3. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

23-26 Eylül 2021

Concorde Luxury Resort | KKTC

"Hibrit Kongre"

www.obstetrikjinekolojitartismalikonular.org

BİLİMSEL PROGRAM ve BİLDİRİ ÖZETLERİ KİTABI

İÇİNDEKİLER

HOŞGELDİNİZ

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

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

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

3. Obstetrik ve Jinekoloji Tartışmalı Konular Kongresine katılın ve şunları yapın:

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

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

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

Saygılarımızla,

M. Faruk Köse
Kongre Eş Başkanı

Ali Ayhan
Kongre Eş Başkanı

Rıfat Gürsoy
Kongre Eş Başkanı

Akın Sivaslıoğlu
Kongre Eş Başkanı

Nejat Özgül
Genel Sekreter

JİNEKOLOJİ VE OBSTETRİK TARTIŞMALI KONULAR DERNEĞİ

Başkan
M. Faruk Köse

Başkan Yardımcısı
Mete Güngör

Genel Sekreter
Nejat Özgül

Sayman
M. Murat Naki

Üye
Ali Ayhan

KONGRE EŞ BAŞKANLARI

M. Faruk Köse
Ali Ayhan
Rıfat Gürsoy
Akın Sivaslıoğlu

KONGRE GENEL SEKRETERİ

Nejat Özgül

BİLİMSEL KURUL

Süleyman Engin Akhan
Şadıman Kıykaç Altınbaş
Murat Api
Mehmet Macit Arvas
Osman Aşıcıoğlu
Cem Soner Atabekoğlu
Mehmet Vedat Atay
Erkut Attar
Turgut Aydın
Ruhşen Aytaç
Selcen Bahadır
Muhterem Bahçe
Mustafa Bahçeci
Abdülkadir Bakay
Özcan Balat
Petek Balkanlı
Mehmet Sinan Beksaç
Sinan Berkman
Tevfik Tugan Beşe
Kutay Ömer Biberoğlu
Telce Ayşen Boza
Nuray Bozkurt
Emel Canaz
Arif Serhan Cevrioğlu
Mehmet Yavuz Ceylan
Mete Çağlar
Ebru Çelik
Çetin Çetin Çelik
Mustafa Çetiner
Nuri Danışman
Ahmet Demir
Talat Umut Kutlu Dilek
Nasuh Utku Doğan
Ozan Doğan
Özlem Dural
Ahmet Fatih Durmuşoğlu
İlkkan Dünder
Evrim Erdemoğlu
Cemal Tamer Erel
Ali Ergün
Serkan Erkanlı
Kubilay Ertan
Özlem Evliyaoğlu
Necati Fındıklı
Ender Gedik
Ahmet Göçmen
Mehmet Gökçü
Pınar Çilesiz Göksedef
Şevki Göksun Gökulu
Hüsnü Görgen
Fatih Güçer
Murat Gültekin
İsmet Gün
Serdar Günalp
Rıza Haldun Gündoğdu
Mete Güngör
Ali Sami Gürbüz
Cemil Gürses
Süleyman Güven
Yılmaz Güzel
Kadir Güzin
Ali Haberal
Servet Özden Hacıvelioğlu
Mehmet Harma
Müge Harma
Recep Has
Mete Işıkoğlu
Ümit İnceboz
Serkan Kahyaoğlu
Osman Fadıl Kara
Yücel Karaman
Fulya Kayıkçıoğlu
Esra Bulgan Kılıçdağ
Yalçın Kimya
Yakup Kumtepe
Tansu Küçük
Ali Küçükmetin
Murat Naki
Rıza Madazlı
Ramazan Mercan
Mehmet Mutlu Meydanlı
Veli Mihmanlı
Muhittin Tamer Mungan
Şafak Olgan
Özay Oral
Adnan Orhan
Uğur Fırat Ortaç
Özgür Öktem
Murat Öz
Sabit Sinan Özalp
Demir Özbaşar
Kemal Özerkan
Kemal Özgür
Ülkü Özmen
Ahmet Aydın Özsaran
Serdar Serin
Ahmet Akın Sivaslıoğlu
Feride Söylemez
Hamdullah Sözen
Veysel Şal
Mehmet Levent Şentürk
Erhan Şimşek
Tayup Şimşek
Özgüç Takmaz
Ömer Lütfi Tapısız
Çağatay Taşkıran
Hasan OnurTopçu
Tayfun Toptaş
Hakkı Gökhan Tulunay
Mert Turğal
Orhan Ünal
Evrim Ünsal
Işın Üreyen
Yusuf Üstün
İbrahim Üzün
Mehmet Ali Vardar
Gülizar Füsun Varol
Doğan Vatansever
Ferda Verit
Kayhan Yakın
Ömer Tarık Yalçın
Ethem Serdar Yalvaç
Cenk Yasa
Mehmet Yılmazer
Ahmet Tevfik Yoldemir
Kunter Yüce
Atıl Yüksel

* Soyadına göre sıralı olarak düzenlenmiştir

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BİLİMSEL PROGRAM

23 Eylül 2021, PERŞEMBE — *SALON 1*

14:00-14:30 **AÇILIŞ TÖRENİ** — M. Faruk Köse

14:30 - 15:30 **OTURUM 1: TÜRKİYE'DE KANSER KONTROLÜ**

Oturum Başkanı: ***H. Gökhan Tulunay***

14:30-14:50	Türkiye'de Kanser Kayıtçılığı	Aysun Ergün
14:50-15:10	Türkiye'de Kanser Kontrol Programı	Murat Türkyılmaz
15:10-15:20	Tartışma	

15:20-15:30 **ARA**

15:30-16:30 **OTURUM 2: İNFERTİLİTE (PANEL)**
OVARYEN REZERV KORUNABİLİR Mİ? BOZULMUŞ OVER REZERVİ DÜZELTİLEBİLİR Mİ?

