Online
2. Obstetrik ve Jinekoloji Tartışmalı Konular Kongresi

21-24 Eylül 2020

"Online Kongre"

Bilimsel Program ve Bildiri Özetleri Kitabı

www.obstetrikjinekolojitartismalikonular.org

İÇİNDEKİLER

ÖNSÖZ

Değerli Meslektaşlarımız,

Bilim, eğitim, araştırma ve sosyal buluşmalar çerçevesinde gerçekleştirdiğimiz toplantılarımız maalesef bu yıl dünyayı etkisi altına alan Covid-19 pandemisi sebebiyle fiziki olarak gerçekleştirilemeyecek gibi gözükmektedir. Kongre başkanlarımız ve dernek yönetim kurulumuz ile insan sağlığına yönelik riskleri göz önünde bulundurduğumuzda 21-24 Eylül tarihlerinde gerçekleştirecek olduğumuz kongre buluşmamızı online olarak yapmaya karar verdik.

Aldığımız bu karar ile tüm konuşmacı, oturum başkanı, katılımcılar ve endüstri temsilcilerinin sağduyu ile hangi şartlarda olursa olsun verecekleri destekler ve anlayışları için şimdiden teşekkür ederiz.

Önümüzdeki yıl daha sağlıklı ve Covid-19 pandemisinin tüm etkilerinde kurtulmuş olarak tekrardan sizlerle aynı havayı solumayı, birlikte paylaşmayı ve fiziksel ortamlarda 22-26 Eylül 2021'de Bodrum'da buluşmayı temenni ediyoruz.

Sağlıklı günlerde buluşmak dileğiyle…

Saygılarımızla

M. Faruk Köse
Düzenleme Kurulu Adına

KONGRE EŞ BAŞKANLARI


M. Faruk Köse


Ali Ayhan


Rıfat Gürsoy


Akın Sivaslıoğlu

KONGRE SEKRETERİ


Nejat Özgül

JİNEKOLOJİ VE OBSTETRİK TARTIŞMALI KONULAR DERNEĞİ

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Başkan Yardımcısı
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Genel Sekreter
Nejat Özgül

Sayman
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Üyeler
Ali Ayhan
Rıfat H. Gürsoy
M. Mutlu Meydanlı
U. Fırat Ortaç
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19 Mayıs Mah. 19 Mayıs Cad. Nova Baran Center No: 4, 34360, Şişli / İstanbul - Türkiye
Tel: 0 212 381 46 00 Pbx - Faks: 0 212 258 60 78
E-posta: obstetrikjinekolojitartismalikonular@figur.net

BİLİMSEL KURUL

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Mehmet Macit Arvas
Osman Aşıcıoğlu
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Erkut Attar
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• Soyadına göre sıralı olarak düzenlenmiştir.

BİLİMSEL PROGRAM

Online 2. Obstetrik ve Jinekoloji Tartışmalı Konular Kongresi

"Online Kongre"

21-24 Eylül 2020

PROGRAMA GENEL BAKIŞ

21 Eylül, Pazartesi		22 Eylül, Salı		23 Eylül, Çarşamba		24 Eylül, Perşembe	
ANA SALON		ANA SALON		ANA SALON		ANA SALON	
17:00-17:15	Açılış Töreni					17:00-17:50	Sözel Bildiri Oturumu-3
17:20-17:50	Türkiye'de Kanser Epidemiyolojisi	17:40-18:10	Serviks Kanseri ve HPV Epidemiyolojisi ve Ulusal Tarama Programı	17:20-17:50	Ulusal Kanser Tarama Programında Karşılaşılan Sorunlar		
18:00-19:00	Tekrarlayan Düşükler	18:20-19:20	Gebelikte Sistemik Hastalıklar	18:00-19:00	Menopoz	18:00-19:00	Endometriosis
19:10-20:10	PCOS ve Hirsutismus	19:30-20:10	Preinvaziv Lezyonlar	19:10-20:10	Menstruasyon ve Anormal Uterin Kanamalar	19:10-20:10	Obstetrik Kanama
20:20-21:20	Adneksiyel Kitleler	20:20-20:45	Keynote Konuşma	20:20-20:45	Keynote Konuşma	20:20-21:20	Doğumun Zamanlaması
		20:55-21:30	Uydu Sempozyumu MSD	20:55-21:30	Uydu Sempozyumu benovis		
21:30-22:30	Cerrahi Komplikasyonlar	21:40-22:40	Laparoskopik Histerektomi	21:40-22:40	Kontrasepsiyon	21:30-22:30	Obstetrik ve Jinekolojide Görüntüleme
22:40-23:00	Akılcı İlaç Sunumu	22:50-23:50	Sözel Bildiri Oturumu-1	22:50-23:50	Sözel Bildiri Oturumu-2	22:40-23:15	Pelvik Organ Prolapsusları ve Tedavi

21 Eylül 2020, Pazartesi — *Ana Salon*

17:00-17:15 **Açılış Töreni**

17:20-17:50 **Türkiye'de Kanser Epidemiyolojisi**

Oturum Başkanı: ***Ali Ayhan***
Konuşmacı: ***Murat Türkyılmaz***

18:00-19:00 **Tekrarlayan Düşükler**

Panel Başkanı: ***Recep Has***
Panelistler: ***Ahmet Gül, Cenk Sayın, İbrahim Kalelioğlu***

Panel Konuları

Trombofil taramasını yapalım mı? Kime? Nasıl Yapalım?

Kromozom anomalileri ve taraması

Cfdna ile kromozom anomalileri taraması

19:10-20:10 **PCOS ve Hirsutismus**

Panel Başkanı: ***Cihat Ünlü***
Panelistler: ***Ahmet Zeki Işık, Fahrettin Keleştemur, Barış Ata, L. Cem Demirel***

Panel Konuları

Etiyolojide yeni olan neler var, tanıda hangi kriterler kullanılmalı

Aşırı tanı (over-diagnose) söz konusu mu?

Jinekolojik endokrin sorunlar

Uzun vadede metabolik-endokrin sorunlar, tedavi hedefleri

20:20-21:20 **Adneksiyel Kitleler**

Panel Başkanı: ***Fuat Demirkıran***
Panelistler: ***Yavuz Salihoğlu, Tayup Şimşek, Davut Güven***

Panel Konuları

Adneksiyel kitleler

Tanısal yaklaşım

Adolesan çağda yaklaşım

Üreme çağında yaklaşım

Postmenopozal çağda yaklaşım

21:30-22:30 **Cerrahi Komplikasyonlar**

Panel Başkanı: ***Sinan Özalp***
Panelistler: ***Hüsnü Çelik, Ahmet Göçmen, Hakkı Tankut Akay, Erman Aytaç***

Panel Konuları

Gastro-intestinal komplikasyonlar

Ürolojik komplikasyonlar

Damar yaralanmaları

22:40-23:00 **Akılcı İlaç Sunumu**

Konuşmacı: ***Özgüç Takmaz***

22 Eylül 2020, Salı — *Ana Salon*

17:40-18:10 Serviks Kanseri ve HPV Epidemiyolojisi ve Ulusal Tarama Programı

Oturum Başkanı: ***Ali Haberal***
Konuşmacı: ***Nejat Özgül***

18:20-19:20 Gebelikte Sistemik Hastalıklar

Panel Başkanı: ***Rıza Madazlı***
Panelistler: ***Miğraci Tosun, Cüneyt Evrüke, Selim Büyükkurt, Filiz Yanık***

Panel Konuları

Gebelikte hipertansif hastalıklar
Gebelikte diabet
Gebelikte kardiak hastalıklar
Gebelikte enfeksiyon hastalıkları

19:30-20:10 Preinvaziv Lezyonlar

Panel Başkanı: ***U. Fırat Ortaç***
Panelistler: ***Kunter Yüce, Macit Arvas, Nejat Özgül***

Panel Konuları

ASCCP yeni sitolojik yönetim
ASCCP yeni histolojik yönetim
Tedavi yöntemleri
Takip

20:20-20:45 Keynote Konuşma

Onkofertiliteye Güncel Yaklaşım
Konuşmacı: ***Ali Ayhan***

20:55-21:30 Uydu Sempozyumu

Ülkemizde HPV'nin Yükü ve HPV Asılarının Önemi
Moderatör: ***M. Faruk Köse***
Konuşmacı: ***Nejat Özgül***

MSD

21:40-22:40 Laparoskopik Histerektomi

Panel Başkanı: ***Mete Güngör***
Panelistler: ***İlkkan Dünder, Gürkan Uncu, Çağatay Taşkıran, Salih Taşkın***

Panel Konuları

Batına giriş ve trokar yerleşim yerleri
Adım adım histerektomi
Vajen kaf kapatılması: Dehisens ve prolapsusu engellemek için öneriler
Komplikasyondan nasıl kaçınabiliriz? Üreter gözlemi / diseksiyonu: Ne zaman ve nasıl?

22:50-23:50 Sözel Bildiri Oturumu-1

Oturum Başkanları: ***Ömer Lütfi Tapısız, Oğuzhan Kuru***
SS-01 / SS-09

23 Eylül 2020, Çarşamba — *Ana Salon*

17:20-17:50 Ulusal Kanser Tarama Programında Karşılaşılan Sorunlar

Oturum Başkanı: ***Gökhan Tulunay***
Konuşmacı: ***Fahriye Ünlü***

18:00-19:00 Menopoz

Panel Başkanı: ***Fatih Durmuşoğlu***
Panelistler: ***Hakan Seyisoğlu, Levent Şentürk, Tamer Erel***

Panel Konuları

Postmenopozal sorunlar; önem sırası nasıldır, her kadında aynı mı?
Menopoza bakış açısı; WHI öncesi ve sonrası, günümüzdeki durum nedir?
Tedavi hedeflerinde HRT önerilen durumlar ve süreler
Osteoporoz tedavisinde estrojen dışı alternatifler tatminkar mı?

19:10-20:10 Menstruasyon ve Anormal Uterin Kanamalar

Panel Başkanı: ***M. Faruk Köse***
Panelistler: ***Ercan Baştu, M. Mutlu Meydanlı, Cem İyibozkurt***

Panel Konuları

Anormal uterin kanama tanısı
Cerrahi tedavi mi yoksa medikal tedavi mi?
AUB'da medikal tedavi

20:20-20:45 Keynote Konuşma

Corona Virüs ve Dünyadaki Etkileri
Konuşmacı: ***Emin Kansu***

20:55-21:30 Uydu Sempozyumu

Kadın ve Erkek Üreme Sağlığında Aging / Anti Aging
Oturum Başkanı: ***M. Murat Naki***
Konuşmacılar: ***Cem Fıçıcıoğlu, Hakan Özveri***

21:40-22:40 Kontrasepsiyon

Panel Başkanı: ***Faruk Buyru***
Panelistler: ***Yaprak Üstün, Barış Ata, Özlem Dural***

Panel Konuları

Doğum kontrol haplarıyla ilgili efsaneler gerçekler
Yeni nesil doğum kontrol haplarının artıları
Kontrasepsiyonda danışman kim olmalı?

22:50-23:50 Sözel Bildiri Oturumu-2

Oturum Başkanları: ***Coşkun Salman, Emine Karabük***
SS-10 / SS-18

24 Eylül, Perşembe — *Ana Salon*

17:00-17:50 **Sözel Bildiri Oturumu-3**

Oturum Başkanları: ***Esra Özbaşlı, Yakup Baykuş***
SS-19 / SS-29

18:00-19:00 **Endometriosis**

Panel Başkanı: ***Rıfat Gürsoy***
Panelistler: ***Kutay Biberoğlu, Bülent Urman, Erkut Attar, Turgut Aydın***

Panel Konuları

Etiyolojiye güncel bakış
Tanı için non-invaziv yöntemler var mı?
Pelvik endometriozis, endometrioma, adenomyozis farklı hastalıklar mı?
Tedavi kime, ne zaman, hangi yöntem

19:10-20:10 **Obstetrik Kanama**

Panel Başkanı: ***Nuri Danışman***
Panelistler: ***Müfit C. Yenen, Acar Koç, Tamer Mungan, Ali Acar, Özlem Pata***

Panel Konuları

Tanı ve genel yaklaşım
Medikal tedavi
Cerrahi tedavi
Obstetrik kanamaların maternal mortalite ilişkisi

20:20-21:20 **Doğumun Zamanlaması**

Panel Başkanı: ***Namık Demir***
Panelistler: ***Metin İngeç, Zeki Şahinoğlu, Cem Batukan, Esra Esim Büyükbayrak***

Panel Konuları

Term gebelikte vaginal doğum ve sezaryenin zamanlaması
Akciğer maturite testleri; güncel durum
IUGR'de doğumun zamanlaması
Steroid ve MgSO4 uygulaması: Doz ve zamanlama

21:30-22:30 **Obstetrik ve Jinekolojide Görüntüleme**

Panel Başkanı: ***M. Murat Naki***
Panelistler: ***Aytaç Yüksel, Deniz Akata, Mustafa Özmen***

Panel Konuları

Obstetrik
jinekolojik
CT ve MRI, PET CT
Obstetrikte gastroestantinal anormaller

22:40-23:15 **Pelvik Organ Prolapsusları ve Tedavi**

Panel Başkanı: ***Akın Sivaslıoğlu***
Panelistler: ***Yakup Kumtepe, Fuat Demirci, Yusuf Üstün, Eren Akbaba***

Panel Konuları

POP yönetiminde örgünün yeri var mı? Kime ne zaman örgü?
Sakrokolpopeksi apikal prolapsus yönetiminde vazgeçilmez midir?
Laparaskopik apikal prolapsus alternatiflerinin etkinliği nedir?
Ön ve arka kompartman defektkerinin yönetiminde etkin tedavi alternatifleri nelerdir?
POP cerrahisine antiinkontinans Cerrahisi ne zaman eklenmelidir? Vajinal histerektomide ipuçları nelerdir?

SÖZLÜ BİLDİRİLER

SB-01
Evaluation of presence of dry eye and Meibomian gland dysfunction in patients with polycystic ovary syndrome

Özgür Şahin[1], Mustafa Kalaycı[2]

[1]Canakkale Mehmet Akif Ersoy State Hospital Gynecology and Obstetrics Clinic

[2]Antalya Education and Research Hospital Eye Clinic

TİTLE: Evaluation of presence of dry eye and Meibomian gland dysfunction in patients with polycystic ovary syndrome

AIM: Polycystic ovary syndrome is an endocrinopathy characterized by chronic anovulation and hyperandrogenism. Hormonal changes can affect Meibomian gland function. Our aim in this study was to evaluate the tear function tests and Meibomian gland functions of women with polycystic ovary syndrome in Somalia.

METHODS: The study was carried out in Somalia Mogadishu-Turkey Training and Research Hospital. 25 women (group 1) with polycystic ovary syndrome and 25 healthy volunteers (group 2) between the ages of 18-40 were included in the study. The ocular surface disease index (OSDI) of all participants was calculated. In order to evaluate tear film stability in two groups, tear break up time (TBUT) measurement and Schirmer I test were used to evaluate lacrimal gland functions. In addition, meibomianitis findings were recorded and the results were compared statistically. RESULTS: The mean OSDI score was significantly higher in group 1 than in group 2 ($p < 0.05$). In addition, TBUT and Schirmer I test results were lower in group 1 than in group 2, and the results were statistically significant ($p < 0.05$). The incidence of meibomianitis was 24% in group 1, while it was 8% in group 2 and was statistically significant ($p < 0.05$). CONCLUSION: Tear dysfunction and Meibomian gland dysfunction may be present in patients with polycystic ovary syndrome and regular eye control should be offered to patients.

Keywords: dry eyes, Meibomian gland dysfunction, polycystic ovary syndrome

SB-02
The effect of our infertility clinic approach on assisted reproductive treatments satisfaction

Umut Sarı

Department of Gyneacology,Acıbadem Atakent Hospital,Istanbul, Turkey

AIM: It is believed that a detailed explanation to an infertile patient helps improve the treatment period. In our clinic, we performed a survey screening to investigate the satisfaction of our patients about the explanation of treatment.

MATERIALS-METHOD: The study was planned at Atakent Acibadem Hospital IVF center between 2018-2019 as a prospective study and the patients who applied to our clinic for the first time were included in the study. A total of 200 patients were investigated regarding the cause of infertility, education status, satisfaction of clinic's service, understanding of the treatment and the actions of medical staff.

RESULTS: When the couples were analyzed, male parties were predominantly university graduates while female parties were predominantly high school graduates. As the result of our survey regarding the positive effect of detailed explanation to understanding the treatment, we observed that detailed explanation was significantly more helpful in patients who applied by themselves ($p<0.0001$) and patients with education level of high school graduate and above ($p=0.014$). Even though further explanation of medical staff and clinical service satisfaction were observed to have a positive effect on patients' cooperation to treatment, these parameters were not found statistically significant.

DISCUSSION: Detailed and accurate education of patients and having them understand the treatment is a necessity for medical care. Performing a treatment process exactly as explained increases the patients' trust as well as showing the need to increase the quality of medical care. The entire medical staff, with the lead of the physician, need to work systematically to make sure the patient understands the treatment.

Keywords: Infertility, Satisfaction, Information

SB-03
Optimal timing of the loop electrosurgical excision procedure according to different phases of the menstrual cycle

Kemal Gungorduk[1], Orhan Şahin[2]

[1]Mugla Sitki Kocman University Training and Research Hospital, Gynecologic Oncology Unit, Muğla, Turkey

[2]Okmeydanı Training and Research Hospital, Obstetrics and Gynecology Unit, University of Health Sciences, Istanbul, Turkey

OBJECTIVE: To determine whether treatment of cervical precancerous lesions in the follicular phase or luteal phase of the menstrual cycle affects perioperative and postoperative blood loss during the LEEP. METHODS: In this randomized trial, 73 patients were assigned to either the follicular phase group (n = 37) or the luteal phase group (n = 36). Ultimately, the conditions of 36 patients in the follicular phase group and 34 patients in the luteal phase group were analyzed. The primary outcome measure was median early postoperative blood loss. Secondary outcomes were median intraoperative bleeding, the rate of late postoperative bleeding, and persistent vaginal bleeding. The study was registered with ClinicalTrials.gov (NCT03952975).

RESULTS: Baseline demographic data were similar in the two groups. Median intraoperative blood loss was significantly lower in the follicular phase group than in the luteal phase group (32.7 [20.1–78.3] vs. 44.6 [30.4–104.2] mL, respectively; $P < 0.001$). Median early postoperative blood loss was also lower in the follicular phase group than in the luteal phase group (209.2 [67.7–468.6] vs. 289.0 [120.3–552.8] mL, respectively; $P = 0.01$). Moreover, the rate of late postoperative bleeding was higher in the luteal phase group than in the follicular phase group (20.6% vs. 2.8%, respectively; $P = 0.02$). Performing LEEP during the luteal phase of the menstrual cycle independently increased the rate of late postoperative bleeding.

CONCLUSION: Performing LEEP during the follicular phase of the menstrual cycle significantly reduces median intraoperative blood loss, early postoperative blood loss, and the rate of late postoperative blood loss.

Keywords: loop electrosurgical excision procedure, menstrual cycle, blood loss

SB-04

Retrospective analysis of patients with high risk HPV positivity: Tertiary center results

Ceyda Karadag
Department of Gynecologic Oncology, Akdeniz University Faculty of Medicine, Antalya, Turkey

OBJECTIVE: Our aim is to retrospectively analyze the general demographic features, smoking, contraception preference, cytology and colposcopic biopsy results of patients with high risk HPV (human papilloma virus) positivity within the national screening program in our clinic between 2019-2020.

MATERIAL-METHODS: The data of patients with high-risk HPV (hrHPV) positive who applied to our Gynecological Oncology Clinic between January 2019-January 2020 were analyzed retrospectively. Cytology results were evaluated. All patients had colposcopy.

RESULTS: The mean age of the patients was 43.09 ± 9.71, and the mean parity was 2.01 ± 1.35. 315 (68.8%) of the patients didn't use any contraception method. While 176 patients were in menopause, 282 were in the reproductive period. 232 (50.7%) of the patients were smoking. When the cases were evaluated according to HPV types, the type 16 and 18 coexistence had the highest rate, while 205 (44.8%) was followed by only the type 16 positivity 82 (17.9%). When the cytology results of the cases were evaluated, the cytology of 144 (31.4%) patients was negative in terms of intraepithelial lesion and malignancy, as a result of 96 (21%) ASCUS, 152 (33.2%) cytology LSIL, 30 (6.6%) ASC-H and 36 (7.9%) were HSIL. In accordance with the literature, the most common cytology abnormality associated with HPV positive cases was LSIL. When colposcopy results were evaluated, LSIL was also in the first rank with 329 (71.8%) patients. As a result of colposcopic biopsy, 83 (18.1%) patients had HSIL, 162 (3.5%) results were normal, and 7 (1.5%) patients had squamous cell carcinoma.

CONCLUSION: HPV is not only the most common sexually transmitted disease worldwide, but also it is among the leading causes of cervical cancers. The risk of cervical cancer that may accompany should not be forgotten, and patients with high-risk HPV positivity should be evaluated by colposcopy.

Keywords: HPV, hrHPV, Cervical cancer.

Table 1

Age		43,09±9.71
Gravida		2,74±1.77 (3 (0-7))
Parity		2,01±1,35 (2 (0-6))
Abortion		0,34±0,64 (0 (0-4)
Chronic disease	Yes No	62 (%13,5) 396 (%86.5)
Contraception	Yes No	143 (%31,2) 315 (%68,8)
Oral contraceptive	Yes No	44 (%9,6) 414 (%90,4)
Condom	Yes No	40 (%8,7) 418 (%91,3)
Menopause status	Yes No	176 (%38,4) 282 (%61,6)
Smoking	Yes No	232 (%50,7) 226 (%49,3)

Demographic characteristics of hpv positive cases

Table 2

HPV types	16 18 16+18 16+others 18+others 16+18+others other types	82 (%17,9) 22 (%4,8) 205 (%44,8) 49 (%10,7) 18 (%3,9) 7 (%1,5) 75 (%16,4)
Cytology	NILM ASCUS LSIL HSIL ASCH	144 (%31,4) 96 (%21) 152 (%33,2) 36 (%7,9) 30 (%6,6)
Colposcopic biopsy	Normal LSIL HSIL SCC Chronic cervicitis	16 (%3,5) 329 (%71,8) 83 (%18,1) 7 (%1,5) 23 (%5)

HPV types, cytology and colposcopic biopsy results. (NILM: Negative intraepithelial lesion and malignancy) (SCC: Squamous cell cervical cancer)

SB-05

Comparison of IL-1, IL-6, TAS, TOS, and catalase levels for safety of water immersion and epidural analgesia during the labor

Ümit Yasemin Sert[1], Tuba Çandar[2], Nezaket Kadıoğlu[3], Özlem Uzunlar[1], Yaprak Engin Üstün[1]

[1]University of Health Science, Zekai Tahir Burak Women's Health and Education and Research Hospital, Department of Obstetrics and Gynecology, Ankara, Turkey

[2]Ufuk University Faculty of Medicine, Department of Medical Biochemistry, Ankara, Turkey

[3]University of Yüksek Ihtisas,Department of Obstetrics and Gynecology, Ankara, Turkey

AIM: Water immersion and epidural analgesia are both pain relief methods used to perceive less pain during the labor process. There are concerns about the maternal and fetal outcomes, although studies presented no significant complication directly related to these methods. Catalase is one of the most important antioxidant defense enzymes. Total serum oxidant (TOS), antioxidant (TAS) levels are the other markers of oxidative balance. Cytokines such as interleukin-1 (IL-1), and interleukin-6 (IL-6) are detected in the amniotic fluid during the healthy pregnancy. The level of these cytokines tends to increase during labor. However, the levels are determined much higher in case of infection We aimed to compare the IL-1 and 6 levels, TAS, TOS, and catalase levels of births with epidural analgesia, water immersion and conventional birth without analgesia.

METHOD: A total of 88 patients were included in the study (The water immersion group included 29 patients, while the epidural analgesia and control group included 30 and 29 patients respectively). IL-1, IL-6, catalase, TAS, TOS levels, neonatal Apgar scores, duration of birth process and demographic data were compared between three groups. Catalase measurement was made by using the Human CAT (catalase) ELISA kit (Fine Test/Wuhan Fine Biotech Co., Ltd) at ELISA reader branded MRC UT6100. IL-1 and IL-6 measurement was made by using Human interleukin 1 Alpha (IL-1 alpha) and Human interleukin

6 (IL-6) ELISA kit (Fine Test/Wuhan Fine Biotech Co., Ltd) at same analyzer. Total oxidant status (TOS) and Total antioxidant status (TAS) were measured spectrophotometric method by using the measurement kit of Rel Assay Diagnostic.

RESULTS: Data analysis was performed by using IBM SPSS Statistics version 17.0 software. There was no significant difference between the three groups in terms of age, Body mass index (BMI), gravidity, parity, gestational week, and birth weight ($p>0.05$). TOS and IL-6 levels were significantly lower in epidural group than others ($p=0.031$, $p=0.019$ respectively). There was a statistically significant difference between the three groups in terms of 1st and 5th minutes APGAR scores. APGAR scores of the epidural group at 1st and 5th minutes were significantly lower than the water and control group ($p<0.001$ and $p<0.001$ respectively). In the study, there was no significant difference between the three groups in terms of TAS, IL-1, and catalase levels ($p>0.05$)

CONCLUSION: This prospective study aimed to compare the oxidative markers (TAS, TOS, and catalase) and infection markers (IL-1 and IL-6) during the labor with water immersion, epidural anesthesia used as pain relief methods, and conventional labor without pain control. Results demonstrated that labor with epidural anesthesia and water immersion is associated with lower TOS and IL-6 levels compared to the control group. However in our study the water immersion and epidural analgesia were found to have no adverse effect on oxidative status and infection parameters of patients.

Keywords: Epidural for labor analgesia, Interleukin, Oxidative stress, Water immersion

SB-06
Embryo implantation in ex vivo uterine culture

Elif Ganime Aygün
Acıbadem Atakent Hastanesi Tüp Bebek Bölümü, Istanbul, Turkey

OBJECTIVE: Developing an embryo in ex-vivo conditions is one of the most difficult and popular studies in reproductive biology. None of the studies so far has given sufficient results and ex-vivo embryo has been viable no longer than 12-14 days. In this study, we aim to test the effect of ex-vivo cultured uterus tissue in the implantation and development of embryo with the aim of creating the closest model to in-vivo conditions.

METHOD: The experiment was designed in two steps. In the first step, we aimed to create the optimum conditions for the viability of in vitro endometrium tissue. In the second step we tested the potential benefits of this in vitro cultured endometrium in the implantation and function of ex-vivo cultured embryo. Experiment model was tested in full thickness uterus specimens in Wistar-Albino adult rats and 4 uterine tissue cultures were formed. Group A: Full thickness rat uterus culture. Group B: Uterus culture supported with Ishikawa cells. Group C: Full thickness uterus culture buried under 3D fibrin matrix. Group D: Full thickness uterus tissue supported with Ishikawa cells and buried under 3D fibrin matrix. In the first step of the experiment, uterus culture was evaluated in the 15th day and function is tested by glucose consumption, lactic acid production and histopathological properties. In the second step, the most appropriate culture was chosen and 7th day embryo implantation was performed. 14 days after embryo transfer, histopathological examination was performed to evaluate implantation with haematoxylin-eosin, Ki-67, vimentin, HCG and cytokeratin stains. Nanog and sox-2 gene mutations were also measured to evaluate the viability of the embryo.

RESULTS: In the first step, when compared to the other groups, the highest glucose consumption and lactic acid formation were observed in uterus tissue supported with Ishikawa cells and/or uterine tissue supported with Ishikawa cells and buried in 3D Fibrin matrix. In the examination of the histological scores of these groups, tissue quality and compaction in observed best in tissues buried in fibrin matrix. In the second step, 3 embryos in 7th day were given to three different 3D fibrin matrix coated endometrial tissues. Two of these 3 attempts were resulted in implantation. Unlike the surrounding tissues, in the histological analysis of these implants, embryo development markers suchs as vimentin, hcg, cytokeratin and Ki-67 were expressed. Additionally, embryonic cell markers such as nanog and sox-2 markers were positive, and the embryonic tissues developed gastrulation.

DISCUSSION: Full thickness uterus tissues cultured in 3D fibrin matrix were observed to have viability and function for 21 days, these tissues were suggested as a support for embryo implantation and development. With the concomitant data, in order to have a viable embryo for a longer period in vitro conditions, 3D fibrin matrix buried uterus culture model can be used. Our study demonstrated that in rat model early stage embryogenesis can be maintained in ex-vivo conditions and embryonic cell marker expressions were obtained.

