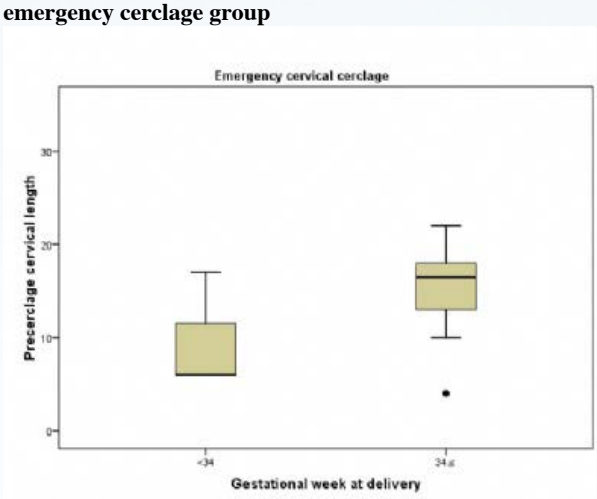
MATERIAL-METHOD: Retrospective review of transvaginal cervical cerclage procedures results over a 7 year period from a tertiary referral center.: Seventy five patients with singleton pregnancies and diagnosis of cervical insufficiency included in study. Data collected retrospectively from hospital records. Multiple pregnancies and pregnancies with confirmed infection were excluded from the study. Statistical analysis included Mann Whitney U test, Chi-square and Fischer exact tests. Results Twenty seven of 75 patients were in emergency cerclage group and 48 of them were in prophylactic group. Mean BMI, hospitalization time and gestational week at cerclage were significantly higher whereas latency period was significantly shorter for emergency group. Mean gestational week at delivery was 35,6±4,5 and 33,6±5,9 weeks in prophylactic and emergency group respectively (p:0,117).Delivery ratios under 34th gestational week was 20.8% and 37 % in prophylactic and emergency group respectively (p:0,175). Birthweight, delivery at and after 34th gestational week was higher in prophylactic group whereas complication rate was higher in emergency group but these differences were not statistically significant. High body mass index is associated with more deliveries before 34 week in prophylactic group. Precerclage cervical length was shorter in patients who delivered before 34 gestational week at delivery. Effects of neutrophil-lymphocyte ratio on cerclage was not conclusive.

CONCLUSION: Prophylactic and emergency cerclage procedures have comparable results regarding gestational week at delivery. High

BMI and low precerclage cervical length may have adverse effects on success of cerclage procedures. Meanwhile we could not make a certain conclusion on predictive effects of neutrophile-lymphocyte ratio.

Keywords: Cervical insufficiency, Cervical cerclage, emergency cervical cerclage, neutrophil-lymphocyte ratio

Precerclage cervical length and gestational week at delivery in emergency cerclage group



Precerclage cervical length and gestational week at delivery in prophylactic cerclage group

SS-50

The expressions of Oct-4 CD44 and E-cadherin in eutopic and ectopic endometrial tissues in women with endometriosis

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OBJECTIVE:Endometriosis is an estrogen-dependent inflammatory disease that causes infertility and chronic pelvic pain. Oct-4 is a molecular marker for pluripotent cells and it plays an essential role in maintaining the undifferentiated state needed for cell pluripotency. Previous studies have demonstrated that Oct-4 is expressed in the embriyonic stem cells, the germ cells and the endometrial cells. CD44 is an integrated membrane protein that acts as a multifunctional cell surface adhesion molecule that plays a role in cell-cell and cell-matrix interactions. E-cadherin is an adhesion glycoprotein that expressed by eutopic and ectopic endometrium. It is an epithelial cell–cell adhesion molecules that modulates a wide variety of processes, including cell polarization, migration and cancer metastasis. The aim of this study was to investigate the expression paterns of Oct-4, CD44 and E-cadherin in eutopic endometrial tissue from women with endometrioma and compared them with control endometrial tissues from women without endometrioma.

MATERIALS-METHODS: In this study, the Oct-4, CD44 and E-cadherin expressions in the eutopic endometrial tissue samples from women with endometrioma (n=32) was evaluated and compared with control endometrial tissue samples from women without endometrioma (n=30).

RESULTS: Immunohistochemical expression of Oct-4 was significantly higher in eutopic endometrial tissue speciment of women with endometrioma than control subjects ($p<0.05$). However, the expression of CD44 and E-cadherin were significantly lower in eutopic endometrial tissue samples of women with endometrioma than control endometrial tissue samples ($p<0.05$).

CONCLUSION:The discovered differences in eutopic endometrial tissue samples in women with and without endometrioma may indicate a possible relationship between these stem cells molecules and moleculer basis of endometrioma. Moreover, decreased expression of E-cadherin in endometrial tissue in women with endometrioma was associated with advanced stages of endometriotic lesions.

Keywords: Endometriosis, oct4, Cd44, infertility, ecadherin

SS-51

Operating room nursing in gynecologic oncology surgeries: Our one-year, single-center experience

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OBJECTIVE: This study aims to evaluate the role of supportive operating room nursing in gynecologic oncology surgeries.

MATERIALS-METHODS: This study included patients who were diagnosed with a gynecologic malignancy and underwent surgery at Malatya Training and Research Hospital, Department of Obstetrics and Gynecology between July 2018 and August 2019. Supportive operating room nursing services provided were recorded.

RESULTS: A total of 58 patients were operated. The median age of the patients was 63 (range, 30 to 89) years. Of the patients, 27 were diagnosed with endometrial cancer, 16 with ovarian cancer, seven with cervical cancer, two with tubal cancer, two with a leiomyosarcoma, one with an endometrial stromal sarcoma, one with a carcinosarcoma, one with malignant peritoneal mesothelioma, and one with vulvar cancer. Before the operation, the following preparations for each patient were provided: (1) one or two days before surgery, the patient was visited at the bedside and the diagnosis, scope of surgery, and informed consent form were evaluated; (2) the patient was informed about the preoperative measures and procedures and that the operating room was fully equipped with necessary appliances and instruments to regain her health; (3) the patient was informed about the intensive care services, if she met the intensive care unit monitoring criteria; (4) the patient was welcomed in the preoperative waiting room and the operating room was described using the visual materials; (5) the patient was provided comfort by informing the patient that surgery would be performed by an experienced team; (6) the patient was informed that she would stay asleep until surgery is over and would be anesthetized and experience no pain; (7) the patient was informed that the pathological examination results would be available in 10 to 15 days and that the results must be interpreted by her treating physician; (8) the patient was informed about the importance of postoperative follow-up visits and that she must attend to the scheduled visits as recommended by her treating physician; and (9) vascular, gastrointestinal instrument set and energy devices were kept ready for use in the operating room to increase our surgical skills and to prevent possible complications.

CONCLUSION: Obstetrics and gynecology specialists are fully capable of performing related surgeries following the most recent and valid protocols. However, it should be kept in mind that nursing is one of the most compassionate disciplines for female patients, as it offers empathy. Evidence-based care must be provided and professional development and the need for skillful multidisciplinary teams must be adopted to improve the gynecologic oncology nursing in Turkey.

Keywords: Gynecologic oncology, Operating room nursing, Oncologic surgery

SS-52

The mobility of bladder neck in patients with stress incontinence

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OBJECTIVE: The objective of this study is to evaluate the objective parameters of dynamic changes in the bladder neck in patients with stress incontinence through ultrasonography and to determine practicability of this evaluation in incontinent and continent patients.

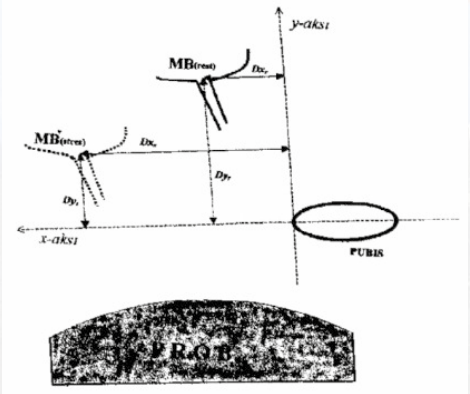
METHODS: The study group consisted of 43 patients with stress incontinence, while 20 patients presented with the complaints other than incontinence were assigned to the control group. The measurements were made in patients and control groups with full bladder in the supine position through insertion of the linear probe beneath the urethral meatus. Length, total width and submucosal thickness of the urethra and the distance between the bottom of symphisis and urethra were measured. Cephalocaudal and ventrodorsal mobilities of the bladder neck were measured at rest and following valsalva maneuver.

RESULTS: The length of the urethra was slightly lower in the patient group, although no significant difference was found between the two groups. In addition, no significant differences were found between the groups in terms of the total width and submucosal thickness of the urethra. Cephalocaudal mobility in the bladder neck was significantly higher in the patient group, compared with the control subjects and ventrodorsal mobility was also significantly higher in the patient group than in the controls.

CONCLUSION: Ultrasonography is a very useful and easily applicable imaging modality for the evaluation of cephalocaudal mobility of the bladder neck in patients with stress incontinence.

Keywords: Bladder neck mobility, stress incontinence, ultrasonography

Figür 1: Schematic view of our measurement method



MBr, s: Position of bladder neck at rest and during valsalva Dyr: Distance between bladder neck and the bottom end of the pubis at rest Dys: Distance between bladder neck and the bottom end of the pubis during valsalva Dxr: Distance between bladder neck and the bottom end of pubis in ventrodorsal direction (y axis) at rest Dxs: Distance between bladder neck and the bottom end

of pubis during valsalva Δy: Cephalocaudal mobility (Dyr-Dys), in the case of bladder neck exceeding pubis (Dyr+Dys) Δx: Ventrodorsal motility (Dxs-Dxr)

Table 1

	Patient Group n=43	Control Group n=20	p
Length of the urethra (mm)	35,83 ± 2,53	36,64 ± 1,08	0,174; p>0,05
Total width of the urethra (mm)	14,44 ± 1,66	13,54 ± 1,87	0,059; p>0,05
Submucosal thickness of the urethra (mm)	6,92 ± 1,12	6,37 ± 1,13	0,076; p>0,05
Cephalocaudal mobility in bladder neck (mm)	17,06 ± 2,09	4,89 ± 1,89	0,001; p<0,01**
Ventrodorsal mobility in bladder neck (mm)	5,28 ± 4,21	1,43 ± 0,75	0,001; p<0,01**

Distribution of ultrasonographic findings by groups

SS-53

Endometrial polyps and concomitant uterine pathologies in hysterectomy specimens

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AIM: To evaluate relationship between endometrial polyps and concomitant uterine pathologies in hysterectomy specimens.

METHOD: Histopathological data of patients who underwent hysterectomy at Ankara Baskent University Hospital, between 2007 to 2017 were screened. Patients with a pathological diagnoses of endometrial polyp were retrospectively evaluated. Hysterectomy specimens which contain 1) endometrial cancer arising from an endometrial polyp, 2) endometrial intraepithelial neoplasia or complex atypical hyperplasia in a polyp and 3) benign endometrial polyp included in the study. Extra-uterine malignancies and uterine malignancies without a polyp origin were excluded. Cases were divided into two groups which are benign (group1) and premalignant/ malingnant (group2). Presence of adenomyosis, adenomyomatous polyps, more than one polyp, polypoid shape, leiomyomas and their location were compared between groups.

RESULTS: 538 endometrial polyps which met the criteria were detected. 323 were in group 1 and 215 were in group2. Mean age of patients were 63.4 (±11.9) in group 1 and 58.2 (±14.1) in group 2. In group 2, age of patients was significantly lower (p<0.05). Polypoid shaped polyps were significantly higher in group 2 than group 1, 48.4% vs. 10.5%, respectively (p<0.05). Presence of multiple polyps was 25.1% in group 1, and 18.6 % in group 2, whereas it was not statistically significant. Presence of adenomyosis, adenomyomatous polyps, more than one polyp, leiomyomas and their location did not differ significantly between two groups.

CONCLUSION: No strong association was found between endometrial polyps and uterine disorders however polypoid shaped polyps seems to have a higher association with premalignant/ malignant potential. Endomettrial polyps are frequent uterine disorders and further investigation may contribute to the literature.

Keywords: Endometrial, Hysterectomy, Polyp, Polypoid shape, Uterine disorder

SS-54

Prognostic factors associated with Hipec in Recurrent epithelial ovarian cancer

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AIM: The aim of the study was to evaluate the prognostic factors in patients with recurrent ovarian cancer who subjected to cytoreductive surgery and Hiperthermic İntraperitoneal Chemotheraphy

MATERIAL-METHODS: This retrospective cohort study was carried out in Baskent university school of medicine,department of gynecology and obsterics,division of gynecologic oncology.Medical records of patient who undergone cytoreductive surgey plus hipec were evaluated. 82 patients were operated and recieved HİPEC in our clinic between the years of 2015-2019,all patients included in complication evaluation but only ovarian and peritoneal cancers (71) were enrolled in OS and PFS analyses.During cytorective surgery only patients with R0 resection recieved 75 mg/m2 cisplatin at the temparature of 41,5 C for 60 minutes and HİPEC was administred with closed technique.

RESULTS: Median age of chort was 58 years (23y-78y),Median follow up time was 12 months (2m-46m).60 (84,6 %) patients were subjected to secondary cytoreduction while 8 (11,2 %) had undergone tertiary cytoreductive surgery and finally 3(4,2 %) had quarternary cytoreductive surgery.Median lenght of time of stay at hospital was 10 days (4-60 days).Most of the patients had high grade serous histology (84,6 %).37 (52,1 %) patients were platinum resistant while 34 (47,9 %) were platinum sensitive. Characteristics of patient are given in table 1.Platinum sensitivity did not affect neither OS nor PFS in multivariant analayses(table 2,4).Recieving bevacizumab before hipec and presence of ascites during surgery were independently affected OS and PFS,in addition reciving HİPEC before 5,5 months after last chemotheraphy cycle affected PFS (table 4).Most common complication of HİPEC was post operative ileus(10,1 %) and transient serum creatinine elevation (8,9 %). Conslusion:HİPEC in recurrent ovarian carcinoma is promisng treatment with mild to modarate complication rates however patient selection must be very carefully.İn the light of current study,patients who recieved bevacizumab previously and have ascites does not seem to benefit from HİPEC.

Keywords: Hiperthermic İntraperitoneal Chemotheraphy,Recurrent Ovarian Cancer.

Characteristics of Patients

Median Age	58 y (23-78)
Median Follow up Time	12 m (2-46)
Type of Cancer Ovary Peritoneal Appendix Mesothelioma Endometrium Total	68 (86.1 %) 3(3,8 %) 5(6,3 %) 2(2,5 %) 1((1,3 %) 82
Histology High Grade Serous Mucinous Low grade Serous Endometrioid Clear cell	60 (75.9%) 2(2,5 %) 2 1 3
Median time after last Chemotheraphy	5,5 m (1-44)
Median Number of Chemotheraphy Lines	2 (1-8)
Preoperative Albumin Level	3,9 (2,6-4,6)
Pre operative Ca 125 level	101 (14-34709)
Number of patients Recieved Bevacizumab before HİPEC	34 (43 %)
Type of Surgery Primary İnterwal Debulking Secondary Tertiary Quarternal	6 2 60 (75,9 %) 8(10,1 %) 3(3,
Platinum Sensitive	34
Platinum Resistant	37

Complications of HİPEC

	Number	%
İleus	8	10,1
GİS Perforation	4	5,1
Wound İnfection	3	3,8
Transient Elevated serum creatine	7	8,9
No Complication	57	68,4
İntra abdominal Abces	1	1,3
Chronic Renal Failure	2	2,5
Total	82	100

Cox -Regression Multivariant analses of factors affecting Overall Survival

	HR	95 CI (upper-lower)	P value
Bevacizumabe before Hipec	6,7	(1,39-32,3)	0,018
Presence of Ascites	5,3	(1,65-17,5)	0,005
Time after last chemo	0,92	(0,82-1,12)	0,084
Number of lines of Chemo before Hipec	1,2	(0,7-2,2)	0,4
Albumine	1,25	(0,7-29)	0,1
Paltinum Sensitivity	1,2	(0,8-1,15)	0,32

Cox -Regression Multivariant analses of factors affecting Progressin Free survival

	HR	95 CI (upper-lower	P value
Bevacizumab before Hipec	4,17	(1,7-10,2)	0,001
Presence of Ascites	3,1	(1,32-7,62)	0,01
Time after last chemo (5,5 months)	2,9	(1,16-7,26)	0,023
Number of lines of Chemo before Hipec	1,15	(0,8-1,6)	0,6
Albumin	1,23	(06-4,8)	0,2
Paltinum Sensitivity	1,01	(0,12-7,23)	0,1

SS-55

Hymen Protecting Hysteroscopy: Case Series

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INTRODUCTION: Virginity in adult patient can be a challenging issue for gynaecologist especially who are dealing with complaint such as vaginal bleeding. Both diagnosis and treatment options are limited in patients who choose to save her virginity. In this case series we present a case series of patients who underwent hymen protecting operative hysteroscopy for removal of uterine pathologies.