Oturum Başkanı: ***H. Rıfat Gürsoy***

Panelistler: ***Kutay Biberoğlu, Ahmet Erdem, Özgür Öktem, Sezcan Mümüşoğlu***

Panel Konuları

- Over rezervi nedir, ne değildir?
- Over rezerv testleri; En prediktif olanı hangisi?
- Over rezervini korumak adına yapılacak şeyler var mıdır; yaşam biçimi, beslenme, gıda takviyeleri, ilaçlar vs
- Over rezervini bozan medikal tedaviler, cerrahi girişimler nelerdir?
- Hormonal kontrasepsiyon over rezervini nasıl etkiler?
- Adneksle yönelik cerrahi over rezervini bozar mı?
- Hangi ovaryen kitleler cerrahi gerektirir, her endometrioma çıkarılmalı mıdır?
- Sterilizasyon amacıyla salpenjektomi mi, yoksa konvansiyonel ligasyon mu?
- Histerektomi olgularında yapılan salpenjektomi over rezervini bozar mı?
- Over dokusu, oosit, embriyo dondurulması; Kime, ne zaman, yaş sınırı var mı?
- Bozulmuş over rezervini düzeltmek mümkünmüdür; Stem cell, PRP ve diğer bazı alternatifler çözüm olabilir mi?

16:30-17:00 **ARA**

17:00-18:00 **OTURUM 3: ADNEKSİYEL KİTLELER (PANEL)**

Oturum Başkanı: ***Sinan Özalp***

Panelistler: ***Çağatay Taşkıran, Tayup Şimşek, Hüsnü Çelik, Aydın Özsaran***

Panel Konuları

- Adölesan
- Reprodüktif Dönem
- Postmenopozal

18.00-19.00 **OTURUM 4: İLK TRİMESTER TARAMALARI (PANEL)**

Oturum Başkanı: ***Atıl Yüksel***

Panelistler: ***Seher Başaran, Özlem Pata, İbrahim Kalelioğlu***

Panel Konuları

İlk Trimester Taramaları

•Hücre Dışı Serbest DNA (cfDNA)

24 Eylül 2021, CUMA — *SALON 1*

09:00-09:50 OTURUM 5: TÜRKİYE'DE SERVİKAL KANSER TARAMALARI

Oturum Başkanı: ***Müfit C. Yenen***

09:00-09:20	HPV ve Servikal Kanser Epidemiyolojisi	Ali Ayhan
09:20-09:40	Türkiye Servikal Kanser Tarama Programı	Nejat Özgül
09:40-09:50	Tartışma	

09:50-10:00 ARA

10:00-11:00 OTURUM 6: GEBELİK VE SİSTEMİK HASTALIKLAR

Oturum Başkanı: ***Cenk Sayın***
Panelistler: ***Ragıp Atakan Al, Esra Esim Büyükbayrak, Bilge Çetinkaya Demir, Cihan İnan***

Panel Konuları

- Diabet
- Hipertansiyon
- Kalp Hastalığı

11:00-12:00 KEYNOTE KONUŞMA

Oturum Başkanı: ***Ali Haberal***

Son 60 Yılda Jinekolojik Onkolojideki Gelişmeler — Ali Ayhan

12:00-12:45 UYDU SEMPOZYUMU — MSD

Oturum Başkanı: ***Nejat Özgül***

Türkiye'de HPV ve HPV Aşılarının Önemi — M. Faruk Köse

12:45:13:30 ARA

13:30-14:30 OTURUM 7: HER YÖNÜ İLE LUTEAL FAZ (PANEL)

Oturum Başkanı: ***Sezai Şahmay***
Panelistler: ***İsmail Çepni, Mehmet Çetinkaya, Ata Topçuoğlu, Emre Göksan Pabuçcu***

Panel Konuları

- Kısaca progesteron ve ve luteal faz fizyolojisi
- Lueal faz yetmezliği fizyopatolojisi
- Sebep progesteron yetersizliğimi, reseptör defektimi, bazen her ikisimi
- Kısa luteal faz ayrı bir antitemi
- Stimüle sikluslarda luteal faz yetmezliği niçin daha sık görülür
- En doğru tanı hangisi; midluteal progesteron ölçümü, reseptör tayini; histopatolojik günleme
- Stimüle sikluslarda daha sık görüldüğü gerçeğinden yola çıkarak her stimüle siklusta luteal destek yapılmalımıdır
- Luteal destek için hangi preparat ve hangi yol optimaldir
- IUI ve IVF/ICSI'de luteal destek ne zaman başlamalı? Ne kadar devam etmelidir? Progesteron mu, progestinler mi?
- Prematür LH piki ve geç proliferasyon fazında erken progesteron yükselmesinin olumsuz sonuçları nelerdir?