Keywords: Invitro model, co-culture, tissue culture, extracelluler matrix

SB-07
Female genital trauma with tissue loss caused by a fall from a bicycle

Mehmet Altıparmak[1], Ahmet Akın Sivaslıoğlu[2], Tolga Halıcı[2]
[1]Department of Plastic and Reconstructive Surgery, Muğla Sıtkı Koçman University Faculty of Medicine, Mugla, Turkey
[2]Department of Obstetrics and Gynecology Muğla Sıtkı Koçman University Faculty of Medicine, Mugla, Turkey

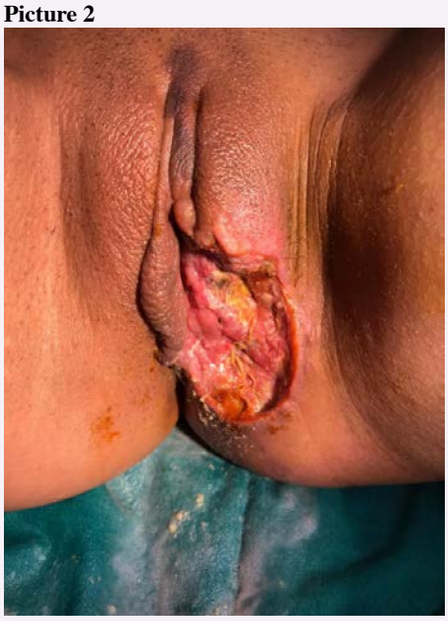
Female genital trauma may develop due to obstetric and gynecological reasons. In addition, these traumas can cover all or part of the genital system according to the way they occur. For this reason, when faced with such traumas it is important that evaluation and treatment of these patients must be made by experts as soon as possible. In our case, reconstructive surgery was performed to repair the vulvar trauma that was caused by a fall from a bicycle and can not be corrected with primary healing. We believe that this case report will be an example of the good results achieved by specialists which vulvar traumas resulting in tissue loss and requiring surgical treatment

Keywords: Reconstructive Surgery, Vulvar Trauma, V-Flap

Picture 1

Photograph of the 24 years of old female patient with vulvar trauma caused by a fall from a bicycle who is consulted from Emergency Room

Picture 2



Photograph of the vulva after the debridement

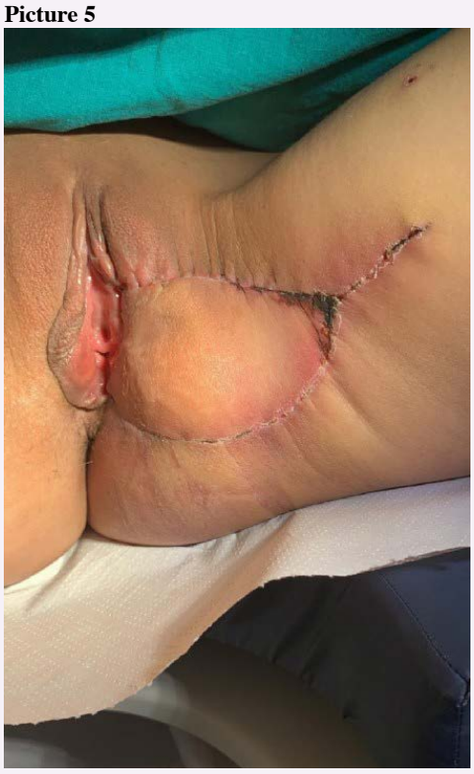
Picture 3

Photograph of the vulva at the end of reconstructive surgery with V-flap advancement

Picture 4

Photograph of the vulva at the postoperative fifth day when patient discharged from the hospital

Picture 5



Photograph of the vulva at outpatient visit after two weeks

SB-08
Endometriosis and stem cells

Fadime Kahyaoğlu[1], Mehmet İbrahim Tuğlu[1], Fadime Kahyaoğlu[2]
[1]University of Celal Bayar, Faculty of Medicine, Histology and Embryology Department, Manisa, Turkey
[2]Irenbe OBGYN and IVF Clinic, Izmir, Turkey

OBJECTIVE: The endometrium with the uterine mucosa is a complex, dynamic and regenerative tissue necessary for human reproduction. It shows continuous and regular cyclic regeneration. Progenitor stem cells, which perform rapid regeneration, can sometimes grow in unexpected places by crossing the endometrium. Endometriosis is an inflammatory, estrogen-related condition associated with pelvic pain and infertility. It affects about 10% of women of reproductive age and 20 to 50% of infertile women, while 71 to 87% of women with chronic pelvic pain have endometriosis. Endometrial lesions are located primarily on the pelvic peritoneum and ovaries; rarely, endometriosis can be found in the pericardium, pleura, lung parenchyma, and even in the brain. Despite its frequency and effect on quality of life, the pathogenesis of endometriosis cannot be clearly explained. In addition, migration of stem cells to the ectopic region is associated with endometriosis. Stem cells are capable of self-renewal as well as differentiation to progenitors by asymmetric cell division. The hypothesis of the presence of stem cells in the human endometrium has been suggested many years ago by Prianishnikov (1978) and Padykula et al. (1989). Since then, many efforts have been made to support this possibility. Although studies have identified different types of stem cells in the human endometrium, there are differences of opinion about the localization or established markers of this population. The aim here is to reveal the latest data in the light of both endometriosis and recent literature on stem cells associated with the endometrium. It is also an assessment of the potentials of immunomodulators, microRNAs and exosomes, which are new methods of treatment for endometriosis.

METHOD: In the literature, experimental and clinical studies in recent years were examined. The data were evaluated and interpreted.

CONCLUSION: Stem cells were found to be highly promising experimentally. In clinical studies, it was thought that more data was required. It was decided that immunomodulators, microRNAs and exosomes provide experimentally significant contributions, but clinical studies are in the early stages, and more studies with reliability and efficacy assessments should be made.

Keywords: endometrium, endometriosis, stem cell, immunomodulator, microRNA, exosome

SB-09
Use of Corticosteroids in Pregnant Women with COVİD-19

Fatma Horasan Altıntaşoğlu
Dr. Fatma Horasan Gynecology, Obstetrics and IVF Clinic

Introduction and Purpose: Novel coronavirus SARS-Cov-2 was declared a global pandemic by WHO on 12 March 2020 and number of cases increase every day. While most of the individuals infected with the virus pull trough as asymptomatic or with mild symptoms, others face serious death rates having severe acute respiratory distress. Right after the emergence of this disease, guides on how should pregnant women and babies be managed in the face of Covid-19 infection have been published. The purpose of this study is to investigate the decrease in neonatal mortality and morbidity against the maternal risks of using antenatal corticosteroid for fatal lung maturation in mothers with Covid-19. Model studies carried out on this subject have been collected.

Materiel and Method: Studies about pregnancy that were published after the Novel Coronavirus (Covid-19) outbreak have been examined and advantages and disadvantages of corticosteroids with regards to the mother and the infant have been studied. During the study, a theoretical cohort study has been carried out and 10.000 women who are infected with Covid-19 and 24-33 weeks into their pregnancy and under the threat of premature birth have been defined.

Findings: 10.000 women who are 24, 28, 29, 30, 31, 32 and 33 weeks into their pregnancy have been parted in doubles. In a theoretical cohort study that involves10.000 women who were hospitalized with Covid-19 and 24, 28, 31, 33 weeks into their pregnancy and under the threat of premature birth, 2200 women for each week have been given steroids and 1500 of them have not. Later on, rates of being put into intensive care and death have been determined. And with babies, rates of Acute Respiratory Distress Syndrome (ARDS), Intraventricular Hemorrhage (IVH) and neurodevelopmental delay have been recorded. In a theoretical cohort study that involves10.000 women who consult YBÜ with Covid-19 and 29, 30, 31 weeks into their pregnancy and under the threat of premature birth 745 pregnant women per week have been given steroids and 500 of them have not. Maternal death rates have been recorded, and with infants rates of ARDS, IVH and neurodevelopmental delay have been determined.

Conclusion: According to the theoretical cohort study, Administration of antenatal corticosteroids at less than 32 weeks of gestation for hospitalized patients and less than 30 weeks of gestation for patients admitted to the ICU resulted in higher combined maternal and infant outcomes compared with expectant management for women at high risk of preterm birth with COVID-19 infection. Since the judgment on the care of preterm women and infants in intensive care is controversial, risks, benefits and alternatives must be considered in intercourses with patients. This decision analysis have been made due to the poorness of data that shows use of antenatal corticosteroid for preterm birth with Covid-19 positive patients. Therefore, the care on women with Covid-19 who have respiratory disorder must be individualized and a multidisciplinary approach must be carried out towards these patients.

Keywords: Corticosteroid, COVİD-19, Pregnancy,

Gebelik ve Covid-19

Gebelik ve Covid-19

SB-10

High perceived stress levels and accompanying low urine pH associated with bladder pain symptom severity

Esra Cihan[1], Ahmet Cihan[2]

[1]Department of Obstetrics and Gynecology,Nigde Omer Halisdemir University,Turkey

[2]Department of Urology,Nigde Research and Training Hospital,Turkey

OBJECTIVE: The clinical relevance of urine pH and perceived stress levels associated with bladder pain syndrome (BPS) patients has not yet been clarified. In the present study, we hypothesized that urine pH and perceived stress levels may differ in patients with BPS and they may be related to each other.

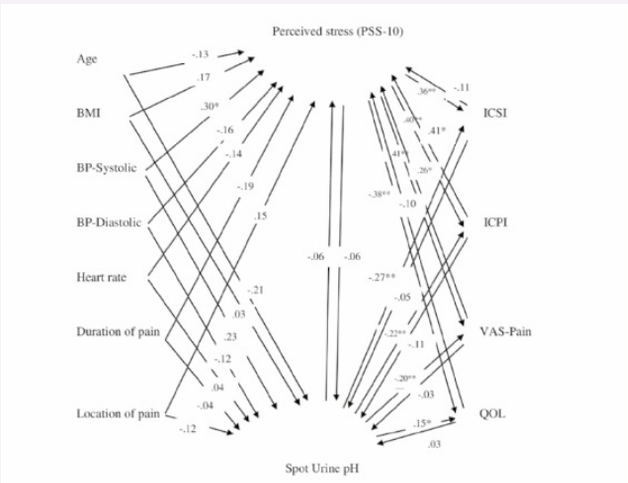
METHOD: A prospective case-control study was conducted to test the hypothesis. Newly diagnosed BPS patients over 18 years of age were included in the patient group. The control group consisted of healthy volunteers subjects over 18 years of age. Perceived stress scale ratings (PSS-10), spot urine pH measurements, interstitial cystitis symptom index (ICSI), interstitial cystitis problem index (ICPI), visual analog scale for pain (VAS-Pain), and quality of life (QOL) scores were evaluated. The Independent Samples t-Test and multivariate regression with path analysis were performed.

RESULTS: The study evaluated 84 BPS patients and 86 healthy subjects. Mean spot urine pH, PSS-10, ICSI, ICPI, VAS-Pain, and QOL scores differed between the patient and control groups. Spot urine pH level (p=.01 OR:.31) and PSS-10 scores (p=.01 OR: 1.1) remained as significant predictors of BPS in multivariate analysis. Lower urine pH and higher perceived stress were found to be associated with worse ICSI, ICPI, VAS-Pain, and QOL scores.

CONCLUSION: Acidic urine pH and high perceived stress levels are associated with the presence of BPS. Perceived stress is independent from urine pH as they each relate to BPS symptoms in a bidirectional manner.

Keywords: Bladder pain, Interstitial cystitis, Perceived stress, Urinary acidosis, Urine pH

Results of path analysis from multivariable regression of the study variables



*Correlation coefficients at multivariable regression analysis were given in the figure. *indicates p ≤.05 and **indicates p <.01*

SB-11

Hydronephrosis Caused By Pelvic Organ Prolapse İn Africa

Özer Birge

Akdeniz Üniversitesi Tıp Fakültesi, Kadın Hastalıkları ve Doğum Ana Bilim Dalı, Antalya

OBJECTIVE: We aimed to evaluate the severity of hydronephrosis and related factors in patients with uterine prolapse.MATERIAL

METHODS: 4320 women who applied to the Sudan Nyala Turkish Hospital Gynecology and Obstetrics outpatient clinic between January 2018 and January 2019 were scanned and 528 patients diagnosed with uterine prolapse were included in the study.Patients' uterine prolapse severity was classified according to the pelvic organ prolapse classification system and the patients were divided into 5 groups. Demographic and clinical features, incontinence types, pre- and postoperative creatinine levels, and hydronephrosis grade of patients were compared.The data were evaluated with Statistical Package for the Social Sciences (SPSS) -21.0 program.ANOVA and chi-square test were used for the correlations. p <0.05 was considered statistically significant

RESULTS: 7 patients (1.3%) stage 0, 126 patients (23.9%) stage 1, 223 patients (42.2%) stage 2, 119 patients (22.5%) stage 3, 53 patients (10%) were included in stage 4 prolapse group and variables were compared. The mean age of the patients was 41.9±11.1 in the stage 0 prolapse group and 68.2±15.3 in stage 4 prolapse group.While only one patient with 5 or more deliveries was at stage 0,all of the patients in stage 4 had 5 or more deliveries,13.2% of stage 4 group had spontaneous vaginal delivery and 75.5% had assisted vaginal delivery.The mean age at first birth was 19.7±5 years in stage 0 prolapse group and 15.7±1.1 in stage 4 group,98.1% of patients were 18 years or younger in stage 4 group. All patients in the stage 3 prolapse group had BMI between 30-39 and all patients in the stage 4 prolapse group had BMI of 40 and above.All patients in stage 3 and 4 prolapse groups were operated, and all patients in stage 0 were followed-up.Significantly more urinary incontinence accompanied in stage 3 and 4 prolapse group than stage 0,1 and 2 prolapse group.Stage 0 group patients had no hydronephrosis,and the mean creatinine level was 0.9±0.08 mg/dL.The severity and rate of hydronephrosis increased as the stage increased.Before the operation in the stage 4 patient group,24(43.5%)patients had grade 3 hydronephrosis,29(54.7%)patients had grade 4 hydronephrosis,the mean creatinine level was 2.5±0.99 mg / dL and 46(86.8%) patients were with creatinine level>1.3;After operation,32(60.4%) patients had no hydronephrosis,10(18.8%)patients had grade 1 hydronephrosis,11(20.8%)patients had grade 2 hydronephrosis,mean creatinine level was 1±0.07mg/dL and no patients with creatinine level >1.3.

CONCLUSION:Pelvic organ prolapse is a multifactorial herniation of pelvic organs out of the urogenital hiatus due to pelvic floor dysfunction.The main etiological factors in pelvic organ prolapse are older age, grand-multiparity,vaginal delivery and obesity.The most important problem in patients with severe POP is hydronephrosis due to urethral curl or urethral obstruction which is a result of cystocele squeezing the urethra under the pubic bone.In this study,a significant relationship was found between prolapse stages and hydronephrosis. Also,hydronephrosis severity increased as age, body mass index and comorbidity increased.The first step in reducing the prevalence of pelvic organ prolapse may be to reduce grand multiparity.In order to prevent the progression of pelvic organ prolapse resulting in hydronephrosis,

women should be made conscious about gynecological examination in the menopausal period.

Keywords: assisted vaginal delivery, grand-multiparity, hydronephrosis, pelvic organ prolapse

SB-12
Evaluation of sexual dysfunction in infertile patients

Şule Atalay Mert, Yaprak Üstün
Etlik Zübeyde Hanim Gynecology and Obstetrics Education and Research Hospital, Department of Infertility,Health Sciences University, Ankara, Turkey

AIM: Assessing sexual dysfunctions in infertile patients and supporting them during the treatment process.

INTRODUCTİON: Infertility is defined as the inability of couples in the reproductive period to conceive despite regular unprotected sexual intercourse for one year. The World Health Organization (WHO) reports the rate of infertile couples in the world as approximately 8-12.3%. It is known that the rate of infertility has increased up to 30% in recent years. The most important factor in this increase is the increased awareness of couples and late marriage and late childbirth due to social conditions. Studies have also reported that psychiatric symptoms are more common in women than men in infertile couples. The reasons are shown as couples' anxiety about having a child, timed sexual intercourse planning, perception of inadequacy, stress and the length of the treatment process.

METHOD: In our study, 60 female patients between the age of 18-45 who were followed up in the infertility outpatient clinic between November 2019 and December 2019 and who had primary or secondary infertility for at least 1 year. Sixty female control patients between the age of 18-45 who were followed up family planning outpatient clinic who had no infertility problem, had spontaneous pregnancy, had no infertility treatment history. They were evaluated after local ethical approval was obtained. Patients who were not previously diagnosed with sexual dysfunction, and who had no psychiatric disorder or a history of psychiatric medication were included in the study. Patients with a history of systemic illness, continuous medication use, psychiatric illness or use of psychiatric medication were excluded from the study. The patients were informed about the study and their consents were obtained, then the sociodemographic characteristics recorded,and then Female Sexual Function Index (FSFI), Arizona Sexual Experiences Scale (ASES), Golombok-Rust Sexual Satisfaction Scale (GRSSS) were administered to the patients.

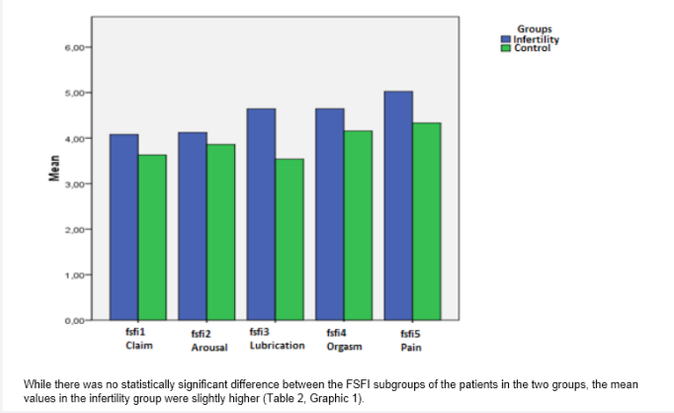
RESULTS: The mean age in our study was 28.51 ± 4.86 in the infertility group and 32.40 ± 7.69 in the control group (p = 0). Statistically, the duration of marriage between the 2 groups were higher in the control group as expected (Table 1). The birthplace of the patients, birthplace of their husband and where they live were found higher in the city (p = 0.041, p = 0.022, p = 0.008). While there was no difference between other sociodemographic characteristics (Table 1).

While there was no statistically significant difference in FSFI, ASES results. The third subgroup of the GRSSS, which was avoiding,was found to be significantly lower in infertility group.

CONCLUSİON: In our study was evaluated the same age group,but no significant difference was found between the two groups in comparison of the sexual function scales. This result was attributed to the long marriage duration of the patients in the control group and the absence of anxiety about having children. That's why more studies are needed to evaluate the effect of the duration of marriage and the anxiety of having children on sexual functions and to increase the awareness of patients.

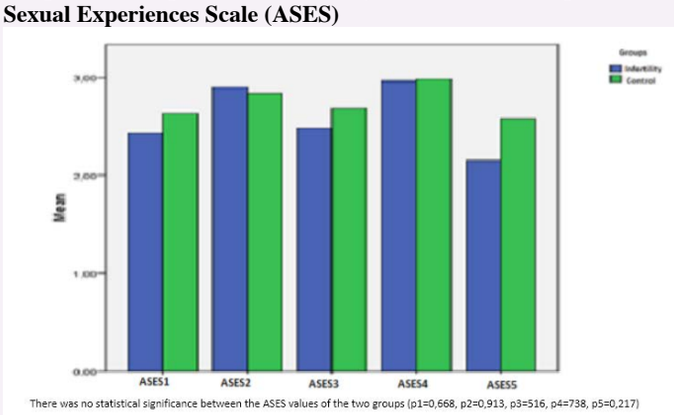
Keywords: Infertility, Sexual Dysfunctions, Golombok-Rust Sexual Satisfaction Scale (GRSSS),Female Sexual Function İndex (FSFI), Arizona Sexual Experience Scale (ASES)

Graphic 1: Comparison of FSFI (Female Sexual Function Index) Subgroups in Infertility and Control Groups



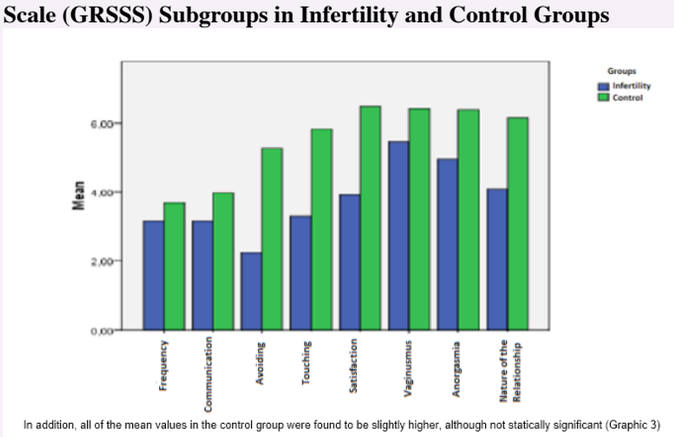
While there was no statistically significant difference between the FSFI subgroups of the patients in the two groups, the mean values in the infertility group were slightly higher (Table 2, Graphic 1).

Graphic 2: Comparison of Infertility and Control Group Arizona Sexual Experiences Scale (ASES)



There was no statistical significance between the ASES values of the two groups (p1=0,668, p2=0,913, p3=516, p4=738, p5=0,217)

Graphic 3: Comparison of Golombok-Rust Sexual Satisfaction Scale (GRSSS) Subgroups in Infertility and Control Groups



In addition, all of the mean values in the control group were found to be slightly higher, although not statically significant (Graphic 3)

TABLE 1. Comparison of Infertility and Control Group Sociodemographic Features

	Infertility Group (N=60) Mean±Std dev.		Control Group (N=60) Mean±Std dev.		P value
Age	28,51±4,86		32,40±7,69		0
Age difference between spouse	3,63±3,042		4,22±4,22		0,132
Marriage age	23,53±4,82		21,7±4,28		0,167
Husband's marriage age	26,65±5,54		25,46±4,83		0,724
Duration of marriage	4,817±4,027		11,35±8,21		0
	N	%	N	%	
Education status					
Primary school	7	11,7	12	20	
Middle school	9	15	6	10	
High school	28	46,7	21	35	0,055
License	14	23,3	13	21,7	
Graduate	2	3,3	8	13,3	
Husband's education status					
Primary school	7	11,7	14	23,3	
Middle school	16	26,7	7	11,7	
High school	21	35	17	28,3	0,053
License	13	21,7	14	23,3	
Graduate	3	5	8	13,3	
Place of Birth					
Rural	15	25	17	28,3	
City	45	75	43	71,7	0,041
Husband's place of birth					
Rural	16	26,7	22	36,7	
City	44	73,3	38	63,3	0,022
Place of residance					
Rural	3	5	7	11,7	
City	57	95	53	88,3	0,008
Working status					
Not working	39	65	27	45	
Working	20	33,3	31	51,7	0,170
Student	1	1,7	2	3,3	
Husband's working status					
Not working	1	1,7	0	0	0,044
Working	59	98,3	60	100	
İncome status					
0	40	66,7	28	46,7	
501-1500	2	3,3	2	3,3	0,138
1500>	18	30	4	6,7	
Husband's income status					
0	1	1,7	0	0	
500	1	1,7	4	6,7	0,114
501-1500	3	5	5	8,3	
1500>	55	91,7	51	85	
Marriage type					
Arranged marriage	24	40	27	45	0,297
Flirt	36	60	33	55	
Relationship					
no	46	76,7	45	75	0,673
yes	14	23,3	15	25	

Table 2: Comparison of FSFI subgroups between infertility and control groups

	Infertility (N=60)		Control (N=60)		
	Mean ±	Std. Dev	Mean ±	Std. Dev	P Value
FSFI 1 (Claim)	4,08	1,12005	3,63	1,06203	0,175
FSFI 2 (Arousal)	4,125	1,10417	3,86	1,10809	0,948
FSFI 3 (Lubrication)	4,645	0,80326	3,54	0,85889	0,175
FSFI 4 (Orgasm)	4,6467	0,99106	4,16	1,0342	0,974
FSFI 5 (Satisfaction)	5,0267	1,05796	4,3333	1,09028	0,531
FSFI 6 (Pain)	4,3467	1,36089	3,94	1,39505	0,861
FSFI TOTAL	26,87	4,74143	23,4967	4,24735	0,642

FSFI: Female Sexüel Function Index

Table 3: Comparison of Golombok-Rust Sexual Satisfaction Scale (GRSSS) Between Infertility and Control Groups

	İnfertility (N=60)		Control (N=60)		
	Mean	Std. Dev	Mean	Std. Dev	P Value
Golombok 1 (Frequency)	3,1667	1,7961	3,6833	1,56759	0,155
Golombok 2 (Communication)	3,1667	2,30082	3,9833	1,94406	0,178
Golombok 3 (Avoiding)	2,2333	2,27266	5,2667	3,12923	0,038
Golombok 4 (Touching)	3,3	2,75127	5,8333	3,27893	0,136
Golombok 5 (Satisfaction)	3,9167	2,88944	6,4833	3,40235	0,281
Golombok 6 (Vaginismus)	5,4667	2,80113	6,4167	2,5197	0,715
Golombok 7 (Anorgasmia)	4,95	2,98258	6,3833	3,00334	0,686
Nature of the relationship	4,0833	2,14943	6,15	2,7851	0,094

In the GRSSS subgroups, between infertile patients and control patients, the 3rd subgroup (avoidance) was statistically significantly lower in the infertility group (p = 0.038) (Table 3).

SB-13

Risk factors for para-aortic lymph node metastasis in endometrioid type endometrial cancer

Zeliha Fırat Cuylan
Department of gynecologic oncology, Ankara city hospital, Ankara, Turkey

Objecti ve The purpose of this study was to determine the risk factors for paraaortic lymph node (LN) metastasis in endometrioid type endometrial cancer (EEC) patients who underwent comprehensive surgical staging.

Methods: Women diagnosed with EEC who underwent comprehensive surgical staging including pelvic and paraaortic LN dissection between 2007 and 2018 were included in this retrospective study. Patient data were analyzed with respect to para-aortic LN involvement, and predictive factors for para-aortic LN metastasis were investigated. Women with non-endometrioid-type endometrial cancer, those with mixed histologies (10% or more non-endometrioid component), and those with incomplete medical records were excluded from the study. Clinicopathological features of women with and without LN involvement were compared by chi square test. A p value < 0.05 was considered to indicate statistical significance. Variables with a p value less than 0.05 were included into the multiple logistic regression analysis. The impact of each factor on LN metastasis was evaluated.

Results: A total of 587 women who were diagnosed with EEC and underwent comprehensive surgical staging were included in the final analysis. The median age of the patients were 58 years (range 28-85). There were 57 (9.7%) patients with LM metastasis in entire study population. Forty-eight women had (8.2%) pelvic and 35 (6%) women had para-aortic LN metastasis. Isolated pelvic LN metastasis was detected in 21 (3.6%), and isolated para-aortic LN metastasis in 6 (1%) of patients. Univariate analysis revealed that the risk of para-aortic LN metastasis significantly increased in patients with lymphovascular space invasion (LVSI) (p<0.001), grade 3 tumor (p<0.001), myometrial invasion ≥ 50% (p<0.001), primary tumor diameter ≥3 cm (p<0.001), cervical stromal invasion (p=0.005), adnexal involvement (p<0.001), pelvic LN metastasis (p<0.001) and ≥ 35 IU/L CA-125 (p<0.001). In multivariate analysis, the presence of LVSI [odds ratio (OR), 46.35; 95% confidence interval (CI), 5.20–91.2; p = 0.001] and pelvic LN metastasis (OR, 25.5; 95% CI, 8.23–78.93; p < 0.001) remained as independent risk factors for para-aortic LN involvement in women with EEC.

Conclusion: The presence of LVSI and pelvic LN involvement appear to be independent risk factors for para-aortic LN metastasis in patients with EEC.

Keywords: Endometrioid type endometrial cancer, surgical staging, lymph node metastasis

SB-15

Prognostic factors in low grade epithelial ovarian cancers

Hasan Aykut Tuncer
Department of Obstetrics and Gynecology, Division of Gynecological Oncology, Akdeniz University School of Medicine Hospital, Antalya, Turkey

Aim: Epithelial ovarian cancer is the the most important cause of death

among all gynecological cancers. The two-tier histological grading system divides ovarian cancers into two grades as low grade and high grade. These different histological grades have substantial clinical impact on chemotherapy response and surgical outcome. Low grade serous ovarian cancers represent %6-8 of all epithelial ovarian cancers and they have limited response to chemotherapy. However current evidence for the management strategy of low grade epithelial ovarian carcinomas are based on clinical trials predominantly involving high grade epithelial ovarian cancers which are highly chemosensitive. Due to rarity of low grade epithelial ovarian cancers, clinical trials regarding treatment strategies are quite a few. Therefore, the prognostic factors on overall survival of low grade epithelial ovarian cancers were evaluated in the present study.

Material & Methods: Patients who had undergone surgery for ovarian cancer in gynecological oncology department of Akdeniz University between 2004 and 2019 were retrospectively reviewed. The study population included women who had histopathologically proven low grade epithelial ovarian carcinoma. Patients' clinical, surgical and pathological datas, neo-adjuvan and adjuvan chemotherapies and follow-up times were recorded. All operations were performed by gynecological oncologists with aim of achieving maximal or optimal cytoreduction. Optimal cytoreduction was defined as less than or equal to 1 cm maximal diameter of the largest residual tumor, whereas suboptimal debulking was defined as > 1 cm of residual tumor after primary cytoreductive surgery (CRS). Adjuvan treatment were decided by both gynecological oncology surgeons and medical oncology physcians in Akdeniz University. Overall survival (OS) was defined as the time period between primary CRS to the date of death or the last follow-up.