MATERIAL-METHOD: The patients who were admitted to our clinic for gynecological complaints were chosen as the study pool of the study. There were 7 patients with the desire of saving their virginity who were diagnosed with various indications that operative hysteroscopy was indicated. After obtaining informed consent from all patients, hymen protective hysteroscopy technique was used for removal of gynecologic pathology.

RESULTS: The mean age of the patients was 37.7 (max 48, min 29). All patients were admitted to our clinic with a complaint of irregular bleeding or heavy menstrual bleeding. After physical examination and imaging studies in five patients submucous myoma with various diameters and in two patients endometrial polypoid mass were detected (Table 1) All procedures were performed in operating room under general anesthesia. Hysterescope was inserted to the vagina from sub-urethral site of hymenal ring an "no-touch technique" which is described by Bettochi et al. was used. Morcelation was used if the mass is bigger than 1 cm before removal from vagina.

DISCUSSION: Virginity is a personal choice depending on etnic or religious reasons which can be a barrier for evaluation and treatment of patients. There are case series of virgin patients who underwent treatment of uterine or vaginal septum which obstructs the blood flow in adolescent period in the literature. However, removal of myoma can be more challenging but possible with hymen-protecting hysterocopy.

Keywords: Hymen protecting, Virginity, Hysteroscopy

Features of the patients who underwent hymen protecting hysteroscopy

Patient No	Age	Complaint	Diagnosis	Diagnostic Imaging	Size of the Lesion (mm
1	36	HMB	Myoma Uteri	MR	38x36
2	42	IB	Myoma Uteri	MR	25x21
3	39	HMB	Myoma Uteri	MR	39x38
4	29	HMB	Endometrial Polyp	USG	15x10
5	48	IB	Myoma Uteri	USG	28x22
6	41	HMB	Myoma Uteri	MR	53x41
7	29	HMB	Endometrial Polyp	USG	15x15

SS-56

Outcomes of patients with krukenberg tumors from gastric, colorectal and appendix cancer

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PURPOSE: Gastric, colorectal and appendix cancer occasionally metastasize to the ovaries and metastatic tumors have worse prognosis than primary ovarian cancers. The aim of this study was to describe clinical outcomes of cytoreductive surgery in metastatic tumors to the ovaries and present the single center experience over a ten-year period.

MATERIALS-METHODS: The data of 859 patients who underwent surgery for ovarian mass in our center between January 2007 and July 2017 were evaluated retrospectively. Fifty patients (5.8%) who had metastatic tumor from gastric (n:13), colorectal (n:27) and appendix (n:10) cancers to the ovaries in pathological examination included the study.

RESULTS: Mean ages of patients with gastric, colorectal and appendix cancers were 42.8 ± 10, 51 ± 14.7, and 55.3 ± 13.3, respectively. Median overall survival of gastric, colorectal and appendix cancers were 8.9, 25.3, and 18.2, respectively. Bilateral ovarian involvement was related with poor survival compared with unilateral involvement. Chemotherapy had beneficial effect on survival.

CONCLUSION: The prognosis of the metastatic tumors to the ovaries is poor but achieving a complete resection and optimal debulking surgery may improve survival.

Keywords: appendix, colon, gynecology, metastasis, rectum, stomach

SS-57

Müllerian Anomaly Associated with Chronic Pelvic Pain: A Case of Non-Communicating Rudimentary Horn

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INTRODUCTION: Chronic pelvic pain; is a pain that lasts for at least 6 months in women, especially in the lower abdominal region and pelvis, which is continuous or intermittent, unrelated to sexual intercourse and menstruation.Although the cause of chronic pelvic pain cannot be found in many patients, it is generally secondary to gynecological causes such as pelvic inflammatory disease, pelvic adhesion, endometriosis, ovarian residue and ovarian retention syndrome, pelvic congestion syndrome.Also; non-gynecological causes such as irritable bowel syndrome, myofascial pain syndrome and psychosocial factors may also cause chronic pelvic pain.In terms of diagnosis and etiology we aimed to present a case with chronic pain localized to the right lower quadrant, which has been progressive for approximately 4 years.

CASE PRESENTATION: A 14-year-old nulliparous female patient presented to our outpatient clinic with the pain localized to the right lower quadrant, which progressively increased during menstruation. Vaginal appearance was normal on vaginal examination.Abdominal ultrasonography showed two uterine cavities. The thickness of the endometrium in the left uterine cavity was 14 mm, and the right uterine cavity endometrium was 17 mm with dense fluid echo inside. Magnetic resonance imaging(MRI) showed uterine didelfis unicollis appearance.Endometrial fluid with a thickness of 12 mm was observed at the right uterine horn level.Fluid intensities were observed in the left endometrial cavity reaching a thickness of 9 mm. Bilateral kidneys were normal.In the diagnostic hysteroscopy performed with the help of campo without damaging the hymen, only one cervix and small uterine cavity were displayed with the only left tubal ostium. Therefore, the left unicornuate uterus was diagnosed and laparoscopy

was performed.In laparoscopy unicornuate uterus was observed on the left side and there was a non-communicating rudimentary horn independent of the uterus but associated with the right tube with unicorn appearance about 5 cm diameter on the right side.After observation right rudimentary horn and right tuba were excised and sent to the pathology.

DISCUSSION: Unicornuate uterus associated with rudimentary horn is one of the rare gynecological anomalies with approximately 1/100000[1].Müllerian anomalies were defined by the American Society for Reproductive Medicine (ASRM) into 7 groups and the unicornuate uterus was divided into 4 subgroups[2].Our case fits the second definition in this classification which was rudimentary horn with endometrial cavity not associated with the uterus.Although it is said in the literature that endometriosis, intraabdominal adhesions and renal anomalies can be seen in such cases, we did not find this in our case[3].In patients presenting with chronic pelvic pain, urinary tract abnormalities and pelvic mass suspicion, mullerian anomalies should be considered and, when detected, should be excised, preferably laparoscopically.

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Keywords: Chronic pelvic pain,Mullerian,Laparascopy

SS-58

Delivery methods and cesarean indications in immigrant pregnant women

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AIM: The number of immigrant women who give birth in our country is increasing gradually.
Revealing the delivery methods and cesarean indications in immigrant women may lead to find deficiencies in the management of births in these population. In this study, it was aimed to reveal the delivery methods and cesarean indications in immigrant pregnant women.

METHOD: Immigrant pregnant women who gave birth in Etlik Zübeyde Hanım Training and Research Hospital between 2013-2016 were retrospectively analyzed. The study population is the immigrant pregnants of Afghanistan, Syria, Iraq and other foreign countries. Birth records of the patients were investigated. Demographic charecteristic; age, gravida, parity, delivery method (vaginal delivery, cesarean section) and priority indications for cesarean section were recorded.

RESULTS: 1572 cases were evaluated in this study. The median age of the patients was 26 and 1086 women (69.1%) were multiparous. 760 (48.3%) women had no pregnancy follow-up in the first and second trimesters. 1227 (78.1%) pregnant had vaginal delivery. Indications for caesarean section in 345 women with cesarean section were; previous cesarean section (N: 95, 27.6%), labor dystocia (N: 92, 26.7%), fetal distress (N: 80, 23.4%), cephalopelvic disproportion (N: 44, 12.8%), breech presentation (N: 15, 4.3%), hypertension during pregnancy (N: 14, 4.1%) and multiple pregnancy (N: 5, 1.2%).

CONCLUSIONS: It is noteworthy that the rate of cesarean section is high in immigrant pregnant women. Vaginal delivery is the preferred method of birth due to early and late complications of cesarean delivery. For this reason, vaginal birth encouraging practices, trainings and social services should be conducted in immigrant pregnant women.

Keywords: Cesarean section, vaginal birth, pregnancy, Turkey.

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P-01

Use of Sentinel Lymph Node Algorithm and Reflex Frozen Section in Low-Risk Endometrial Cancer

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OBJECTIVES: The aim of this study is to determine the side-specific and overall lymphadenectomy rates in low-risk clinically early stage endometrial cancer patients by incorporating intra-operative frozen section examination of uterus to identify the patients with failed mapping by sentinel lymph node (SLN) mapping algorithm.

METHODS: Patients with apparently early stage endometrial cancer from six institutions were included to this study between February 2016 and July 2019. Side-specific and overall pelvic lymphadenectomy rates were retrospectively calculated and compared to theoretical lymphadenectomy rates in low-risk patients who were failed to map.

RESULTS: Out of 372 patients who had undergone SLN mapping algorithm, 230 patients were categorized as low-risk according to uterine features. In 167 patients (72.6%) SLNs were detected bilaterally and in 44 patients (19.1%) unilaterally. Nineteen (8.3%) patients were failed to map bilaterally. Eight (3.5%) nodal metastasis were detected. Metastasis were limited to SLNs in 7 patients and SLN+non-SLN metastasis was seen in one patient. Two of these metastases were detected in unilaterally mapped patients and both were limited to SLNs. If all patients who failed to map had undergone side-specific lymphadenectomy, 107 (28.8%) patients would have undergone either unilateral or bilateral lymphadenectomy, yielding an 18.4% rate of side-specific lymphadenectomy. If reflex frozen section would have been applied to these patients, these rates would have been 11.8% and 7.4% respectively.

CONCLUSIONS: SLN mapping algorithm seems like a reasonable approach for evaluation of nodal status in low-risk endometrial cancer patients since all metastases included SLNs. Reflex frozen section analysis may further decrease lymphadenectomy rates by identifying patients at lowest risk for lymphatic metastasis.

Keywords: endometrial cancer, frozen section, lymphatic metastasis, sentinel lymph node

Table 1. Clinicopathologic Characteristics of Low-Risk Patients

Age, (years), mean (range)	56.8 (36-84)
BMI, (kg/m²), mean (range)	32.4 (17.9-57)
Surgical route	
Laparotomy, n (%)	32 (14)
Laparoscopy, n (%)	168 (73)
Robotic, n (%)	30 (13)
Type of lymphadenectomy	
Only SLND, n (%)	62 (27)
BPLND, n (%)	131 (57)
BPPALND, n (%)	37 (16)
Dye	
ICG	165 (71.7)
MB	65 (28.3)
Detection rate	
At least 1 SLN	211 (91.7)
Bilateral	167 (72.6)
Unilateral	44 (19.1)
None	19 (8.3)
Tumor size, (mm), mean (range)	22.6 (2-80)
Histology	
Endometrioid	227 (98.7)
Mucinous	3 (1.3)
Myometrial invasion	
None	45 (19.6)
<1/2	185 (80.4)
Grade	
1	45 (19.6)
2	185 (80.4)
LVSI	
Negative	216 (93.9)
Positive	14 (6.1)
Stage	
IA	218 (94.8)
IB	2 (0.9)
IIIA	2 (0.9)
IIIC1	7 (3)
IIIC2	1 (0.4)
Nodal metastasis, #	8 (3.5)
SLN metastasis, #	8 (3.8)

P-02

Non-Sentinel Lymph Node Metastasis Risk in Patients with Sentinel Lymph Node Metastasis in Endometrial Cancer

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OBJECTIVES: The aim of this study is to identify risk factors which can predict non-sentinel lymph node metastasis when sentinel lymph node (SLN) is positive.

METHODS: We retrospectively reviewed patients diagnosed with endometrial carcinoma who underwent surgery including SLN mapping algorithm and ultrastaging procedure in six centers between February 2016 and July 2019.

RESULTS: 372 patients were included to this study. There were 43 patients with lymphatic metastasis and 36 of them had SLN metastasis: 18 (50%) macrometastasis, 9 micrometastasis (25%) and 9 (25%) isolated tumor cells (ITC). Four cases were diagnosed with side-specific lymphadenectomy and 3 had isolated paraaortic metastasis. More LVSI and Grade 3 disease were seen in patients with macrometastatic disease compared to low-volume metastasis (p=0.041 and p=0.016 respectively). Twelve (33.3%) of the patients with metastatic SLN also had non-SLN metastasis. Type of SLN metastasis (p=0.001) and presence of LVSI (p=0.033) were found to be risk factors for non-SLN metastasis.

CONCLUSIONS: Macrometastasic SLNs were detected commonly in patients LVSI and grade 3 disease. Macrometastatic SLN is associated with non-SLN involvement. Leaving these metastatic nodes in situ should be evaluated on further studies.

Keywords: endometrial cancer, lymphatic metastasis, sentinel lymph node

Table 1. Clinicopathologic features associated with non-SLN metastasis

	Total, 36 (100)	Only SLN, 24 (66.7)	Non-SLN, 12 (33.3)	p value
Age, (years), median (range)	63.5 (37-77)	62 (38-75)	65.5 (37-77)	0.592
BMI, (kg/m^2), median (range)	30 (20.8-52.3)	31 (22.7-52.3)	30 (20.8-40.1)	0.164
Menopausal status				0.343
Premenopause	6 (16.7)	3 (12.5)	3 (25)	
Postmenopause	30 (83.3)	21 (87.5)	9 (75)	
Tm size, (mm), median (range)	47 (16-100)	45 (20-100)	55 (16-85)	0.963
Histology				0.569
Endometrioid	29 (80.6)	19 (79.2)	10 (83.3)	
Serous	3 (8.3)	3 (12.5)	0	
Clear cell	2 (5.6)	1 (4.2)	1 (8.3)	
Carcinosarcoma	2 (5.6)	1 (4.2)	1 (8.3)	
Myometrial invasion				0.086
<1/2	13 (36.1)	11 (45.8)	2 (16.7)	
>1/2	23 (63.9)	13 (54.2)	10 (83.3)	
Grade				0.247
1	3 (8.3)	3 (12.5)	0	
2	15 (41.7)	11 (45.8)	4 (33.3)	
3	18 (50)	10 (41.7)	8 (66.7)	
LVSI				0.033
Negative	8 (22.2)	8 (33.3)	0	
Positive	28 (77.8)	16 (66.7)	12 (100)	
Stage				<0.001
IIIC1	26 (72.2)	24 (100)	2 (16.7)	
IIIC2	10 (27.8)	0	10 (83.3)	
SLN met type				0.001
Macrometastasis	18 (50)	7 (29.2)	11 (91.7)	
Low-volume	18 (50)	17 (70.8)	1 (8.3)	
Risk				0.156
Low-risk	8 (22.2)	7 (29.2)	1 (8.3)	
High-risk	28 (77.8)	17 (70.8)	11 (91.7)	

P-03

Women with Human papilloma virus; Their knowledge and attitude about cervical cancer

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OBJECTIVE: HPV-based screening was first implemented in Turkey in 2014. As it is well known the success of any cancer screening policy is known to be closely related to the population's participation in screening programs and baseline knowledge about cancer and the screening program. Popular awareness, knowledge and attitudes towards cervical cancer, HPV and the screening program was investigated among women with positive HPV test after HPV-based screening began in Turkey.

METHODS: A gynecologist administered questionnaire was conducted to 58 women aged 30 to 65 years in a tertiary care settings. All women had positive Hpv test diagnosed in national cancer screening center. Sociodemographic characteristics, awareness, knowledge and attitude toward HPV, cervical cancer, HPV vaccine national HPV based cervical cancer screening of participants were assed. The questionnaire comprised 4 parts: Part 1: Demographic and sociocultural questions, Part 2: Awareness, knowledge and attitude towards HPV infection, cervical cancer and HPV vaccine, Part 3: Awareness and attitude about cervical cancer screening.

RESULTS: The median participant age was 45 years. Five (8.6%) participants had graduated from a university or received higher education. 44 (75.8%) women were living in the city center, and 10 (17.2%) participants had an annual family income above the poverty line. 16 participants (27.6%) had heard about HPV, and only three (5.2%) had knowledge of HPV transmission. 35 (60.3%) participants had heard about the national cervical cancer screening program, and among those who had heard about the national cervical cancer screening program 31 (88.6%) indicated that health professionals were the source of information.

CONCLUSION: In the present study, a majority of participants had inadequate knowledge about HPV, cervical cancer and national cervical cancer screening. Women should be educated about cervical cancer. Efficiency of information sources other than health care providers should be increased. Especially television and internet based visual information should be provided.