14:30-15:00 ARA

24 Eylül 2021, CUMA — *SALON 1*

15:00-16:00 OTURUM 8: ÜROJİNEKOLOJİ (PANEL)

Oturum Başkanı: ***Akın Sivaslıoğlu***
Panelistler: ***Yakup Kumtepe, Yusuf Üstün, Derya Kılıç, Eren Akbaba***

Panel Konuları

Antiinkontinans: Kime, hangi cerrahi?
• TVT, TOT, RetroTOT, tek insizyonlu mini askılar, Burch
Askı cerrahisi komplikasyonları yönetimi
Apikal prolapsus tedavisinde laparoskopik yöntemler
• L/S Sakrokolpopeksi, Lateral Süspansiyon, Pektopeksi
Apikal prolapsus yönetiminde vajinal yöntemler
PIVS, Sakrospinöz fiksasyon, İliokoksigeal fiksasyon
Sistosel tanısı nasıl konulmalıdır? Etkin tedavi nedir?
Rektosel tanısı nasıl konulmalıdır? Etkin tedavi nedir?
Vajinal histerektomi'de ip uçları nelerdir?
Pelvik taban egzersizlerinin ürojinekolojik semptomlardaki yeri

16:00-16:45 UYDU SEMPOZYUMU

GENSENTA

Oturum Başkanı: ***Akın Sivaslıoğlu***

Aşırı Aktif Mesanede Güncel Durum — Hüseyin Tarhan, Derya Kılıç

16:45-17:45 OTURUM 9: SEZARYEN SONRASI SORUNLU DURUMLAR (PANEL)

Oturum Başkanı: ***Selim Büyükkurt***
Panelistler: ***Mehmet Serdar Kütük, Ebru Alıcı Davutoğlu***

Panel Konuları

• İstmosel
• Sezeryan Skar Gebeliği
• Plasenta Yapışma Anomalileri

18:00-19:00 SÖZEL BİLDİRİ - 1

Oturum Başkanı: ***Yakup Baykuş***

SS-01	Management and clinical results of Covid-19 positive pregnant women in our pandemic center	*Alev Esercan*
SS-02	Is it rational to make fetal reduction in multifetal pregnancies?	*Alev Esercan*
SS-03	Ovarian torsion in the third trimester of pregnancy	*Fatih Aktoz*
SS-04	MRI is more than diagnosing endometrioma in rectosigmoid endometriosis	*Cemil Gürses*
SS-05	Effects of estrogen use following operative hysteroscopy on IVF outcomes in cases with T-shape uterus	*Ahmet Emin Mutlu*
SS-06	Rare cases of ectopic molar pregnancy	*Nazlı Aylin Vural*
SS-07	Laparoscopic Repair of Isthmocele With Hysteroscopic Assistance, a Simple Technique with Marking Sutures	*İpek Betül Özçivit*

24 Eylül 2021, CUMA — *SALON 2*

10:00-11:00 **OTURUM 10: MENOPOZ (PANEL)**

Oturum Başkanı: ***Fatih Durmuşoğlu***

Panelistler: ***Hakan Seyisoğlu, Sezai Şahmay, Tamer Erel, Levent Şentürk***

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?

13:30-14:30 **OTURUM 11: DOĞUM SONU KANAMALARINDA JİNEKOLOJİK ONKOLOJİNİN YERİ (PANEL)**

Oturum Başkanı: ***Yaprak Üstün***

Panelistler: ***Samet Topuz, Filiz Avşar, M. Murat Naki, Banu Kılıçaslan***

Panel Konuları

- Tanı
- Tıbbi Tedavi
- Cerrahi Yaklaşım

14:30-15:00 **ARA**

15:00-16:00 **OTURUM 12: ANTENATAL FETAL İYİLİK HALİ (PANEL)**

Oturum Başkanı: ***Özlem Pata***

Panelistler: ***Serdar Yalvaç, Mert Turğal, Deniz Karçaaltınçaba, Hakan Timur***

Panel Konuları

- Değerlendirme yöntemleri
- Testler ne zaman, kime, hangi Aralıklarla
- USG ve Doppler USG'nin yeri var mı?
- Anormal sonuçlarda yönetim

16:45-17:45 **OTURUM 13: İNFERTİLİTEDE ANDROLOJİNİN YERİ (PANEL)**

Oturum Başkanı: ***Esat Orhon***

Panelistler: ***Serdar Günalp, Kaan Aydos, Tansu Küçük, Lale Karakoç Sökmensüer***

Panel Konuları

Fertilizasyon öngörüsünde önem kazanan klasik ve yeni parametreler

- Yeni WHO manuel ne gibi değişiklikler getirdi?
- Değer kazanan yeni testler
- Erkek infertilitesinde genetik testler, ne zaman?
- Başarılı bir IUI için sperm parametrelerinde bir eşik değer var mıdır?
- IUI sikluslarında ovulasyon tetikleme kriterlei nelerdir, inseminasyon için en uygun zaman hangisidir?
- KOS+IUI sikluslarında GnRH antagonistleri, Letrozol kullanılmalımıdır. Luteal destek gerekli midir?
- Azoospermiye güncel yaklaşım, değişen bir şey var mı?
- Tekrarlayan TESE'lerde başarı şansı nedir?
- OPU günü taze TESE mi, yoksa önceden dondurulmuş çözülmüş sperm mi?
- ICSI başarısını artıran uygulamalar
- Sperm parametrelerini düzelten medikal tedaviler var mıdır?
- ROSI'de güncel durum nedir?
- Stem cell, PRP uygulamaları bir ümit olabilir mi?