Statistical analyses were performed using the SPSS version 23.0 statistical software (IBM Corp., Armonk, NY, USA). The Kaplan–Meier method was used to create survival curves and Long-rank test was used to calculate the differences between survival curves. We performed a univariate Cox-regression model to determine the prognostic factors for OS. Multivariate analysis was applied to variables with p values < 0.05 in the univariate analysis. A p value < 0.05 was accepted to be statistically significant.

Results: 46 patients were identified and included in the present study. Mean ± Sd age of the study population was 46 ± 13.76. Optimal cytoreduction was achieved in 37 (80.4%) patients. Charecteristics of the study population were presented in Table 1. With a median follow-up of 103 (25th-75th percentile: 32.50-147.50) months, 5 year OS of the study population was 83.2 months. Mortality occured in 11 (23.9%) cases. Accoording to multivariate analysis; optimal cytoreductive surgery was the only prognostic factor for low grade epithelial ovarian cancers. Suboptimal CRS increases the occurance of mortality compared with optimal CRS (Hazard Ratio [HR] 18, 95% confidence interval [CI] 15.078–20.922; p < 0.001) (Table 2).

Conclusions: Optimal cytoreductive surgery has clinical significance in the prognosis of low grade epithelial ovarian cancers. For this rare ovarian cancers, all surgical efforts should be made to ensure that no tumor tissue is left behind.

Keywords: Cytoreductive surgery, low grade epithelial ovarian carcinoma, overall survival

Table 1

Charecteristics of the study population

	Parameters	Values(%)
Age	Mean ± Sd	46 ± 13.76
Gravida	Median 25th-75th Percentile	2 1-4
Parity	Median 25th-75th Percentile	2 1-3
Menopausal status	Premenopausal Postmenopausal	22 (47.8) 24 (52.2)
Primary treatment	NACT CRS	3 (6.5) 43 (93.5)
CRS	Optimal Suboptimal	37 (80.4) 9 (9.6)
Adjuvan chemotherapy	+ -	33 (71.7) 13 (28.3)
Stage (Figo)	I II III IV	19 (41.3) 6 (13.0) 19 (41.3) 2 (4.4)
Hystology	Serous Endometrioid Mucinous	20 (53.5) 6 (13.0) 20 (43.5)
Lymph node involvemenet[a]	+ -	7 (17.1) 34 (82.9)
Omental involvemenet	+ -	17 (37) 29 (63)
Peritoneal cytology	+ -	12 (26.1) 34 (73.9)

[a]: Lenfadenectomy was not performed in 5 patients.
Abbreviations: NACT, Neoadjuvan chemotherapy; Figo, International Federation of Gynecology and Obstetrics; CRS, cytoreductive surgery

Table 2

Univariate and multivariate analyses for overall survival in women with low grade epithelial ovarian carcinoma

	OS[a] (%)	Events[b]	Univariate			Multivariate
			p	HR	CI 95%	p
Age (years) ≤48 >48	 92.3[c] 66.9	 1/23 (4.3%) 10/23 (43.5%)	0.002			
Menopausal status Premenopausal Postmenopausal	 91.7[c] 68.4	 1/22 (4.5%) 10/24 (41.7)	0.005			
Stage[d] I-II III-IV	 94.7 76.2	 3/23 (13.0%) 6/18 (33.3%)	0.047			
Primary treatment Surgery NACT	 87.0 33.0	 9/43 (20.9%) 2/3 (66.7)	0.002			
Adjuvan Chemotherapy Yes No	 87.2 72.5	 8/33 (24.2%) 3/13 (23.1%)	0.807			
Histological type Serous Endometrioid/Mucinous	 77.4 84.6	 5/20 (25.0%) 6/26 (23.1%)	0.446			
Lymphadenectomy Yes No	 86.5 60.0	 9/41 (22.0%) 2/5 (40.0%)	0.187			
Lymph node involvemenet[e] Yes No	 85.7 86.6	 3/7 (42.9%) 6/34 (17.6%)	0.099			
Omental involvemenet Yes No	 67.2 92.0	 6/17 (35.3%) 5/29 (17.2%)	0.106			
Peritoneal cytology + -	 64.8 89.6	 5/12 (31.7%) 6/34 (17.6%)	0.105			
CRS Optimal Suboptimal	 96.2 33.3	 3/37 (8.1%) 8/9 (88.9%)	<0.001	18	15.078-20.922	<0.001

Abbreviations: OS, overall survival; LN, lymph node; LVSI, lymphovascular space invasion; HR, hazard ratio; CI, confidence interval; CRS, cytoreductive surgery.
[a] 5-year overall survival (exception [c])
[b] The number of cases with death.
[c] (Exception for OS[a]) OS at 106 months, no deaths before 106 months.
[d] Staging is performed in 41 patients.
[e] Lymph node involvement could be evaluated in 41 patients as 5 patients were not undergone lymphadenectomy.

SB-16
Perinatal complications of adolescent pregnancies

Serap Fırtına Tuncer
Department of Obstetrics and Gynecology, Antalya Education & Research Hospital, Antalya, Turkey

Aim: Adolescent pregnancy is defined as pregnancy in girls before aged 19 years at delivery day. Globally, adolescent pregnancy is an important and common health problem. Adolescents aged 15–19 years contribute to 12% of global, annual births and 10% of global, annual maternal deaths. Pregnancy in adolescents has been associated with not only maternal health problem but also associated with adverse perinatal outcomes such as preterm birth, low birth weight, intrauterine growth retardation (IUGR) and perinatal deaths. Therefore in the present study perinatal complications of adolescent pregnancies were investigated.

Material and Methods: The birth datas of women who gave birth in Antalya Education & Research Hospital in between January 2019 to July 2020 were examined. Adolescent pregnancy was defined as the pregnancy less than 19 years at the delivery day. Patients' clinical caharecteristics, mode of delivery, antenatal visits and adverse perinatal complications were recorded. Antenal visit was accepted as adequate if the patient has at least one clinical evaluation in the obstetric department in each trimester. Otherwise it was accepted as inadequate. Adverse perinatal complications were defined as preterm birth, low birth weight, IUGR, perinatal excitus and requirement of neonatal intesive care unit. The Statistical Package for the Social Sciences version 23.0 for Windows software program (IBM Corp., Armonk, NY, USA) was used for statistical analyses. Frequencies of categorical variables were found using descriptive statistics. Continuous variables were evaluated with an analytical method (Kolmogorov–Smirnov test) to assess whether they were normally distributed or not. As all were abnormally distributed, parameters were expressed as medians and percentiles. The response variable was adverse perinatal complications. The Mann–Whitney U test for abnormally distributed parameters and chi-squared test for categorical variables, respectively, were used to evaluate the relationship of those categorical and continuous variables with the response variable. P-values of less than 0.05 were defined as statistically significant.

Results: 64 adolescents were evaluated in the present study. The median age of the study population was 18 (range: 14-18). Neonatal intensive care was required in 18 (28.1%) births. Preterm birth and low birth weight were ocuured in 13 (20.3%) pregnancies. IUGR was diagnosed in 6 (9.4%) pregnancies. 2 (3.1%) pregnancies were complicated by perinatal death. Charecteristics of the study population was given in Table 1. Perinatal complications were observed in 25 adolescents (39.1%) in total, since some complications occurred together. According to univariate analysis it was seen that adverse perinatal complications were more related with low maternal body weight (p=0.001) and low maternal BMI (p=0.014) (Table 2).

Conclusions: Perinatal complications are more common in in adolescents with low body weight and low body mass index. Pregnancy should not be recommended in adolescents since body development and body weight should not reached to values in adult ages. In the presence of a pregnancy adequate nutrition and body weight gain should be provided for all adolescents.

Keywords: Adolescent pregnancy, BMI, perinatal complications

Table 1

Table 1: Charecteristics of the study population

Charecteristic	Parameters	Values (%)
Age (years)	Median	18
	25th-75th percentiles	17-18
Gravidity	Median	1
	25th-75th percentiles	1-1
Parity	Median	1
	25th-75th percentiles	1-1
	Nullipar	58 (90.6)
	≥ 1	6 (9.4)
Age group	≤16	12 (18.8)
	>16	52 (81.2)
Maternal body weight	Median	50
	25th-75th percentiles	50-55
Maternal height	Median	160
	25th-75th percentiles	155-160
BMI	Median	22.7
	25th-75th percentiles	21.1-24.9
Birth week	Median	38
	25th-75th percentiles	37-39
Fetal Body Weight	Median	2950
	25th-75th percentiles	2550-3370
APGAR score (1st m)	Median	8
	25th-75th percentiles	4-9
APGAR score (5th m)	Median	10
	25th-75th percentiles	7-10
Antenatal visits	Adequate	34 (53.1)
	Inadequate	30 (46.9)
Mode of delivery	Vaginal birth	34 (53.1)
	Cesarean	30 (46.9)
Neonatal intensive care	+	18 (28.1)
	-	46 (71.9)
Preterm birth	+	13 (20.3)
	-	51 (79.7)
Low birth weight	+	13 (20.3)
	-	51 (79.7)
IUGR	+	6 (9.4)
	-	58 (90.6)
Perinatal excitus	+	2 (3.1)
	-	62 (96.9)

Abbreviations: IUGR, Intrauterine growth retardation; BMI, body mass index

Table 2

Table 2: Relationship between adverse perinatal outcomes and possible risk factors

Charecteristics	Parameters	Adverse maternal fetal outcome		Univariate analysis
		Present	Absent	P value
Age (years)	Median	18	18	0.290
	IQR	1	1	
Gravidity	Median	1	1	0.826
	IQR	0	0	
Parity	Median	1	1	0.826
	IQR	0	0	
Maternal body weight	Median	52	57	0.001
	IQR	7	6	
Maternal height	Median	155	158	0.194
	IQR	9	7	
BMI	Median	21.99	23.42	0.014
	IQR	3.41	2.69	
Antenatal visits	Adequate	11 (32.4)	23 (67.6)	0.242
	Inadequate	14 (46.7)	16 (53.3)	

Abbreviations: IQR, Inter quartile range; BMI, body mass index

SB-17
Clinicopathological Characteristics of 7 Patients with Cytoreductive Surgery and Chemotherapy due to Serous Ovarian Carcinoma and Developed Subcutaneous Recurrence: A Single Center Analysis

Caner Çakır
Etlik Zübeyde Hanım Eğitim ve Araştırma Hastanesi

Epithelial ovarian cancers are the first in the list of deadliest cancers in the female genital system today. Although the standard approach of the disease is primary cytoreduction and chemotherapy, most of the advanced stage diseases experience relapse. Although at least one of these nuclei is subcutaneous tissue, treatment is difficult. Generally, the approach is radio-chemotherapy and the success rate is low. Keywords: Serous Ovarian Carcinoma, Subcutaneous Recurrence

OBJECTIVE: Epithelial ovarian cancers are the deadliest among female genital cancers. Serous Carcinoma histology is the most common. This histology is often found in high grade form. Its standardized treatment is cytoreduction and chemotherapy, but some patients are evaluated for interval surgery after neoadjuvant chemotherapy because cytoreduction cannot be applied in the operation. The disease is usually caught in an advanced stage and relapse occurs frequently in the first 2 years. Subcutaneous recurrence, which is among these recurrences, is observed very rarely. In this study, it was aimed to evaluate the clinicopathological features of patients with skin recurrence that developed in patients operated on for serous ovarian cancer.

METHOD: In this study, 7 patients (1%) of 701 serous ovarian cancer patients who were treated and followed up in the Gynecological Oncology Clinic between January 1993 and December 2018 were included in the evaluation.

RESULTS: The mean age of the patients at the time of diagnosis was 63 (range 54-74). High grade serous carcinoma histology was seen in all patients. They were diagnosed when 1 patient was Stage III B, 5 patients were Stage III C, 1 patient was Stage IV B. Standard taxan-platinum chemotherapy was given to all patients. The patients were followed up every 3 months for the first two years. The diagnosis of subcutaneous recurrence was made on average 21 months after the end of treatment (range 9-54). All patients were diagnosed with symptomatic findings and imaging methods. Chemotherapy was given to 7 patients, 3 patients underwent surgical excision only. The mean follow-up period of the patients was 79 months (range 44-125). During the follow-up, 3 patients died of the disease.

CONCLUSION: Epithelial ovarian cancer (EOC) ranks first among the deadliest cancers of the female genital system. Having advanced stage disease at the time of diagnosis is considered to be poor in terms of prognosis. Primary cytoreduction and chemotherapy are the standard approach, but recurrence is frequently encountered in this disease. Although the success of relapse treatment is low, the approach is appropriate according to the body area with recurrence. Multi-center studies are needed in this rare patient group.

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Keywords: Serous Ovarian Carcinoma, Subcutaneous Recurrence, Primary Cytoreduction,

SB-18
Prognostic value of lymphovascular space invasion in patient with FIGO 2018 stage IB-IIA cervical cancer

Koray Aslan
Department of Gynecologic Oncology, Ankara City Hospital, Ankara, Turkey

INTRODUCTION: Lymphovascular space invasion (LVSI) is considered one of the intermediate-risk factors for recurrence in patients with early-stage cervical cancer. However, it remains controversial whether LVSI is an independent prognostic factor in patients with early-stage cervical cancer. A literature review reported that only 3 of 25 studies found that LVSI was an independent risk factor affecting survival in women with early cervical cancer. Some of the studies suggested that LVSI may be associated with the lymphatic metastasis, while lymphatic metastasis is directly correlated to the prognosis of patients with cervical cancer. This study aimed to clarify the prognostic value of LVSI in women with the International Federation of Gynecology and Obstetrics (FIGO) 2018 stage IB-IIA cervical cancer.

METHODS: In this single center retrospective study we included the women who had FIGO 2018 stage IB-IIA cervical cancer and, those had undergone radical hysterectomy with systematic retroperitoneal lymphadenectomy. We excluded women with rare histologies, patients with incomplete medical records and those who received only pelvic lymphadenectomy. The information including age, histologic type, primary tumor size in greatest dimension (cm), depth of stromal invasion, LVSI (absent/present), microscopic parametrial invasion (yes/no), vaginal surgical margins (negative/positive), number of LNs removed (total/pelvic/para-aortic) stage of disease and type of adjuvant therapy (no/ radiotherapy/radiochemotherapy) were extracted from the database of the instutuion. LVSI considered positive when the tumor cells were detected within endothelium-lined spaces. The prognostic value of LVSI was evaluated with univariate log-rank tests and multivariate Cox regression models.

RESULTS: We included 106 women who had FIGO 2018 stage IB-IIA uterine cervical cancer in the final analyses. The median age of the patients was 52 (range 26–77) years at the time of surgery and the median follow-up was 45 months (range 9–119 months). Twenty-three (21.7%) patients had stage IB1, 31 (29.2%) patients had stage IB2, 27 (25.5%) patients had stage IB3, and remaining 25 (23.6%) patients had stage IIA disease. There were 65 (61.3%) women with positive LVSI. Univariate analyses showed that primary tumor diameter ≥4.0 cm (p=0.015), positive vaginal surgical margin (p=0.018) and positive LVSI status (p=0.039) were significantly associated with decreased 5-year DFS. Multivariate analyses showed that primary tumor diameter ≥4.0 (hazard ratio [HR]=6.15; 95% confidence interval [CI]=1.05–35.78; p=0.043) and positive vaginal surgical margin (HR=7.04; 95% CI=1.24–39,72; p=0.027) remained as independent adverse prognosticators for DFS. Univariate analyses showed that primary tumor diameter ≥4.0 cm (p=0.037) and stromal invasion ≥2/3 (p=0.011) were significantly associated with decreased 5-year OS. On multivariate analyses, there were no independent adverse prognosticators for OS.

CONCLUSION: We conclude that LVSI is not an independent prognostic factor of survival in women with FIGO 2018 stage IB-IIA cervical cancer who underwent radical hysterectomy and systematic

lymphadenectomy. However, prospective studies are needed to delineate prognostic value of LVSI.

Keywords: Cervical cancer, Lymphovascular space invasion, Survival

Table 1. Clinical and pathological characteristics of 106 patients with 2018 FIGO stage IB-IIA cervical cancer

Characteristic	Values
Age (yr)	52(25-77)
Histopathology Squamous cell carcinoma Non-squamous cell carcinoma	83(78.3%) 23(21.7%)
Tumor size (cm) <4 ≥4	70(66.0%) 36(34.0%)
Vaginal surgical margin Negative Positive	95(89.6%) 11(10.4%)
Stromal invasion <2/3 ≥2/3	47(44.3%) 59(55.7%)
Microscopic parametrial involvement No Yes	99(93.4%) 7(6.6%)
Lymphovascular space involvement Absent Present	41(38.7%) 65(61.3%)
No. of total LNs removed (median, [range]) No. of pelvic LNs removed (median, [range]) No. of para-aortic LNs removed (median, [range])	51(24-119) 39(14-92) 12(5-45)
2018 FIGO stage IB1 IB2 IB3 IIA	23(21.7%) 31(29.2%) 27(25.5%) 25(23.6%)
Adjuvant treatment None Radiotherapy Chemoradiotherapy	25(23.6%) 56(52.8%) 25(23.6%)
Follow-up (months)	45(9-119)

Table 2. Univariate and multivariate analyses of 106 women with 2018 FIGO stage IB-IIA cervical cancer for disease-free survival

Characteristics	Cases (5-year PFS [%])	Univariate analyses p value	Multivariate analyses HR 95% CI p
Age (yr) ≤52 >52	4/53 (91.4) 5/53(88.6)	0.99	
Histopathology Squamous cell carcinoma Non-squamous cell carcinoma	7/83 (90.0) 2/23 (90.3)	0.85	
Primary tumor size (cm) <4.0 ≥4.0	3/70 (94.4) 6/36 (82.3)	0.015	6.15 (1.057-35.784) 0.043
Positive surgical margins No Yes	6/95 (92.6) 3/11 (78.1)	0.018	7.04 (1.248-39.725) 0.027
Cervical stromal invasion <2/3 ≥2/3	1/47 (97.9) 8/59 (84.2)	0.019	2.58 (0.275-24.174) 0.406
Parametrial invasion Absent Present	7/99 (91.9) 2/7 (68.6)	0.114	
LVSI Absent Present	1/41 (97.6) 8/65 (84.9)	0.039	7.534 (0.808-70.210) 0.076
Adjuvant treatment None Radiotherapy Chemoradiotherapy	1/25 (96.0) 5/56 (89.6) 3/25 (86.3)	0.45	
FIGO stage IB1 IB2 IB3 IIA	0/23 (100.0) 2/31 (92.4) 4/27 (83.3) 3/25 (86.2)	0.182	

Table 3. Univariate and multivariate analyses of 106 women with 2018 FIGO stage IB-IIA cervical cancer for overall survival

Characteristics	Cases (5-year 0S [%])	Univariate analyses p value	Multivariate analyses HR 95% CI p
Age (yr) ≤52 >52	2/53 (95.8) 4/53 (90.4)	0.69	
Histopathology Squamous cell carcinoma Non-squamous cell carcinoma	5/83 (92.7) 1/23 (94.7)	0.58	
Primary tumor size (cm) <4.0 ≥4.0	2/70 (95.8) 4/36 (88.1)	0.037	2.227 (0.432-11.485) p=0.915
Positive surgical margins No Yes	4/95 (94.9) 2/11 (77.9)	0.076	

Cervical stromal invasion <2/3 ≥2/3	0/47 (100) 6/59 (87.9)	0.011	14.138 (0.001-1.887) p=0.945
Parametrial invasion Absent Present	5/99 (94.1) 1/7 (80.0)	0.54	
LVSI Absent Present	1/41 (97.6) 5/65 (89.9)	0.131	
Adjuvant treatment None Radiotherapy Chemoradiotherapy	1/25 (96.0) 3/56 (93.6) 2/25 (90.2)	0.57	
FIGO stage IB1 IB2 IB3 IIA	0/23 (100.0) 1/31 (95.7) 3/27 (87.5) 2/25 (90.0)	0.22	

SB-19
Atypical vulvar-genital injury

Ebru İnci Coşkun, Rauf Melekoğlu
Inonu University Medical Faculty Department of Gynaecology and Obstetrics Malatya Turkey

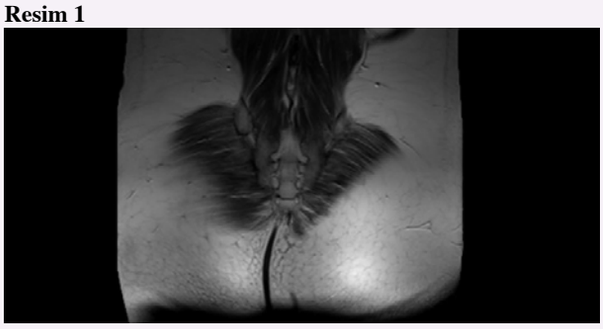
OBJECTIVE: Genital trauma can affect vulva, labia, vagina urethra and anus externally but also can affect bladder, pelvic bones, bowels and internal genital organs. In general, these injuries are seen during delivery in obstetric patients and in gynecologic patients as a result of sexual abuse or unwilled injury during intercourse and self mutilation. If there is not any internal injury, external genital injuries usually do not have mortality. However external injuries should be managed properly since they can result in some clinical situations like dyspareunia or fistula. Accidential injuries of the vulva are usually seen in sports activities like bicycle.

CASE: In this report there is an accidental external genital injury occured by firecracker the patient came across in her neighbourhood. The vital signs of the 60 years old female patient were stable. There was a wide ecchymosis in the vulvar area, mons pubis, also in abdominal wall. Hematoma was placed on the vulvar region and sized 8 cm in average. There was a 1-2 cm skin dehiscence on the mons pubis. There was no active bleeding neither vaginal nor vulvar. Also there was not any penetrating lesion in vulva or vagina. Penetrating lesions can also cause problems in the peritoneal cavity. Before the imaging mehods, no compression for drainage of the hematoma has been done. It has been considered if the hematoma was limited by itself in the tissue plans. This should be clarified first. Intravenous fluid hydration has been applied and abdominopelvic magnetic resonance imaging has been undertaken. In the MRI, there has been 85x76 mm hematoma in the labium majus dexter. Also wide subcutanous oedema and subcutanous hematoma has been confirmed. The skin dehiscence has not been sutured at first for the purpose of controlled drainage of the hematoma gradually in the following days. An urinary Foley catheter has been placed to prevent any urinary retention because of the pressure of the hematoma. Cold compress application was undertaken for the first and the second day intermittently. Hemoglobin values were controlled and a unit of eritrocyte suspension has been given. Cause the first Hemoglobin value was 11.9 gr/dL and 8.5 gr/dL later and the patient had some orthostatic hypotension and anemia syptoms like dizziness but they were mild symptoms. The wound was seem clean but the cause of a burning and explosive material and the ground could have soil, prophylactic antibiotherapy has been used. For the resolution of the oedema, eau de goulard has been used. Controlled drainage has been done once or twice a day. Also it has been followed that if there is any necrosis because of the tension that hematoma made. In some cases vascular embolization could be required. In the fifth day we have sutured the dehiscence and excharged the patient on the sixth day of the trauma.

RESULT: Immediate and meticulous evaluation should be done not only for the appearing signs but also for an internal injury probability. Hydration, cold compression and urinary catheterization should be considered at the first step of management.

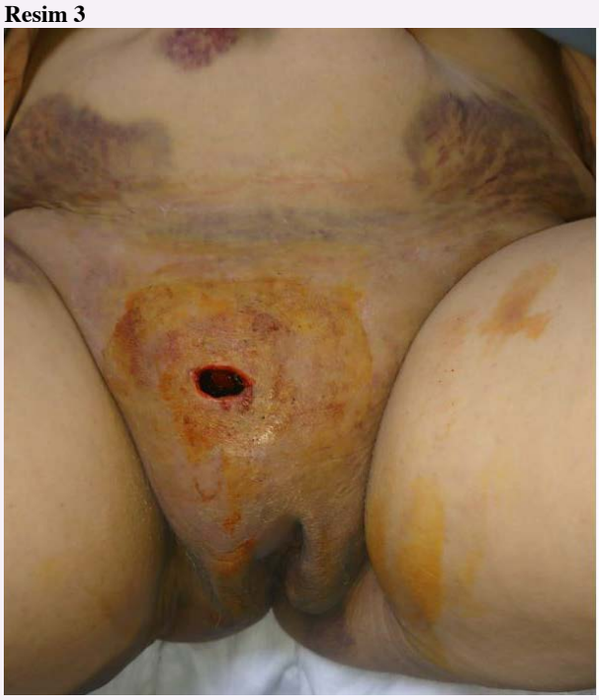
Keywords: vulvar injury, vulvar trauma, vulvar hematoma, genital injury, genital trauma

Resim 1



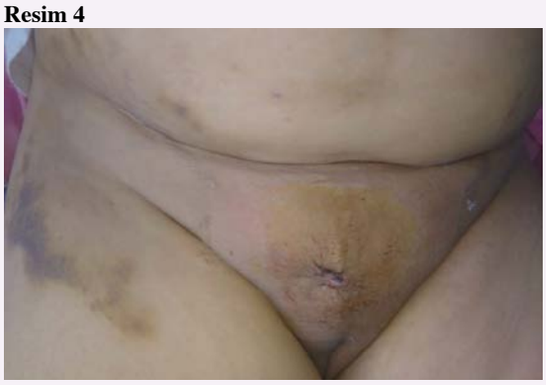
Example of an image (MRI)

Resim 3



Skin dehiscence and abdominal area subcutanous ecchymosis

Resim 4



After discharge-Day 12.

Resim2

The first days of hospitalization

SB-20

Prognostic impact of tumor localization in the uterus confined endometrioid endometrial cancer

Ghanim Khatib, Bekir Kahveci
Department of Obstetrics and Gynecology, Cukurova University, Adana, Turkey

AIM: This study aimed to determine the prognostic impact of tumor localization in the uterus confined endometrioid endometrial cancer.

MATERIALS-METHOD: File records were retrospectively reviewed. Patients whose tumor localization (fundus, corpus, isthmus or common) was clearly noted in their pathological reports were designated. Of them, those with stage I-II, endometrioid histology and thorough follow-up data were recruited and survival rates were compared between patients according to their tumor localization.

RESULTS: The study was conducted with 99 uterus confined endometrioid endometrial cancer patients. Distribution of tumor localization was as the following: fundus 37 (37,4%), corpus 24 (%24,2), isthmus 6 (6,1%), and common 32 (32,3%). By the univaryant analysis, isthmic tumors were found to be associated with significantly lower 5-year disease-free survival (64%), comparing to the others (fundus: 100%, corpus: 94%, common: 94%) (p=0.033) (Figure 1). However, this difference was not confirmed by the multivaryant analysis (HR: 0.037, CI: 0.000-2.345). In term of cancer specific survival, there was no significant difference between patients with respect to the tumor localization (Figure 2). CONCLUSION: Tumor localization was not an independent prognostic factor for both disease-free and cancer specific survival in the uterus confined endometrioid endometrial cancer.

Keywords: Endometrial cancer, tumor localization, survival.

Figure 1. Disease-free survival curve over a 5-year period by tumor location.

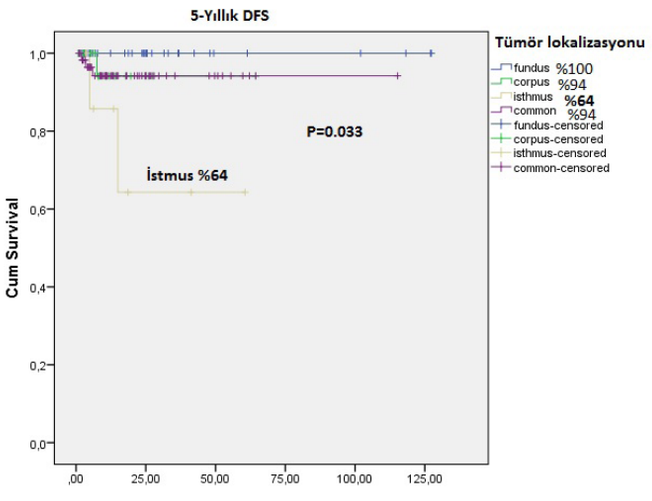
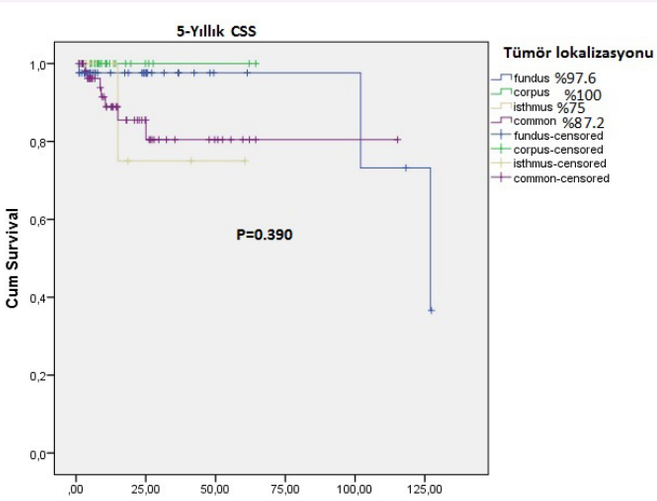


Figure 2. Cancer-specific survival curve over a 5-year period by tumor localization.