Keywords: Hpv, cervical cancer, screening, Turkey

P-04

Pulmonary Benign Metastasizing Leiomyoma with Intravenous Leiomyomatosis of Uterus: A Case Report

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AIM: Benign metastasizing leiomyoma (BML) is a rare disorder that leiomyoma tissue metastasise extrauterine sites. The most frequent site of metastasis is the lungs. In most cases, there is a previous history of hysterectomy for uterine leiomyoma. Pathogenesis is not still clear, however the metastasis of a uterine lesion through lymphovascular spread or hormone-sensitive proliferation of smooth muscle cells were suggested. Intravenous leiomyomatosis (IVL) is also defined as an intraluminal growth of benign smooth muscle cells in either venous or lymphatic vessels outside the confines. We herein report a case of pulmonary BML and uterine IVL in a premenopausal woman with no previous history of uterine surgery.

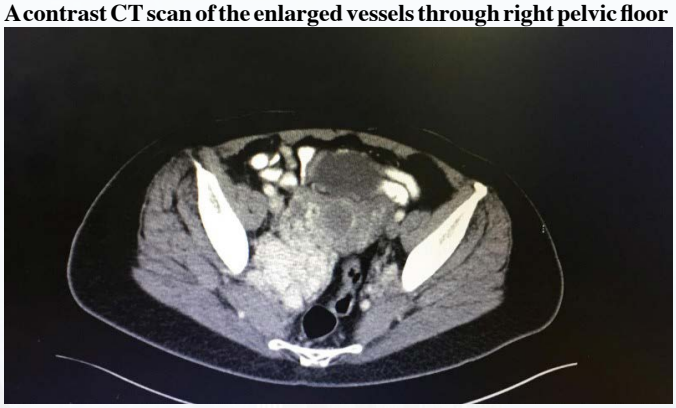
CASE: A 45 year-old female gravida 2, para 2 presented with progressive shortness of breath. Thoracoabdominal CT showed multiple pulmonary nodules bilaterally, with the largest diameter of 20 mm, concerning for metastatic disease and no further abdominal pathology was seen. She underwent a thin needle biopsy and histopathology revealed a suspiciton of mucinous neoplasm. Endoscopy and colonoscopy were performed and there was no sign of primary tumor. Wedge resection of the largest lesion for diagnosis was planned. Tumor was estrogen and progesterone receptors positive, has a low proliferation index and was reported as BML. After discussing the options with the patient, treatment with tamoxifen and follow up thoracal imaging for pulmonary nodules was planned.

Follow up scans showed significant regression in pulmonary nodules. 3 years after, control scan showed a solid mass that cannot be seperated from the uterine wall and right adnexa with the possible invasion to the hypogastric vein. An abdominal mrg was performed which showed arteriovenous malformations without any intraluminal proliferation on the right pelvic floor. A total abdominal histerectomy and bilateral salpingo-oopherectomy was planned. İntraoperatively uterus was larger than normal range and ovaries were normal. On the right pelvic floor including the uteroovarian ligament there were abnormal arteriovenous enlargements. Final pathology reported an intravenouse leiomyomayosis of uterus and a 1.5 cm intramural leiomyoma. Daily letrozole treatment was planned postoperatively and she is currently being followed up as an outpatient with control thorax scans for pulmonary metastases.

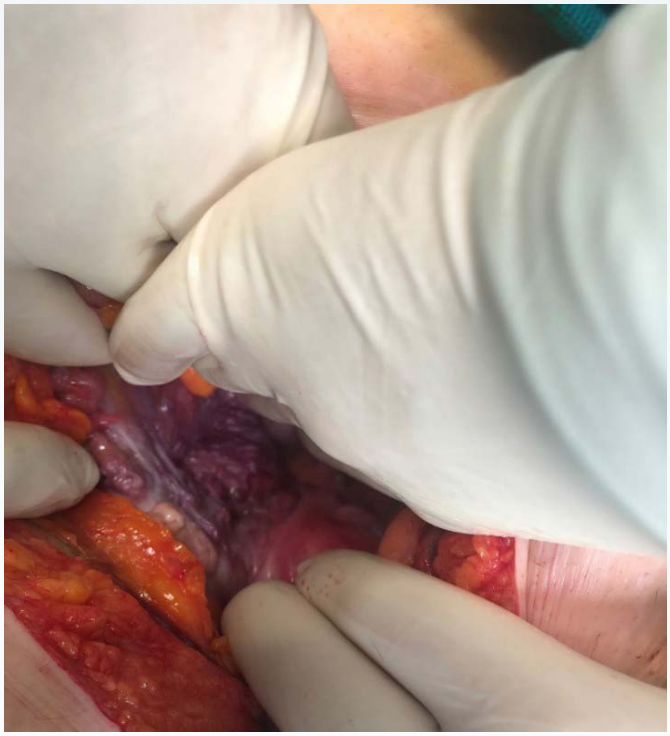
DISCUSSİON- CONCLUSION: Recent researches involving comparative genetic hybridization, clonal number, and copy variance showed that IVL and BML share the same cytogenetic origin. Uterine leiomyomatas are tend to grow hormone-dependent. It is seen to regress after menopause. Pulmonary metastases are also found to be positive for estrogen and progesterone receptors. Management of BML is still controversial. Hormonal therapies such as tamoxifen and aromatase inhibitors has been shown to shrink tumour size. Chemical and surgical menopause could be a choice of treatment. For both IVL and BML, total resection of the lesion should be considered, if possible. In conclusion, BML and IVL are both rare conditions without a management guideline. Management strategy should be discussed with the patient and must be individualisied.

Keywords: Benign metastasizing leiomyoma, Intravenous leiomyomatosis, leiomyomayosis

A contrast CT scan of the enlarged vessels through right pelvic floor



Intraoperative image of arteriovenous malformation in the right adnex



P-05

Transient diarrhea and anal incontinance after laparascopic sacrocolpopexy procedure

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OBJECTIVE: We aimed to share two cases of transient diarrhea and transient anal incontinence after laparoscopic sacrocolpexy procedure.

MATERIALS-METHODS: Patients' data were collected from the hospital electronic files. Age, parity gravida, operation history, physical examination findings, length of hospital stay,amount of blood loss were recorded.

RESULTS: The ages of the patients were 48 and 59, respectively, and they had a history of Total abdominal hysterectomy due to leiomyoma and abnormal uterine bleeding. BMI was 24kg / m2 and 26kg / m2 respectively. The patients had 3 and 2 normal vaginal births respectively. No additional systemic diseases was detected. Physical examination revealed stage 4 vaginal vault prolapse in both of them. Laparoscopic sacrocolpopexy procedure was performed in both patients.A macroporus poliprolen Y shape mesh was inserted on the vesicovaginal fascia anteriorly and rectovaginal fascia posteriorly, long tail was fixed on anterior longutidunal ligament at the level of sacrum1.Mesh was fixed with 2-0 prolene sutures. 2gr iv Cephalosporine group antibiotic was administered. Operations lasted an average of 90min. Mean blood loss was 230ml.No complications were observed at the operations. Gas discharge was positive at postoperative one day. Patients vital signs were stable. Diarrhea and anal incontinance started postoperative 19th hours. stool cultures were normal. We continued with iv hydration and broad spectrum antibiotic. Anal sphincters were evaluated with anal manometry in consultation with general surgeon but no pathology was detected. Patients were followed up for 12 days in the hospital due to diarrhea and stool incontinence. The diarrhea was improved on the 10th day stool incontinence was improved on the 12th day.Patients were discharged with healing.

CONCLUSIONS: Intestinal obstruction, bowel perforation, spondylitis, osteomyelitis are well known complications of sacrocolpopexy procedure.Transient anal incontinance and diarrhea weren't reported before. Stretching of the bowel due to mesh and postoperative tissue edema can cause pressure on the sacral 1 nerve root, can cause neurological dysfonction of bowel and anal sphincter. So we should know that this condition is temporary and should conservative management.

Keywords: anal incontinance,diarrhea,sacrocolpopexy,

P-06

Comparison of Maternal Results of Late Cord Clamping in Caesarean section

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OBJECTIVE: The late clamping of the umbilical cord increases the blood transfusion from the placenta to the newborn at birth, thereby increasing the blood volume in the newborn. Nowadays, it is recommended to clamp the umbilical cord after waiting 30 90 seconds for all births. There is insufficient study of the maternal effects of late clamping of the umbilical cord. It is aimed to investigate retrospectively the maternal outcome of cesarean sections in this procedure which can be performed more easily and safely during normal delivery.

MATERIAL-METHODS: The file information, operative notes, birth record books and archive records of patients with cesarean section between January 2017-November 2017 were reviewed retrospectively in our clinic. Patients were divided into two groups. Patients in the first group were immediately clamped following umbilical cord infant birth, and in the second group they were separated by approximately one minute for cord clamping. Subsequently, maternal postpartum hemoglobin, hematocrit values, postpartum blood transfusion requirement, duration of hospital stay, and postoperative hemoglobin and hematocrit in anemic patients were compared in two groups.

RESULTS: There were 408 patients in total, including 231 in the late cord clamped group and 177 in the early cord clamped group. None of our patients had maternal mortality or postpartum hysterectomy.

The demographic characteristics of the patients were similar, such as age, gravida, parity, blood group, additional disease, cesarean indications, gestational weeks. The body mass index of patients in the late cord clamped group was lower than the other group. When the groups were compared, there was a statistically significant difference in terms of operation time. In the early cord clamped group, mean duration of operation was 33.47 (± 7.97) minutes; in the late clamped group was 30.9 (± 7.87) minutes. There was also a difference in the length of hospitalization between the two groups. The mean duration of hospitalization was 1.98 (± 0,414) days in the early clamped group and 1.85 (± 0,452) days in the late clamped group. There was no significant difference between groups in preoperative hemoglobin and hematocrit values. There was a significant difference in hemoglobin and hematocrit change between the two groups. The hemoglobin and hematocrit decline was more pronounced when the cord was late clamped. There was no difference in blood transfusion between the two groups. There was no statistically significant difference between the postoperative hemoglobin and hematocrit changes in the patients with moderate anemia in the cases with moderate and mild anemia. Among the groups with mild anemia, the decrease in postoperative hemoglobin and hematocrit was statistically significant in the late cord clamped group compared to the early cord clamped group. However, in both mild and moderate anemia patients, there was no significant difference in the need for blood transfusion and duration of hospital stay in both groups.

CONCLUSION: Late cord clamping in the cesarean can be safely performed without an increased risk of severe postpartum hemorrhage. In patients with mild to moderate anemia, late cord clamping does not increase maternal mortality and morbidity.

Keywords: Late cord clamping, cesarean delivery, postpartum hemorrhage, maternal anemia

Geç kord klemplenen ve erken kord klemplenen hastaların demografik özellikleri

Tablo 3. Geç kord klemplenen ve erken kord klemplenen hastaların demografik özellikleri

	Kontrol	Geç Kord Klempleme	P değeri
Yaş	28 (13-42)	29 (18-44)	0,306*
VKI	29,3 (20,8-40,21)	28,7 (18,6-44)	0,019*
Gravida	2 (1-10)	2 (1-9)	0,975*
Parite	1 (0-5)	1 (0-5)	0,680*
Abort	0 (0-7)	0 (0-4)	0,744*
Ek hastalık			
Yok	156 (%88,1)	199 (86,1%)	0,690**
HT	2 (1,1%)	4 (1,7%)	
DM	8 (4,5%)	8 (3,5%)	
Epilepsi	4 (2,3%)	5 (2,2%)	
Hipotiroidizm	1 (0,6)	6 (2,6%)	
Diğer	5 (3,4%)	9 (3,9%)	
Gebelik haftası	38 (27-42)	38 (32-41)	0,523*
Sezeryen Endikasyonu			
Eski	95 (53,7%)	130 (56,3%)	0,445**
Distosi	19 (10,7%)	16 (6,9%)	
Malprezentasyon	47 (26,6%)	55 (23,8%)	
İlerlemeyen Eylem	9 (5,1%)	15 (6,5%)	
Diğer	4 (2,3%)	12 (5,2%)	
İri Bebek	3 (1,7%)	3 (1,3%)	

VKI: Vücut kitle indeksi; HT: Hipertansiyon; DM: Diyabetus Mellitus

*Mann Whitney Test

**Ki kare

Hafif anemisi olan hastalarda hemoglobin ve hematokrit değişimi

Tablo 8. Hafif anemisi olan hastalarda hemoglobin ve hematokrit değişimi

	Kontrol	Geç Kord Klempleme	P değeri
Hb Değişimi	0,7 (0-2,2)	0,9 (0-3,7)	0,032*
Htc Değişimi	1,5 (0-7,30)	3,1 (0-10,4)	0,001*
Kan transfüzyonu	2	2	0,951
Transfüzyon Miktarı	2 (2-2)	2 (2-2)	0,951
Yatış Süresi	2 (2-2)	2 (2-2)	0,030

Hb: Hemoglobin; Htc: Hematokrit

*Mann Whitney U test

Maternal sonuçların geç kord klemplenen ve erken kord klemplenen gruplar arasında karşılaştırılması

Tablo 4. Maternal sonuçların geç kord klemplenen ve erken kord klemplenen gruplar arasında karşılaştırılması

	Kontrol	Geç Kord Klempleme	P değeri
Operasyon Süresi	34 (17-51)	34 (17-68)	0.01*
Yatış Süresi	2 (1-3)	2 (1-3)	0,005*
Preop Hb	11,7 (7-14,9)	12,2 (8,3-14,9)	0,024*
Preop Htc	35,9 (21,3-45,2)	37 (26,1-44)	0,065*
Postop Hb	10,8 (5,7-14)	10,9 (6,3-14,2)	0,673*
Post Htc	33,2 (19,2-47,6)	33,2 (19,2-42,7)	0,977*
Hb Değişimi	0,9 (0-4)	1,1 (0-5,7)	0,005*
Htc Değişimi	2,7 (0-14,8)	3,5 (0-17,1)	0,004*
Kan transfüzyonu	8 (4,5%)	3 (1,3%)	0,063*
Transfüzyon Miktarı	0 (0-4)	0 (0-4)	0,098*

Hb: Hemoglobin; Htc: Hematokrit

*Mann Whitney Test

Moderate anemisi olan hastalarda hemoglobin ve hematokrit değişimi

Tablo 7. Moderate anemisi olan hastalarda hemoglobin ve hematokrit değişimi

	Kontrol	Geç Kord Klempleme	P değeri
Hb Değişimi	0,6 (0,1-2,3)	0,35 (0,1-1,1)	0,610*
Htc Değişimi	2,4 (0-6,3)	1,0 (0,1-3)	0,171*
Kan transfüzyonu	4	0	0,114
Transfüzyon Miktarı	2 (0-4)	2 (2-3)	0,114
YatışSüresi	2 (2-3)	2 (2-2)	0,762

Hb: Hemoglobin; Htc: Hematokrit

*Mann Whitney U test

P-07

Tubaovarian abscess treatment: a research hospital experience

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OBJECTIVE: The aim of this study is to evaluate tuboovarian abscesses treated and followed in our clinic.

MATERIAL-METHOD: Between January 2016 and August 2019, patients who were hospitalized with tuboovarian abscess in our clinic were recruited, retrospectively. The age of the patients, clinical and sonographic presentation, pelvic inflammatory design risk factors, antibiotic therapy, surgical treatment, time interval between hospitalization and surgery, laboratory infection parameters and length of hospital stay were recorded.

RESULTS: We detected 37 patients with prediagnosis of tubo-ovarian abscess were hospitalized. After hospitalization, TOA was ruled out in 8 patients. 29 patients were reviewed. Seven (25.9%) patients underwent surgical treatment because of failed antibiotic therapy. Twenty (74.1%) patients treated successfully with parenteral antibiotic. Ceftriaxone and metronidazole regimen were used in the majority of patients (40.7%), Piperacillin / tazobactam was frequently used for antibiotic regimen changes. Total abdominal hysterectomy and bilateral salphingooopherectomy in 3 of 7 (42.3%) patients who underwent surgery and salpingectomy, salpingoopherectomy, bilateral salpingoopherectomy and abscess evacuation were performed in other patients. Medical treatment failure and need of surgery are more common in patients who have large abscess (volume:>60 cm3 or size: >5cm), elevated CRP levels (>6,7 mg/L) and high ESR (>50 mm/hr).

CONCLUSION: Treatment in tuboovarian abscesses may vary according to clinical, sonographic and laboratory findings; however, treatment should be planned more individually.

Keywords: tuboovarian abscesses, antibiotic therapy, surgical treatment

P-08

Port-site metastasis of granulosa cell tumor of the ovary

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Etlik Zübeyde Hanım Women's Health Teaching and Research Hospital, Ankara

AIM: To present a case managed in our institution.