25 Eylül 2021, CUMARTESİ — *SALON 1*

09:00-10:00 **OTURUM 14: TEKRARLAYAN GEBELİK KAYIPLARI**

Oturum Başkanı: ***Nuri Danışman***
Panelistler: ***Serdar Ceylaner, Can Tekin İskender, Cem Şanhal***

- Etyoloji
- Risk Faktörleri
- Tanı
- Tedavi

10:00-11:00 **OTURUM 15: SERVİKS PREMALİGN LEZYONLARI (PANEL)**

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

- Yeni ASCCP Sitolojik Yönetim Kılavuzu
- Yeni ASCCP Histolojik Yönetim Kılavuzu
- Tedavi Yöntemleri
- Takip

11:00-11:30 **ARA**

11:30-12:00 **KEYNOTE KONUŞMA**

Oturum Başkanı: ***M. Faruk Köse***

Corona Enfeksiyonlarında Doğrular ve Gelecek — Mehmet Ceyhan

12:00-12:45 **UYDU SEMPOZYUMU** — Exeltis Rethinking healthcare

Oturum Başkanı: ***Erol Tavmergen***

Vajinit Tedavisinde Yeni Çalışmalar — Fatih Durmuşoğlu, Ferruh Acet

12:45-13:30 **UYDU SEMPOZYUMU**
GEBELİK, BESLENME VE VİTAMİNLER — VITABIOTICS SCIENCE OF HEALTHY LIVING

Oturum Başkanı: ***Aytaç Yüksel***

12:45-13:05	Gebelik bekleyen kadında beslenme, vitaminler ve folik asit desteğinin önemi	Emine Karabük
13:05-13:25	Gebelikte demir eksikliği desteği nasıl yapılmalı?	Özgüç Takmaz
13:25-13:30	Tartışma	

25 Eylül 2021, CUMARTESİ — *SALON 1*

13:30-14:30 OTURUM 16: PROGESTERON (PANEL)

Oturum Başkanı: ***M. Cihat Ünlü***
Panelistler: ***L. Cem Demirel, Özlem Moraloğlu Tekin, Davut Güven, Turgut Aydın, Esra Kuşçu***

Panel Konuları

- Yapısı ve Preparatlar
- Preterm Doğumda
- İnfertilitede
- Anormal Uterin Kanamada
- Onkolojide

14:30-15:00 ARA

15:00-16:00 OTURUM 17: İNFERTİLİTEDE HİSTEROSKOPİNİN YERİ (PANEL)

Oturum Başkanı: ***Bülent Urman***
Panelistler: ***Ahmet Zeki Işık, Barış Ata, Gürkan Bozdağ, Esra Bulgan Kılıçdağ***

Panel Konuları

İnfertil kadında histeroskopi mutlaka yapılması gerekli bir işlem midir?

- Hangi fizik muayene ve ultrasonografi bulguları histeroskopi için endikasyon oluşturur
- Tekrarlayan implantasyon başarısızlığında histeroskopinin yeri nedir?
- Polip ya da myom mevcut olan infertil hastalarda hangi durumda histeroskopi gereklidir?
- Uterusun konjenital ya da akkiz yapısal bozukluklarında (septum, dismorfik uterus, sineşi) histeroskopinin yeri

16:00-17:00 OTURUM 18: İNTRAPARTUM DOĞUM YÖNETİMİ (PANEL)

Oturum Başkanı: ***Gökhan Yıldırım***
Panelistler: ***Aytaç Yüksel, Ahmet Tayyar, Tuğba Saraç Sivrikoz***

Panel Konuları

- Fetal İyilik Hali Nasıl Değerlendirilmeli?
- Doğum İndüksiyonu, Kime, Ne Zaman, Nasıl?
- Doğum İndüksiyonunda Kullanılan Ajanlar ve Yöntemler
- Ne zaman Vaginal Doğum, Ne Zaman Forceps ve Vakum, Ne Zaman Sezaryen?

17:00-18:00 SÖZEL BİLDİRİ - 2

Oturum Başkanları: ***Derman Başaran, Emine Karabük***

SS-08	Giant Borderline Musinous over tumor determined insidentally during caserian	*Şeyma Dağlıtuncezdi Çam*
SS-09	Application of Bakri Balloon in postpartum hemorrhage after cesarean section: A tertiary center experience	*Anil Ertürk*
SS-10	Gynecologic Mullerian Anomalies: Unicorn Uterus	*Gazi Güner*
SS-11	Twin pregnancy in rudimentary horn	*Aysegul Bestel*
SS-12	Concurrent endometrial cancer in women with atypical endometrial hyperplasia	*Gülnur Tanrıverdi Kılıç*
SS-13	The effect of anesthesia mode on maternal and neonatal outcomes in placenta previa cases	*Emine Kırşan*
SS-14	Genital ulcer in adolescent	*Esra Tamburacı*