SB-21
Laparoscopic Sentinel Lymph Node Mapping in Endometrial Cancer

Seda Şahin Aker, Fırat Ortaç
Department of Gynecologic Oncology,Ankara University Ankara

Endometrial cancer is the most common gynecological malignancy in developed countries. The annual number of new cases is 27.8 / 100,000, the number of deaths is 4.8 / 100,000. 67% of the cases are early stage and 20%of the cases are stage 3. Lymph node positivity is an important prognostic factor for endometrial cancer and determines the need for postoperative adjuvant treatment. The necessity of total excision of lymph nodes in surgical treatment is controversial.Lymph node dissection causes complications such as bleeding, nerve damage, prolonged surgery time, and increased hospital stay, as well as long-term morbidities such as lymphocysts and lymphedema in patients and affect the quality of life negatively. These results led to the development of sentinel lymph node mapping, which reduces morbidity by identifying the metastatic lymph node.In our case we present a 48 years old women diagnosed endometrioid type of endometrial cancer. Pet-CT showed only uterin 18F FDG positivity. We used indociyanin green for mapping. In video presentation we present how to open the retroperitoneal area and how to evoluate and excise of sentinel lymph nodes.

Keywords: endometrial cancer, sentinel lymph node, indocyanin green

SB-22
Our initial experience with Da Vinci Xı Robotİc system on Urogynaecologic procedures

Adeviye Elçi Atilgan
istanbul Medipol University, Department of Urognaecology, İstanbul, Turkey

AIM: This study was aimed to evaluate the intraoperative and postoperative outcomes of Urogynaecologic procedures performed with da Vinci Xi Robotic system.

PATIENTS AND METHODS: Retrospective file records of women with symptomatic stages III or IV Pelvic Organ Prolapse(POP) operated with Da vinci XI robotic system by a single surgeon were included for data analysing from October 2019 and February 2020. After physical examination, urodynamic studies and POP-Quantification system(POP-Q), the patients underwent Robotic Sacrohysteropexy or Sacrocolpopexy when patient hysterectomised with or without anti-incontinence surgery-Burch procedure in the presence of concomitant Urodynamic Stress Urinary İncontinance (SUI). Follow-up examinations were performed at 1 and 6 months later with POP-Q system.

RESULTS: 6 patients underwent a robotic urogynecologic procedüre at this period.3 women underwent Robotic Sacrohysteropexy, 2 women underwent Robotic assisted Lateral Uterine Suspension and a Robotic Burch colposuspension performed to a woman for SUI as women did not agree with using mesh or sling procedures.The mean age of patients was 54 (range:36-59) years and mean body mass index was 26.2kg/m2(range;24-30).Mean duration of surgery was 242minutes (range:180-320). Before surgery, the mean POP-Q stage was +3.1C (3-4) and the POP-Q values for the anterior (Aa, Ba), posterior (Ap, Bp) and apex (C) of the vagina were: Aa - 2, Ba -1.0, Ap - 1.0, Bp + 1.3, and C +2.1. After surgery, the mean POP-Q stage was 0 and the POP-Q values had improved to Aa -3, Ba -4, Ap - 3.6, Bp - 2.65, and C - 7.28. The mean (range) estimated blood loss during surgery was 280 (50-150) mL. The mean hospital stay was 2.4 (2-4) days. For Robotic Burch colposuspension procedure, her cough- stress test was negative at control examinations. In our series, there were no conversions to open. The postoperative course was uneventful in all patients; and there was no recorded complications occurred.

CONCLUSIONS: Our preliminary experience with da Vinci Xi system demonstrated feasibility and safety for Urogynaecologic procedures for selected patients. Further studies with a larger series will show the role of da Vinci Xi surgical system for urogynaecologic procedures.

Keywords: Robotic surgery, Urogynecology, Pelvic organ prolapse

SB-23
Prophylactic balloon occlusion of internal iliac arteries in the management of placenta accrete spectrum: a case report

Gonca Eldem[1], Nejat Özgül[2], Bora Peynircioğlu[1], Deniz Akata[1], Özgür Deren[2]
[1]Department of Radiology, Hacettepe University Faculty of Medicine, Ankara, Turkey
[2]Department of Obtetrics and Gynecology, Hacettepe University Faculty of Medicine, Ankara, Turkey

AIM: Rises in the cesarean section rate over the last decades have led to an increase in the prevalence of placenta accreta spectrum (PAS). Intra and post-surgical outcomes of women affected by PAS are directly related to the depth and topography of placental invasion. Accurate prenatal diagnosis is fundamental and pre-planned management with a multi-disciplinary team is crucial to avoid maternal morbidity and mortality. Herein, we report a case of placenta previa complicated with percreta managed by a multi-disciplinary approach with prophylactic balloon occlusion of internal iliac arteries (PBOIIA) and cesarean hysterectomy.

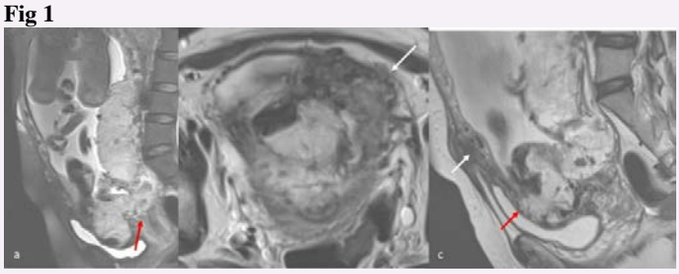
CASE: A 34 years old woman with G3P2L2 and 30 weeks 2 days of gestation was admitted due to placenta previa and a suspicion of placenta accreta spectrum. MRI revealed a heterogeneous placenta covering the entire cervix. Additional signs of abnormal placentation of lumpy contours and rounded edges, disruption of hypointense line at myometrial interface and loss of fat planes between the bladder posterior and uterine lower anterior segment were visualized (Fig 1). With the initial diagnosis of placenta previa complicated by placenta percreta an elective cesarean hysterectomy with PBOIIA was decided. At 35 weeks and 3 days of gestation the patient was first delivered to the interventional radiology unit. Under local anesthesia bilateral common femoral arteries were punctured with US guidance and percutaneous balloon angioplasty (PTA) catheters were inserted into the IIA(s) with a cross over technique simultaneously by two interventional radiologists (Fig 2). After evaluating the degree of occlusion by test injections, the balloons were deflated and secured in place and the patient was directly taken to the operating room for planned surgery. All possible measures were taken to reduce the radiation dose. Cesarean section was performed under general anesthesia. After the delivery of the infant the umbilical cord was clamped and the balloons were immediately inflated

by the interventional radiologist present in the room. The placenta was visualized as invading the anterior uterine wall and the bladder serosa. With cautious resection from the bladder serosa a total hysterectomy was performed with the abnormal placenta left in situ under inflated balloons occluding the internal iliac arteries. No excessive bleeding was observed. After hemostasis was achieved the balloons were deflated but left in place in case of possible delayed bleeding requiring intervention. Following closure of the abdominal incisions the patient was extubated and transferred to the clinic for follow up. The inserted sheaths were then removed at bedside. No complication due to PTA catheters or sheaths were observed.

DISCUSSION: Management of deliveries complicated by abnormal placentation might involve cesarean hysterectomy or cesarean section with uterus preservation. Several endovascular interventional techniques can be used in both procedures for hemorrhage control. Currently the available evidence shows that any kind of endovascular intervention for hemorrhage control significantly reduces blood loss volume compared with no endovascular intervention. Every technique has its own advantage and disadvantage however no well-designed comparative study between these approaches and also regarding the best endovascular intervention required in relation to the degree of placental invasion is available

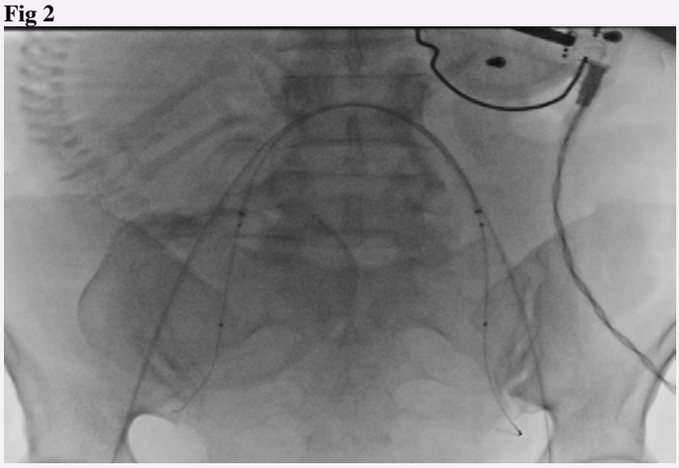
Keywords: placenta accreta spectrum, placenta previa, prophylactic balloon occlusion of internal iliac arteries, interventional radiology, hemorrhage control

Fig 1



Sagital (a and c) and axial T2 MRI images show that the placenta is covering the entire cervix (red arrow in a). Abnormal heterogenity, disruption of myometrial line (white arrows in b and c), loss of fat planes with the bladder (red arrow in c) are findings of abnormal placentation.

Fig 2



Balloon catheters inserted in bilateral internal iliac arteries

SB-24
Should retroperitoneal approach be preferred in every hysterectomy?

Mehmet Sait Bakır, Ceyda Karadağ
Department of Gynecologic Oncology, Akdeniz University Faculty of Medicine, Antalya, Turkey

Today, minimally invasive approaches have become a frequently preferred surgical procedure in all gynecological pathologies. In Europe, total laparoscopic hysterectomy has become the main alternative for total abdominal hysterectomy. Total laparoscopic hysterectomy is associated with less blood loss, shorter hospital stay and extremely low rates of infection and ileus. The retroperitoneal approach in laparoscopic hysterectomy allows uterine artery ligation and reduces blood loss; it also provides ureteral visualization and assists safe surgery. Although it is preferred by gynecologist oncologists in almost every case, it is performed for benign reason; endometriosis surgery, tubaovaryen abscess, myoma uteri cases that disrupt the anatomical structure of the uterus and cases with extensive intraabdominal adhesions can be preferred by gynecologists. We wanted to present a total laparoscopic hysterectomy with retroperitoneal approach to our case diagnosed with endometrial intraepithelial neoplasia in this video presentation.

Keywords: Minimally invasive surgery, retroperitoneal approaches in hysterectomy, total laparoscopic hysterectomy.

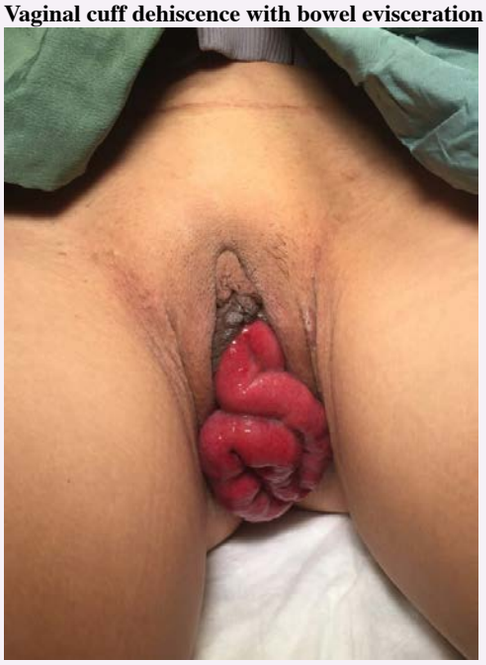
SB-25
Vaginal Cuff Dehiscence with Complete Bowel Evisceration

Ihsan Bağlı
Gazi Yaşargi Eğitim Araştırma Hastanesi, Department of Obstetric and Gynecology, Diyarbakır, Türkiye

Vaginal cuff dehiscence (VCD) is a rare postoperative complication of total hysterectomy. Presenting symptom is acute pelvic or abdominal pain accompanied by nausea and vomiting. Immediate recognition and surgical repair are crucial for successful management. A 48-year-old para 1+0 presented with complaints of pelvic pain associated with sexual activity, four months after a total labdominal hysterectomy. Without necessary of speculum examination, only inspection was enough to see presence of eviscerated bowel out of the vagina. laparoscopic assessment was planned but bowels could not reducted through the transvaginal route. So that, abdominal approach was setted. The occurrence of VCD after hysterectomy has been linked to overuse of electrocautery, prolonged inflammatory response, suturing methods and excessive shortening of the vagina. Although we carefully sutured the vaginal cuff for not shortening the vaginal length, it was measured as seven cm after the surgery. Laparoscopic, abdominal and vaginal approaches are the routes for repairing VCD. However, it depends on the clinical presentation and surgeon expertise. Careful history, and physical examination are vital factors in guiding clinicians to diagnose and treat VCD. Nevertheless, an ideal modality remains variable to each case.

Keywords: Evisceration, Hysterectomy, Vaginal cuff dehiscence,

Vaginal cuff dehiscence with bowel evisceration



SB-26
Case of myoma in rectovaginal space in anvanced stage endometriosis: the importance of preoperative assessment in the intraoperative approach

Özer Birge, Ceyda Karadağ
Department of Gynecologic Oncology, Akdeniz University Faculty of Medicine, Antalya, Turkey

A 46 years old patient without a history of pregnancy was admitted with complaints of tenesm, dyspareunia and chronic pelvic pain. Pelvic diffusion MRI endometrium is natural, several types of 4 fibroids, the largest of which are 17 * 15 mm in the uterus, 40 * 40 mm and 37 * 20 mm endometrioma in size in the right ovarian area; endometrioma with a size of 59 * 38 mm was reported in the left ovary. It was also stated that both tubas formed a tubaovarian complex with ovaries. When the images of MRI are examined; a mass of about 6 cm (myoma?) was observed in the rectovaginal space. This mass was not reported in the MRI report. During the operation, it was observed that the omentum was adhered to the anterior abdominal wall in the pelvis. After the adhesions were opened, it was observed that the uterus, both ovaries and tuba were conglomerated and adhered in their intestines. Frozen pelvis was present. After laparoscopic hysterectomy and bilateral salpingoooferectomy are completed; the rectovaginal space was evaluated with the rectal touch. The mass was palpated. Then, fibroid in the rectovaginal space were removed. The operation was completed without complications. Based on the case; We see that preoperative evaluation is of great importance. We should not forget that the imaging reports sometimes cannot provide enough information; and we believe that the surgeon must also examine the cases imagings before the planned operation.

Keywords: frozen pelvis, myoma uteri, rectovaginal space,

SB-27
Does emergency cervical cerclage is an effective method for the obstetric outcomes of twin pregnancies?

Fırat Tülek[1], Ali Gemici[2]
[1]Memorial Atasehir Hospital Department of Obstetrics and Gynecology
[2]Guven Hospital Department of Obstetrics and Gynecology

Preterm delivery and its morbidity is the major problem of the twin pregnancies. On of the problem causing preterm delivery is the cervical insufficiency. Cervical cerclage treatment is a controversial issue for the treatment of cervical insufficiency especially at the twin pregnancies. At this research we present obstetric outcomes of an sevent twin pregnancies treated with emergency cervical cerclage. A total of seven patients were enrolled to the study. All patients have prolapsed amniotic membranes. Speculum examination was done to all patients. The patients gestational age below 24 weeks without a history of amnion fluid discharge is included for the cervical cerclage treatment.

RESULTS: Tolat of 7 twin pregnancies were examined. All of the patients are nullpar and 6 of them were pregnant with assisted reproduction technologies. One patient had a positive amniotic culture. Median age of the patients was 35,1 (min 28 max 42). Median gestationa week at the coeval cerclage is 22 weeks (min 19 max23). Mean gestational age at the deliver is 27 weeks and 6 days (min 20 weeks max 37 weeks). Mean time period after cerclage is 5 weeks and 6 days (min 4 days max 14 weeks). Coclusion: İn selected patients emergency cercival cerclage may provide acceptable obstetric outcomes at the twin pregnancies.

Keywords: Twin pregnancy, emergency cervical cerclage, cervical insufficiency

Results of the emergency cerclage

Patients	Gestationa-lage	Delivery time	Morbididty	Crp preope-rative	Culture
1	22 weeks	37 weeks	No	4,5mg/l	negative
2	23 weeks	32 weeks	NİcU	3,7 mg/l	negative
3	23 weeks	34 weeks	Nicu	3,9 mg/l	Negative
4	20 weeks	21 weeks	Amion fluid discharge	6,4 mg/l	N/A
5	20 weeks	20 weeks 4 days	Fetal demise	4,5mg/l	Stafilocous aereus
6	22 weeks	23 weeks 4days	Chorioamni-onitis	3,2 mg/l	Negative
7	19 weeks	23 weeks	Spontaneus delivery İmmaturity	2,7mg/l	Negative

Nice: Neonatal intensive unit N/A not available

SB-28
Single Port Video-Assisted Thoracic Surgery (VATS) and Cardio-phrenic Lymph Node Resection in a Patient with Advanced Epithelial Ovarian Cancer

Fatih Dinçer, Oğuzhan Kuru
Department of Gynecologic Oncology,University of Health Sciences Tepecik Education and Research Hospital, İzmir, Turkey

BACKGROUND: İt is well known that complete cytoreduction with no residual tumor after debulking surgery will improve progression-free and overall survival in patients with advanced epithelial ovarian cancer (AEOC). Tools that accurately predict the presence of metastatic ovarian cancer outside the abdominal cavity (especially in the pleura) are limited. Parenchymal disease in the lung and pleural involvement can leave patients with residual disease. Video-assisted thoracic surgery (VATS) allows to evaluate the disease status in thoracic cavity so provides a change in the disease stage and patient management.

CASE: A 45-year-old woman was admitted to our hospital due to presumed AEOC. CT of the thorax and abdomen showed a 13 cm sized heterogeneous ovarian mass with mild ascites and unilateral pleural effusion. CA 125 level was > 4933 U/mL. Initially, a single port VATS was performed through the right pleura as the upfront surgery was the goal. In the procedure, no macroscopic disease was seen in pleural cavity but an enlarged cardiophrenic lymph node (CPLN) was suspected that was not realized in the radiologic evaluation before. Random pleural biopsies were taken and a chest tube was placed through the port incision. Than, a laparatomy was done and complete cytoreduction was achieved. In the part of debulking surgery, extended CPLN resection was also performed through sub-xiphoid approach. Final pathological diagnosis was Stage IV A (positive pleural cytology), Grade 2, endometrioid ovarian adenocarcinoma. Post-operative period was uneventful and patient was discharged on 7th day.

CONCLUSIONS: VATS is a feasible and effective way to evaluate the pleural and parenchymal disease of the lung via minimally invasive approach, also may led surgeons to determine which patients are ideal candidates for upfront surgery or neoadjuvant chemotherapy. CPLN resection should be considered in cases of suspicious involvement to confirm extra-abdominal disease and achieve complete cytoreduction.

Keywords: VATS, Cardio-phrenic Lymph Node Resection, Ovarian Cancer.

SB-29
Micro-RNAs and their role in endometriosis and epithelial ovarian cancers associated with endometriosis

Canan Kelten Talu[1], Çağnur E. Ulukuş[2]
[1]University of Health Sciences, Department of Pathology
[2]University of Dokuz Eylül, Department of Pathology

The aim of this presentation is to describe the role of micro-RNAs (mi-RNA or mi-R) in endometriosis and whether circulatory mi-RNAs could be a potantial non-invasive biomarker to diagnose the disease as well as to detect the cases in which epithelial ovarian carcinoma (endometrioid carcinoma, clear cell carcinomas and low grade serous carcinoma) may arise in the setting of endometriosis.

Mi-RNA are short, single-stranded non-coding RNA molecules that regulate gene expression at the postranscriptional level. Several studies have found mi-RNA signatures representative of disease in various diseased tissue, as well as urine, serum, plasma and other body fluids in different type of pathologies. These features of mi-RNAs make them an approprate candidate for biomarker. Since many mi-RNAs are tissue specific, their systemic dysregulation in peripheral blood points towards a distinct pathology. Mi-RNA are now considered as leading biomarkers, for diagnostic purposes, disease stratification and therapeutics. An ideal biomarker is one which is specific to the disorder, can be detected early in the disease process, accessible from peripheral tissue, stable, reproducible, and associated with the disease mechanism. Thus, mi-RNA may be an attractive biomarker due to their tissue specificity and lower structurel complexity. They are stable in blood, urine, and tissues and serve as possible biomarkers for many neoplastic and non-neoplastic pathologies.

It is considered that mi-RNA play a significant role in the pathogenesis of endometriosis and have the potential of being promosing biomarkers. Circulating mi-RNA as a non-invasive diagnostic tool may shorten the delay in the diagnosis of the endometriosis, thus alleviating the suffering of women and reducing the cost of health care. Up to the present, despite varying studies on circulating mi-RNA in endometriosis, no single mi-RNA or any panel of them seems to meet the criteria of a diagnostic biomarker for endometriosis or ovarian carcinoma in the setting of endometriotic foci. However, miR-200 family (mi-R-200a, miR-200b and miR-141), one of the most studied miRNAs associated with endometriosis, were reported as dysregulated both in blood and the tissues of most of the patients with endometriosis. miR-20a, miR-143, miR-199, miR-22, miR-17-5p, miR-125b-5p, let7d, miR-141-5p, miR-155, miR574-3p, miR-139-3p, miR-199a, miR-122, miR-145, miR-542-3p were reported as the other circulating mi-RNAs for endometriosis. Additionally, elevated expression of miR-200 family (miR-200c-3p ve miR-200a-3p, miR-141) and down-regulated expression of miR-125b and miR-205 were identified in epithelial ovarian cancers associated with endometriosis. mi-RNA 126, miR-9, miR-325, miR-191, miR-381 were detected as the other circulating miRNAs for epithelial ovarian cancers associated with endometriosis.

We aimed to summarize the concept 'mi-RNA' and the role of mi-RNAs in endometriosis and in epitelial ovarian cancers associated with endometriotic tissues

Keywords: micro-RNA, mi-RNA, endometriosis, endometriosis-associated epithelial ovarian cancers

POSTER BİLDİRİLER

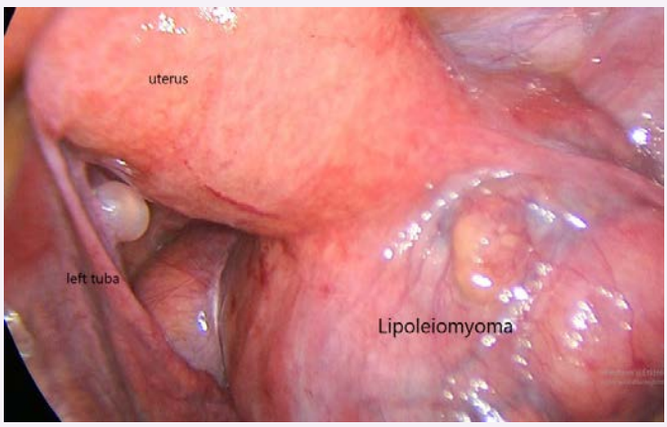
EP-02
A rare benign tumor of the uterus; Lipoleiomyoma

Erson Aksu
Department of Medical services and techniques,Vocational School of Health Services, Rumeli University, İstanbul, Turkey

The first report as a "Myolipoma of soft tissue" was thought to have been described in 1991 by Meis and Enzinger. Lipoleiomyomas that a variant of uterine myomas are rare benign neoplasms of uterus. The incidence varies from 0.03 to 0.2%. Lipoleiomyoma consists of smooth muscle cells and mature lipocytes. These tumors generally occur in asymptomatic but they can present with symptoms similar to leiomyomas of the same size and location. Because of it's rarity we reported this. The exact etiology is not well known, but is thought to represent fatty metaplasia of the smooth muscle cells of a leiomyoma. Histologically, it is composed of variable amounts of adipocytes and smooth muscle cells, separated by thin fibrous tissue. Lesions can vary in size from a few mm to a few cm. A 55-year-old postmenopausal woman presented with distension of abdomen per one year. Gynecological examination revealed no abnormalities of vulva, vagen and cerviks. Findings of transvaginal ultrasonography examination revealed bulky uterus with thickened endometrium of 8 mm and hyperechoic bilobulated masses of myoma in right-posterior wall of uterus measuring 14*8*7 cm in diameter with a poor vascularity on color Doppler examination. All the standard serological and hematological parameters were within normal range. CT showed predominantly fat-containing mass arising from uterus of measuring 13*9*8 cm(figüre 1). MRI revealed the predominant fatty component in the 13cm mass and additionally the lesion showed fat suppression(figüre 2). The patient underwent laparoscopic total abdominal hysterectomy with bilateral salpingo-oophorectomy because of mass and age(figüre 3). On gross examination of the specimen, the uterus measured 15*8*7 cm and had two intramural-subserosal masses. There are mature lipocyte communities in the stroma consisting of spindle nucleus, spindle stoplasma cells in the sections of tissue samples. The fallopian tubes appeared grossly normal. Uterine lipoleiomyoma is a rare type of leiomyoma including a amount of adipocytes. These benign tumors of the uterus do not cause death. Thus, it is important that physicians be aware of this condition as it presents with clinical symptoms similar to leiomyoma but has distinctive radiological and histological appearance. Imaging studies play an important role especially in preoperatively demonstrating the fatty nature and exact location. General imaging differential considerations include; benign cystic ovarian teratoma, malignant degeneration of cystic teratoma, non-teratomatous lipomatous ovarian tumor, pelvic lipoma, pelvic liposarcoma, very rare lipomatous tumors of the uterus: angiomyolipoma, fibromyolipoma, myelolipoma of uterus. The complex histogenesis of these tumors, which may arise from mesenchymal immature cells or from direct transformation of smooth muscle cells into adipocytes are comfirmed by immunocytochemical studies. The final pathological examination confirms the exact diagnosis.

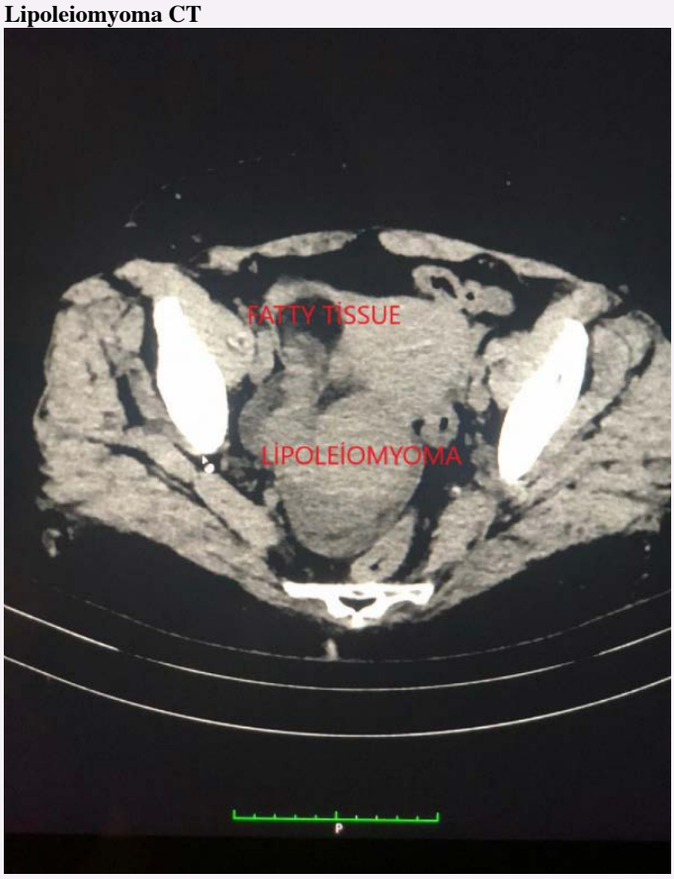
Keywords: lipoleiomyom, patogenesıs, adiposit

Lipoleiomyom surgical appearance



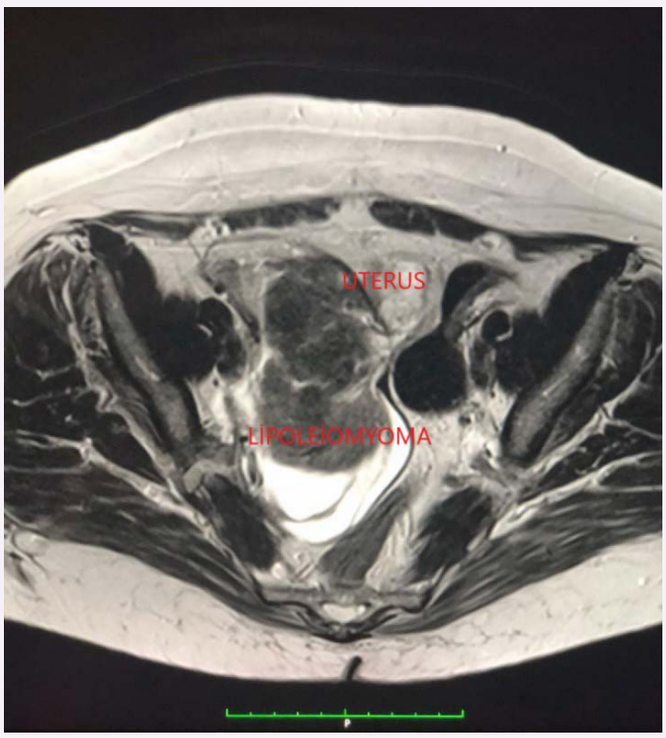
Lipoleiomyom surgical appearance (Figure3)

Lipoleiomyoma CT



Lipoleiomyoma CT screening (figure1)

Lipoleiomyoma MRI



Lipoleiomyoma MRI (figure 2)

EP-05
Cervical cancer in young females at aged ≤30 years

Dilek Yüksel, Fulya Kayıkçıoğlu
Department of Gynecologic Oncology, Health Science University, Etlik Zübeyde Hanım Women's Health Teaching and Research Hospital

OBJECTIVE: According to GLOBOCAN 2018 statistics, 570,000 new cervical cancer diagnoses are determined each year and 311,000 patients die. Cervical cancer is the fourth most common gynecological malignancy. Cervical cancer ranks 10th in our country. Most of the cases are diagnosed at an advanced stage. According to 2012 data in our country, the age-standardized rate of all cancers in women is 188.2 per 100,000 and cervical cancer is 4.5. In other words, the total number of women with cancer seen in a year is around 1695. Among these, cervical cancer constitutes approximately 2.3 % of the total number of cases. The mean age of cervical cancer cases in our country is 48.7 years. Cervical cancer is among the most common cancers in women in the 25-49 age group with 2.3%. The purpose of this study was to examine cervical cancer cases ≤ 30 age.