Case presentation: A 43-year-old woman, gravida 0, has been followed up for granulosa cell tumor of the ovary, presented to our clinic with a mass palpated on her abdomen. On May 2009 laparoscopic right sided ovarian cystectomy was done, and the frozen section was reported as granulosa cell tumor of the ovary. Fertility sparing debulking surgery was made (right unilateral salpingo-oophorectomy + bilateral pelvic and paraaortic lymphadenectomy + peritoneal biopsy+ appendectomy) and stage IA tumor was reported in the final pathology, and no adjuvant treatment was given. During the laparoscopic cystectomy the unruptured 4*5 cm cyst was removed with an endobag. She delivered two healthy children two and six years after the surgery by in vitro fertilization. On June 2019, after ten years from the first diagnose, she presented with a palpable mass on her left side abdomen. An exploratory laparatomy was done. A 3 cm solid mass was determined under the left port site. Also a total abdominal hysterectomy and right sided unilateral salpingo-oophorectomy was added. The final pathology specimen was reported as metastatic granulosa cell tumor. Chemotherapy regimen of 6 cycles taxane and carboplatin was given to her.

CONCLUSION: Granulosa cell tumors have a very good prognosis and recurrence is seen rarely. However, recurrence and distant metastasis are known to occur usually as late as after 10 to 30 years of initial diagnosis. Most recent site of the recurrence is the pelvis; but it can be seen in extrapelvic sites such as lung, liver, brain, bone, diaphragm, abdominal wall, and adrenal gland metastases. The overall incidence of port site metastasis (PSM) in gynecological cancers varies from 1%-10 % in literature. To our knowledge this is the first case of a granulosa cell tumor of the ovary with port-site metastasis. Patients with granulosa cell tumor should be evaluated for late recurrences; thus, patients should be kept on a long-term follow-up protocol and PSM should be kept in mind in the laparoscopic treated patients.

Keywords: Granulosa cell tumor, ovarian cancer, port-site metastasis,

P-09

Uterocutaneous Fistula: Diagnosis and Management

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She was 29 years old and had three cesarean section history. She had a 21 week pregnancy. She was admitted to the maternity ward with the suggestion of anhydroamniosis and termination of pregnancy by the perinatology clinic. After 3 days of medical treatment, hysterotomy was decided because of delivery. Since the patient described bleeding in the incision line during the menstrual bleeding period on the 21st postoperative day, the uterocutaneous fistula was detected on tvusg and mr. Abdominal fistullectomy was performed.

Keywords: uterocutaneous fistula, fistulloctomy, abnormal menorragie

fistula tract intraoperative image

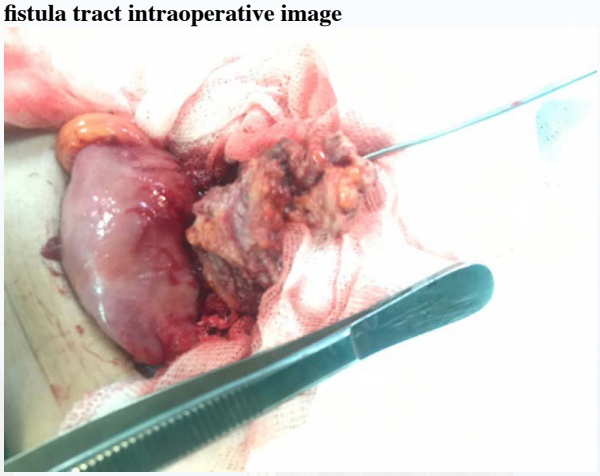
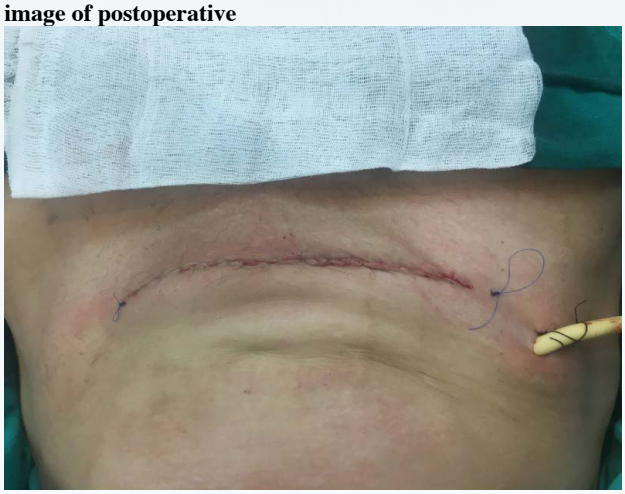
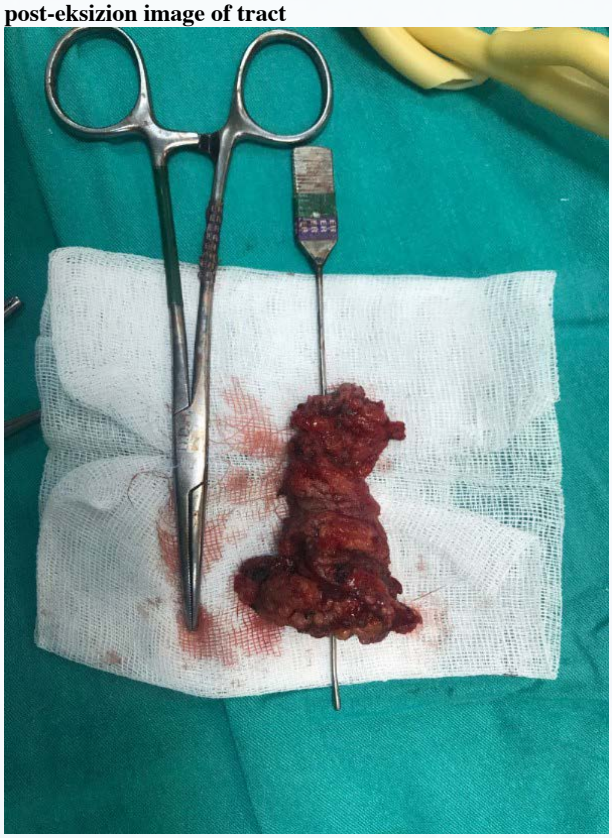


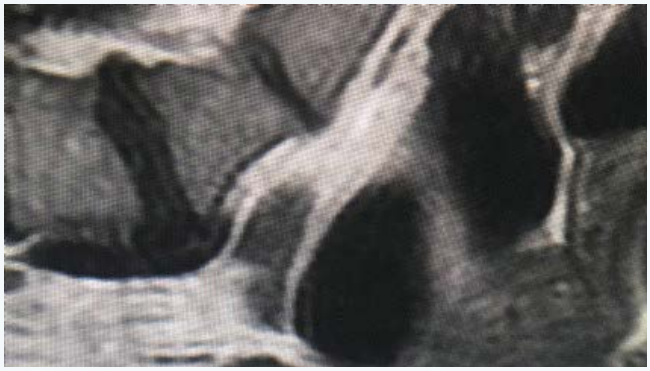
image of postoperative



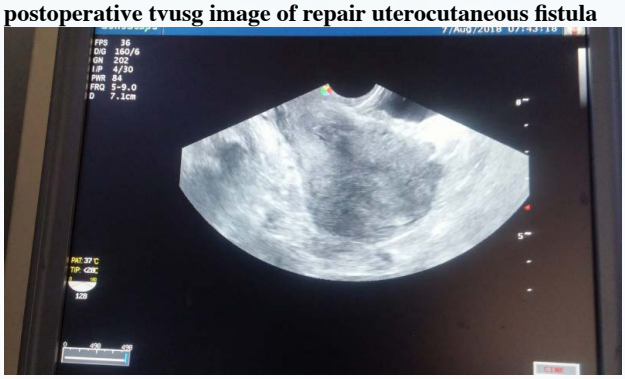
post-eksizion image of tract



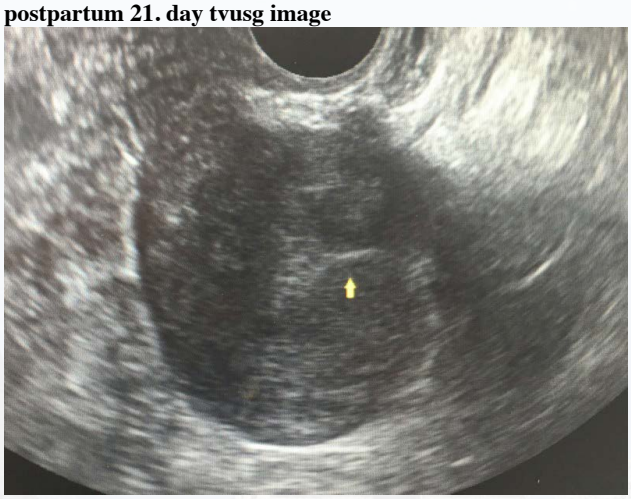
postoperative magnetic resonans image of repair uterocutaneous fistula



postoperative tvusg image of repair uterocutaneous fistula

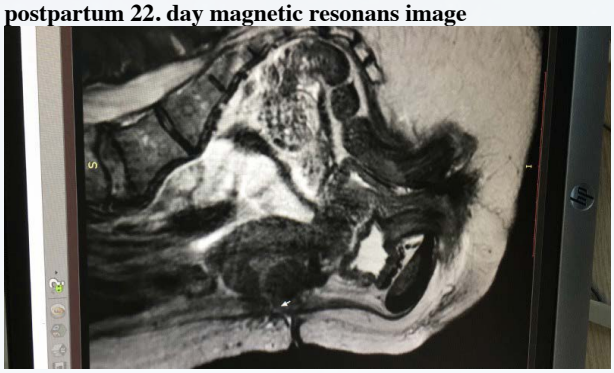


postpartum 21. day tvusg image



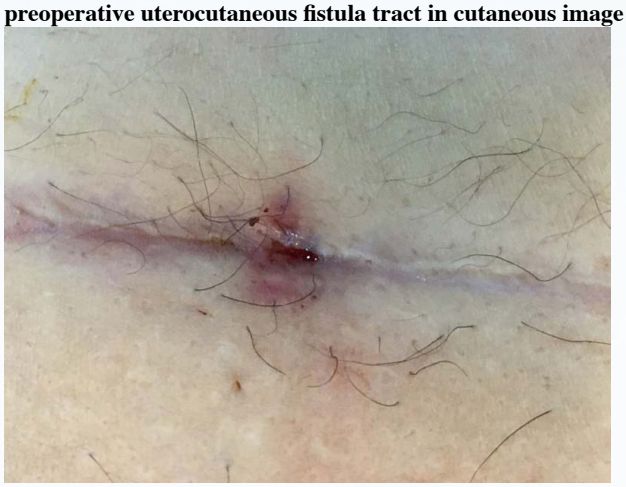
fistula from endometrium to serosa in this image

postpartum 22. day magnetic resonans image

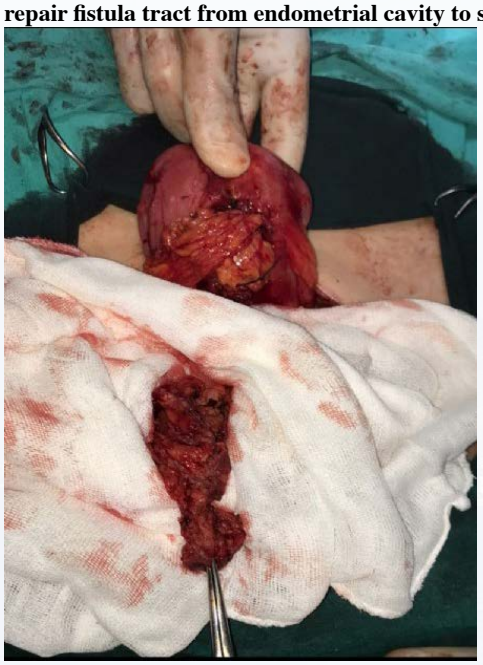


uterocutaneous fistula tract in this magnetic resonans image

preoperative uterocutaneous fistula tract in cutaneous image



repair fistula tract from endometrial cavity to serosa



P-10

Elevetion of serum anti-Mullerian hormone level after multiple myomectomy

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AIM: To present a case with increased anti-Mullerian hormone (AMH) level after multipl myomectomy.

METHOD: A 31-year-old newlywed woman presented with abdominal mass. The patient was anemic (Hb: 7.0 gr/dl). Preoperative AMH level of the patient was 0.62 ng/ml. Ultrasonography revealed several fibroids with the largest size of 10 cm. Myomectomy was performed and eight myomas were extracted. Pathology confirmed leiomyoma with the largest size of 9,5 cm.

RESULTS: Pathology confirmed leiomyoma with the largest size of 9,5 cm (Figure 1). 4 months after surgery, serum AMH level was measured as 1.17ng/ml.

CONCLUSION: Further studies in the larger series will reveal the possible positive effects of myomectomy on ovarian reserve.

Keywords: Myomectomy, anti-Mullerian hormone, ovarian reserve, infertility.

Figure 1

Fibroids

P-11

Undiagnosed placenta previa percreata presenting obstetric emergency in district hospital:Case report

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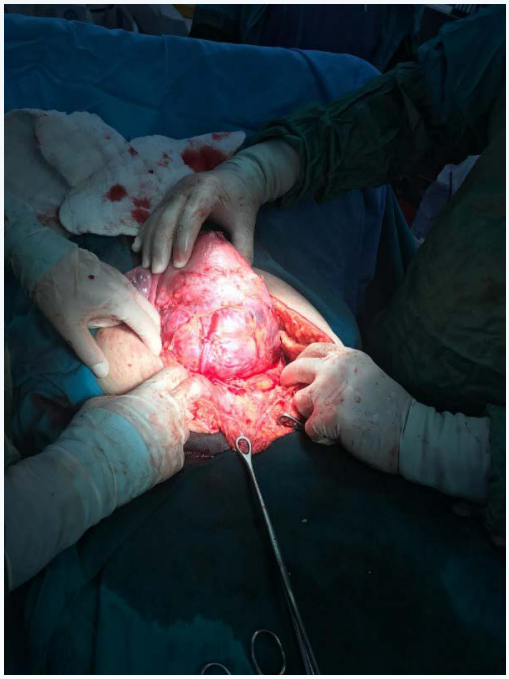
Placenta previa is a placental implantation anomaly where the placenta is located close to the internal os and its incidence has been reported as 0.5%. One of the most important complications of placenta previa is the presence of placental percreta. Nowadays, the incidence of placenta percreta increases due to the increase in the number of cesarean sections.

CASE: A 31-year-old patient who had previously delivered by cesarean section twice was referred to the Batman Maternity and Child Diseases Hospital by ambulance from the district hospital (Kozluk State Hospital) with a preliminary diagnosis of detachment placenta. The ultrasound examination performed on arrival at our hospital revealed a live breech-like fetus whose measurements were consistent with approximately 36-37 weeks of gestation. The placenta closes the cervical internal os completely and the anterior bladder uterine line is not clearly observed. In Doppler ultrasonography, many lacunae in the placenta, hypervascularized areas, and the sonolucing area between the placenta and myometrium could not be clearly observed. As a preoperative diagnosis, placenta previa percreata was considered and the second surgeon was called for immediate assistance, and blood and blood products were urgently requested for surgery. Perioperative observation revealed placental areas invading the bladder and uterine serosa, but the old incision line was not observed. (Figure 1) With a vertical incision, a single live apgar 9-10 baby was removed and the placenta and its attachments were left in. Hysterectomy decision was taken. Perioperative 3 units of erythrocyte suspension and 1 unit of fresh frozen plasma transfusion were performed. Postoperative bladder injury and fistula did not develop.

CONCLUSION: The key to managing cases of placental adhesion anomalies is early diagnosis and subsequent delivery planning.The most striking finding in ultrasonography is the presence of large, irregular, and multiple lacunae. In the literature, in cases with placenta percreta; It is recommended to plan delivery at the end of 35 weeks of gestation after necessary preparations for massive blood transfusion and multidisciplinary approach. Hysterectomy is a traditional treatment for many years under the management of placenta percreta. During peripartum hysterectomy, bladder, bowel, vascular injuries, disseminated intravascular coagulation and genitourinary fistula may be complicated by changes in the pelvic region due to pregnancy. It would be appropriate to select placenta percreta cases for fertility conservation conservative surgery and to plan them in a tertiary center by an experienced operation team.

Keywords: CesareanHysterectomy,Obstetricemergency,Undiagnosed Plasenta Previa Percreata

Resim -1



P-12

Cesarean Myomectomy(Giant myom) in District Hospital Conditions:Fertility Sparing Surgery-Case Report

Erhan Okuyan[1], Murat Tandogan[2], Mustafa Ersoz[1], Hasine Golge Atlı[1]
[1]Batman Maternity and Children's Health Hospital
[2]Kozluk State Hospital

Uterine myomas are the most common pelvic tumor of women in reproductive age (1). They are seen in approximately 0.05-5% during pregnancy (1). In this case report, we aimed to show our approach to the patient who applied to the hospital urgently under the conditions of district hospital (Kozluk State Hospital) in southeastern Anatolia region, that it was difficult to obtain blood and blood products. We aimed to share our experience in a such challenging case that could be encountered in clinical practice in the district hospital in the peripheral region while the doctor was only physician in his branch.