25 Eylül 2021, CUMARTESİ *SALON 2*

10:00-11:00 **OTURUM 19: KOZMETİK VE FONKSİYONEL JİNEKOLOJİK CERRAHİ (PANEL)**

Oturum Başkanı: ***Akın Sivaslıoğlu***
Panelistler: ***Sevtap Hamdemir Kılıç, Gökmen Sukgen***

Panel Konuları

- Labioplasti, Hudoplasti, Vajinoplasti teknikleri
- Platelet Rich Plasma (PRP) hazırlanması
- shot, G Shot, Vulvar Erojen Ağ PRP uygulamaları
- Vajinal hiyaluronik asit uygulamaları
- Labium majus dolgu uygulamaları
- Vajinal sıkılaştırmada 'ip' uygulamaları

13:30-14:30 **OTURUM 20: MENSTURASYON VE ANORMAL UTERİN KANAMALAR (PANEL)**

Oturum Başkanı: ***M. Mutlu Meydanlı***
Panelistler: ***Fuat Demirkıran, Çetin Çelik, Serdar Serin, Coşkun Salman***

Panel Konuları

- Tanı
- Tıbbi Tedavi
- Cerrahi Yaklaşım

15:00-16:00 **OTURUM 21: PRETERM DOĞUM (PANEL)**

Oturum Başkanı: ***Sermet Sağol***
Panelistler: ***Özgür Deren, Tuncay Nas, Sabahattin Altunyurt***

Panel Konuları

- Risk Faktörleri, Tanı
- Tokolitik Ajanlar
- Progesteron
- Cerrahi Yaklaşım
- Doğum Şekli

16:00-17:00 **OTURUM 22: MİNİMAL İNVAZİV CERRAHİ (PANEL)**

Oturum Başkanı: ***Mete Güngör***
Panelistler: ***Kemal Özerkan, Evrim Erdemoğlu, Salih Taşkın, Burak Karadağ, M. Murat Naki***

Panel Konuları

- Laparoskopik histerektomide tartışmalı konular
- Şüpheli adneksiyel kitlelerde tartışmalı konular

25 Eylül 2021, CUMARTESİ — *SALON 2*

17:00-18:00 **SÖZEL BİLDİRİ - 3**

Oturum Başkanları: ***İsmail Güler, Özgüç Takmaz***

SS-15	Can laboratory findings and symptoms predict ovarian torsion in patients presenting with ovarian masses and pelvic pain?	*Murat Gözüküçük*
SS-16	Extraperitoneal lymph Node Dissection in Cervical Canser: Laparoscopic Paraaortik Bulky Lymph Node Dissection	*Gazi Güner*
SS-17	diagnosing ovarian torsion in female patients admitted to a training and research hospital	*Necdet Öncü*
SS-18	Endometrıum changes after delivery	*Gülden Anataca*
SS-19	Analyse of the ce¬sarean birth rate according to Robson ten groups classification system.	*Ali Buhur*
SS-20	Analyse of the cesarean birth rate according to Robson 10 groups classification system	*Ali Buhur*
SS-21	Early Postoperative CT at Primary Cytoreductive Surgery	*Edis Kahraman*
SS-22	Analysis of the pregnancy outcomes in pregnant women with COVID-19	*Mustafa Deveci*

26 Eylül 2021, PAZAR — *SALON 1*

09:00-10:15 **SÖZEL BİLDİRİ**

Oturum Başkanı: ***Emine Karabük***

10:15-11:30 **SÖZEL BİLDİRİ**

Oturum Başkanı: ***Özgüç Takmaz***

11:30-12:00 **Akılcı İlaç Sunumu**

Konuşmacı: ***Esra Özbaşlı***

12:00 **KAPANIŞ**

3. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

23-26 Eylül 2021 / Concorde Luxury Resort | KKTC

SÖZLÜ BİLDİRİLER

SS-01

Management and clinical results of Covid-19 positive pregnant women in our pandemic center

Alev Esercan[1], Emre Ekmekci[2], Melek Hamidanoglu[3], Osman Yuksekyayla[4]
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[2]Department of Perinatology,Sanliurfa Education and Training Hospital,Sanliurfa,Turkey
[3]Department of Infectious Diseases,Sanliurfa Education and Training Hospital,Sanliurfa,Turkey
[4]Department of Internal Medicine,Sanliurfa Education and Training Hospital,Sanliurfa,Turkey

Nowadays, COVID-19 infection is the greatest global health problem and is being described as the worst tragedy after the Second World War, by lots of countries. In Turkey, the first case is declared on March 11, 2020. The number of cases diagnosed are increasing quickly since then. Pregnancy is a special issue due to poor prognosis of viral pneumonias during pregnancy. According to our experience, viral infections are going more severe during pregnancy and pregnant women are more susceptible to coronavirus infections and poor perinatal outcomes. In this study, we aimed to describe management, clinical results, obstetric and neonatal outcomes of Covid-19 RT-PCR positive pregnant women in our pandemic center. This study was a national prospective cohort study between March 11, 2020 and September 30, 2020. Only Covid-19 PCR positive pregnant women are included in this study. Covid-19 PCR negative and clinically suspicious pregnant patients weren't enclosed within the study population. Also, pregnant patients who had radiological findings compatible with Covid-19 infection were not included in the study if their Covid-19 PCR tests were negative.