MATERIAL-METHOD: We retrospectively evaluated patients with cervical cancer cases diagnosed at the age of 30 years and younger in our clinic between 2010 and 2020. The clinical, surgical and pathological data of the patients were collected from the gynecologic oncology department electronic database system.

RESULT: A totaly 12 patients were recruited from our clinic electronic database sysytem.The median age of the patients were 27 (range;14-30).Three patients were under 19 years old.The histopathologic results of them were rabdomyosarcoma.The remaining 6 patients were aged between 25-30 years. The histopathologic results were squamous cell carcinoma in 6 patients, microinvasive carcinoma in 1,adenosquamous in 1 and glassy cell carcinoma in 1 patient. The median follow-up time was 65 month (range,3-120). During this period 5 patients were dead of disease. All but two patients underwent surgery. The two patients received chemoradiotherapy due to advanced stage disease. Three patients with rabdomyosarcoma were treated surgically and recevived adjuvant chemotherapy.2 of them were disease free now and the other patients were dead of progressive disease at 12th month. Ovarian transposition were applied all three patients.

DISCUSSION: Although the mean age for cervical cancer is 48 in our country, cervical cancer is also seen in patients under the age of 30. The diagnosis of rhabdomyosarcoma should be kept in mind in patients under 19 years of age. Therefore, histology other than SCC should definitely come to mind at younger ages. Cervical smear screning after the age of 21 and hpv test after the age of 30 is a suitable algorithm for our country. Human papillomavirus — HPV vaccination, which can be applied between the ages of 9 and 13, should be taken as a preventive measure against cervical cancer that can be seen at an early age. When the use of HPV vaccines becomes widespread, we can say that non-HPV dependent types will increase relatively.Cervical cancer and its precursor lesions can be easily diagnosed with screening programs and their methodologies are well documented. Screening supports diagnosis and helps to improve survival rates.

Keywords: Cervical Cancer, cervical screening, human papilloma virus vaccine, younger patients

EP-07
Comparison of Risk Factors and Neonatal Outcomes in Early-Onset and Late-Onset Preeclampsia

Özgül Bulut
Department of Pediatrics, Division of Neonatology, Istanbul Medeniyet University Goztepe Training and Research Hospital, Istanbul, Turkey

We aimed to compare the maternal risk factors and early neonatal outcomes in early-onset and late-onset preeclampsia. This retrospective study was performed at a tertiary referral university clinic. Pregnant patients diagnosed with preeclampsia at <34 weeks gestational age (early-onset preeclampsia, EOP group) were compared with those diagnosed at ≥34 weeks (late-onset Preeclampsia, LOP group). Out of 92 patients, 45(49%) were EOP and 47 (51%) were LOP. High body mass index was an independent risk factor for LOP in the logistic regression analysis (p=0.012). Cesarean delivery and intrauterine growth retardation rates were significantly higher in the EOP group (p=0.01, p=0.025). Neonatal morbidities and hospitalization rates in the neonatal intensive care unit were significantly higher in the EOP group (p<0.05, p=0.005, respectively). EOP was found to be an important risk factor for adverse neonatal outcomes while high body mass index during pregnancy was associated with late-onset preeclampsia.

Keywords: early-onset, late-onset, neonatal outcomes, preeclampsia, risk factors.

EP-08
Laparoscopic Ovarian Transposition

Sertaç Ayçiçek, Dinçer Yıldırım
Department of Obstetrics and Gynaecology, Diyarbakır S.B.Ü Gazi Yaşargil E.A.H, Diyarbakır, Turkey

26 years old, stage-3 rectum ca. Virgo is sick. Sparing surgery was performed before radiotherapy was applied by radiation oncology. Both ovaries were inserted laparoscopically into the retroperitoneum above the common iliac vessels and fixed to the peritoneum with 2.0 silk suture.

Keywords: laparoskopi, ovarian transpozisyon, rectum ca

EP-09
Ureteral catheterization during pregnancy, obstetric outcomes: clinical experience

Alev Esercan[1], Tuncer Bahçeci[2], Emre Ekmekci[1]
[1]Department of Obstetrics and Gynecology, Sanliurfa Training and Research Hospital, Sanliurfa, Turkey
[2]Department of Urology, Sanliurfa Training and Research Hospital, Sanliurfa, Turkey

OBJECTIVE: Some degree of hydronephrosis as a result of the physiological changes in pregnancy is common and is called as physiological hydronephrosis of pregnancy, especially on the right side due to physiologic changes of pregnancy. It is not uncommon to have pregnant women with intractable flank pain resulting from renal obstruction and who thus require hospital admission, and the condition is more complicated if associated with urinary stone disease. In this condition, the only choice may be mandatory to place a double j uretheral stenting. However, performing this operation during pregnancy may be bewared by the physician or the patient due to pregnancy specific risks. We aimed to present our experience about uretheral stenting during pregnancy at our center.

PATIENTS and METHODS: Data were retrospectively collected from the Department of Urology at a tertiary center in Sanliurfa, from June 2017 to July 2020.All pregnant patients who had undergone uretheral stenting during pregnancy due to different indications were enrolled in the study. Time of stenting, delivery time, indications, side of catheterization and complications were saved. Intractable flank pain as an indication was defined as flank pain that could not be relieved by conservative medical management. Patients who have been delivered iatrogenically before the labor, due to other indications were excluded from the study.

RESULTS: In this period total 36 patients were detected who had undergone uretheral stenting during pregnancy. Mean age of patiens was 24,9±3,8 years. 6 patients were primigravida and 30 were multiparous. All had the stenting for the first time during pregnacy. There was no recurrent case or had stenting on previous pregnancies. 6 patients had renal calculi and the indication was intractable flank pain at 30 patients. The side of stenting was right at 31 patients. Mean gestational age at application was 23 weeks and the mean delivery time was 37 weeks. All patients had grade 3 hydronephrosis. 12 patients were delivered before 37 weeks (33%) and only 2 patients were delivered before 34 weeks of pregnancy(5%). 14 patients had urinary tract infection during post stenting period. All stents were in place till delivery and any stent migration have not been detected.

CONCLUSION: In our study, 33% of patients have been delivered before 37 weeks, however only 5% have been delivered before 34 weeks of pregnancy after uretheral catheterization during pregnancy. Uretheral stenting may have an association with prematurity however this association does not seem to be related with severe prematurity. Mild prematurity and urinary tract infections seem to be simple complications of stenting during pregnancy.

Keywords: uretheral catheterization, pregnancy, hydronephrosis

Patient chracteristics and results of patients

Indication of urethe-ral catheterization	Intractable flank pain 31 (84%)	Urinary calculi 6 (16%)
Gestational age on catheterization	23±5.9 weeks	12-36 weeks
Gestational age on delivery	37±2.5 weeks	29-41 weeks
Side of catheteriza-tion	Right 31	Left 5
Urinary infection	Yes 14	No 22

EP-10
Fetal life saving surgery: perimortem cesarean

Yıldız Akdaş Reis, Fahri Burçin Fıratlıgil
Department of Gynaecology, Etlik Zübeyde Hanım Education and Research Hospital, University of Health Sciences, Ankara, Turkey

AIM: Cardiopulmonary arrest is a rare condition that can be observed at a rate of approximately 1/30000 during pregnancy and intrapartum period (1). Perimortem cesarean (CS) has been performed as a rare surgical procedure since ancient years (2). However, in recent years, more awareness of this procedure has developed in the medical community. When we look at the current recommendations, it is accepted that the procedure should be performed after five minutes of unsuccessful cardiopulmonary resuscitation (CPR) for maternal resuscitation (3). When administered in a timely manner, it is critical for fetal survival as well as maternal resuscitation (3). With this case, we aimed to present a case of perimortem CS that we applied after cardiopulmonary arrest in our patient who was followed up during labor.

CASE: 38-year-old-multiparous, 33 weeks pregnant applied to the emergency service with the signs of leaking amniotic fluid. In the anamnesis; it was determined that she had undergone right nephrectomy and used various drugs for asthma. In addition, it was learned that she had two vaginal deliveries without any complications. In the first examination of the patient, 2-3 cm dilatation and 30-40% effacement were detected. Meanwhile, the referral process was initiated for the patient, who had respiratory distress and was evaluated by a pulmonologist due to bilateral pretibial pitting edema, to be referred to a multidisciplinary center. During this period, salbutamol-budesonide was applied along with oxygen therapy to the patient, whose respiratory rate was 21, oxygen saturation was 90%, pulse 96/min and blood pressure 120/80 mmHg. In the meantime, CPR was initiated in the

patient who developed cardio-pulmonary arrest. When there was no response to CPR within the first five minutes, perimortem CS decision was taken. A single live baby girl of 1740 g was delivered and given to the neonatal team. Meanwhile, the patient who continued CPR was accepted as maternal exitus at the end of 45 minutes.

DISCUSSION: When perimortem CS is applied within the first 5 minutes, it can both save fetal life and theoretically contribute to the applied CPR by eliminating the effects of aortocaval compression so may play a role in improving maternal circulation. When we examine the literature, it is emphasized that perimortem CS should be initiated within four minutes and the baby must be delivered within the 5th minute of maternal arrest (4). In addition, the American Heart Association (AHA) published a guideline in 1992; In case of maternal arrest, if spontaneous circulation did not return despite maternal CPR, perimortem CS application was approved. Since 1992, the AHA recommendations have become the standard for perimortem CS (5). In our case, in accordance with the literature, perimortem CS procedure was applied in the fifth minute of CPR in order to save fetal life and reduce aortacaval compression, but maternal exitus could not be prevented. In conclusion, perimortem CS is a life-saving surgical procedure that is rarely required, but can achieve positive maternal and neonatal outcomes when applied on time.

Keywords: cesarean, fetus,life saver, perimortem,

EP-11
Covid-19 Fear in Health Sciences Students

Sümeyye Ahi[1], Barış Çıplak[2], Halime Aydemir[1], Arda Borlu[3], Fatma Ergün[1]

[1]Kırşehir Ahi Evran University Faculty of Health Sciences, Midwifery Department, Kırşehir, Turkey

[2]Kırşehir Ahi Evran University Faculty of Medicine, Department of Obstetrics and Gynecology, Kırşehir, Turkey

[3]Erciyes University Faculty of Medicine, Department of Public Health, Kayseri, Turkey

AIM: In this study, it was aimed to determine the fear of Covid-19 of Kırşehir A.E.Ü Faculty of Health Sciences students.

METHOD: The universe of this descriptive study consists of 1508 students enrolled in the university in question. Using the research sample Epi info 2000 program, the prevalence whose universe is unknown with a known formula was taken as 50%, and the minimum sample size was calculated as 307 with a 90% confidence interval and an acceptable sampling error of 0.05. The study was terminated with 341 students who volunteered to participate in the study. The survey questions of the research were prepared on Google Drive and sent to the students via social media. The questionnaire consists of a total of 26 questions and fear of coronavirus-19 scale. Descriptive characteristics are presented as numbers and percentages.

RESULTS: The average age of the students is 21.19±0.13 (min.18-max.38). 54.8% of the students are from Midwifery, 27.0% from Nursing and 18.2% from Child Development. 91.8% of the participants are women. The variables of students related to covid-19 are given in table 1. The total score average of the Coronavirus Fear Scale is 17.7097±5.84. The Mean Score of Coronavirus Fear (MSCF) of individuals over 65 years of age at home is higher than MSCF, but the difference between them was not significant (t[339]=1.496;p>0.05). MSCF of smokers is lower than MSCF of non-smokers, but the difference was not significant (t[48.301]=- 0.271;p>0.05). MSCF of those with chronic disease is higher than MSCF, but the difference between them was not significant (t[339]=0.840;p>0.05). MSCF of those who do not comply with social distance is higher than that of those who comply, but the difference was not significant (t[34.652]=0.257;p>0,05). MSCF of those who have contact with the person with Covid-19 suspect is lower than MSCF of those who do not, but the difference was not significant (t[339]=-0.683;p>0.05) (Table 2). There is a significant difference between students' economic status and MSCF (F=3.537;p<0.05). The fear of coronavirus of those with poor economic status is higher than those with a good economic situation. There is a significant difference between following the news about Covid-19 and MSCF (F=3.981;p<0.05) and those who follow the news about Covid-19 compared to those who do not have coronavirus fear and those who stopped following, and those who stopped following news about Covid-19 were found to have higher fear of coronavirus than those who did not follow at all.

CONCLUSION: Those with poor economic conditions and those who follow the news are more afraid. While it was expected that the fear score of smokers, those with 5 or more people in their home, individuals who were diagnosed with covid-19 nearby, and those who had contact with the person with suspected covid-19 were expected to be higher. This may be because the questions were not fully understood by the students. Working on larger groups of this research will shed light on identifying the fear of Covid-19 and taking measures.

Keywords: Coronavirus-19, Coronavirus Fear, Fear Of Coronavirus-19 Scale

Fear of Coronavirus-19 Scale

Fear of Coronavirus-19 Scale

1. I am most afraid of coronavirus-19.
2. It makes me uncomfortable to think about coronavirus-19.
3. My hands become clammy when I think about coronavirus-19.
4. I am afraid of losing my life because of coronavirus-19.
5. When watching newsandstoriesabout coronavirus-19 onsocial media, I become nervous or anxious.
6. I cannot sleep because I'm worrying about getting coronavirus-19.
7. My heart races or palpitates when I think about getting coronavirus-19.

The participants indicate their level of agreement with the statements using a five-item Likerttype scale. Answers included "strongly disagree,""disagree,""neither agree nor disagree," "agree," and "strongly agree". The minimum score possible for each question is 1, and the maximum is 5.A totalscore is calculated byadding upeach item score (ranging from 7 to 35). The higher the score, the greater the fear of corononavirus-19.

EP-12
Placenta previa - Case report

Firangiz Mirzazada, Ozge Sehirli Kinci, Ahmet Akin Sivaslioglu
Department of Obstetrics and Gynecology, Mugla Sitki Kocman University, Mugla, Turkey

Placenta previa (PP) refers to the abnormal condition where placenta partially or completely covers the internal cervical os. (1). Placenta accreta (PA), on the other hand, is a condition of abnormal placental implantation (API) which is characterized by insufficiency of decidua basalis, either regional or diffuse, and is divided into three: In the event of placenta accreta, chorionic villi-myometrium attachment is superficial, not invasive. In case myometrium is invaded, it is called placenta increta and once entire myometrium is passed through reaching deep to the uterine serosa then the condition is called placenta percreta. Different types of placental abnormalities frequently coexist. Moreover, in line with the increasing number of Cesarean sections, incidence of API also gets higher. (1). API puts the inflicted pregnant women at an higher risk of morbidity and mortality (2).

Here, we present management of PP and concomitant PA in a case with no previous uterine surgery.

A 36-year-old gravida 1 para 0 woman with no history of past uterine surgery presented for advanced ultrasonography (USG) at 22 weeks of gestation. During her exam, PP and PA were suspected. USG revealed placenta was originating from corpus posterior and thus posteriorly blocking the entire internal cervical os, and the appearance of the hypoechoic area between bladder and uterus was not intact (Figure 1). Magnetic resonance imaging (MRI) was performed at 26 weeks of gestation to pursue a detailed evaluation of suspected API, with scan results confirming PP and PA (Figure 2). Subsequent to the appropriate blood preparation, Cesarean delivery was conducted at 36 weeks of gestation. Once the abdomen has been entered through a Pfannenstiel incision, and checked at the lower segment, the visceral peritoneum was bloated over the uterine surface and the area adjacent to the bladder was intensely vascularized. Sharp dissection was applied to carefully separate bladder from anterior surface of uterus. Visual check revealed placenta was posteriorly located at the lower segment completely covering the cervical os. Spontaneous separation of placenta aided with controlled traction of cord and fundal massage was attempted but failed. Then, placenta was manually detached and removed. The lower segment, uterus and placenta had no well-circumscribed boundaries. Upon removal of placenta, gush of bleeding occurred. Cho square sutures were placed to the bilateral isthmic region to take bleeding under control. Once blood loss reverted to a normal level, uterine tone was assessed and confirmed to be normal. The uterus was closed a with a continuous No. 1 Vicryl suture. After ensuring hemostasis, abdomen was closed in accordance to the anatomy and surgery. The patient did not need any blood transfusion during or after the surgery and was discharged 3 days after.

Keywords: placenta previa, cho suture, placenta accreta

figure 1

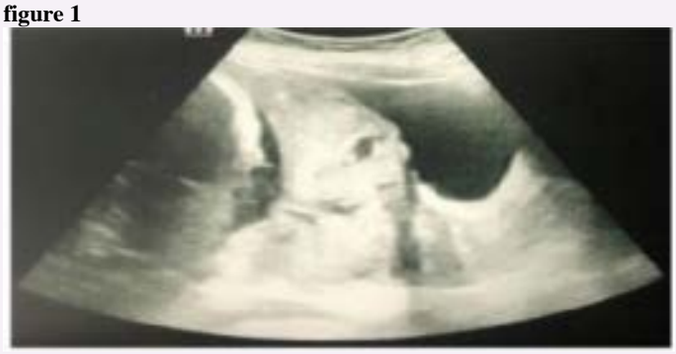
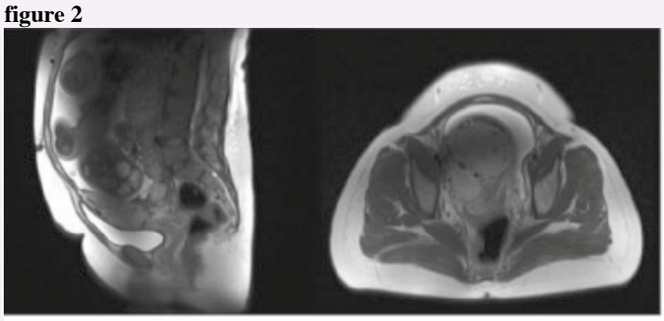


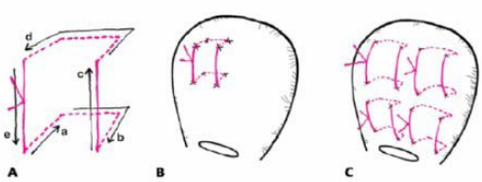
Image of Transabdominal USG: Placenta lies posterior to anterior from corpus posterior, completely obstructing internal cervical os.

figure 2



Pelvic MRI

schema 1



Cho square sutures (3)

EP-13
Coital Injury Making Damage In Perineal Body

Begüm Aktaş, Sezen Bozkurt Köseoğlu, Deniz Akın Gökbel, Farida Hajıbayli, Berfin Küçükler, Hilal Ezgi Türkmen
Department of Obstetrics and Gynecology, Muğla Sıtkı Koçman University Faculty of Medicine, Muğla, Turkey(1-2-3-4-5)

Introduction: The perineal body is a fibromuscular structure between the posterior fourchette and the anus. Structures forming the perineal body; bulbospongiosus muscle, deep transverse perineal muscle, compressor urethra muscle, external anal sphincter, internal anal sphincter, levator ani muscles. The perineal body is critical to maintaining the integrity of the pelvic floor. In this article, a case of coital injury that causes damage to the perineal body and rectovaginal fascia is presented.

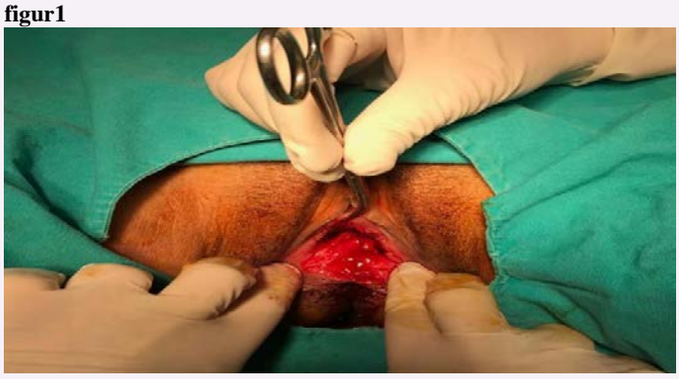
Case report: Twenty-three years old patient who had no pregnancy before applied to our clinic with complaint of vaginal bleeding after coital activity. It was learned in the anamnesis that the patient previously had regular coital activity. Her blood pressure was 100/70 mmhg and her pulse was 94 betas/min. In her gynecologial examination, an anteroposterior diameter of approximately 4 cm and transverse diameter of 4 cm laceration area were observed between the vaginal introitus and the entrance of the anus. Laseration was observed to proceed by dissecting the rectovaginal fascia deep within the perineal body. In the transvaginal ultrasonography, the uterus was normal and bilateral adnexes were observed normal. There was no free fluid in the abdomen. In the complete blood count, hb: 6.9 hct: 21.2. Laceration repair was planned for the patient under general anesthesia. In the observation, it was observed that the integrity of the midline was lost in the rectovaginal fascia in addition to the perineal bodyb defect. The borders of the laceration area were kept with allis clamps. Rectovaginal fascia was visualized and pliced in midline. Following repair of the rectovaginal fascia, the vagina mucosa and the perineal body were closed with a single fast-melting suture material.

The patient with anemia and tachycardia received 2 units of red blood cell suspension transfusion. The patient who had no problem in the postoperative period was discharged.

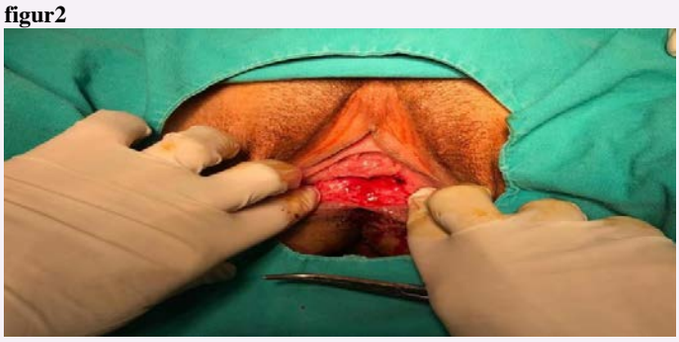
Discussion: Life threatening injury requiring treatment has been described very rarely in literature. Postcoital injuries are less in adults, more in premenopausal women.. First sexual intercourse, menopause, breastfeeding, congenital anomalies of the genital system and radiation history to the pelvic area can be considered as risk factors. In our case, the injury was posterior in line with the literature, but transfusion was performed to the patient who developed anemia due to hemorrhage due to coital damage. Although superficial abrasions can be managed conservatively, the treatment of vaginal laceration often requires surgical repair. As a result, this case presents a case of coital damage involving the rectovaginal fascia and the perineal body in the posterior vagina after the coit. In the approach to the patient with coital damage, care should be taken to ensure the integrity of the perineal body and the rectovaginal fascia, which is indisputable in anogenital function, by correctly defining the anatomical defect in posterior injuries.

Keywords: Anatomy, Body, Coit

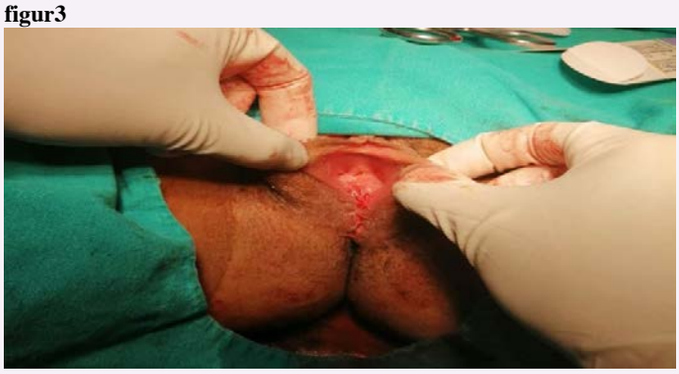
figur1



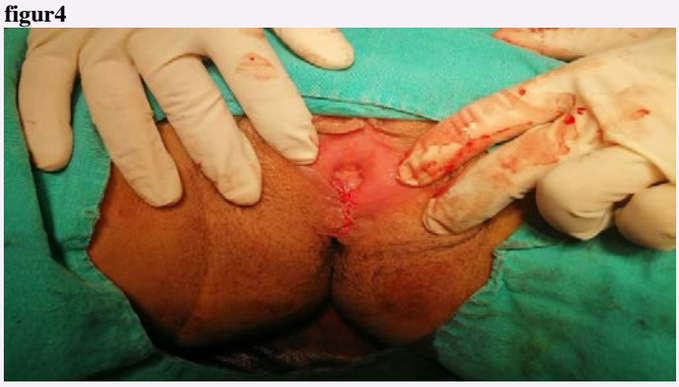
figur2



figur3



figur4



EP-14
Autologous fascia retropubic midurethral sling placement

Adeviye Elçi Atilgan[1], Ali Acar[2], Fatma Kılıç[2], Emine Türen Demir[2], Asiye Uzun[1]

[1]istanbul Medipol University, Department of Gynecology and Obstetry, İstanbul, Turkey

[2]Necmettin Erbakan University, Department of Gynecology and Obstetry, Konya, Turkey

AIM: We planned to share a retropubic autologous rectus fascia midurethral sling procedure.

METHODS: A 45-year old woman diagnosed with stress urinary incontinence (SUI) as physical exam,Urodynamic investigation and cough-stress test. Surgical treatment methods were explained. The patient was opposed to any mesh procedures due to risk of erosion. She also didnt agree with laparascopic Burch procedure as having possible risk of general complications related to laparascopy. She informed about autologous rectus fascia procedure and signed consent was obtained. A rectus fascial strip measuring 8 × 1.5 cm rectus fascia was harvested at operation room under sterile condition. The harvested fascia reclosed with delayed absorbable suture and incision site was closed with an absorbable suture.As like Tension freee vaginal tape (TVT) procedure,2cm midürethral incision was performed and harvested fascia was attached each TVT handle with a non absorbable suture. Then each handle was passed through retropubic area. The rectus fascia, like a sling was then appropriately layed on midürethral level with a tension free manner.Then cystoscopy was performed to check bladder injury.Lastly,the midürethral incision was closed with an absorbable suture.

RESULTS: The patient had an uncomplicated postoperative period. She voided spontaneously after foley catheter was removed 6 hours later. We performed transabdominal ultrosonography to measure postvoid residual urine volüme. It was 40cc as a normal range.We followed up her 1 week later 1 month and then 6 months later, she had no urinary leakage.

CONCLUSIONS: The autologous rectus fascia retropubic midurethral sling procedure may be recommended to patients who don't agree with mesh procedures.Certainly,many more reports with longer follow-up are needed to decide the safety and efficacy of this procedure.