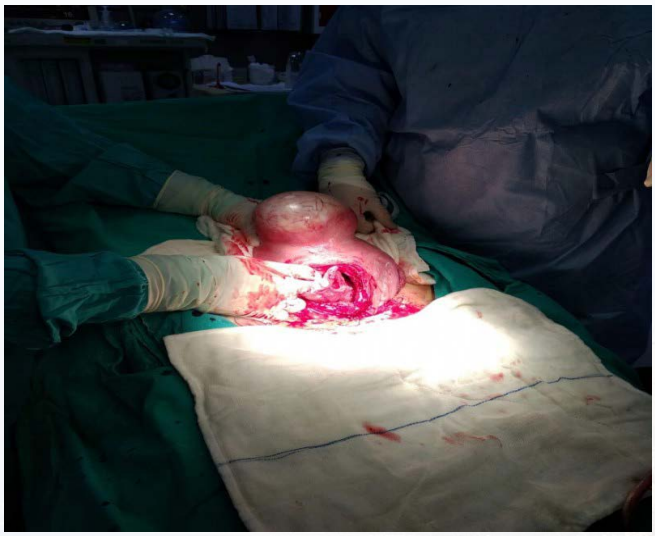
RESULTS:A 27-year-old patient g3p2y2, applied to the emergency department with the complaint of pain and twinge who had not have any previous operation. In anamnesis; the first pregnancy examination was in the 12th week and 6 x 8 cm(centimeter)subserosis fibroids were observed on the fundus anterior wall.The patient hadn't come her visits regularly. Emergency obstetric ultrasonography which was performed at the gestational week of 39; revealed a 15 * 12 cm subserous fibroids in the right anterior wall of uterus fundus.Because of breech delivery,cervical dilatation of 5 cm, and 70 % effacement and negative pouch; emergent cesarrean operation was decided. Surgery was started by obtaining erythrocyte suspension and fresh

frozen plasma reserve from the city center, which is approximately 70 kilometers away. The perioperative fibroid size was 16 * 17 cm (Picture 1). Myoma surface had atypical vascularization so myomectomy was decided due to risk of acute abdomen and postpartum degeneration. Myoma uteri was duly removed and sutured in three layers with the technic of figure of eight sutures. İntraoperative excessive bleeding was not observed. Preoperative hemoglobin was10.9 g/dl(deciliter) hematocrit 34 %, platelets 199 thousand; Right after the operation hemoglobin was 10.6 g/dL hematocrit 33 %, platelets 230 thousand. No blood and blood product transfusion was needed in postoperative service follow-ups. Postoperative fever or acute abdomen was not observed. She was discharged with full recovery at postoperative 48th hour.

CONCLUSION: To leave uterine fibroids in uterus during cesarean section can be seen as a good strategy to prevent bleeding.With a short-term perspective, this approach may seem correct. Studies have revealed the contradictions of this approach in the long term. The safety of cesarean myomectomy has been reported in the last 10 years; Recent studies have shown that performing myomectomy during cesarean section does not increase the incidence of intra-operative bleeding and uterine atonia compared to the group undergoing cesarean section alone (2). İn the long term;because of risk of intraabdominal adhesions and possible loss of fertility; fertility-preserving surgery can be performed safely with the right preoperative preparation even in the district hospital in the peripheral regions, and as a state service officer, young gynecolog and obstetricians can safely perform cases of cesarean myomectomy.

Keywords: Ceserean Myomectomy,Fertility Sparing Surgery,Giant myom

Picture-1



P-13

Laparoscopic management of a postmenopausal woman diagnosed with concomitant adnexal torsion and ovarian cyst rupture

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AIM: Continuous dull pain is the most common presenting symptom in postmenopausal women with adnexal torsion. However ovarian cyst rupture presents itself with sudden onset sharp pelvic pain. In the present case, we demonstrated a postmenopausal woman presenting with acute pelvik pain who also suffers from chronic dull pelvic pain. We demonstrated the laparoscopic management and intraoperative images of the patient.

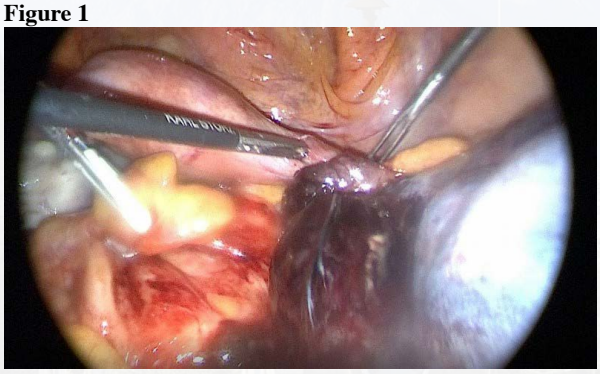
METHODS: 52 year old woman presented with sudden onset sharp pelvic pain. Her menopause age was 42. Ultrasound examination revealed a 90 x 91 mm left ovarian cyst. She also explained that she had a dull pelvic pain for many years. Emergent laparoscopic surgery was performed.

RESULTS: 200 ml of hematom and left tuboovarian torsion with ruptured ovarian cyst were observed intraoperatively (Figure 1). Cyst was about 10x15 cm in dimensions. Ovary and fallopian tube were rotated three times around themselves. They were detorsioned and afterwards salpingooferectomy was performed. The material were removed from 15 mm trochars in an endobag (Figure 2). The patient had a quick postoperative recovery period and discharged at day 1.

CONCLUSION: Concomitant adnexial torsion and ovarian cyst rupture in a postmenopausal woman is an uncommon event. It can be managed successfully by laparoscopy.

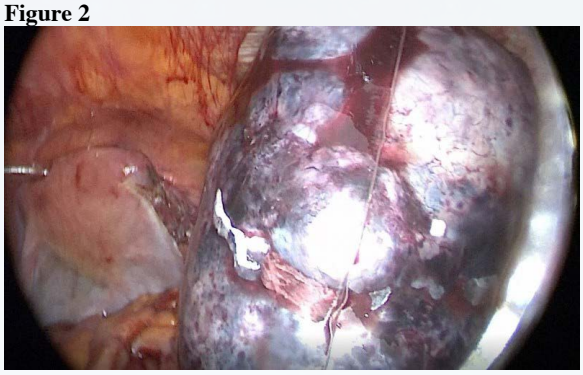
Keywords: Laparoscopy, adnexal torsion, ovarian cyst rupture

Figure 1



Left tuboovarian torsion with ruptured ovarian cyst and intraabdominal hematom

Figure 2



The ovary and adnex were removed from 15 mm trochars in an endobag.

P-14

Adolescent pregnancy outcomes: data from a research hospital

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OBJECTIVE: The aim of this study was to evaluate the results of adolescent pregnancy in our clinic.

MATERIAL-METHOD: Between July 2018 and August 2019, the patients who gave birth in our clinic were screened for pregnancies aged 19 and under. Parameters of birth and neonatal outcomes of 89 patients were recorded.

RESULTS: 89 (6,16%) of 1445 deliveries performed at our clinic at the time of the study were adolescent pregnancies with antenatal follow-up. Of the 89 patients, 24 were 17 and under, 65 were 18 and 19 years old. While only one patient was 15 years old, delivery was performed by cesarean in 7 of 89 patients (7.87%) due to previous cesarean section. 6 (85.7%) of these 7 patients were Syrians, and 40.4% of total adolescent pregnancies were foreign nationals, most of whom were Syrians. Of the 89 patients, 21 (23.6%) delivered by cesarean section for various reasons, while the total cesarean rate in this period was 41.4%. The primary cesarean rate was 11.76% in total, whereas it was 15.70% in adolescent pregnancies. The mean birth week of the patients was 39.2 + - 0.2 weeks and the mean birth weight was 3054.86 gr. Of the 89 patients, 12 (13.5%) required neonatal intensive care and maternal and neonatal serious morbidity and mortality were not observed.

CONCLUSION: Unexpected complications related to pregnancy can be seen more prominently in adolescent pregnancies. Close monitoring of adolescent pregnancies will prevent possible problems.

Keywords: adolescent pregnancies, neonatal outcomes, antenatal follow-up

P-15

Think different: Uterus bicornis in a patient with a preliminary diagnosis of placental abruption- Case report

Erhan Okuyan, Adem Yoldas, Necim Yalcin, Hasine Golge Atli
Batman Maternity and Children's Hospital

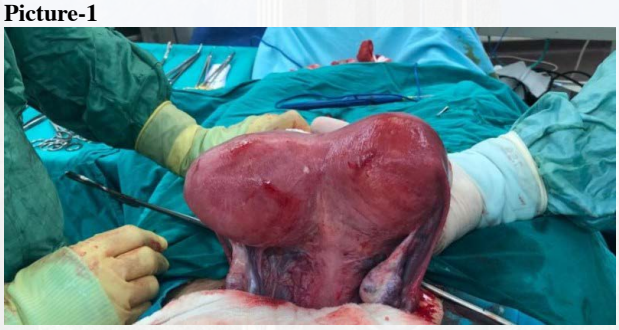
Uterine anomalies are usually incidental findings in our environment, because of the limited spread of noninvasive diagnostic procedures and low socioeconomic level. We present a case of a 32-year-old patient, presented at 38 weeks of gestation with antepartum hemorrhage secondary to detachment of placenta.Uterine bicornis was diagnosed during emergency cesarean section despite the fact that she had regular pregnancy controls.

CASE: A 32-year-old patient who had 1 term vaginal delivery and who had regular antenatal follow-up in this pregnancy, admitted to our emergency department with excessive vaginal bleeding. Ultrasonography findings are; breech presentation, amniotic fluid is reduced,38-39 weeks of gestation, placenta adhered to the anterior wall and aproximetely 4 centimeters abruption of placenta. The patient was admitted to emergency cesarean section due to placental abruption. Single live 3100 gram female baby was delivered with apgar 8-10. Uterine bicornis anomaly was detected in perioperative observation (Figure-1).Postoperative service follow-up was normal and the patient was discharged at 48th hour.

DISCUSSION: Pregnancies of women with Mullerian anomalies have potential obstetric complications. However, pregnancies within bicornuate uteri have better obstetric outcome than other Mullerian fusion defect. Clinical diagnosis of uterus bicornis unicollis is difficult; therefore, most often the malformation goes undetected and is discovered incidentally during laparoscopy or during hysterosalpingography, ultrasound scan(three dimensional), and resonance magnetic imaging(2,3,4). The malformation may be discovered during laparotomy or during cesarean section, as in our case. The treatment of uterus bicornis depends on the clinical presentation. It ranges from observation in asymptomatic women with normal obstetric outcomes to cervical dilatation and metroplasty.

Keywords: Congenital Anomaly,Term birth, Uterus bicornis.

Picture-1



P-16

Extremely high levels of both CA125 and CA19-9 in a patient with spontaneously ruptured endometrioma

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AIM: CA125 is an ovarian tumor marker and primarily used in follow up of the patients. CA125 may also increase in benign conditions such as endometrioma. However the levels of CA125 rarely increase above >100 IU/ml in patients with endometriosis. CA19-9 is especially used in diagnosis and follow up of the patients with pancreas cancer. In the present case we demonstrated a patient with preoperatively ruptured endometrioma who had extremely high serum levels of both CA125 and CA19-9.

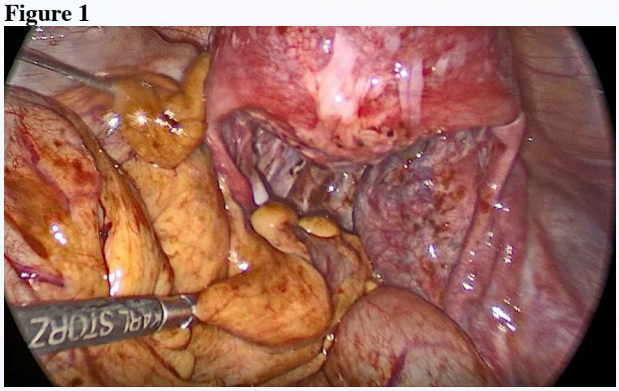
METHOD: A 24 year old woman was presented with acute pelvic pain. Physical examination revealed abdominal tenderness. 7x9 cm ovarian mass was observed in ultrasonographic evaluation. Serum CA125 and CA19-9 levels were 2706 and 926, respectively. Laparoscopy was performed.

RESULTS: Ruptured endometrioma in left ovary and intraabdominal hematom were observed in laparoscopy (Figure 1). Cystectomy was performed. Cyst wall was removed entirely (Figure 2). Histologic examination confirmed endometrioma.

CONCLUSION: A ruptured endometrioma should be considered in a patient with acute pelvic pain, high levels of both CA125 and CA19-9. Laparoscopy should be a diagnostic and treatment method in a patient with ruptured endometrioma.

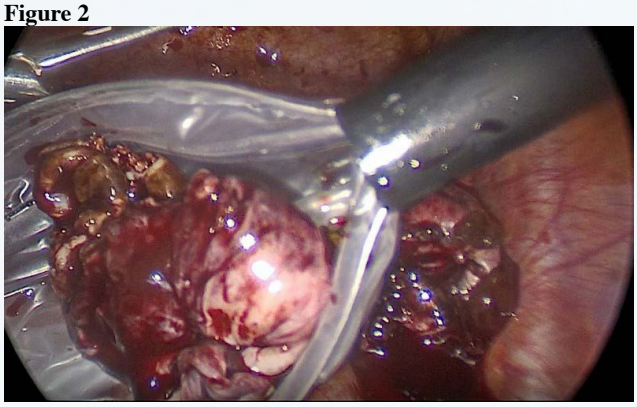
Keywords: CA125, CA19-9, endometriosis, endometrioma.

Figure 1



Ruptured endometrioma in left ovary and intraabdominal hematom

Figure 2



Cyst wall was removed entirely

P-17

The Effects of gonodotropics used for induction of ovulation on disease course in a patient with systemic lupus erythematosus: a case report

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AIM: Systemic lupus erythematosus (SLE) is a systemic autoimmune disease course with attacks. Some medications and conditions cause exacerbations of the disease. One of the causes of acute exacerbation is the increased estrogen level in the body. Although the rate of fertility in SLE is similar to normal healthy population, ovulation induction and IVF may be needed in patients with SLE. Invitro fertilization (IVF) and the medications used for induction of ovulation increase the endogenous estrogen level, thus causing the exacerbation of lupus. Various medications are used for IVF. The mechanism of action of those medications is different but they ultimately increase the level of estrogen. Contrary to this information, we would like to share the clinic results of lupus related to the patient who was prepared for IVF with different gonodotropic drugs that we encountered in the clinic.

CASE: A 41-year-old woman with lupus had IVF for four times since she had no spontaneous pregnancy. The patient underwent ovulation induction for IVF twice with a year between them using follitropin alpha. Following the end of both cycles, she experienced lupus attacks for which rituximab treatment was given. The patient had to use a contraception method since pregnancy is contraindicated for one year after the treatment with rituximab. At the end of this period, the patient applied for IVF since she had no spontaneous pregnancy. This time, since the patient was 41 years old, human menopausal gonadotopin was used for induction of ovulation. This medication caused no lupus attacks in the patient. Thus, ovulation induction could be repeated using the same medication. Also, no attack occurred at the end of this cycle.

CONCLUSION: Patients with SLE have been reported to develop acute exacerbation as a result of increased endogenous estrogen secondary to the medications used for IVF and ovulation induction

independent of their types. However, this patient who was encountered in our clinical practice can be shown as an example for the hypothesis that the type of medication might also play an effective role in the development of acute exacerbation of lupus.

Keywords: Systemic lupus erythematosis, In vitro fertilization, ovulation induction.

P-18

Endometrial cancer metastasis to the frontal lobe; a rare presentation of a gynaecologic tumor

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AIM: To present a case managed in our institution.

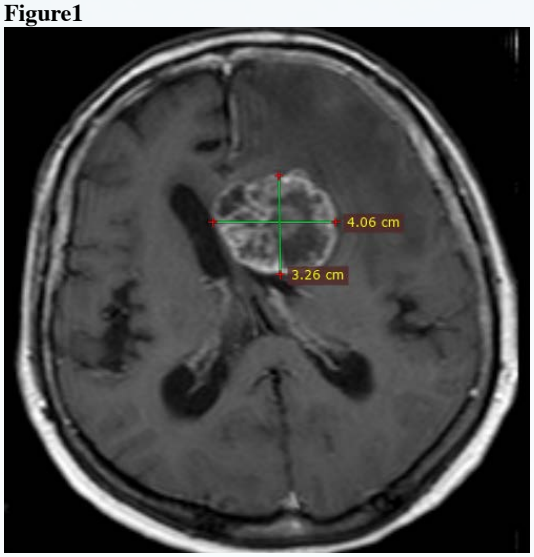
METHODS: This is a case report.