Between march and september 2020; 3552 patients were hospitalized in pandemic services and out of them 104 pregnant women were diagnosed as Covid-19 disease proven by RT-PCR test. Compatible radiologic findings for COVID-19 were positive in 39 (37%) cases. A Rhesus positive was the most common blood group (83%). 45% of patients had blood group A. Pneumonia rate was 13%.

40% of our patients delivered during the study period and 22 (53%) patients out of them were delivered by cesarean. Ninety one cases (87.5 %) had mild COVID-19. Respiratory support was required in 3 (2%) cases and all of these patients received nasal oxygen therapy. One of the cases were admitted to ICU and intubated.

This patient had a cardiac ejection fraction of 30% and died after 5 days of hospitalization with diagnosis of sudden cardiac arrest/ postpartum cardiomyopathy. The mean length of hospital remain was 5 days. In our study, no virus was detected within the nasopharyngeal and/or oropharyngeal swabs of infants. Also, placentas of abortion materials were tested about Covid-19 and all of them were negative.

In conclusion, the clinical course of COVID-19 during pregnancy appears to be mild. We recommend testing of patients with history of close contact even they are asymptomatic. The hospitalization of all pregnant women,and management of them by multidisciplinary team is also recommended.

Keywords: Covid-19, pregnancy, pneumonia, cesarean

SS-02

Is it rational to make fetal reduction in multifetal pregnancies?

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[2]Department of Perinatology,Sanliurfa Education and Training Hospital,Sanliurfa,Turkey

INTRODUCTION: Nowadays, because the pregnancy is postponed to older ages, applications to assisted reproductive techniques are rising. The rate of multiple pregnancy also increases in association with this. While multiple pregnancies are qualified as high risk pregnancies, preterm delivery is the most common cause of morbidity and mortality in triplet pregnancies.

Although the studies indicate a positive effect of multifetal pregnancy reduction on pregnancy outcomes, procedure associated pregnancy losses should be kept in mind. The aim of our study is to evaluate pregnancy outcomes after multifetal reduction procedures performed in triplets and higher multiple pregnancies obtained with assisted reproductive treatments and to compare the outcomes in the group without reduction. Patients with a history of habitual abortion or preterm delivery were excluded from the study.

METHODS: The pregnancies obtained after ovarian hyperstimulation and underwent multifetal reduction at the Perinatology Clinic of Sanlıurfa Training and Research Hospital between July 2017 and May 2021 were retrospectively evaluated. The ovarian hyperstimulation methods applied, total number of fetuses at the beginning, the pregnancies that were undergone to reduction and obstetric results of pregnancies were recorded. In addition, the obstetric outcomes of triplet pregnancies that were obtained by ovarian hyperstimulation and without reduction were also evaluated in the same period.

RESULTS: During this period, 15 multifetal reduction procedures were performed due to multiple pregnancies that were obtained after total ovarian hyperstimulation. In all cases targeted number of fetuses after the procedure was two. Reductions were performed from five to twins in one case, from triplets to twins in six, and from quadruplets to twins in eight cases. Total abortion occurred within the first week after the procedure in one case with twin reduction from five to twins and in two cases with reduction from quadruplet to twins. Patients preferred to continue pregnancies without reduction at 3 quadruplet, 1 sextile and 31 triplet pregnancies that were obtained by ovarian hyperstimulation and no abortion observed on their follow-up. There was no statistically difference between multifetal reduction group and non-reduction group according to age and gravidity($p>0.05$). All patients gave birth by cesarean section. Mean gestational age at birth in reduction group was 34.6± 1.66 (32-38), while in non-reduction group was 31.52±2.36 (26-34) gestational weeks. There was statistically difference between groups according to gestational age at birth($p<0.01$). Gestational week at birth was lower in non-reduction group.

CONCLUSION: Although there is a risk of abortion, multifetal reduction may be beneficial in preventing preterm delivery and the associated adverse consequences. However, early and late neonatal outcomes between groups should be evaluated.

Keywords: multifetal reduction, multiple pregnancy, ovarian hyperstimulation

SS-03

Ovarian torsion in the third trimester of pregnancy

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Introduction: Ovarian torsion in the third trimester of pregnancy is rare. Approximately 15% of ovarian torsion cases occur during pregnancy. Most of them are diagnosed in the first trimester. Diagnosis of ovarian torsion cases in third trimester is challenging because using ultrasound in the diagnosis is difficult due to the size of uterus.

Case presentation: A 28 years-old, gravida 1 parity 0, pregnant patient was admitted to the emergency room with severe right upper abdominal pain at 35 weeks and 2 days of gestation. She was diagnosed with dermoid cyst at 6 weeks of pregnancy. She had no other known disease. No pathology was detected in the pregnancy follow-ups. On ultrasonography, a fetus compatible with 35 weeks and a mass of 11x7 cm in the right upper quadrant of abdomen were observed. Leukocytosis and elevated C-reactive protein were detected. Ovarian torsion was suspected via Doppler ultrasonography. Magnetic resonance imaging was performed to rule out other causes of acute abdomen (Figure 1). No causative pathology was detected. A general surgeon evaluated the patient. No additional recommendations were given. We decided to operate the patient with diagnosis of dermoid cyst torsion.