Keywords: Tension free vaginal tape, stress ürinary incontinance, mesh, non-mesh, autologous fascia

EP-16
Covid-19 in pregnancy with cases

Hidayet Şal

Fatsa Devlet Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, Ordu

It is known that mothers and fetuses are at risk for poor results due to coronavirus (COVID-19) pandemic.Although most pregnant women infected with COVID-19 have good results in the literature, in a recently published systematic review, 3% severe maternal morbidity has been demonstrated in COVID-19 pregnancies.However, since the number of cases transferred to the literature is not at the desired level, there is no clear consensus on the effects of COVID-19 infection on pregnant women and fetuses. And with the transfer of COVID-19 cases to the scientific community, clinical management experiences in COVID - 19 positive pregnancies are expected to increase.In our clinic, we wanted to share with you two cases of COVID-19 diagnosed in the second trimester, one resulting in intrauterine fetal death and the other in the healthy term.CASE 1:A 32-year-old (G2P1) patient with 23 weeks of gestation according to her last menstrual period admitted to us with shortness of breath, cough, and high fever. No major pathology was detected in fetus.It was observed that coagulation parameters deviated from normal limits one day after hospitalization. A nasopharyngeal swab was taken, and COVID-19 detected. In the patient who described abdominal pain and found to have intrauterine fetal death in the USG. Birth induction was started. the control PCR test of the patient was negative. COVID-19 infection was not detected in the swab taken from the Ex fetus.CASE 2:A 28-year-old (G1) patient with 28 weeks of gestation according to her last menstrual period admitted to us with fever.She was positive after COVID-19-PCR. During her follow-up in the hospital, no pathology was found in the case of fetal well-being. The closely monitored case was admitted to us at 37 weeks of gestation due to the inability to feel baby movements, and abdominal pain. In the evaluation made, the decision of cesarean delivery was made due to loss of variability, fetal tachycardia in the NonStres Test, and non-response to fetal resuscitation steps. With the thought that there may be a transition to the baby by transmission, the baby was administered the post-birth COVID-19 test, but it was negative. The first COVID-19 cases were reported in December 2019 from Wuhan, China, and subsequently, the infection spread worldwide.With the spread, one of the biggest groups wondering how much they will be affected by this infection was pregnant women, and the other was fetuses. Considering the newborn,no evidence of COVID-19 was transmitted by vertical transmission between mother and baby.In a review evaluating 108 COVID-19 positive pregnant women, it was stated that COVID-19 may be associated with severe maternal morbidity during pregnancy, and the possibility of maternal-fetal transmission cannot be completely excluded.It was seen that COVID-19 infection had different effects in both cases we presented.Consequently, COVID-19 positive pregnants should be defined as high-risk pregnancies and carefully monitored, and measures to prevent neonatal infections should be taken. In the follow-up and treatment of COVID-19 infection during pregnancy, a multidisciplinary approach is critical in terms of diseases that may develop in the fetus and mother.

Keywords: COVID-19, high risk pregnancy, intrauterine death

EP-17
Removal of IUD penetrated into the mesentery by laparoscopic method

Samet Kadir Mutlu, Mehmet Ferdi Kıncı, Ahmet Akın Sivaslıoğlu
Department Obstetrics and Gynecology, Mugla Sıtkı Kocman University, Mugla, Turkey

The intrauterine device (IUD) is the most commonly used method of LARC because of its high efficacy and safety, ease of use, and cost effectiveness. It provides a nonsurgical option for pregnancy prevention that is as effective as surgical sterilization. Serious complications are rare and include expulsion, PID, contraceptive failure and perforation (0.01%) Malposition is a less serious side effect and occurs in up to 10% of women. Most malpositioned devices (73.1%) were noted to be in the lower uterine segment or cervix. Perforation of the uterus is one of the most serious complications associated with insertion of IUD. According to recent studies, this lesion occurs in 0.87 per 1000 cases, but statistics generally fluctuate between 0.05-13 per 1000 insertions. Primary perforations occur at the time of IUD insertion, and secondary or delayed, perforations are usually assumed to be caused by reactive uterine contractions. In this case, we talked about laparoscopic management of the lost intrauterine device, which penetrates the mesentery.

A 36 years old woman with a history of a caesarean section (G1P1) applied to our clinic for a routine gynecological examination. It was learned that the patient's menstruation was regular, protected by a spiral. During the speculum examination, the IUD rope was not seen. IUD echogenicity in the uterine cavity was not observed in TV USG imaging. Therefore the patient was then given a CT scan. In the CT report, IUD localization was observed in mesanteric fat in the anterior neighborhood of the colon in the right quadrant. The patient underwent diagnostic laparoscopy and the missing IUD was observed embedded in mesanteric adipose tissue. Some of the fat tissue was resected and the IUD was removed from the west using endobag method.

Uterine perforation and migration of the IUD into abdominal or pelvic organs are major complications of IUD insertion. Most patients with ectopic IUD may be asymptomatic. Some patients suffer from chronic pelvic pain, lower abdominal bulge, irregular vaginal bleeding, or other discomforts. Migration of IUD to abdominal organs may cause corresponding discomfort. The IUD insertion should be performed by an experienced gynecologist. Women who opt for IUD should be regularly monitored by pelvic or abdominal cavity ultrasonography, if necessary. Misplaced IUDs can be diagnosed simply with speculum examination. Missing threads is the usual sign and may be due to unrecognised expulsion, enlarged uterus due to pregnancy, the IUD threads becoming detached or, most importantly, perforation. Ultrasonography, hysteroscopy, X-ray, MRI, fluoroscopy are also useful tools for diagnosis, computerized CT if necessary for the diagnosis of localization in lost IUD cases should be used. Flat abdominal graph should be the first option in cases of lost IUD. Laparoscopy is the first option in intraabdominal IUD cases. Laparotomy should be selected if there is evidence of intestinal perforation or sepsis. Chronic pelvic pain in abdominal placement, urinary tract infections in bladder placement, irritation and non-specific pain with tenezm in bowel placement are reported in lost IUD cases depending on the area where migration occurs and the amount of migration

Keywords: intrauterin device, malposition, laparoscopy

(Fig. 1a)

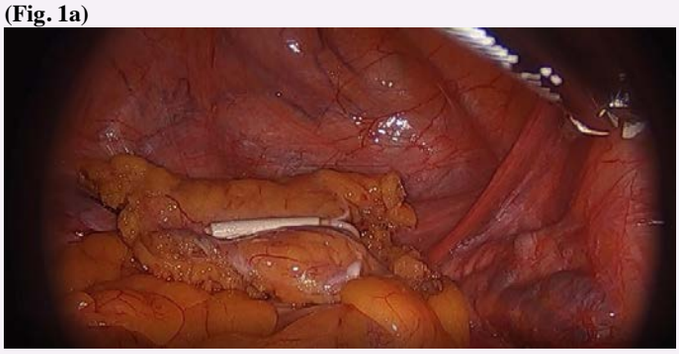
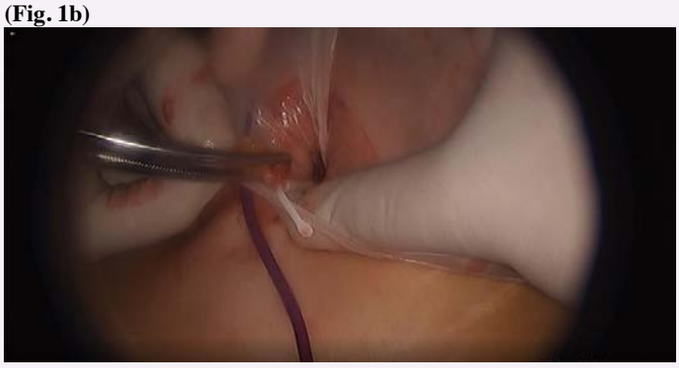


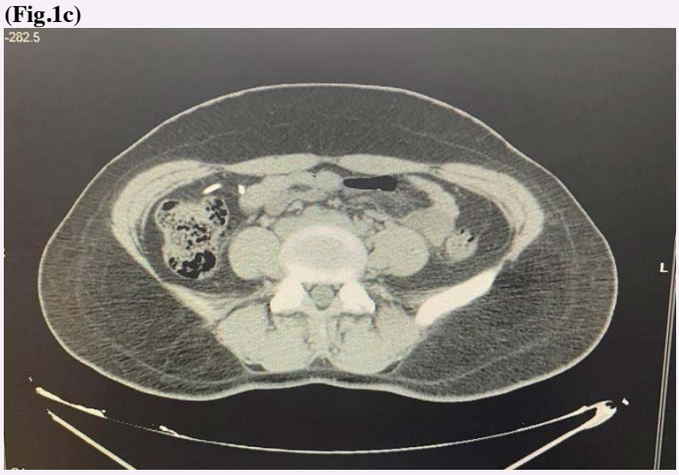
image of IUD penetrating into the mesentery

(Fig. 1b)



removal of the IUD from the abdomen by endobag method

(Fig.1c)



IUD localization was observed in mesanteric fat in the anterior neighborhood of the colon in the right quadrant

EP-21
Relationship Between Bilirubin Levels And Carotid Intima-Media Thickness In Polycystic Ovary Syndrome Patients

Murat Turfan[1], Emin Asoğlu[2], Ramazan Danzuk[3], İlker Duman[4], Mehmet Ergelen[5]

[1]Acibadem Taksim Hospital,Department of Cardiology Istanbul, Turkey

[2]Mardin State Hospital, Department of Cardiology, Mardin, Turkey

[3]Biruni University Faculty of Medicine, Department of Gynaecology and Obstetrics, Istanbul, Turkey

[4]Kagithane State Hospital, Department of Cardiology, Istanbul, Turkey

[5]Kolan Sisli Hospital, Department of Cardiology, Istanbul, Turkey

OBJECTIVE: Polycystic ovary syndrome is a multifactorial disorder. Many studies have shown an increased risk of atherosclerosis in this patient group. In some of these studies, carotis intima media thickness was also increased. It is known that the protective effects of bilirubin from atherosclerosis depend on its antioxidant properties. However, this effect has not been investigated in PCOS patients.

METHODS: Thirty seven patients with a diagnosis of PCOS aged younger than 40 year and thirty six healthy women were included in the study. Serum bilirubin levels and other blood parameters in at least 12-hour fasting states were determined. Carotid artery ultrasonography imaging was performed by the same experienced operator. Average of left and right carotid arteries was taken as one variable

RESULTS: Serum bilurubin levels were significantly lower (p: 0,02)in PCOS patients. In addition, IMT in this group was significantly higher. CIMT showed a significant positive correlation with LDL levels and a significant negative correlation with bilirubin levels in both the groups.

CONCLUSIONS: To the best of our knowledge, this is the first study to evaluate serum bilirubin levels in patients with PCOS. We found that serum bilirubin levels were independently associated with CIMT. Therefore, adverse effects of oxidative stress were shown on vessel structure

Keywords: Bilirubin, Polycystic Ovary Syndrome, Carotid Intima-Media Thickness, Reactive oxygen species

Table 2

Variables	All subjects		PCOS	
	ß-coefficient	P-value	ß-coefficient	P-value
Age	0.204	0.095	0.171	0.39
Waist to hip ratio	0.114	0.48	0.176	0.293
Glucose	0.127	0.322	0.085	0.644
Tryglycerides	0.218	0.064	0.165	0.323
HDL cholesterol	-0.022	0.859	-0.072	0.676
LDL cholesterol	0.287	0.014	0.37	0.023
Total testosterone	0.121	0.298	0.252	0.11
Bilirubin	-0.278	0.022	-1.071	0.042

Table 2. Univariate linear regression analysis with CIMT as the dependent variable

Table I

	PCOS (n=37)	Control (n=36)	Pvalue
Age	25.1 ± 6.6	24.8 ± 5.3	0.874
BMI (kg/m2)	25.6 ± 3	23.8 ± 3.7	0.02
Waist to hip ratio	0.81 ± 0.7	0.76 ± 0.7	0.002
Tryglycerides (mg/dL)	112 ± 39	108 ± 28	0.589
LDL cholesterol (mg/dL)	102 ± 13	98 ± 10	0.13
HDL cholesterol (mg/dL)	50 ± 14	49 ± 10	0.71
Fasting glucose (mg/dL)	97 ± 15	83 ± 10	0.001
HOMA-IR	2.88 ± 0.9	1.99 ± 0.5	0.001
Prevalence of MS (%)	32.4	13.9	0.05
Bilirubin(mg/dl)	0.38 ± 0.07	0.42 ± 0.09	0.02
AST(U/L)	18 ± 8	17 ± 7	0.78
ALT(U/L)	24 ± 7	22 ± 6	0.28
LH (mIU/mL)	7.8 ± 4.4	5.7 ± 3.3	0.02
FSH (mIU/mL)	5.7 ± 1.6	5.3 ± 1.5	0.22
Total testosterone (ng/ml)	0.7 ± 0.3	0.5 ± 0.2	0.003
Estrodiole (pg/mL)	53 ± 24	50 ± 20	0.544
SHBG (nmol/L)	55 ± 32	64 ± 31	0.234
CIMT (mm)	0.47 ± 0.0 6	0.44 ± 0.04	0.019

PCOS, polycystic ovary syndrome; BMI, body mass index; SHBG, sex- hormone binding globulin; FSH, follicle stimulating hormone; LH, Luteinizing hormone; HOMA-IR, homeostatic model assessment for insulin resistance; MS, metabolic syndrome; CIMT, carotid intima media thickness.

Table 1. Clinical features of the patients with PCOS and matched controls

EP-22
Placental Site Trophoblastic Tumors: A Case Series

Çiğdem Kılıç
Department of Gynecologic Oncology, Etlik Zubeyde Hanim Women's Health Training and Research Hospital, Ankara, Turkey

OBJECTIVE: Placental site trophoblastic tumor (PSTT), is a rare form of gestational trophoblastic neoplasms (GTN), originating from intermediate trophoblastic cells. PSTT can occur several months, or even years after the pregnancy including molar and ectopic, miscarriage and abortion or a full term normal pregnancy. The incidence of PSTT is approximately 1/100.000 of all pregnancies and roughly 1-2% of all GTNs, while its mortality is 25%. Most patients present with nonspecific symptoms and signs at diagnosis, such as abnormal vaginal bleeding, amenorrhea and mild elevated serum beta human chorionic gonadotropin (β-HCG) levels (<1000 mIU/mL in 79% of cases). It may secrete human placental lactogen (hPL). Treatment for early stage disease is primarily hysterectomy, however metastatic or recurrent disease often requires a multifaceted approach with chemotherapy and/or surgery. Because of its rarity, over 300 cases have been reported in the literature. The aim of this study is to evaluate the experience of our clinic for 25 years.

MATERIALS-METHODS: Here we present 5 cases of PSTT treated in our hospital between 1992 and 2017.

RESULTS: Two of five patients had term pregnancy, two patients had molar pregnancy and one had abortion prior to diagnosis of PSTT. All

patients had elevated serum β-HCG levels and four patients underwent surgery except one including four total abdominal hysterectomies and two pelvic lymphadenectomies. Immunohistochemical analysis was performed on two patients' samples and both showed positive staining for hPL and β-HCG. Three patients received chemotherapy (two Methotrexate and one Etoposide, Methotrexate, Actinomycin-D, Cisplatin [EMA-EP]). One patient had metastatic nodules in lung parenchyma at the time of diagnosis. No patient had recurrence during follow-up.

CONCLUSION: As PSTT is a rare form of GTN, there have been some difficulties in diagnosis, follow-up and treatment options. The preferred treatment is surgery with hysterectomy± lymphatic sampling. For advanced stage, metastatic and recurrent disease; a combined surgery and chemotherapy treatment is recommended. Adjuvant chemotherapy decision is not clear.

Keywords: Gestational trophoblastic neoplasm, intermediate trophoblasts, placental site trophoblastic tumor

Clinico-pathologic factors of patients

Factors	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Age	24	31	27	35	23
β-hCG (mIU/ml)	304	156	4849	59	199
Antecedent pregnancy	Term pregnancy	Term pregnancy	Molar pregnancy	Abortion	Molar pregnancy
Tumor age	8 months	8 months	3 months	4 months	13 months
Clinical presentation	Irregular vaginal bleeding	Uterine mass	High β-hCG	Irregular vaginal bleeding	Uterine mass
IHC analysis	Not performed	Positive for βhCG and HPL	Not performed	Not performed	Positive for HPL
Prior therapy	Not received	Not received	Not received	Not received	Not received
Treatment	TAH+USO	TAH+BSO + MTX-FA	MTX-FA	TAH+BS + Pelvic LND	TAH+ BS+ Pelvic LND+ EMA-EP + wedge resection (lung)
Follow-up	12 months	93 months	101 months	24 months	35 months
Recurrence	Negative	Negative	Negative	Negative	Negative
Disease status at last visit	No evidence of disease	No evidence of disease	No evidence of disease	No evidence of disease	No evidence of disease

TAH: total abdominal hysterectomy USO: unilateral salpingo-oophorectomy HPL: human placental lactogen MTX-FA: methotrexate- folinic acid LND: lymph node dissection BS: bilateral salpingectomy EMA-EP: etoposide-methotrexate- actinomycin- cisplatin

EP-23
The impact of iron deficiency during gestation on fetus birth weight

Anıl Turhan Çakır[1], İsa Şükrü Öz[2]

[1]Zonguldak Obstetrics and Gynecology Hospital

[2]Afyon State Hospital

AIM: The effect of iron deficiency anemia seen in the mother during pregnancy on birth weight

MATERIAL-METHODS: The data of pregnant women diagnosed with iron deficiency who applied to the gynecology and obstetrics clinic of our hospital between 2018-2020 were scanned.A total of 128 pregnant women with iron deficiency anemia formed the study group.372 pregnant women who gave birth at the same time and did not have iron deficiency anemia constituted the control group. A total of 500 pregnant women were included in the study.Birth weights of babies born of all patients were recorded. The comparison of the groups was done by Student t test for normal distributed data, Mann Whitney test for normal non-distributed numerical data, and chi-square test for categorical data. p <0,05 was considered statistically significant.

RESULTS: While the mean age of the patients in Group 1 was 28.9, the mean age of the patients in Group 2 was 25.8. %9.37 percent of babies of pregnant women with iron deficiency anemia low birth weight (<2500gm) In the control group, the number of fetuses born with low birth weight was 5 (1.3%) More low birth weight fetuses in pregnant women with iron deficiency anemia is statistically significant compared to the control group. There was no statistically significant difference between the groups in terms of other weights. (p=0,145)

CONCLUSION: Iron –deficiency anemia is a modifiable factors to prevent the occurrence of low birth weight baby.

Keywords: anemia,iron deficiency,pregnancy

EP-25
Endometrial Polyp Prolapse to Vagina: A Case Report

Barış Çıplak[1], Eyüp Gökhan Turmuş[2], Mehmet Murat Altındağ[2], Hanifi Şahin[2]

[1]Kirsehir Ahi Evran University School of Medicine, Department of Obstetrics and Gynecology, Kirsehir, Turkey

[2]Malatya Education and Research Hospital, Obstetrics and Gynecology Clinic, Malatya, Turkey

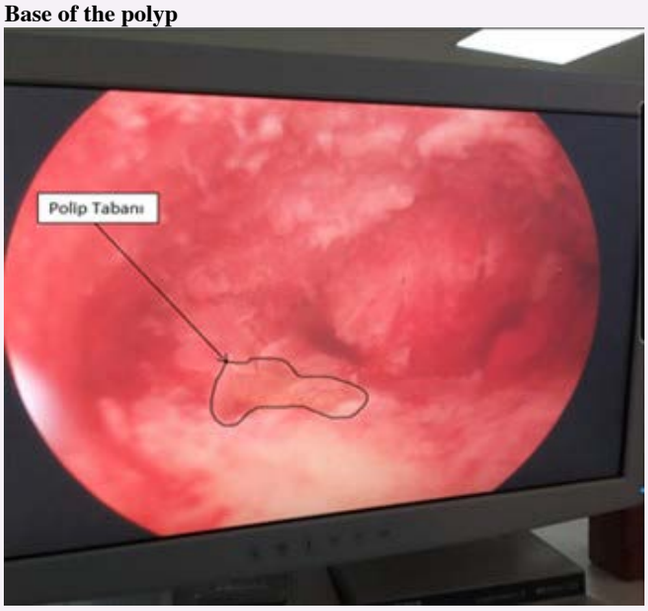
Endometrial polyps are benign masses of the endometrium that grow into the uterine lumen. They can be single or in large numbers. Structurally, they can appear in pedunculated or sessile forms. In rare cases, especially those with stalks may protrude from the cervix towards the vagina. In this article, a pedunculated endometrial polyp prolapse to vagina one year after cesarean delivery was presented.

CASE: A 23-year-old patient who delivered for the first time by cesarean section 1 year ago applied to the gynecology outpatient clinic with the complaint of spot bleedings that started 5-6 months after birth and continued for 6 months. The patient also had a history of post-coital bleeding. The endometrium was evaluated as normal in the ultrasonography. Vaginal speculum examination revealed a polypoid formation of approximately 1x4 cm protruding from the cervix (Figure-1). Operative hysteroscopy was planned for the patient under anesthesia. In hysteroscopy, it was seen that the polypoid formation originated from the lower wall of the uterine endometrial cavity (Figure-2). The formation stretching from a 1-cm thick stalk and protruding from the cervix was removed from the base of the structure hysterescopically, with the help of a resescope, then the probe was curetted and sent to histopathological examination. The pathology result was interpreted as an endometrial polyp. The pathology result of the probe curettage was reported as secretory endometrium.

DISCUSSION: Sizes of the endometrial polyps vary from a few millimeters to a few centimeters. Endometrial polyps are usually less than 2 cm in size. Although rare, they can sometimes reach a size of 4 cm and are called giant polyps. Most of the giant endometrial polyps reported in the literature are mainly related to the postmenopausal period. Since endometrial polyps may have a malignant potential, excisional biopsy and endometrial biopsy should be performed. Endometrial polyps prolapsing to the vagina can be confused with cervical polyps originating from the cervical canal, and fibroids prolapsing to the vagina. These formations arising from different histopathological origins must certainly be removed and examined pathologically. Pedunculated polyps prolapsing to the vagina, which are not common in the young age group and in the early postpartum period, should be kept in mind in dysfunctional uterine bleeding. Besides, these pathological formations with malignant potential, even if low, should be removed hysterescopically if possible.

Keywords: Polyp Prolapsing, Endometrial Polyp, Dysfunctional Uterine Bleeding

Base of the polyp



endometrial polyp prolapse to vagina

EP-26
Pure uterine lipoma; a rare case of uterus

Melike Nur Akın
Muğla Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı

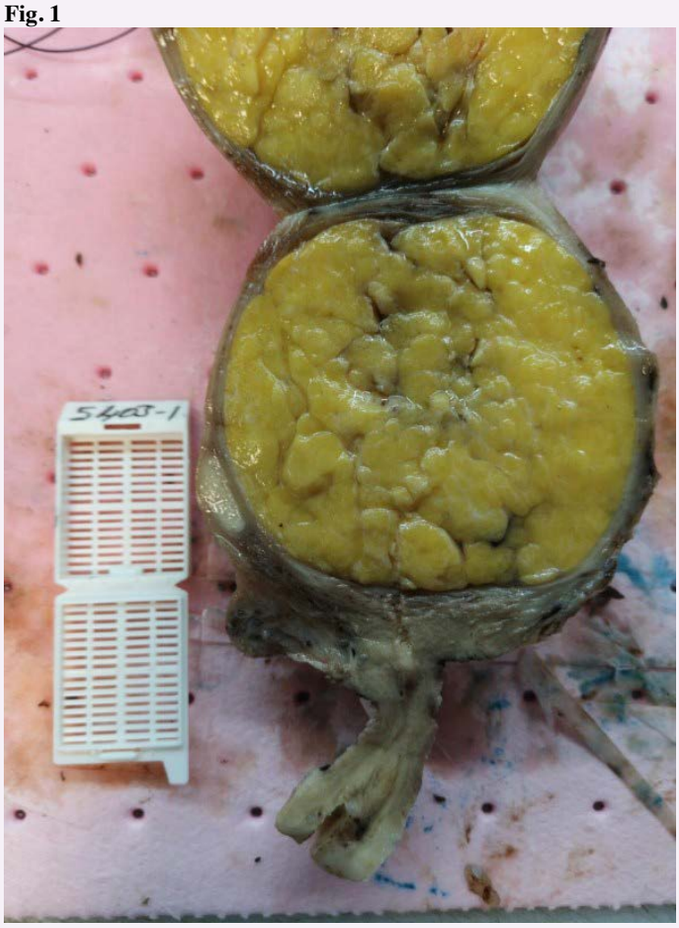
INTRODUCTION: Pure lipoma of the uterus is a rare entity and only a few cases have been reported in the literature. Clinical symptoms and signs are similar to those found in leiomyoma and create preoperative diagnostic confusion. The histopathogenesis is still unclear. We report the case of a 54 year-old postmenopausal woman with pure lipoma of the uterus.

CASE: A 54 year-old postmenopausal, multiparous woman presented with postmenopausal bleeding. On vaginal examination, there was no pathology in vulva vagina and cervix but an irregularly enlarged uterine corpus was detected. On abdominal examination a suprapubic mass was palpable which was about 16 weeks gravid uterine size. The mass was firm and non tender with well defined margins. Ultrasonography (USG) of the abdomen showed a large calcified mass measuring 85x73 mm, arising from the fundus of the uterus and posterior to the urinary bladder. Endometrial echo was not seemed clearly. Sonological diagnosis was calcified intramural myoma. Patient underwent pipelle biopsy. Biopsy result was benign;superficial endometrial epithelium fragments. Total abdominal hysterectomy with bilateral salpingooophorectomy was carried out and the postoperative period was uneventful. Grossly, the uterus and cervix together was measured 14x12x9 cm in size. The cut section showed a well circumscribed yellowish intramural mass measuring 7.5×7.5cm (Fig. 1). Multiple sections were taken and stained with hematoxylin and eosin. The sections showed lobules of mature adipocytes separated by thin vascular connective tissue. The myometrium was pushed to the periphery forming a pseudocapsule along with fibrous tissue (Fig. 2).The endometrium was atrophic.

DISCUSSION: Fatty tumours of the uterus are exceedingly rare with an overall incidence of 0.03-0.2% with pure lipomas being extremely rare. Presence of fat in a musculo-glandular organ has been an enigma for several decades as the adipocyte isn't supposed to be a resident in the milieu of the uterine corpus. In theory adipocyte presence is attributed to misplaced embryonic fat cells, metaplasia of the smooth muscles, proliferation of perivascular fat cells, inclusion of fat cells into uterus during surgery and degeneration of uterine connective tissue. These fatty tumors include pure lipoma and mixed lipoma such as myolipoma, lipofibroma, lipomyoma, and fibromyolipoma. Some of the pure lipomas are co-incidentally associated with other lesions; like struma ovarii, endometrial carcinoma and cervical carcinoma reported. Strikingly, very few cases of isolated pure lipoma of the uterus were reported. These lesions present with variable symptoms most common being pain abdomen, fullness, bleeding per vaginum post menopause and irregular bleeding in menstruating women. This lesion presents a preoperative diagnostic challenge in terms of semblance to a leiomyoma. Sonologically a leiomyoma appears to be of similar or increased echogenicity to myometrium whereas a lipoma appears as an echogenic lesion with a hypoechoic rim representing the compressed myometrium. As a result, although there are various theories for the histopathogenesis of uterine lipomas, it has not been clarified yet. The etiopathogenesis of uterine lipoma is not yet known. It should be borne in mind that masses resembling the giant myoma in the uterus can be lipoma.

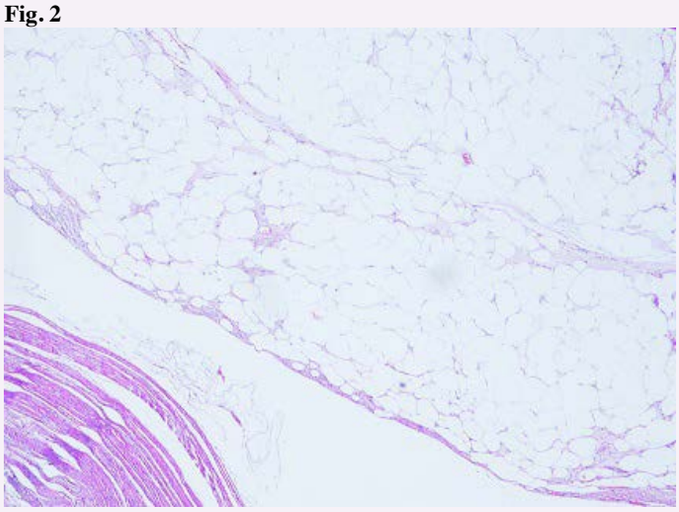
Keywords: Lipoma, Lipo-leiomyoma,Uterus

Fig. 1



Gross appearance of uterine mass

Fig. 2



Section showing compressed myometrium along with adipose tissue, H&E, ×40

EP-27
A Foundatation University Nursing 3nd Grade Student Making BSE And Determining The Information STATUS On This Topic

Ece Kiyanak

Bir Vakıf Üniversitesinin Hemşirelik 3. Sınıf Öğrencilerinin KKMM Yapma ve Bu Konudaki Bilgi Durumlarının Belirlenmesi

Breast cancer is a type of cancer that occurs as a result of uncontrolled proliferation and growth of cells. Breast cancer ranks first among cancer types in women in the world and second among long cancer deaths after cancer. But very few people are aware of this. It occurs in one of every 8of 10 women throughout its life. When breast cancer is deagnosed early, the chances of getting rid of it are very high. The Cancer Research and War Institution recommends that all women undergo a regular breast examination every month between the ages of 20 and 39, undergo a clinical breast examination every 3 years and mammography over 40 years of age. (Şen, 2012; Başar, 2012) (Yeditepe Unıversity, Breast Diseases Diagnosis and Treatment Unit) Despite the developments in the mammographic method, it is know that %80-90 of the detected breast masses are found though women's breast self examination. Therefore, women should have sufficiend knowledge, attitude and behavior about breast self-examination. Woman can get to know the breast tissue and notice the cahnges that ocur early, with regular BSE every month. BSE, which is an economical and easy method that every women can easily apply, is a technique developed in order to search/search for cancer, different from just touching the breast. (Şen, 2012; Başar, 2012) (Yeditepe Unıversity, Breast Diseases Diagnosis and Treatment Unit) Inthisstudy,itwasaimedtodeterminetheknowledgeandbahviors3rdgrade nursing student of a foundation university about BSE and breast cancer. Our sample includes 70 people consisting of 3rd grade nursing students.