CASE PRESENTATION: A 58-year-old woman; who has been followed up for endometrial cancer, was presented to our clinic with nausea, vomiting and mental confusion. She was diagnosed with endometrial cancer in November 2017, and underwent a maximal debulking surgery. Her final pathology was endometrioid adenocarcinoma grade 3, stage IIIC2 according to the International Federation of Gynaecology and Obstetrics (FIGO) classification 2009 with lenfovascular space invasion. She was treated with 50 gray (Gy) of external beam radiotherapy after six cycles of taxane and carboplatin treatment. Her treatment was completed on May 2018. She was on routine follow up in our clinic. She was admitted sixteen months after the initial diagnose, with the complaint of nausea and vomiting for three days. During her initial examination she was discovered that she had mild confusion, memory loss of recent activities and loss of orientation. Biochemical parameters were within normal range. She had no signs of ileus. After she was consulted to our psychiatry department and she was diagnosed with altered mental status, delirium, and a brain computerised tomography(CT) was recommended in order to exclude any pathology. In the brain CT a solitary 3x4 cm lesion at the left frontal region was discovered (Figure1). Frontal lobe metastasectomy was done by the neurosurgery department. According to the immunhistochemical analysis the tumor was estrogen receptor(ER) negative, progesterone receptor(PR) negative, vimentin negative, p40 negative, epithelial membrane antigen (EMA) positive, cytokeratin (CK) 8/18 positive, cytokeratin (CK) 19 positive, cytokeratin (CK) 7 focally positive. The final pathology revealed it was associated with poorly differenciated endometrial cancer metastasis. After the operation the patient was given whole brain radiotherapy (WBRT) for fourteen days. She is still being followed up without any intra abdominal reccurence.

CONCLUSION: Brain metastasis of endometrial carcinoma is very rare, with an incidence of 0.6%. To our knowledge, there are 115 cases in the literature; with high grade and advanced stage primary illness. The median interval of diagnosis of the endometrium cancer and the brain metastasis is reported as 17 months in the literature. Brain metastasis of endometrial cancer is usually solitary and located in the cerebrum. It is suggested that the brain imaging modalities should be considered in patients with advanced stage endometrium cancer who admit with neurologic symptoms after the diagnosis of endometrial cancer, which is usually known as a neurophobic tumor.

Keywords: brain metastasis, endometrial cancer, neurophobic tumor

Figure1



Solitary lesion at the left frontal region

P-19

Subclinical inflammatory markers in obese pregnant patients

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PURPOSE: Obesity that is an important health problem increases 3 times since 1975 in all around the world. According to the World Health Organisation 2018 data, Turkey's 22.3% people are obese. As body mass index (BMI) increases, inflamation mediators increases too at the same time. At severe chronic inflamation due to the megakaryocytes increase,platelets proliferation rises. The plateletes regulate inflammation besides regulating hemostasis and coagulation. Plateletcrit and platelets lymphocyte ratio are the cheap and new subclinical inflammation markers releveant to platelets. It is well known that these markers increase at gestational inflammational events such as gestational diabetes, acute apandicitis and preeclempsia. In this study we aimed to investigate the association between inflammation marker levels and BMI of first trimester pregnant women.

MATERIALS AND METHODS: This is a retrospective study conducted at Konya Training and Research Hospital Department of Obstetrics and Gynecology,between February 1, 2019 and March 1, 2019. The study have 199 healty pregnant patients who admitted to the

outpatient clinic. Patients who have systemic diseases, pancreatitis, leukocytosis, leukopenia and greater than 14 weeks pregnancy were excluded to this study. The patients grouped as normal weight (BMI:18-24.9 kg/m2), over-weight(BMI:25-29.9kg/m2) and obese (BMI>30 kg/m2). The demographic information about patients and serum samples for complete blood count with differentials including neutrophil leukocyte, platelets, NLR, PNR, RDW, MPV, PCT, and PDW were obtained from the patients. Data analysis was performed using SPSS version 22 (SPSS Inc., Chicago, IL, USA). The One-way Anova and Kruskall-Wallis tests were used for compare data between three groups and Tukey and Tamhane's T2 tests were used for multiple comparisons.

RESULTS: We compare the demographic features and subclinical inflammatory marker levels between 103 normal weight,68 over-weight and 28 obese patient. There were no statistically significant differences between the groups in terms of age,gravida and parity. There was statistically significant difference at PLT and PCT levels between groups (p value 0,025 and 0,014 respectively). At subgroup analyse, obese group had higher values of PLT and PCT than normal weight group (p value 0,018 and 0,010 respectively).

CONCLUSIONS: In obese people the inflammatory cytokines such as- TNF-α, IL-6, NFκB, PAI-1 ve CRP are found higher.Platelets and plateletcrit levels show inflammational status at conditions like preeclempsia,sepsis and various hematologic diseases and obesity is an inflammational condition as well as these. So PCT and PLT increase at obesity were found proper according to the data.

Keywords: inflammation, obesity, pregnancy

P-20

Ovarian torsion in a postmenopausal patient of advanced age

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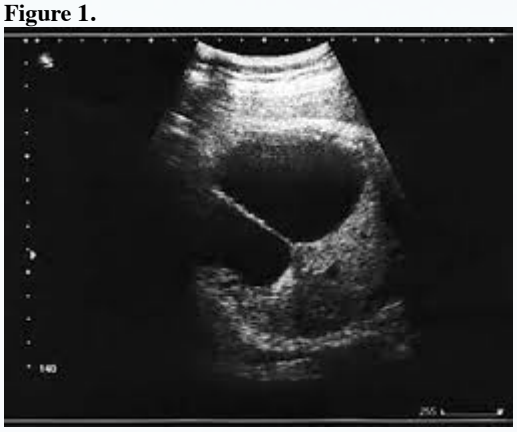
OBJECTIVE: Ovarian torsion (OT) is one of the most common gynecological emergencies and can a□ect women of all ages. Ovarian torsion has a bimodal age distribution, with a tendency to occur in young women (15–30 years old) and postmenopausal women.

CASE: A 83-year-old postmenopausal woman presented with sudden onset of lower abdominal pain and discomfort. A tense mass in the right adnexa was identifed in her vaginal examination and clinical examination of the abdomen revealed abdominal rebound and defense. Ultrasound revealed a well-defned, echo-free cystic mass 8 cm × 10 cm in size on the right side of her uterus with a partial septations (Figure 1). Serum markers of ovarian malignancy were obtained and found to be within normal limits. After approximately 6 h, the patient was taken to the laparotomy for a possible malignant right ovarian cystic mass. An urgent laparotomy was performed which revealed a dark-red, round-shaped ruptured cystic lesion that twisted at the right infundibulo-pelvic ligament site in the right adnexa area (Figure 2). Her uterus and left ovary were normal and there were signs of necrosis on her right ovary and fallopian tube after reduction of the torsion. A right salpingo-oophorectomy was performed and frozen inspection was done. No pathologic diagnosis was performed owing to the complete necrosis of the surgical specimen, but there was no evidence of neoplastic proliferation (Figure 3).

CONCLUSION: For most premenopausal patients with ovarian torsion, we recommend detorsion and ovarian conservation rather than salpingo-oophorectomy, even in the case of a darkened, congested ovary. Ovarian cystectomy is often performed if a benign mass is present. Patients with an obviously necrotic ovary or an ovarian mass that is suspicious for malignancy require salpingo-oophorectomy. Salpingo-oophorectomy is also reasonable for postmenopausal women.

Keywords: Ovarian torsion, postmenopausal, salpingo-oophorectomy.

Figure 1.

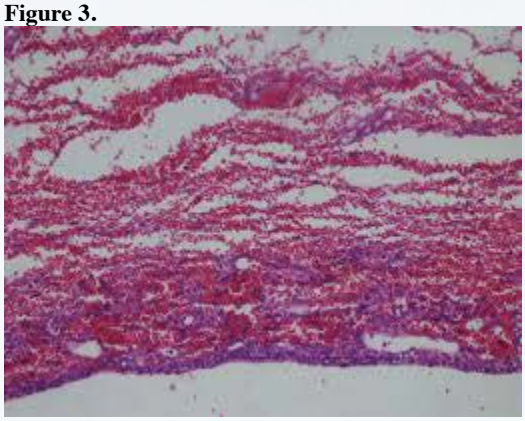


Ultrasound revealed a well-defned, echofree cystic mass measuring 8 cm × 10 cm on the right side of her uterus with partial septations.

Figure 2.

Torted necrotic ovarian mass found at laparotomy.

Figure 3.



No pathologic diagnosis was made owing to the complete necrosis of the surgical specimen, but there was no evidence of neoplastic proliferation.

P-21

Placenta Acreata At 12 Weeks Of Pregnancy: A Case Report

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INTRODUCTION: The placenta accreta is the abnormal invasion of the placenta into the uterine wall. Placenta accreata has become more common in recent years with the increase in cesarean delivery and previous uterine surgeries. Placenta accreata during the first trimester of pregnancy is rare. In this case report, we'll discuss the managemant of a pregnant woman who developed placenta accreta at the early gestational week and has massive bleeding after therapeutic curettage.

CASE PRESENTATION: A 33-year-old pregnant woman with two cesarean deliveries and an ectopic pregnancy treated with methotrexate to our clinic for her first pregnant visit. In the first ultrasonography of the patient; intrauterine single pregnancy in which fetal heart rate is observed, crown rump length (CRL): 17mm, gestasional sac (GS): 31mm, compatible with 8 weeks and 2 days was observed. she hadn't got any complaints. In the ultrasonography performed at first-trimester combined test time; uterine size was approximately 12 weeks of gestation and fetal structures, gestational sac, yolc sac, fetal heart beat were not observed (Figure 1). Instead, irregular bounded hematoma areas with multiple anechoic areas or appearance consistent with molar pregnancy lacunges were observed. The patient didn't have any complaints during this period. The patient was thought to have missed abortion or molar pregnancy and therapeutic curettage was recommended to the patient. The patient had a massive bleeding during therapeutic curettage. Explorative laparotomy was planned because the medical treatment did not stop the bleeding. During laparotomy, abnormal vascularization was observed macroscopically at uterine isthmus level (Figure 2). Since the hemodynamics of the patient detoriated, first bilateral hypogastric artery ligation was performed, but the bleeding didn't decrease. Therefore it was decided to perform a total abdominal hysterectomy. The final pathology result of the patient; placenta previa and placenta accreta were detected (Figure 3).

DISCUSSION: Placenta accreata is the abnormal invasion of the placenta into the uterine wall. Placenta accreata has become more common in recent years with the increase in cesarean delivery and previous uterine surgeries. However, prenatal placenta accreata screening and diagnosis has become more important. Early diagnosis can inform the patient and her family about suspected placental abnormalities and develop an appropriate birth plan. Preoperative preparation, including blood product preparation and appropriate equipment, improves outcome.
Women who have undergone placenta previa, lower anterior placenta, and previous uterine surgery should be looked at the interface between the placenta and myometrium on ultrasonographic examinations performed between about 18 and 24 weeks. In this case, one of the most important risk factors is previous uterine surgery. However, placenta accreata may occur even in early gestational weeks and it isn't possible to make this diagnosis by first trimester ultrasonography. As in this case, the presence of placenta accreta even in early gestational weeks, raise concerns about the management of these cases. As a result, more detailed studies can be done on the methods and additional risk factors for the development of placenta accreata diagnosis and screening methods in early gestational weeks.

Keywords: hypogastric artery ligation, total abdominal histerectomy, placenta accreta, therapeutic curettage, ultrasonography

Figure 1

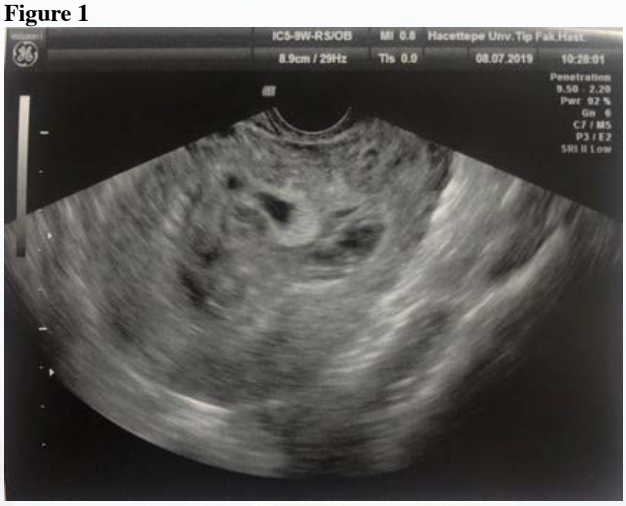


Figure 2

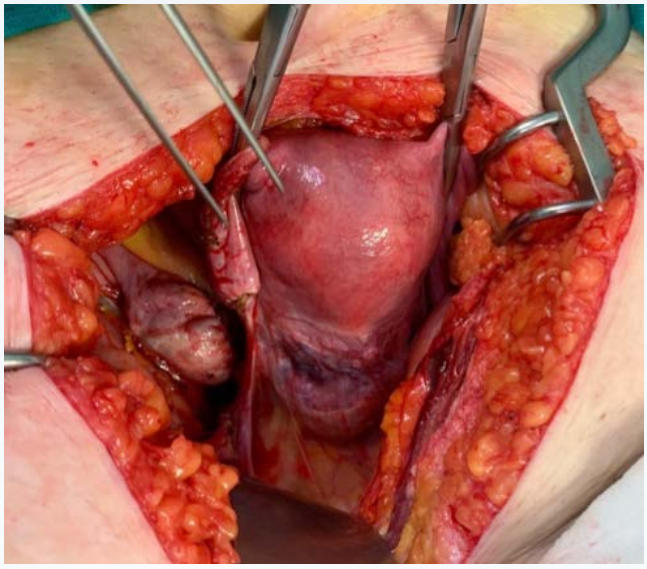
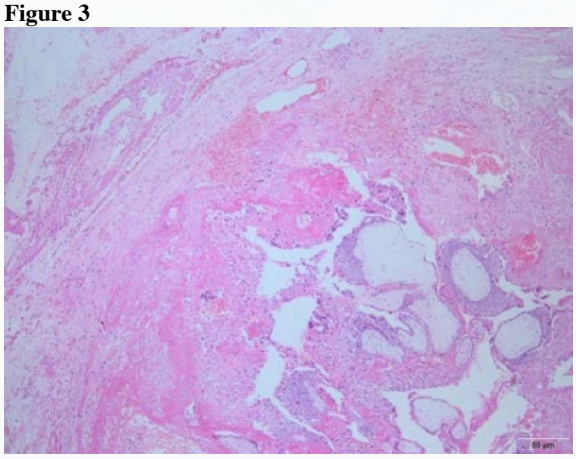


Figure 3



Placental tissues in deep myometrium. There was no placental tissue in the serosa.

P-22

The Effect Of Health Literacy On Fertility: Multiple Giant Uterine Myoma (60 centimeter -4 kilogram) -Case Report

Erhan Okuyan, Halit Atac, Mustafa Ersoz, Eda Eskimez
Batman Maternity and Children's Health Hospital

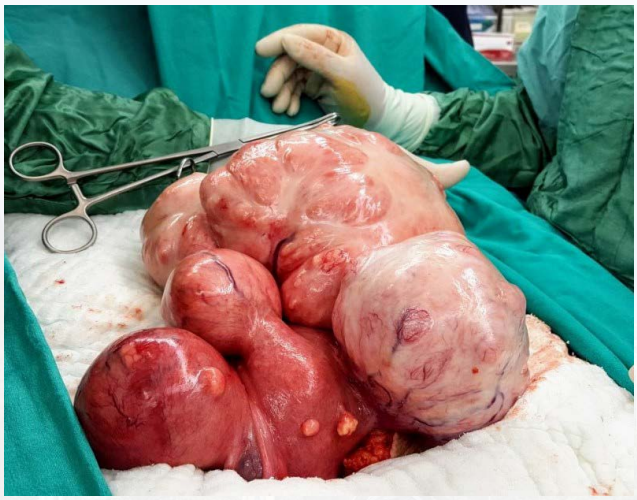
Fibroids are the most common uterine pathology in women of reproductive age.Their sizes are usually variable and those larger then ten centimeter are called giant fibroids.İn this article we aimed to present a case of a primary infertile patient with giant fibroids (the largest one was thirty centimeter) who had not accept the operation before; with her one year follow-up results.