We entered the abdomen with lower median incision. The uterus was observed in size compatible with the gestational week. A 10-cm mass was seen in the right ovary. Right adnexal torsion was observed (Figure 2). Adnexal detorsion and ovarian cystectomy were performed (Figure 3). It was observed that the blood supply of the ovary returned to normal. The patient was discharged without complications. The pathology result was reported as dermoid cyst.

At 40 weeks and 1 day of pregnancy, the patient was hospitalized due to contraction and 4 cm cervical dilation. A 2525-g girl baby was delivered. No complications were observed in the postpartum period.

Discussion: Ovarian torsion in pregnancy is often seen in the first trimester. Functional and dermoid cysts are responsible for two-thirds of the etiology of ovarian torsion in pregnancy. The risk of torsion increases in cases with dermoid cysts in the second and third trimesters due to the enlargement of the uterus towards to upper abdomen.

Non-specific symptoms which are similar to ovarian torsion cases in the normal population such as abdominal pain, nausea and vomiting can be observed during pregnancy. It has been reported that 15% of the patients were misdiagnosed in second and third trimesters of pregnancy due to the difficulties in diagnosis compared to the first trimester. This may increase the risk of maternal and fetal morbidity. For this reason, as in our case, evaluation of the adnexa with ultrasonography in the early weeks of pregnancy, noting the existing pathologies and following them during pregnancy will help to detect clinical conditions that are difficult to diagnose during pregnancy. After diagnosis of ovarian torsion, surgical intervention is required. Although laparoscopic detorsion is a feasible and safe method in pregnant patients, further studies are needed to determine the optimal approach especially in third trimester.

Keywords: ovarian torsion, pregnancy, third trimester

Figure 1

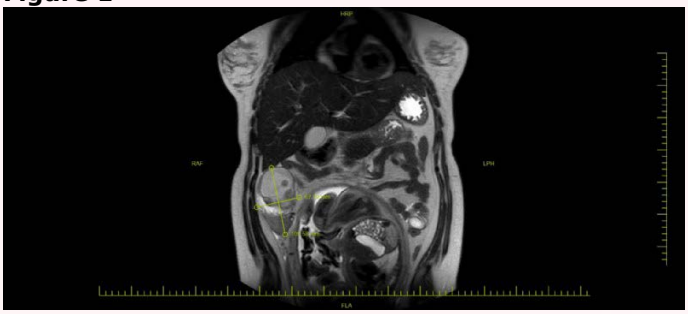


Figure 2

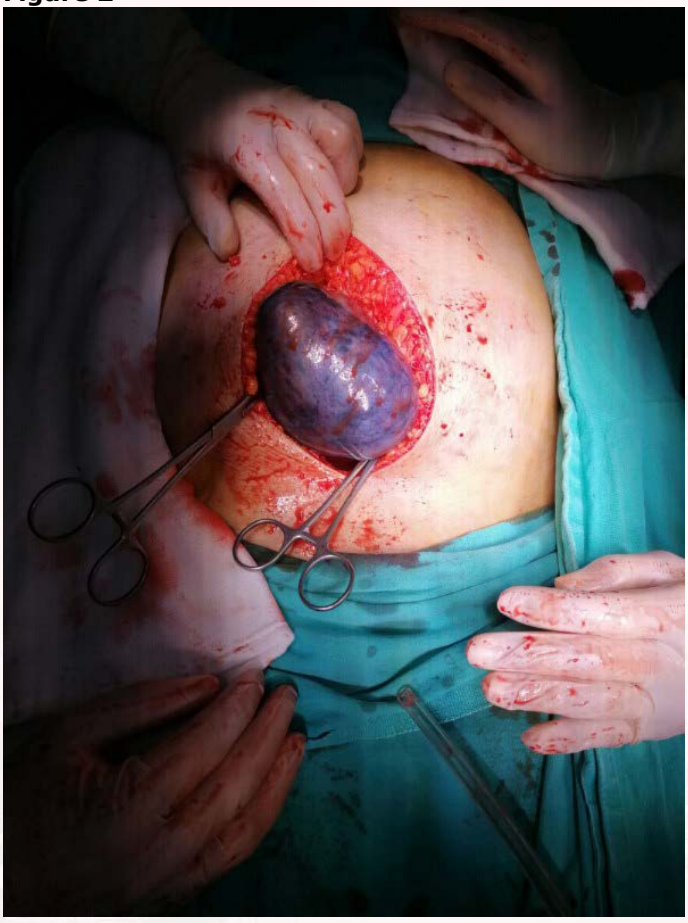
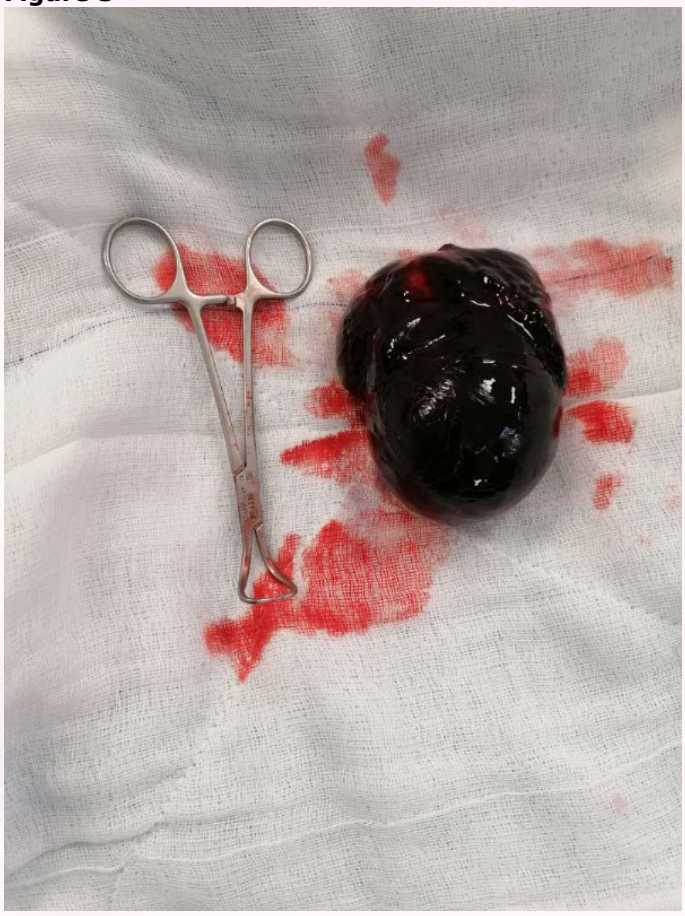