CONCLUSİON: The rate of knowing and doing BSE was found high in the study. However, although the rates of knowing the diagnoctic methods such as ultrasonography and mammography were high, the rates of appliyng these diagnotic procedures were found to be low. In addition, the history of breast cancer in the families og individuals in the study groups was found to be low. In general, when asked why woman do not BSE, the main reason is the lack of information, and it is thought that necessesary incentive and information programs should be made.

Keywords: KEY WORLDS: Mamograph, Breast Cancer, Ultrosonography, BSE

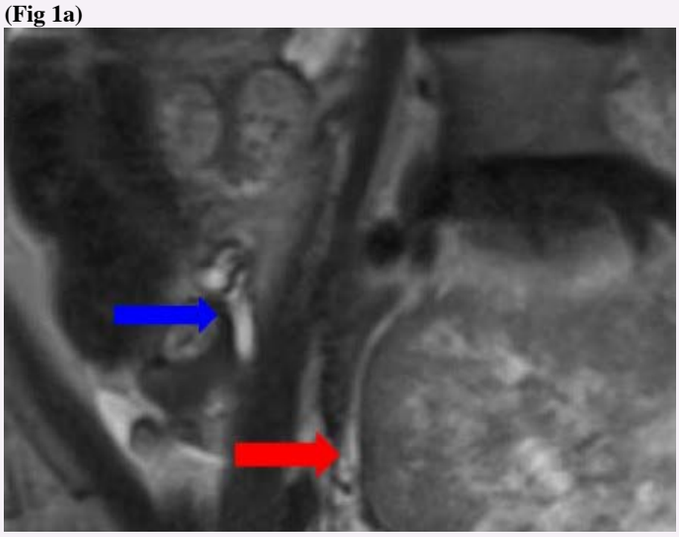
EP-28
An incidental finding of low-grade appendiceal mucinous neoplasm during Staging for Ovarian Cancer: A case report

Berfin Küçükler[1], Kemal Güngördük[2]
[1]Mugla Sıtkı Kocman University Obstetrics and Gynecology Clinic
[2]Mugla Sıtkı Kocman University Gynecology Oncology Clinic

Low grade appendiceal mucinous neoplasms (LAMNs) are rare tumours of the appendix, incidentally discovered in 0.2%–0.3% of all post appendectomy pathology specimens. In the early stage of the growth of LAMN, most patients have no symptoms, and the tumour is diagnosed incidentally during abdominal imag¬ing or laparotomy for presumed acute appendicitis. No previous cases of LAMN with ovarian granulosa cell tumour have been reported to date. A 78-year-old post-menopausal woman patient was referred to our gynecologic oncology clinic with a history of chronic abdominal pain, distension and 14 cm semisolid adnexal mass. Physical examination revealed no tenderness, but a hard and mobile mass palpable in the right iliac fossa. Further investigation by means of transvaginal ultrasound revealed a cystic formation, sized 13 × 95 × 74mm in the right adnexal area. The mass was of mixed structure, comprising of solid and cystic areas. Tumour markers were within normal rates. Computerized tomography was carried out, which identified a semi-solid mass, sized 14 cm, in right adnexal legion (Fig. 1a-b). The patient underwent exploratory under the diagnosis of adnexal mass in which a semi-solid tumour originating from the right ovary. Frozen was performed, which revealed an ovarian malignant tumour. Top of the appendix was adherent to the ovary. Hence surgical stating procedure and appendectomy were performed. The postoperative course was uneventful. The histopathologic examination of the surgical specimen revealed a granulosa cell tumour of the ovary and a low grade appendiceal mucinous neoplasm (Fig 1c-d-e).

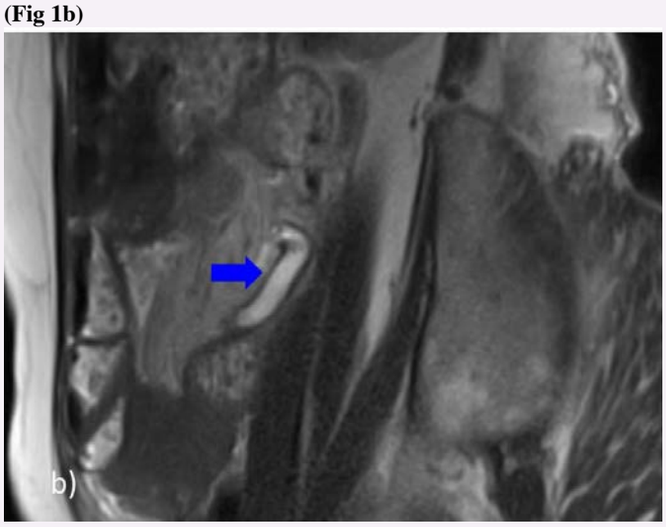
Keywords: Low-grade appendiceal mucinous neoplasm, ovarian granulosa cell tumour, surgery.

(Fig 1a)



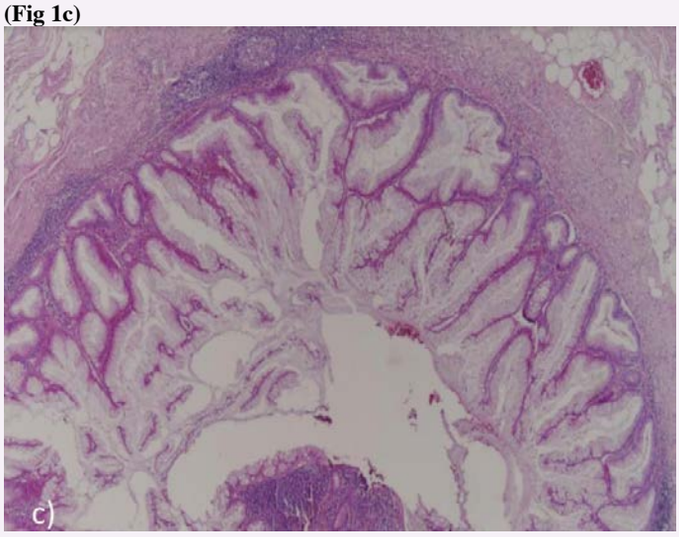
Computerized tomography was carried out, which identified a semi-solid mass, sized 14 cm, in right adnexal legion (blue arrow: appendix, red arrow: semi-solid mass)

(Fig 1b)



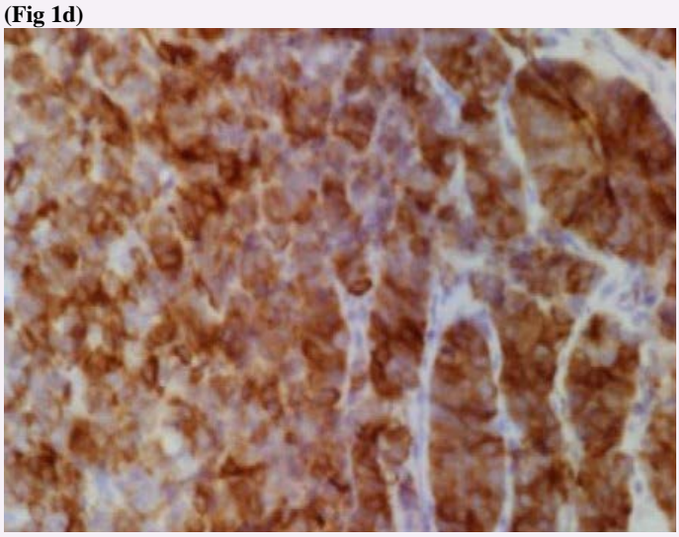
Computerized tomography was carried out, which identified a semi-solid mass, sized 14 cm, in right adnexal legion (blue arrow: appendix)

(Fig 1c)



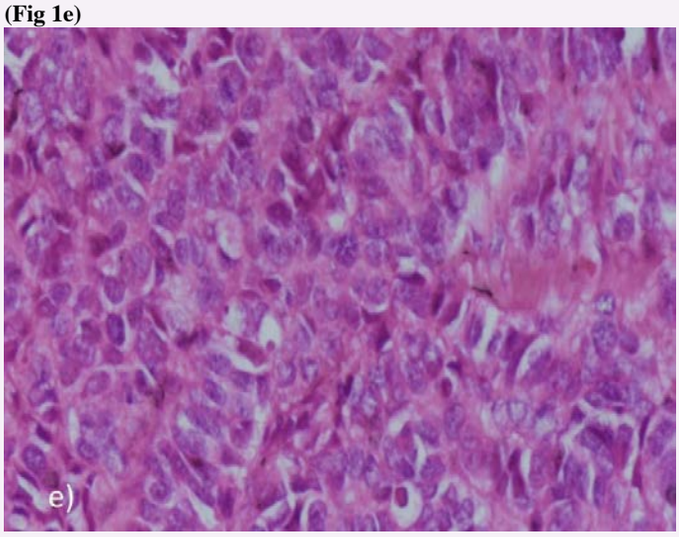
The histopathologic examination of the surgical specimen revealed a granulosa cell tumour of the ovary and a low grade appendiceal mucinous neoplasm

(Fig 1d)



The histopathologic examination of the surgical specimen revealed a granulosa cell tumour of the ovary and a low grade appendiceal mucinous neoplasm

(Fig 1e)



The histopathologic examination of the surgical specimen revealed a granulosa cell tumour of the ovary and a low grade appendiceal mucinous neoplasm

EP-29
Salivary alpha amylase as a atress predictor in pregnant women who have undergone OGTT

Mustafa Melih Erkan
Obstetric and Gynecology, Kent Hospital, izmir, Turkey

OBJECTIVE: The objective of the study is to search the stress in pregnant women whether increase or not with 75 gr oral glukose tolerance test (OGTT).

MATERIAL-METHODS: In this prospectively designed study, we included 20 healthy pregnant women in 23-28 weeks of gestational age, who have undergone 75 gr OGTT and have not had any other stressors. Psychological stress was assessed by using salivary alpha- amylase as a psychological stress biomarker and Hospital Anxiety and Depression (HAD) scale. Salivary alpha amylase levels were measured three times: just before the test (amylase-1), immediately prior to second hour blood sampling (amylase-2) and 24 hours after the OGTT (amylase-3). The results were evaluated with the sociodemographic values and HAD scores.

RESULTS: Amylase-2 level was significantly higher when compared with amylase-1 level. Amylase-3 level was significantly lower than both the amylase-1 and amylase-2 levels.

CONCLUSION: Routine OGTT applied during pregnancy may be a temporary stress factor which does not lead to emotional instability.

Keywords: OGTT, Salivary alpha amylase, pregnancy, stress, HADS

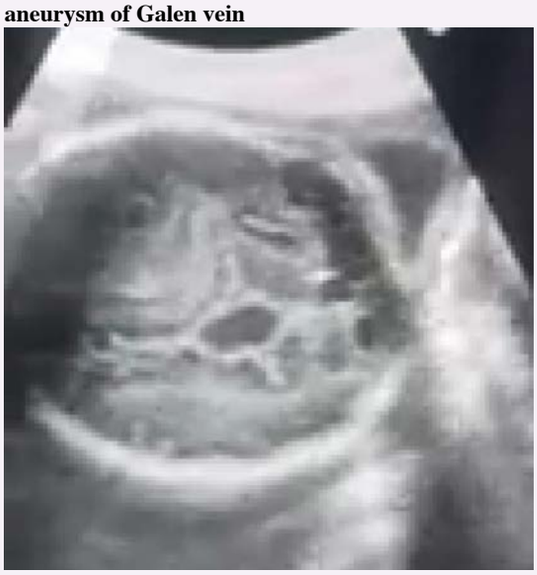
EP-30
Aneurysm of Galen vein in fetus, a rare case

Coşkun Ümit
Sincan Dr. Nafiz Korez Public Hospital, Ankara, Turkey

Aneurysm of Galen vein (AGV) is a rare congenital defect of cerebral vessels. They are formed in first trimester. Mechanism of this defect involves presence of one or more arterovenous fistulas directing blood flow towards a persistent, dilated, proximal part of median prosencephalic vein. Its prevalance is 1/25000 births. Male to Female ratio is 2/1. AGV constitute 1% of all intracranial vascular anomalies. Although rare, they are one of the most frequent arterovenous malformations diagnosed in children both pre and postnatally.The defect develops in the early first trimester but the aneurysm becomes sonographically apparent just in the third trimester. In 90% of cases there is high output heart failure with secondary hydrops. If there is hydrops fetalis at the time of diagnosis than the prognosis is poor. In this case report I aimed to present the prenatal diagnosis of AGV in a 31 weeks fetus. 29 years old woman with an unremarkable obstetric and medical history admitted to our hospital. She said that she couldn't feel her baby's movements for 2 days. On ultrasound examination there was a singleton, male fetus with 5 weeks intrauterine growth retardation in breech presentation. She was in the 31st week of pregnancy according to her last menstrual period. And her last menstrual period confirmed with a first trimester ultrasonogram. There was a midline, fusiform, echo free area measuring 35x20x20 mm in the fetal brain located posterior to the third ventricle. Color flow examination revealed a turbulent flow in the lesion. Doppler velocity waveforms showed high blood flow in the lesion with an increased peak systolic velocity and decreased resistance, compatible with the existence of an arteriovenous shunt. There was a significant cardiomegaly and minimal ascites in fetal abdomen. Patient NST was non reactive and BPP was 4 of 10 with reduced amniotic fluid volume. The fetus was delivered immediately due to the fetal distress. An 1260 gram, male fetus with 0/1 Apgar was delivered. Despite intense support the fetus died at 24 hours after birth. Ultrasound examination is a good choice in case of vein of Galen malformations due to its non-invasive character, safety and low cost. Identification of the turbulent vascular flow inside a supratentorial cystic mass, on the midline, when using color or pulsed Doppler provides a diagnosis and can distinguish between an aneurysm in the vein of Galen and an arachnoid or porencephalic cyst, or a Dandy Walker malformation. So, using color Doppler is essential for differential diagnose of VGAM with other cystic anomalies of the midline of brain. Also prenatal MRI can be used to rule out differential diagnosis with: choroid plexus cysts, porencephalic cysts, arachnoid cysts, pineal tumors. Early prenatal diagnosis and close follow-up of the affected fetus is important. It helps to an early detection of the associated complications such as cardiomegaly and congestive heart failure associated with fetal hydrops.

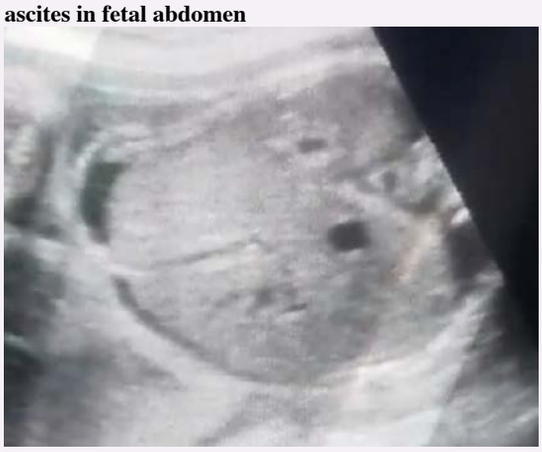
Keywords: Aneurysm, Ascites, Galen vein, Heart failure, Ultrasonogram

aneurysm of Galen vein



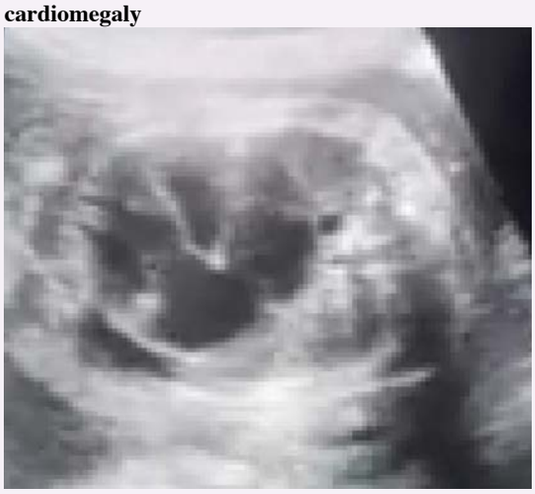
a midline, fusiform, echo free area

ascites in fetal abdomen



non immune hydrops seconder to high output heart failure

cardiomegaly



heart failure

EP-31
Laparoscopik Treatment of Intact Fallopian Tube Torsion Accompanying Paratubal Cyst Torsion

Deniz Akın Gökbel, İsmail Gökbel, Kemal Güngördük, Ahmet Akın Sivaslıoğlu
Department of Gynaecology and Obstetrics, Muğla Sıtkı Koçman University, Muğla, Türkiye

Adnexal torsion constitutes almost 3 percent of surgical emergencies in women. Even though it most commonly occurs among reproductive-age women, it can occurs of all ages until postmenopausal period. Isolated torsion of the tube without ovarian torsion is seen 1:500.000-1:1500000 frequency in reproductive- age women and it's important in differential diagnosis in patients presenting with lower quadrant pain. Benign tubal pathologies are myoma, adenomatoid tumor, paratubal cysts and hydrops tubae. Paratubal cysts are commonly seen in operable stage. They can reach a size of 20 cm in diameter. They are often asymptomatic and slow-growing. Most of them are formed by accessory tubules which identified as hydatid cysts of Morgagni and originated from fallopian tube. If paratubal cysts grow rapidly, torsion was due to this and the treatment consists of surgical excision of the cysts. 22-year-old woman patient who with primer infertility for 5 years was admitted to the M.S.K.U. Training and Research Hospital Obstetrics and Gynecology Department with complaints of abdominal pain, abdominal swelling and abdominal mass was seen on the transvaginal ultrasonography. Ultrasonographic examination demonstrated 8-10 cm in diameter cystic mass at the left adnexa and it was planned that patient had normal tumor markers will be managed by laparoscopic cystectomy. 10*10 cm cyst originating from the left tube was observed intraoperative. Cystectomy and laparoscopic detorsion of the tubal torsion were performed. Methylene blue was given for tubal passage control and it was observed that bilateral open tubal passage. Uterus and ovaries were normal. Hospital stay were 2 days. Patient whom postoperative follow up period was normal was discharged. Pathological diagnosis of cyst was reported as paratubal cyst. We aimed to present the laparoscopic treatment of intact fallopian tube torsion accompanying paratubal cyst torsion at the case of patient who was admitted to clinic with a complaint of chronic pain with this video.

Keywords: Fallopian tube torsion, paratubal cyst torsion, primer infertility

EP-32
Case Report: Mesh Endometrıoma

Mehmet Onur Arslaner, Mehmet Ferdi Kıncı
Kadın Hastalıkları ve Doğum Kliniği, Muğla Sıtkı Koçman Üniversitesi Eğitim ve Araştırma Hastanesi, Muğla, Türkiye

Endometriosis is a common clinical problem in women of reproductive age. When endometriosis is in the form of a well-circumscribed mass, it is called endometrioma. Endometriosis usually involves pelvis, peritoneum, ovaries, pouch of Douglas, and uterosacral ligaments, in addition to abdominal wall, albeit rarely. Meshes are frequently implanted today for the purpose of hernia repair. Synthetic mesh placement has been growing in number with an intent of improving success of certain surgical procedures and prolonging treatment response. With increasing use of meshes, however, mesh-associated complications are coming to light. Such complications cover a broad spectrum including chronic erosion, dyspareunia, pain, infection, formation of abscess and sinus, and injury to rectum, bladder, and vessels. Here, we present a case who previously had undergone surgery due to umbilical hernia and was implanted with a mesh for whom total laparoscopic hysterectomy was indicated as she had uterine myoma and menometrorrhagia refractory to medical treatment. During her surgery, mesh infection was suspected upon which excision was performed and pathology report, in turn, revealed endometrioma.

Keywords: Mesh Endometrioma, Endometrioma, Mesh Complications, Umbilical Hernia, Laparoscopy

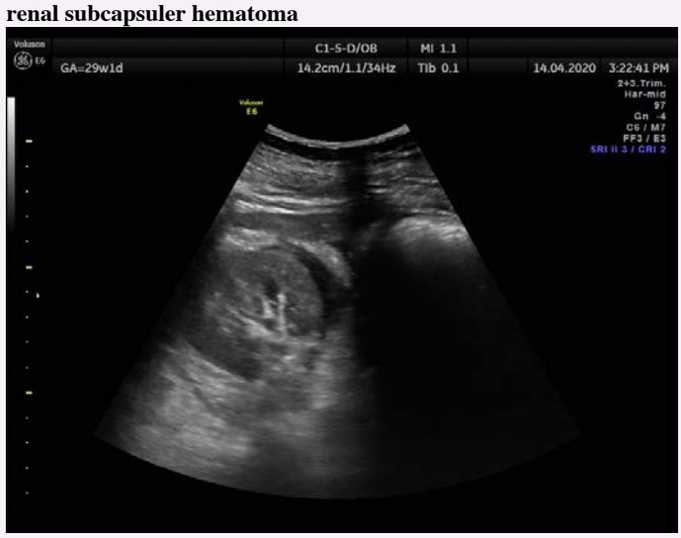
EP-33
Isolated subcapsular renal hematoma in HELLP syndrome

Erdal Şeker, Fatma Başak Sargın
Ankara Üniversitesi, Kadın Hastalıkları ve Doğum Anabilim Dalı, Ankara

Hypertensive disorders during pregnancy, especially severe pre-eclampsia, eclampsia, and HELLP syndrome (Hemolysis, Elevated Liver Enzymes, Low Platelets), are linked to an increase in maternal, fetal, and neonatal mortality and morbidity. Subcapsular renal hematoma, which is rarely seen in severe pre-eclampsia cases, presents with right upper quadrant pain and hypovolemic shock and may be confused with acute abdomen. Subcapsular renal hematoma in pre-eclamptic patients mostly accompanies liver hematoma. This case report presents the clinical management and literature review of an isolated subcapsular renal hematoma in a pre-eclamptic patient, which was complicated with HELLP syndrome and DIC (disseminated intravascular coagulation). Our patient had right upper quadrant pain and hematuria were observed and the diagnosis was confirmed by USG (ultrasonography). The patient was treated with a conservative approach and clinical improvement was achieved without impairment of kidney function. Since early diagnosis and treatment can reduce maternal mortality and morbidity, subcapsular renal hematoma should be kept in mind in patients with pre-eclampsia with an acute abdomen.

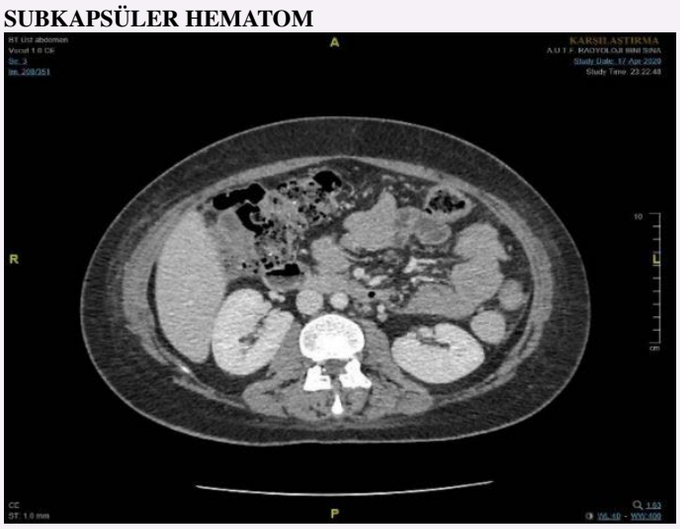
Keywords: Pre-eclampsia, Kidneys, HELLP

renal subcapsuler hematoma

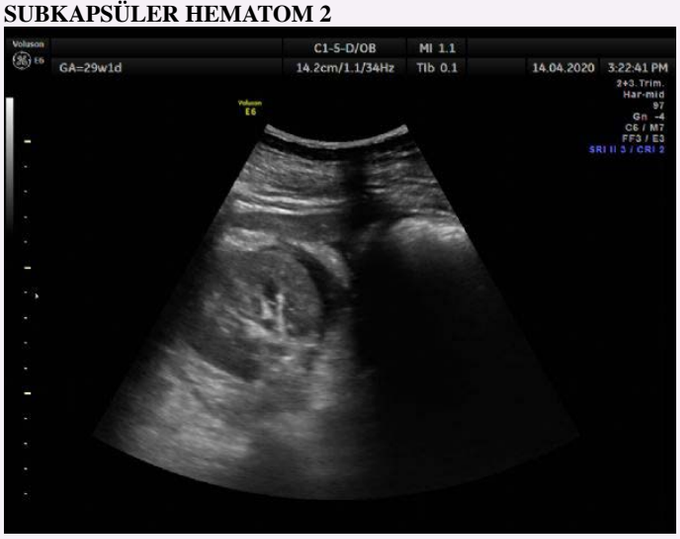


renal subcapsuler hematoma

SUBKAPSÜLER HEMATOM



SUBKAPSÜLER HEMATOM 2



TABLO

Publication	Age	Gestational Week	Gestational Week	Clinical presentation	Acute kidney failure	Imaging / Lateralization	Birth method / treatment	Maternal outcome
Jun et al (8)	41	31	-Superimposed severe preeclampsia -170/130 mmHg	-Left flank pain, hemoglobin decrease	-Yes	USG, MRI / left	-Cesarean section -Hematoma evacuation	-No morbidity
Lee et al (9)	27	34	- Severe preeclampsia -170/130 mmHg	- Left flank pain, hemoglobin decrease	-Yes	USG, CT, MRI /left	-Cesarean section -Conservative treatment	-No morbidity
Kobbie et al (10)	35	37	-Eclampsia, uterine rupture -210/130 mmHg	Hypovolemic shock	-No	USG, CT / bilateral	-Cesarean section +Hysterectomy -Re-laparotomy -Bilateral hypogastric artery ligation	-No morbidity
Kobbie et al (10)	36	Full term	-Postpartum eclampsia -190/120mmHg	-Hypotension, bilateral flank pain	-No	USG, CT / bilateral	-Cesarean section - Conservative treatment	-No morbidity
Anagnostopoulos et al. (12)	27	39	- Severe preeclampsia, placental abruption -160/120 mmHg	-Abdominal pain, Flank mass, hematuria, hypovolemic shock	-Yes	MRI& CT /right	-Vaginal delivery -Right renal artery embolization -Right nephrectomy	-Abscess in the right renal loins - Discharged on post operative day 9
Dhalla et al (11)	28	37	-HELLP syndrome -179/99 mmHg	-Right upper quadrant pain, -Hemoglobin decrease	-No	MRI& CT /right	-Vaginal delivery -Conservative treatment	-Discharged on post operative day 9 -No morbidity

Table 1

EP-34
Fetal Autosomal Recessive Polycystic Kidney Disease: Case Report and Review of the Literature

Miraç Özalp[1], Ömer Demir[2]

[1]Department of Perinatology, Karadeniz Technical University, Trabzon, Turkey

[2]Department of Gynecology and Obstetrics, Karadeniz Technical University, Trabzon, Turkey

AIM: To share our clinical experience and review the literature on prenatal management and postnatal outcomes of autosomal recessive polycystic kidney disease.

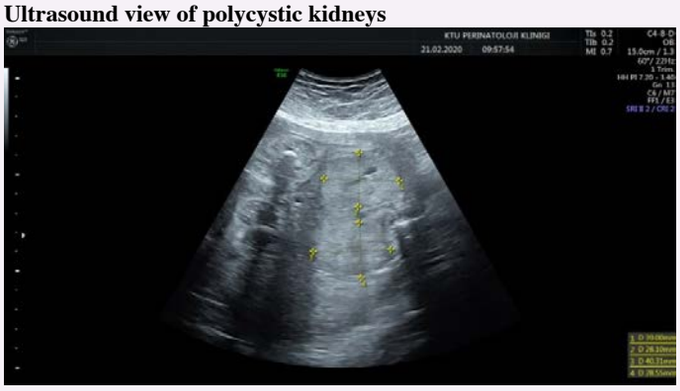
CASE: A 39-year-old, Gravida 4 Parity 3, 23-week pregnant woman was referred to our clinic due to oligohydramnios. The pregnant woman and her husband were cousins, the second child of the family was born at the 35th week and died on the second day after birth due to kidney disease, according to the medical history given by the family. In the current ultrasonographic examination of the pregnant woman who did not have the first and second trimester screening tests of her pregnancy, it was seen that both kidneys in the fetus were in echogenic structure and cystic appearance and were extremely large. Bilateral pelvis renalis could not be distinguished. Oligihydroamnios was present. Fetal development was compatible with the week of gestation and no additional pathology was found. Amniocentesis was applied to the patient. The karyotype result was 46, XY, but a homozygous c.2341C> T (p.Arg781 *) mutation was detected in the PKHD1 gene. The follow-up of the patient continued in our perinatology clinic. No pathology was found in the renal ultrasound performed on the parents and 2 living children. At 32 weeks pregnant, she applied to the emergency delivery room in active labor. On the same day, 2160 g male fetus was delivered vaginally with an Apgar score of 1-5. The newborn died the same day after birth. According to the results of mutation screening in the peripheral blood of the pregnant woman and her husband one week later, homozygous mutation was found in the same location in the pregnant woman and heterozygous mutation in her husband.