FINDINGS: The case was, a forty year old patient who applied to different centers for primary infertility for about ten years.At the time of her first application, multiple intramural and subseroz myomas, the largest of which was six centimeter were found but operation was not accepted by the patient although it was suggested.The physical examination revealed a globally enlarged abdominal mass extending to the left hypochondriac area and under the liver. The ultrasonography revealed multiple myomas of which the largest was 35-37 centimeter intramural one; with different sizes and types (submucose, subserosis, intraligamenter) extending to the anterior, posterior uterus wall and bilateral adnexa. Ultrasonographic findings were supported by MRI(Magnetic Resonance Imaging) and extraabdominal pathologies were ruled out. Patient had severe pain and compression symptoms. A multi- heterogeneous giant fibroid pack was observed after the abdominal entry with the midline incision technic.(Picture-1) Abnormal uterine bleeding patterns such as amenorrhea and menometrorrhagia were not observed in the postoperative one year follow-up period. Approximately six months after surgery, the patient was referred to infertility center for assisted reproductive techniques, live pregnancy could not be achieved yet.

CONCLUSION: Infertility insidence is still high in the population of patients with low sociocultural level who have not been treated or have not accepted the treatment at an early stage due to myoma uteri. As revealed in the literature, it may cause symptoms as a result of mass effect or some other symptoms except the mass effect (1.2).The lack of health literacy is still a serious cause of infertility in Eastern, Southeastern Anatolia and rural areas in clinical practise. About this topic, it is necessary to make sustainable and ongoing education plans for the future in cooperation with social media, ministries and non-governmental organizations.

Keywords: Giant myom, Health literacy,Infertility

Picture-1



P-23

Leiomyoma of the vulva in the course of pregnancy: a very rare clinical condition

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INTRODUCTION: Vulva consists of mons pubis, labium majus/minus, clitoris, vestibule, Bartholin glands, urethra, vagina, and hymen. Vulvar leiomyomas originate from the smooth muscle within the round ligament and erectile tissues. Although the most common localization of myoma is the uterus, rarely it can also be encountered in the vulva that accounts for only 0.03% of all gynecologic tumors and 0.07% of all vulvar tumors. Patients mostly present with painless mass. As the mass increases in size, patient seek physician. Once the vulvar mass is detected after physical examination, radiological evaluation should be done by ultrasonography (USG) and/or Magnetic Resonance Imaging (MRI). The differential diagnosis include angiomyxoma, Bartholin cyst, leiomyosarcoma, and dermatofibrosarcoma. Diagnosis is done after excisional procedure. Histological criteria distinguishes leiomyoma from leiomyosarcoma. As the myoma is a hormone-dependent tumor, it may enlarge in the course of pregnancy. The mainstay of the treatment is surgical excision of the gross lesion. We report a vulvar leiomyoma detected in the pregnancy period, which has the largest size in the literature, up to now.

CASE REPORT: A 32 years old woman presented with painless, vulvar mass at July 2018. Her medical history was normal. She had a operation for liver hydatid cyst 2 years ago. Pelvic MRI showed a 12X5 cm sized, enhanced lesion extending from inguinal region to perineum. Punch biopsy of the lesion showed no malignancy. General surgeon consulted the patient to a gynecologist as he excluded inguinal hernia. But in this period, patient become pregnant. As the vulvar mass gradually enlarged; patient started to have difficulty on standing and presented to physician on her 20 th weeks of pregnancy. A 15 cm vulvar mass localized at her left labium majus was detected at gynecological examination (Figure 1). Pelvic MRI showed a 15X8 cm sized, well-circumscribed, T1 and T2 hyperintense solid-cystic mass (Figure 2). Mass is completely excised and final pathology was vulvar leiomyoma. Immunehistochemistry showed positivity for SMA, Desmin and negative staining for EMA, CD 34, S100. Patient's vaginal delivery was uneventful on 38 weeks of gestation.

DISCUSSION: Leiomyoma of the vulva is a very rare condition. Medical history of painless and enlarging vulvar mass, MRI fetaures, pathological and immunological findings are helpful in the diagnosis. If the mass becomes symptomatic in the pregnancy period, excisional procedure should be done.

Keywords: Leiomyoma, pregnancy, vulva.

Figure 1. Genital examination of the vulvar mass.

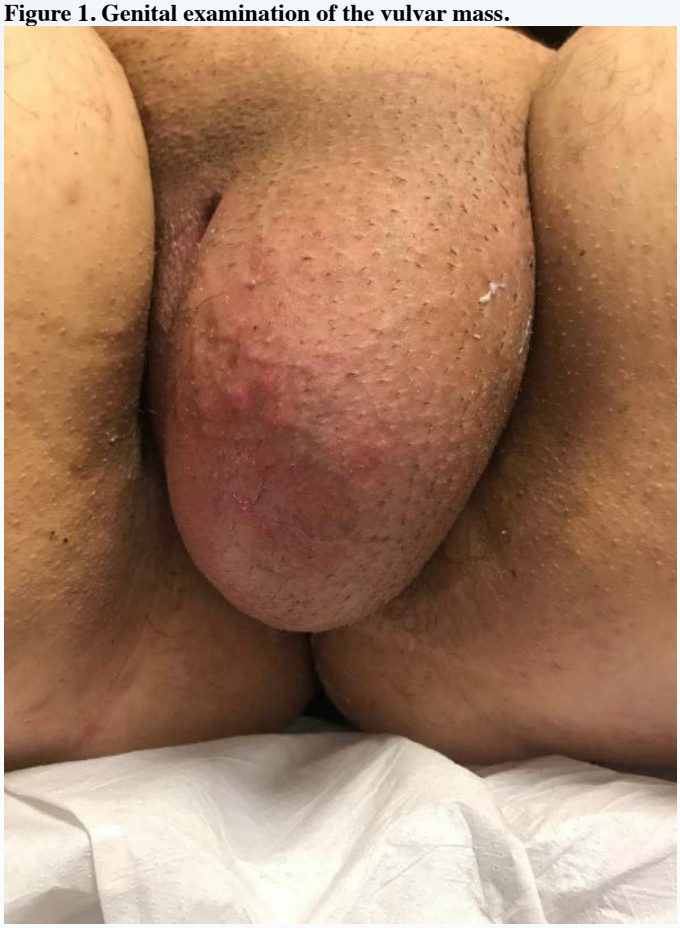
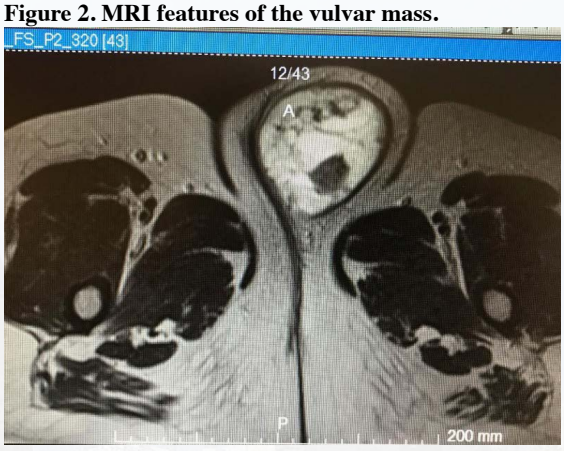


Figure 2. MRI features of the vulvar mass.



P-24

Metastases of breast invasive ductal carcinoma to the endometrium: A very rare case report

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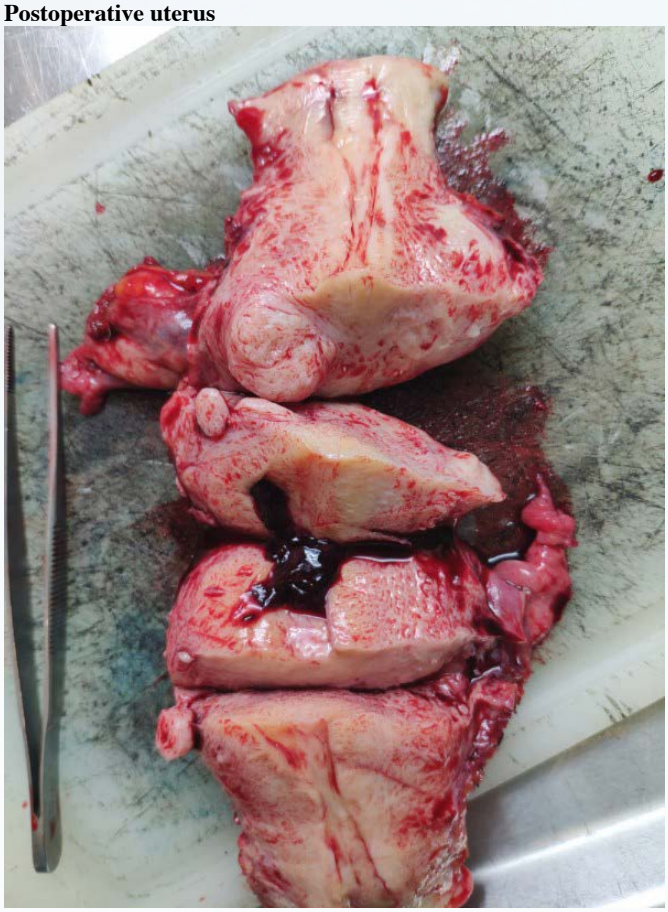
AIM: Breast cancer metastasis to the endometrium is uncommon and invasive lobular cancers are the most common histologic type. Also, invasive lobular cancer of breasts is frequently spread to all gynecologic organs than invasive ductal carcinomas. In this case, we report a case of invasive ductal carcinoma with endometrium metastases and isolated presentation of postmenopausal vaginal bleeding.

CASE: A 56-year-old patient who had a history breast carcinoma presented with a complaint of postmenopausal vaginal bleeding. The patient had underwent modified radical mastectomy 5 years ago. Pathology revealed stage 2, invasive ductal carcinoma of the breast. The patient received 6 cycles of chemotherapy as an adjuvant treatment. After gynecologic examination and ultrasonography, diffuse thickening endometrium was observed. Endometrial sampling was performed. The pathology revealed a metastatic adenocarcinoma with breast cancer origin. Computed tomography shows in the anterior part of the uterus, soft tissue appearance of subserosal myoma with a diameter of 2 cm is observed, there is a small amount of free fluid in the pelvis, several nodules with a diameter of 5 mm perivisceral were observed in the right lung and metastatic lesions are observed in the bone structures. Only Ca 15-3 (75,6 U/mL) was elevated and the other tumor biomarker levels were all in the normal range. The patient had concerns about having another primer cancer and also have discomfort about vaginal bleeding. For those reasons, the patient underwent a total hysterectomy with bilateral salpingo-oophorectomy. Pathological examination revealed metastatic carcinoma in the whole uterine wall, endocervical canal, cervix, bilateral ovaries, right tuba uterine, leiomyoma nodule. Immunohistochemically with the positivity of GATA-3 and negativity of WT1, PAX8, PR, ER, calretinin was observed. No loss of E-cadherin expression was detected. Morphological and immunohistochemical findings are consistent with breast carcinoma metastasis.

CONCLUSION: It is important to distinguish the metastases of endometrium from endometrium cancer. In these cases, the patient's management may be completely different. In our case, because the patient had other extragenital metastases, the surgery did not contribute to the overall survival. Breast cancer patients without extragenital metastasis may benefit from surgery.

Keywords: Breast cancer, metastasis of endometrium, invasive ductal carcinoma

Postoperative uterus



P-25

Nothing is Impossible: Two consecutive term births - Uterus Didelphys Case Report

Erhan Okuyan, Mahmut Karakis, Fethi Karakaya, Hasine Golge Atli, Anil Murat Sever
Batman Maternity and Children's Hospital

Different degrees of congenital malformations occur due to fusion abnormalities of the mullerian ducts in the embryological period or insufficient septum junction. This problem has been known for more than 300 years. (1)Although the actual incidence of congenital uterine anomalies is unknown, the incidence is estimated to be between 0.001% and 10% in the general population.(2) In this report, we aimed to present a case of Uterus Didelphys(UD), which is a rare condition, and had a healthy birth by reaching the term twice in a row.

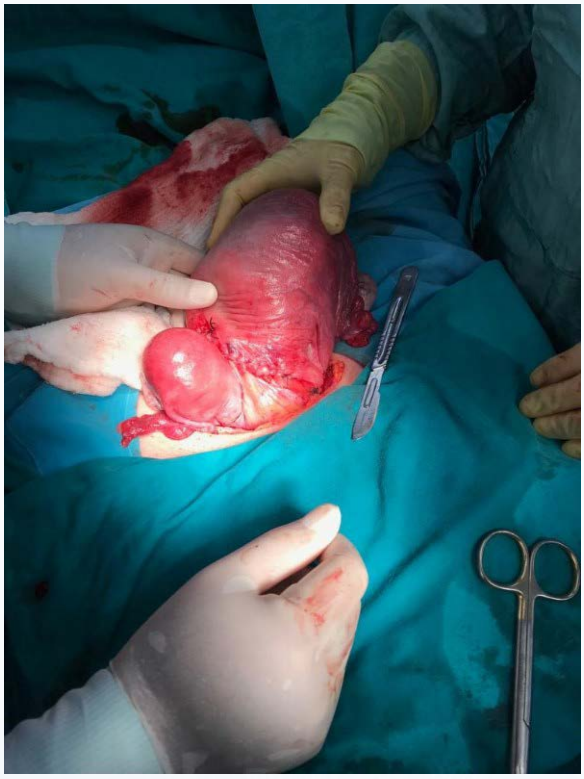
CASE:A 22-year-old woman who had previously delivered by cesarean section with the diagnosis of uterine didelfis was the second pregnancy and all follow-up was performed in our clinic. No urinary system abnormality was observed in our case. The patient was informed about uterus didelfis. She had regular follow-up at every trimester and no problem was observed during pregnancy follow-ups. In the 39th gestational week, pregnancy was observed by cesarean

section in left hemiuterus under elective conditions and a single live apgar 9-10 girls and 3100 gr healthy babies were delivered by pfannenstiel incision (Picture-1,2). Postoperative follow-up was normal and the mother and the baby were discharged with full recovery.

CONCLUSION: Detection of reproductive tract anomalies in early pregnancy is necessary for clinical follow-up. The incidence of premature birth, breech presentation, spontaneous abortion and premature rupture of membranes increases (3). In cases of uterine didelfis, corrective surgical intervention should be avoided unless necessary during pregnancy. This case resulted in two consecutive pregnancies, and careful and close follow-up of pregnancies with these diagnoses is recommended.

Keywords: Congenital anomaly,Term birth,Uterus didelphys

Picture-1



P-26

Bladder injury diagnosed at postoperative 10th day after cesarean

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[2]Isparta City Hospital, Isparta, Turkey

Bladder injury is a rare complication during caesarean.Bladder injury generally occured due to the adhesions and scar tissue resulting from previous abdominal surgery. The increasing rate of caesarean delivery and declining rate of vaginal birth may increase potential caesarean related complications. Most of bladder injuries recognized and repaired intraoperatively. Long term adverse outcomes may be prevented with proper and adequate repair intraoperatively. In this case report we aimed to report a case of bladder injury diagnosed 10 days after caesarean section.

The patient was 32 years old woman that had 39 weeks of gestation. She had an history of emergency laparotomy with midline incision 5 years ago because of acute abdomen due to ruptured endometrioma.

She had also two previous caesarean deliveries. Firm adhesions was observed between uterus and bladder during operation. Adhesions were opened with sharp dissection. No intraoperative injury was observed at the final check of surgical field. Urinary catheter was pulled off uneventfully at 24th hour after operation. No abnormal drainage was observed from urinary catheter and abdominal drain. The patient was discharged at 2nd day of surgery without any complaints. The patient admitted to our hospital with abdominal pain at 10th post operative day. Excessive abdominal distention and discharge from drainage site was observed. Samples from abdominal discharge was collected and analyzed for creatinine levels. The creatinine level of drainage fluid was 22 mg/dl. Blood creatinine level was 2.2 mg/dl. Infection markers were within normal limits. Massive ascites was observed during ultrasonography examination. Oral contrasted tomography was performed in order to exclude a possible intestinal trauma however no intestinal injury was observed. After urinary catheterization both abdominal distention and creatinine levels regressed progressively. Retrograde cystogram was performed and a totally filling bladder with contrast medium was observed.
A cystoscopy was performed and a vicryl suture was observed at the posterior wall of bladder. Patient was discharged from the hospital with urinary catheter. After 6 weeks follow up with urinary catheter the patient returned her normal renal functions with no complications. Control cystoscopy was totally normal and there is no suture material or bladder defect.

CONCLUSION: Because of the increasing rate of caesarean deliveries, obstetricians need to be more careful about potential complications. Although uncommon, iatrogenic bladder injury may be overlooked at the time of surgery. There are multiple signs and symptoms suggestive of bladder injury that can manifest in the early post operative period. Such as lower abdominal pain, ascites, oliguria, hematuria, elevation of blood urea nitrogen and creatinine levels.

Health providers shoud be careful to avoid further patient morbidity.

Keywords: Ascites, bladder injury, caesarean, cystoscopy, suture material

P-29

Is diagnostic laparoscopy effective in unexplained infertility patients when the pregnancy test is negative?

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OBJECTIVE: Can we changed the result with diagnostic laparoscopy performed in patients with negative pregnancy outcome?

INTRODUCTION: If there is no pregnancy in infertile patients, laparoscopy may shed light on lesions such as hydrosalpenx, endometriosis and peritoneal factor (adhesions).

MATERIALl/METHOD: For this purpose, 25 patients were examined which was the pregnancy test negative. In addition 25 patients were referred to infertility treatment without laparoscopy as control group. Patients who applied to Acıbadem University Atakent Hospital IVF Clinic between the years of 2018-2019 were grouped as infertile with unexplain cause. Operation was planned for the patients who were followed up normally by hysterosalpingography without pregnancy at the first treatment. All pelvic pathologies were surgically corrected such as adhesions, endometriosis and hydrosalpenx.

RESULTS: 12 patients in the experimental group spontaneusly pregnant after three months of follow-up. 10 patients conceived with IVF treatment for the second time. As a result, 48,2% pregnancy rate was accepted as statistically significant due to $p<0.05$ when the control group compared to 24.5% spontaneus pregnancy rate.

DISCUSSION: Laparoscopic surgery is an important tool in infertility treatment when adhesion, peritoneal endometriosis and tubal pathologies are considered. Make a surgical decision is the biggest problem for patient. Therefore, it is important to inform the patients correctly.

Keywords: adhesion, endometriosis, IVF, laparoscopy

P-30

Tubal reanastomosis An educative case for to use in low-settings

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Tubal reanastomosis is a highly preferred method that becomes frequent due to the increasing prevalence of divorce and remarriage. Currently, young women is seeking tubal sterilization when they believe to have completed fertility(1). The rate of regret in women under the age of 30 is reported as 20%, and over the age of 30 as 6%(2).
The most common reasons of seeking for tubal reanastomosis are found to be the request for a new spouse after divorce and the request after the death of the children(3). Among the tubal reanastomosis operations, isthmic-isthmic anastomoses have the highest success rates(4,5). Tubal reanastomosis operation was first reported by Gomel in 1974 as laparotomically(6). In this educative report, we present the tubo-tubal anastomosis operationin a step-by-step fashion aiming to be a guide for fresh specialists, particularly for ones working in secondary health centers within limited settings.

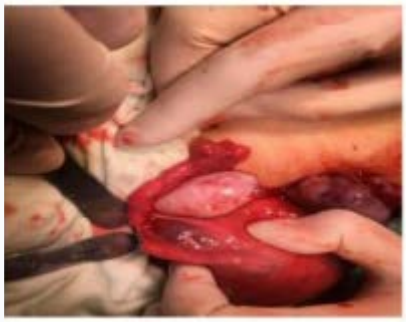
CASE: A 34 year-old parity-3 woman was referred for tubal reanastomosis after her second marriage. She has underwent tubal sterilization during in her last cesarean section with Pomeroy ligation technique. In this case, laparotomy was preferred because abdominal inguinal hernia has been planned by general surgeon as the primary operation to be performed simultaneously with tubal reanastomosis. Under general anesthesia an uterine manipulator was inserted for appropriate manipulation. Blind edge of proximal tuba was excised (Figure 1, 2). Heparinized saline solution was injected into the uterine cavity to ascertain the patency of the proximal segment. The periton around proximal tuba was carefully removed to let approximately 10-mm deperitonized area(Figure 3). Blind proximal edge of distal tuba was excised(Figure 4). The periton around proximal edge of distal tuba was carefully removed to let approximately 10-mm deperitonized area(Figure 5). Heparinized saline solution was injected into proximal edge of the distal tuba through the fimbria and active passage was observed. A double J catheter No.6 was placed in between the tubal parts to bring the tubes to the same plane(Figure 6, 7). The tuba-tubal anastomosis was ensured with interconnecting the serosal layer with four interrupted 5-0 polygalactin sutures(Figure 8, 9). The same steps are repeated contralaterally(Figure 10). Tube splint was not used. Bilateral tubal patency was confirmed with hysterosalpingography at

3rd months after the tubal reanastomosis.

DISCUSSION: It has been reported that the demand for reanastomosis increases over the years after sterilization to 4% in the 3rd year,8% in the 7th year and 13% in the 13th year(7). Although tubal reanastomosis is more likely to be more cost-effective when compared to in-vitro fertilization(IVF), there is no high-quality data in the literature.A prospective cost-effectivity analysis should be performed to clear this issue. Besides, tubal reanastomosis may be non-inferior to IVF due to it is performed for once only.
Maternal age is found to be the most important factor affecting pregnancy rates after tubal reanastomosis(8,9). Pregnancy rates reported after reanastomosis in the literature varies widely with %55-80(10,11). Pregnancy rates decrease as the interval between sterilization to tubal reanastomosis prolonges(12).
This educative report may encourage clinicians as an effective option in centres with low settings.

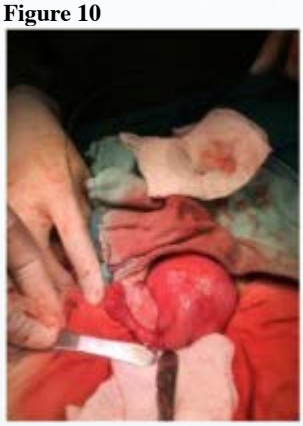
Keywords: Reanastomosis, Tubal surgery, Secondary infertility

Figure 1



Ligated tube with Pomeroy technique

Figure 10

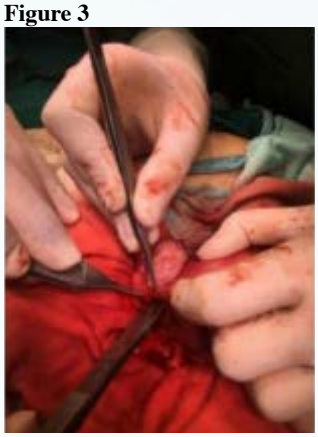


Control of the tubal passage without leakage

Figure 2

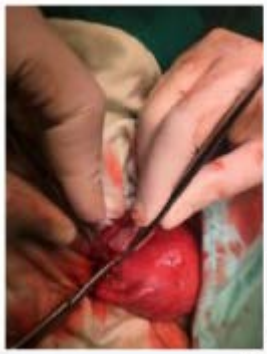
Excision of the blind edge of the proximal tube.

Figure 3



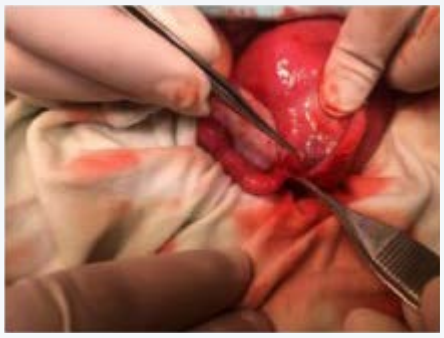
Dissection of the peritoneum of the proximal end

Figure 4



Excision of the blind end of the distal tube.

Figure 5



Dissection of the peritoneum of the proximal part of the distal tube.

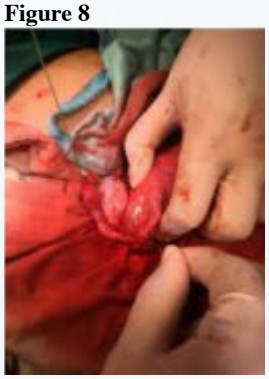
Figure 6

Insertion of the Double J catheter

Figure 7

Approximation of the tubal parts for reanastomosis

Figure 8



Reanastomosis with 5/0 prolen suture.

Figure 9

Reanastomosis and removal of the Double J catheter

P-31

Proteinuria, preeclampsia, total protein content in 24-hour urine, protein / creatinine ratio in spot urine

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AIM: The aim of this study was to compare the total protein content in 24 hours urine with dipstic, protein/creatinine (P / K) ratio in spot urine in our pregnant women who were diagnosed with preeclampsia.

METHOD: In this study, 317 patients who underwent dipstick method, P / K ratio and total protein analysis in 24-hour urine were included in the study with a prediagnosis of preeclampsia at a university hospital gynecology and obstetrics clinic between January 2016 and December 2018. These three values of patients were compared with each other.

RESULTS: The sensitivity of the dipstik method was 67.5%; specificity 61.5%; accuracy was calculated as 64.3%. When the total proteinuria threshold in the 24-hour urine was 300 mg/day, the P-C ratio cut-off value was 0.34 mg protein/mg creatinine, the sensitivity was 68.9% and the specificity was 78.7%. A moderate, significant correlation was observed between total urinary P / K ratio and total proteinuria in 24-h urine (R: 0.629 p <0.001).

CONCLUSIONS: It can be used as an alternative test in the 24-hour urine total protein test of P / C ratio in spot urine in emergencies where there is not enough time for 24-hour total urine analysis.

Keywords: preeclampsia, proteinuria, proteinto creatinine ratio, total protein content in 24-hour urine

P-36

Rare Giant Endometrial Polyp

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Endometrial polyp is overgrowth of endometrial tissue containing gland and stroma into the uterine cavity. Although frequently seen in postmenopausal women, it can be seen in women of all reproductive age groups, including adolescents. Macroscopically, it has pedunculated and sessile forms and usually grows up to 1-2 cm in diameter. Bleeding, pelvic pain and menstrual irregularity are the most common symptoms in women with endometrial polyp. In this case, we report that an 80 year-old woman with postmenopausal bleeding, who was previously pre-diagnosed as endometrial cancer, was transferred to our clinic in order to establish a final diagnosis. During the pre-operative preparation of the patient for the endometrial biopsy, a giant endometrial mass with a height of 10cm spontaneously strangulated then it was removed by itself. In histological examination of the mass was diagnosed as endometrial polyp by the pathologist. Benign causes of postmenopausal bleeding, especially endometrial polyps, should always be considered when considering endometrial cancers.

Keywords: Polyp, Postmenopausal, Bleeding,

Polyp

10 cm giant polyp

P-37

Laparoscopic endometrioma surgery in a patient with didelphys uterus

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AIM: Didelphys uterus is the rarest mullerian duct anomaly. Most patients with didelphys uterus are asymptomatic. In the present case we aim to domanstrate a laparoscopic view of an endometrioma and its management in a patient with didelphys uterus.

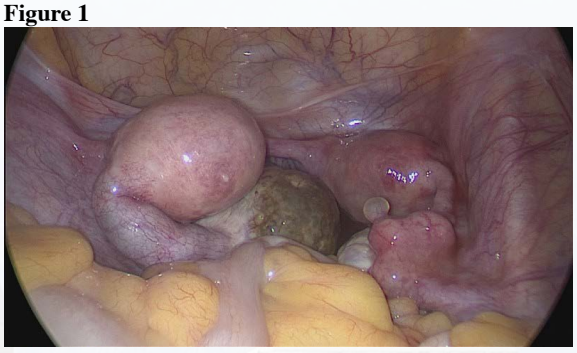
METHOD: A 29-year-old unmarried woman diagnosed with pelvic mass was referred. Magnetic resonance imaging (MRI) revealed left adnexal cyst (87x66 mm, endometrioma ?, serous cyst adenom ?) and hemorrhagic cyst (37x25 mm). Tumor markers were normal. Laparoscopy was performed.

RESULTS: Didelphys uterus was observed (Figure 1). 7 cm ednometrioma was excised (Figure 2). Histology confirmed endometrioma.

CONCLUSION: Laparoscopy is better than any imaging modality for diagnosis of intraabdominal pathologies and genitourinary anomalies.

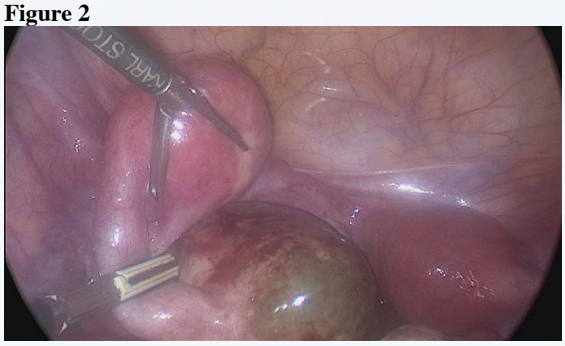
Keywords: Didelphys uterus, mullarian duct anomalies, endometrioma, laparoscopy.

Figure 1



Didelphys uterus, endometrioma

Figure 2



Didelphys uterus, endometrioma

P-38

The Importance of Health Literacy on Perinatal Mortality: Uterine Rupture-Case Report

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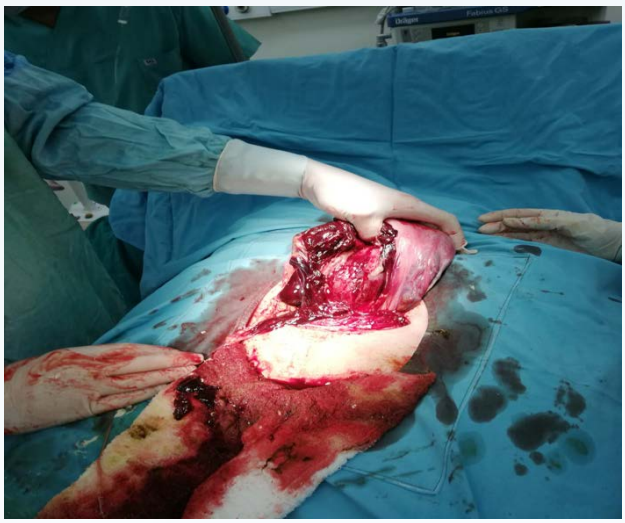
Uterine rupture is one of the most important causes of maternal and fetal mortality. Uterine rupture is often seen as a complication of delivery in pregnant women who had previously delivered by cesarean section.In our case, a 28-year-old,gestational week was 38 weeks, was given elective surgery due to the previous cesarean section.Applied to the hospital on the fourth day despite the pain she had been continuing for three days.In the literature, uterine rupture is estimated to be between 1/2000 and 2500 pregnancies. There is not enough data on this subject in our country. Uterine rupture with perioperative mortality up to 50% remains one of the most feared obstetric complications.(1)

RESULTS:The patient was admitted to our emergency department with pain, reactive non stress test, baseline 110, contraction irregular, cervical patency 3 cm wiping 40% pouch pozitive, blood pressure arterial 90/60, pulse 120,uterine bladder line was not detected on ultrasonographic examination and the patient was diagnosed as uterine rupture. Perioperative observation revealed a full-thickness uterine rupture extending to the right uterine artery.The fetus was removed with apgar 5-8 and the uterine rupture line was repaired properly. (Figure-1,2) Approximately three units of serohemorrhagic fluid were aspirated from the abdomen. In the postoperative period, two units of erythrocyte and one unit of fresh frozen plasma were transfused and discharged with full recovery.

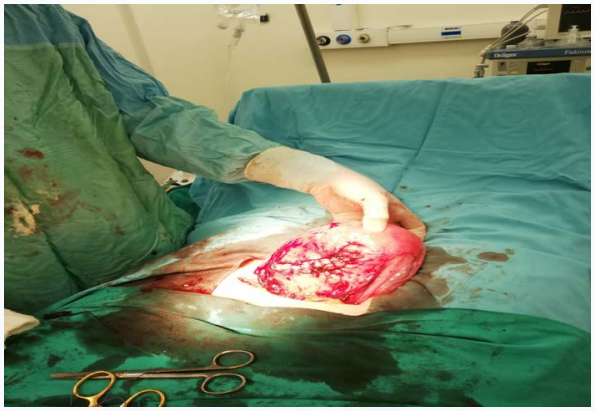
DISCUSSION: Uterine rupture is still common in Southeast - Eastern Anatolia and rural areas where there is no health literacy. Maternal mortality is reported as 6.5-10% in some sources,in some sources it is reported as one percent especially in western societies. (1) The general opinion is that mortality is higher in spontaneous ruptures than scar-induced ruptures. (2) But perinatal mortality can reach up to 50%. Health literacy can be increased and perinatal mortality rates can be reduced by cooperating with both social media and non-governmental organizations.

Keywords: Health Literacy,Perinatal Mortality, Uterine Rupture

Picture-1



Picture-2



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