CONCLUSION: Autosomal recessive polycystic kidney disease (ARPKD) is a rare disorder, occurring in 1:20,000 live births. ARPKD is caused by variants in the polycystic kidney and hepatic disease gene (PKHD1) on chromosome 6p, which encodes the protein fibrocystin/ polyductin.
The sonographic features of ARPKD can initially appear anytime during gestation. Elongated hyperechogenic kidneys with normal transverse and anteroposterior diameters may be the only ultrasound finding before the third trimester. Serial ultrasound examinations with measurement of kidney dimensions that confirm progressive enlargement and reduction in amniotic fluid volume help establish the diagnosis. Follow-up in pregnancy involves assessment of the kidneys and amniotic fluid volume every two weeks. When there is a presumptive diagnosis of ARPKD, neonatal mortality of 30 to 40 percent due to pulmonary hypoplasia has been reported. Besides, there are also cases who started peritoneal dialysis in the early period of life and had kidney transplantation. Fetal death may occur because of severe oligohydramnios, and neonatal death may occur because of pulmonary insufficiency. Management of delivery in cases of suspected autosomal recessive renal polycystic kidney disease needs to be discussed because of the risk of abdominal dystocia. The route and timing of delivery depend on the size of the fetal abdominal circumference and the gestational age.

Keywords: Amniocentesis, autosomal recessive polycystic kidney disease, pregnancy

Postnatal period

Ultrasound view of polycystic kidneys



EP-35
Case report of uterine rupture after robot assisted laparoscopic myomectomy

Eren Kaya, Özgüç Takmaz, Mete Güngör
Department of Obstetrics & Gynecology, Acibadem University, Istanbul, Turkey

INTRODUCTION: Uterine rupture refers to complete disruption of uterine muscle layers during pregnancy period. Previous uterine surgery is one of the most common risk factor for uterine rupture whether it was performed via laparoscopic or open surgery. Short interval between myomectomy and pregnancy is also another risk factor. However, the timing of gestation according to the type of surgery is still controversial. Although some authors claimed that increased suturing capacity of robotic myomectomy procedure might decrease the possibility of uterine rupture, no evidence could be found on the subject. Here we present a case with uterine rupture after robotic myomectomy in 36th weeks of pregnancy.

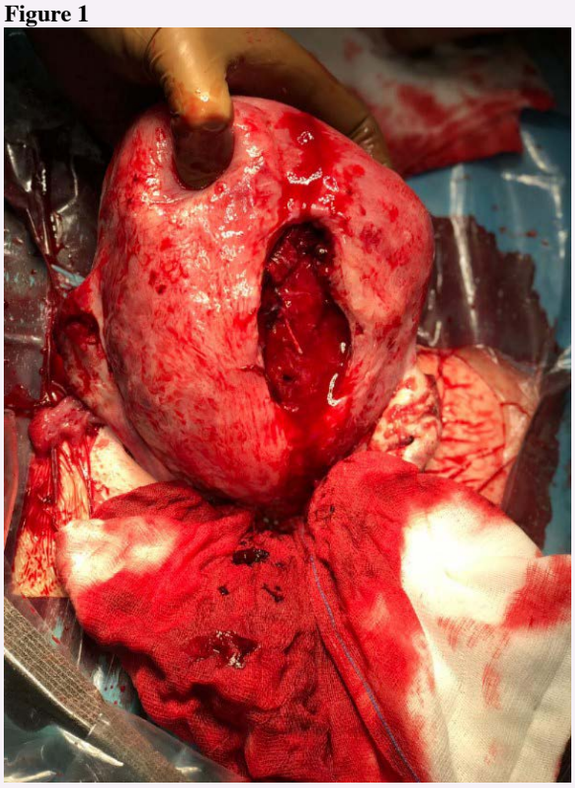
CASE: A 36-year-old primigravid patient with a history of robot assisted laparoscopic myomectomy six months prior to gestation admitted to outpatient clinic at 36th gestational week with the lack of fetal movements, abdominal pain and nausea. On the examination fetal cardiac activity was not observed and there was no sign of placental ablation on ultrasound. The patient's blood pressure was measured as 82/55 mmHg, and the heart rate was 100 bpm. The patient was directly taken to operating room due to possible signs and symptoms of uterine rupture and we observed a large uterine rupture at the site of previous myomectomy and intrauterine lost fetus.

RESULTS: The rupture was repaired, 4 units of erythrocyte suspensions and 2 units of fresh frozen plasma were given intraoperatively. The patient was followed in intensive care unit for one night after the operation. The lowest hemoglobin level was measured as 7.6 mg/dl. The patient was discharged in post-operative day 4 without further complications. The control hemoglobin level in outpatient control visit was measured as 12.9 mg/dl ten days after discharge.

CONCLUSION: The incidence of uterine rupture during pregnancy occurs approximately 1% of the patients who underwent minimally invasive myomectomy. In order to prevent uterine rupture in pregnancy, proper repairing of myomectomy site and timing of the gestation after the surgery seems crucial. Pregnant women who had previous uterine surgery can be followed up more frequently especially in the third trimester for uterine contractions. However, there is still no consensus for follow up protocol for that kind of patients. For the patients with uterine rupture during pregnancy, primary suturing and hysterectomy are the main treatment options. Patient's hemodynamic stability is the leading criteria for the decision of hysterectomy.

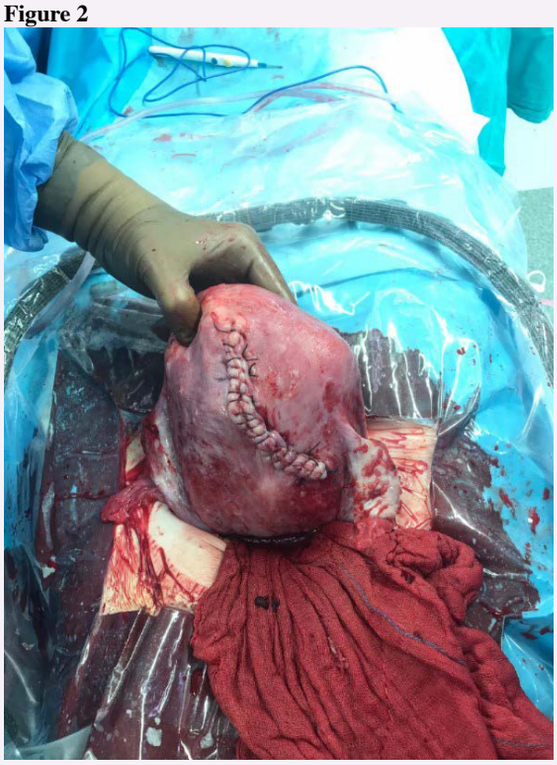
Keywords: Minimally invasive myomectomy, uterine rupture, uterine surgery

Figure 1



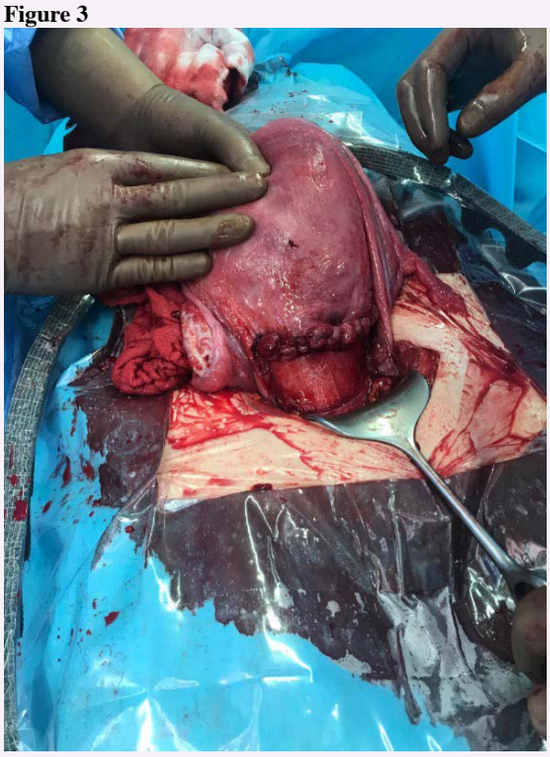
Intraoperative view of ruptured uterus

Figure 2



Uterine rupture in the posterior wall is repaired with primary suturing

Figure 3



Uterine Kerr incision at anterior wall

EP-36
Surgical management of a patient with giant cervical myoma

Farida Hajıbayli, Melike Nur Akın, Burak Sezgin, Ahmet Akın Sivaslıoğlu
Department of Obstetrics and Gynecology, Muğla Sıtkı Koçman University Faculty of Medicine, Muğla, Turkey(1-2-3-4)

OBJECTIVE: Myomas are the most common benign tumors of the uterus that can affect 20-50% of women at late reproductive age. Although most of the myomas are located at the uterine corpus, less than 5% of them can be located at the cervical region and rarely can reach extremely large sizes. In giant cervical myomas, the complaints of urinary incontinence, dyspareunia, prolapse, infections due to prolapse, menometrorrhagia and dysmenorrhea can be seen. Hysterectomy is recommended in giant cervical myomas especially for patients who do not desire fertility. Our aim in this case is to draw attention to the management of a patient with giant cervical myoma that causes urinary incontinence.

MATERIAL-METHODS: 47 years old patient (G5P4Y4A1) applied to our clinic with the complaints of heavy menstrual bleeding, fatigue, dysmenorrhea, dyspareunia, and urinary incontinence. She had a history of cesarean section. In bimanual pelvic examination, uterus was found to be extended to the umbilical level. In vaginal speculum examination, the cervix could not be recognized due to the compression and distortion of the mass. Transabdominal ultrasonography revealed 20x15 cm in diameter cervical solid mass, vesical globe and bilateral grade 1-2 hydronephrosis. The endometrium could not be observed clearly. The uterus was myomatosis in appearance. Magnetic resonance imaging showed a 20-cm diameter solid mass localized at the cervical area (Figure1). The Papanicolaou smear and endocervical canal biopsy results were negative. HPV DNA test was negative. The patient's preoperative biochemical results were as Hg:9.1, Wbc:5.38, Plt: 299. Two units of erythrocyte transfusion was prepared before the operation.

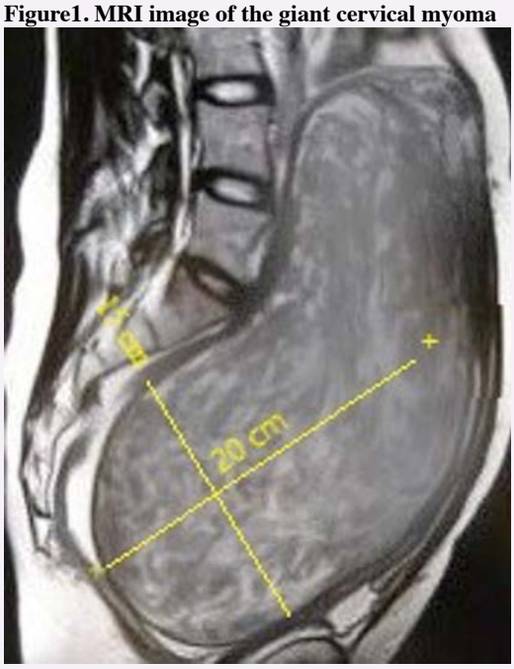
RESULTS: Total abdominal hysterectomy and bilateral salpingo oophorectomy with midline incision was performed. Given the proximity to the cervical mass bilateral ureterolysis was performed. Macroscopic appearance revealed that the uterus was hourglass in shape (Figure2). Histopathology result was confirmed as 20 * 15 cm cervical leiomyoma.

CONCLUSION: The procedure was performed without any complications. The patient had an uneventful course at the postoperative period and she was discharged on the postoperative 3rd day with recommendations. In the postoperative first month follow-up, the urinary incontinence complaints of the patient was regressed.
Difficulties in exploration area and distortion of surrounding pelvic organs should be kept in mind in patients who underwent hysterectomy due to giant cervical myoma. Careful dissection is essential to avoid any injury to surrounding pelvic organs such as ureters, bladder and rectum. Visualization of bilateral ureters is very important in the surgery of these cases, and bilateral ureterolysis may be required.

Keywords: Giant cervical myoma, hysterectomy, ureterolysis, urinary incontinence

Keywords: Giant cervical myoma, hysterectomy, ureterolysis, urinary incontinence

Figure1. MRI image of the giant cervical myoma



MRI image of the giant cervical myoma

Figure2. Macroscopic appearance of the uterus after operation

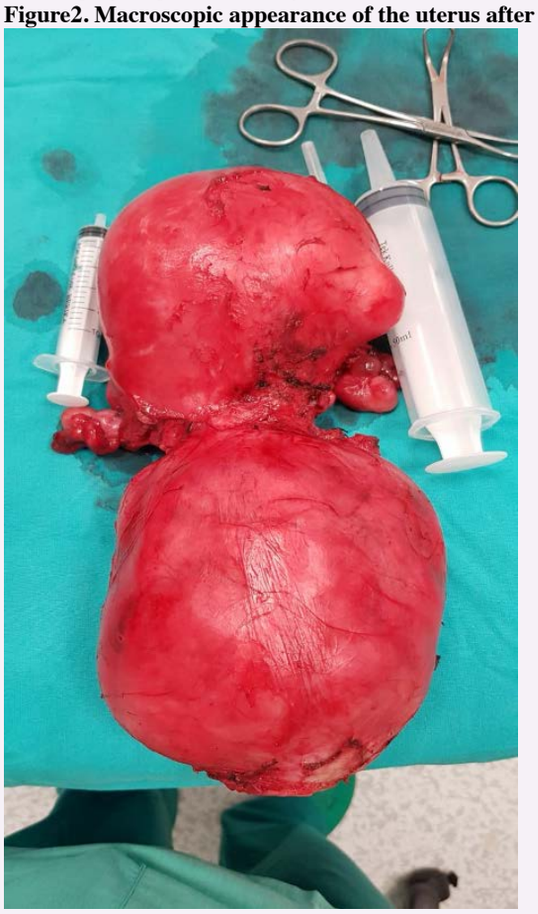


Figure2. Macroscopic appearance of the uterus after operation

EP-38
Spontaneous Complete Uterine Rupture: A Case Report

Eyüp Gökhan Turmuş[1], Barış Çıplak[2], Mehmet Murat Altındağ[1], Eda Adeviye Şahin[1]

[1]Malatya Education and Research Hospital, Obstetrics and Gynecology Clinic, Malatya, Turkey

[2]. Kirsehir Ahi Evran University School of Medicine, Department of Obstetrics and Gynecology, Kirsehir, Turkey

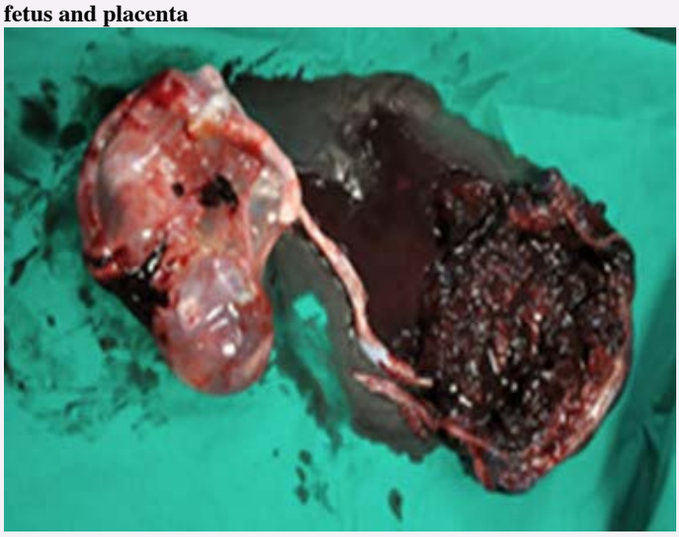
Uterine rupture is an intrapartum emergency with high maternal and perinatal mortality and morbidity, characterized by disruption of the muscular wall integrity of the uterus. It is divided into two according to the involvement of the layers in which the integrity is broken. While, in incomplete uterine rupture (uterine dehiscence), there is separation in the myometrium, the visceral peritoneum, ie the serosa, is intact. In Complete Uterine Rupture, the fetus and its extensions can be palpated in the abdominal cavity with the separation with all layers of the uterus, that is, the full-thickness separation of the serosa covering it. It requires immediate surgical intervention. We present a patient who had multiple cesarean sections and had spontaneous rupture after intrauterine fetal death.

CASE: A 27-year-old G3 P2 Y2 multiparous patient with 2 cesarean sections was admitted to the emergency service at the 26th gestational week. The patient, who had intrauterine fetal death at 26th gestational week as revealed by ultrasound, was admitted to the ward. Induction was not considered for the patient who had manual contractions. Vital and hemogram follow-up was planned. The vital signs of the patient who did not feel significant pain did not deteriorate. The hemogram follow-up performed every four hours proceeded as 11.0, 10.3, 10.5. Uterine rupture was suspected when the intraabdominal mai collection was observed in the control ultrasonography, although the hemogram did not drop and the vital signs did not deteriorate. She was taken to emergency laparotomy. The full-thickness rupture was observed on the uterine incision line (Figure-1) and the fetus was observed in the abdomen. Approximately 500 cc hematoma was observed in the abdomen. After the placenta and its extensions were removed (Figure-2), the uterus was repaired primarily, then the abdomen was cleaned and closed after hemostasis control. The patient was discharged on the second postoperative day since the vitals of the patient were stable and the patient had no active complaints during follow-up.

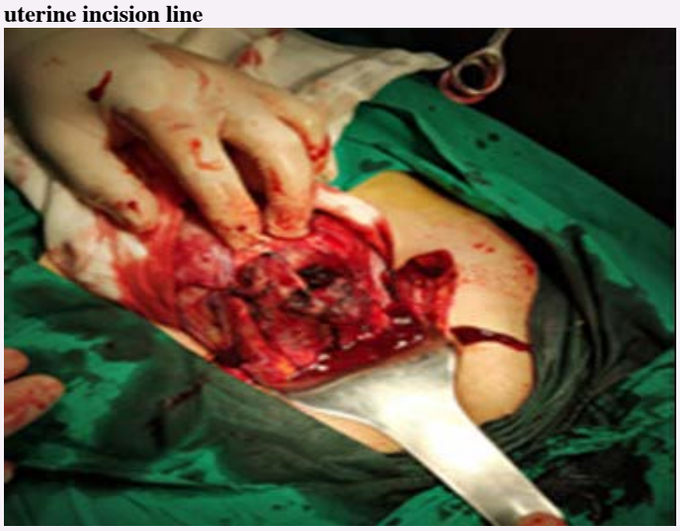
DISCUSSION: The incidence of pregnancy-related uterine rupture is generally reported as 0.07%. Uterine rupture is also divided into two according to whether there has been scarring in the myometrium before. The rate of scarless uterine rupture at delivery has been reported as 0.0033% in general. While the rate of uterine rupture was found to be 0.39% when vaginal delivery was attempted in women who had given birth by cesarean before, this rate was found to be 0.16% in those who underwent elective cesarean section. Naturally, these rates also vary depending on whether it is lower segment or classic, or transverse or vertical. Uterine rupture is a rare but serious obstetric complication that can have very bad consequences for the mother and baby. It is mostly observed in women with uterine scars. Early surgical intervention is the treatment for pregnant women diagnosed with uterine rupture. In conclusion, emergency diagnosis, rapid surgical intervention, and development of neonatal care units will decrease maternal and neonatal mortality and morbidity in uterine ruptures.

Keywords: Complete Uterine Rupture, Spontaneous Uterine Rupture, Uterine Rupture

fetus and placenta



uterine incision line



EP-39
Harlequin Type Congenital Ichthyosis: A Rare Case

Barış Çıplak[1], Eyüp Gökhan Turmuş[2], Mehmet Murat Altındağ[2], Yasemin Işık[2], Mustafa Kara[1]

[1]1 Kirsehir Ahi Evran University School of Medicine, Department of Obstetrics and Gynecology, Kirsehir, Turkey

[2]2 Malatya Education and Research Hospital, Obstetrics and Gynecology Clinic, Malatya, Turkey

Ichthyosis is characterized by cornification of the epidermis due to its desquamation and abnormal differentiation. It is a genetic skin disorder characterized by dry, thickened, scaling skin with severe morbidity and mortality. Harlequin Fetus, the least common and the most severe form of congenital ichthyosis, takes its name from the characteristic face shape of the child. The child's mouth is open and looks like the smile of a clown. It occurs in about 1 in 300,000 births. Here, we present a 24-year-old case with Harlequin-type ichthyosis with common findings who gave birth at 35 gestational weeks and 3 days.

CASE: A 27-year-old patient with a second pregnancy applied to our clinic with complaints of bleeding. There were no other details in the history of the patient who did not have a regular pregnancy follow-up. The patient, who was at 35 weeks and 3 days of gestation according to the last menstrual period, was admitted to the service for bleeding follow-up. Her vaginal examination revealed a 40% effacement with a 2-cm opening. According to the hospitalization ultrasonography, the coming of the single live fetus was compatible with week 34, and no additional pathology was observed. Upon an increase in vaginal bleeding and deterioration of NST during the follow-up, she was taken to the cesarean section with the diagnosis of fetal distress. A male baby of 2380 gr, 47 cm was delivered alive from the patient. Upon observing an anomaly in the baby with spontaneous breathing and who did not require intubation, the newborn team was called and the newborn was taken into intensive care (Figure-1). The baby whose general condition deteriorated was transferred to the university hospital with the prediagnosis of Harlequin-type Ichthyosis as intubated. The baby, who was followed up in neonatal intensive care for about 2 weeks, died due to dehydration and sepsis.

DISCUSSION: Congenital ichthyosis occurs when the hyperkeratosis pattern, which causes thick, horny plaques covering the skin with contraction anomalies in the eyes, ears, mouth and extremities, affects the inutero skin. The skin is covered with armor-like scales and hyperkeratotic epidermis. Harlequin-type ichthyosis is the least common and most severe form. Babies are usually born prematurely, with a severe picture and with a low APGAR score. Most of the time, the diagnosis is made by their external appearance. Usually, death occurs in the first 3 months of life due to sepsis, imbalance in body temperature, feeding problems, and respiratory distress. Babies usually die soon after birth from severe dehydration, sepsis, respiratory failure, hypoglycemia, and renal failure. Mortality in infants was very high until recently, however, the prognosis is much better today. Although systemic retinoids are used effectively in most keratinization disorders, they are also used in Harlequin-type ichthyosis cases. Serious benefits have been achieved from early treatment. Harlequin-type Ichthyosis can be diagnosed in the antenatal period with a careful ultrasonographic examination. Early diagnosis, especially by ultrasonography, in the antenatal period may reduce its morbidity or mortality for the mother and baby.

Keywords: Harlequin Type Ichthyosis, Harlequin Fetus, Congenital Ichthyosis

Harlequin Fetus

EP-40
Postpartum Atypical Takotsubo Cardiomyopathy: A Rare Case

Barış Çıplak[1], İbrahim Aktaş[2], Mehmet Murat Altındağ[3], Eyüp Gökhan Turmuş[3]

[1]Kirsehir Ahi Evran University School of Medicine, Department of Obstetrics and Gynecology, Kirsehir, Turkey

[2]Malatya Training and Research Hospital, Cardiology Clinic, Malatya, Turkey

[3]Malatya Education and Research Hospital, Obstetrics and Gynecology Clinic, Malatya, Turkey

Takotsubo cardiomyopathy is a rare cardiovascular syndrome proceeding with left ventricular dysfunction without coronary artery lesions. Although it is rarely asymptomatic, it causes symptoms such as chest pain, dyspnea, and syncope. Anteroapical ballooning is observed on ventriculography, and regional wall motion abnormalities are detected on echocardiography. In this article, we will present a patient who had a 29-week intra-uterine stillbirth and was diagnosed with Atypical Takotsubo Cardiomyopathy after birth.

CASE: The patient, who had a second pregnancy at the age of 27. In this pregnancy, she applied to our clinic with a complaint of gastroenteritis. The ultrasonography revealed a head-presentation fetus compatible with 29 weeks of gestation with a fetal heartbeat, and sufficient amnion fluid. The patient was hospitalized for hydration and follow-up. The patient, who said that she did not feel the baby movements the next day, was found to have no fetal heartbeat in ultrasonography. It was observed that our patient experienced serious emotional stress in the face of this situation. Pregnancy was terminated by cesarean. On the first postoperative day, the patient had complaints of anginal mild chest pain and dyspnea. The Dynamic Contrast-Enhanced Thoracic Computed Tomography was reported as normal and the Cardiology Department was consulted to evaluate the cardiac etiology of the patient. The ECG revealed suspicious minimal ST elevation in the anterior leads. The anterior wall and apex of the left ventricle were akinetic and ejection fraction decreased to 35% according to echocardiography. Emergency coronary angiography was not considered because the patient's hemodynamics was stable and there were no coronary risk factors, and it was decided that the patient be taken under troponin monitoring first. The troponin values were found to be normal. In the control echocardiography performed 2 days after the first echocardiography, it was seen that the heart functions completely returned to normal. The clinical picture of the patient was evaluated as Atypical Takotsubo Cardiomyopathy due to emotional stress.

DISCUSSION: Takotsubo cardiomyopathy is mostly seen in the elderly, postmenopausal women, and after physical or emotional stress. This condition which is rarely seen in the young age group and pregnant women is also called the Broken Heart syndrome. Emotional stress has been described in 30-40% of the patients. The distribution of sympathetic nerves within the myocardium is associated with segmental wall motion disorder. Sympathetic stimulation is also associated with microvascular dysfunction of the coronaries. The most common ECG finding is ST-segment elevation in the precordial derivations. Cardiac enzymes are often moderately elevated. Cardiac enzymes may be normal in up to 5% of the cases as in our patient. The definitive diagnosis is made by imaging the apex of the left ventricle in a typical hypokinetic and ballooning state by echocardiography or ventriculography and performing coronary angiography showing normal flow in the coronary arteries. It should be kept in mind that Takotsubo Cardiomyopathy may be secondary to emotional stress in the etiology of chest pain and shortness of breath, which we frequently encounter in the postpartum period.

Keywords: Atypical Takotsubo Cardiomyopathy, Postpartum Cardiomyopathy, Broken Heart Syndrome

EP-41
The potential value of red blood cell distribution width in patients with hydatidiform mole

Nazlı Topfedaisi Özkan
TC Sağlık Bakanlığı Ankara Eğitim ve Araştırma Hastanesi

Introduction: Red blood cell distribution width (RDW) is a simple and inexpensive parameter, which reflects the heterogeneity of peripheral red blood cell volume. An increased RDW mirrors a profound deregulation of erythrocyte homeostasis involving both impaired erythropoiesis and abnormal red blood cell survival, which may be attributed to a variety of underlying metabolic abnormalities such as oxidative stres and inflammation. Oxidative stress is related to the deterioration of the prooxidant and antioxidant balance and present in most organs exposed to high oxygen metabolism such as the placenta. Hydatidiform mole (HM) is a gestational trophoblastic disease with two genetically different forms as complete hydatidiform (CHM) and partial hydatidiform mole (PHM). Oxidative stress is one of the risk factors of this disease. The aim of this study was to assess the changes of RDW in patients with HM and analyze the relationship between RDW and hydatidiform mole.

Material and Methods: A retrospective analysis was performed in the Zekai Tahir Burak Women's Health Education and Research Hospital, between January 2017 to March 2018. Fortysix patients who were diagnosed with HM and 50 gestational age-matched healthy pregnant women were included in this study. Blood samples for routine CBC and RDW levels were analyzed.

Results: The RDW values were significantly higher in HM group compared with the control group. We also confirmed that RDW levels were significantly higher in CHM group than PHM group in subgroup analyses.

Conclusion: Our study showed that red blood cell distribution width can be used as a diagnostic and prognostic marker in HM.

Keywords: Inflammation, Hydatidiform mole, Red cell distribution width

Table 1

Variable	Controls (n:50)	Partial Mole (n:16)	Complete mol (n:30)	P value
Age (year)	26.6±7.1	34.2±11.6	39.4±11.1	0.01
RDW (%)	14.5±1.65	16.9±2.18	17.6±2.15	<0.001

Age and RDW in HM and control group

ORGANİZASYON SEKRETARYASI

Figür Kongre Organizasyonları ve Tic. A.Ş.
19 Mayıs Mah. 19 Mayıs Cad. Nova Baran Center No: 4,
34360, Şişli / İstanbul - Türkiye
Tel: 0 212 381 46 00 Pbx - Faks: 0 212 258 60 78
E-posta: obstetrikjinekolojitartismalikonular@figur.net

www.obstetrikjinekolojitartismalikonular.org