Figure 3



SS-04

MRI is more than diagnosing endometrioma in rectosigmoid endometriosis

Cemil Gürses
Sağlık Bilimleri Üniversitesi, Antalya Eğitim ve Araştırma Hastanesi, Radyoloji Kliniği

AIM: To diagnose or confirm the concomitant rectosigmoid involvements of deep infiltrative endometriosis, MRI is the second line imaging and the only non-invasive modality used. However, TVUS and MRI findings are usually contradictory but endometriomas and it is a common problem in everyday practice. The correlation of TVUS and MRI has crucial importance for the treatment strategy.

It is aimed to define the capability of MRI performed with two different techniques for confirmation of TVUS findings

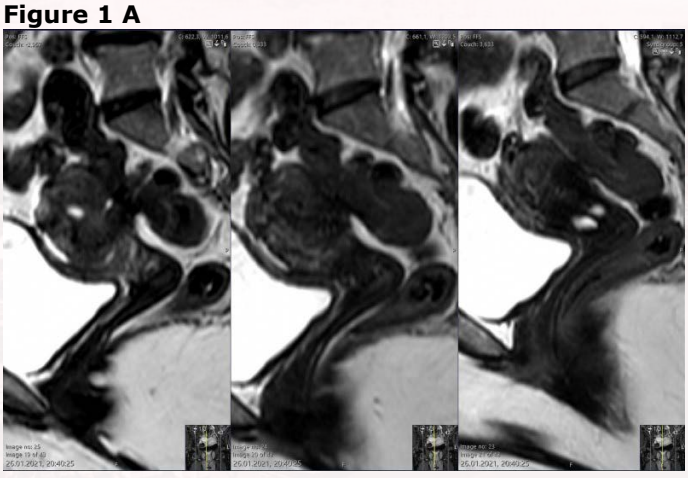
MATERIALS-METHODS: Two different MRI techniques, based on patient preparation, were used; 41 patients in group A with the standard technique (ST), which included the usual procedures and 27 patients in group B with the modified technique (MT), which was determined with some optional procedures defined by the European Society of Urogenital Radiology. In two groups, MRI scans were obtained with two different patient preparation techniques with or without; a bowel enema, an anti-peristaltic agent and a vaginal plus rectal opacification with saline. The 11 of 68 patients in group C had double MRI examination both with ST previously and MT recently (Group C). The results were compared with the TVUS findings.

RESULTS: MRI with the standard technique was able to confirm the endometrioma only, whereas MRI with the modified technique was confirmed in all of the rectosigmoid involvements (Table 1).

CONCLUSION: MRI in suspicion of rectosigmoid endometriosis should be performed with a modified technique to prevent false-negative diagnoses and related complications and to achieve a consensus between gynaecologists and radiologists (Fig.1).

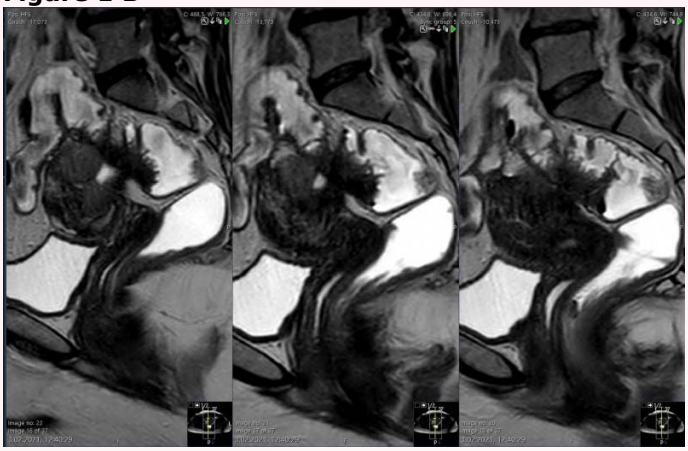
Keywords: Endometriosis, Transvaginal Ultrasonography, Magnetic Resonance Imaging, Deep infiltrating endometriosis

Figure 1 A



Three consecutive slices of T2W MRI examination with ST in the sagittal plane. The abnormality in the anterior wall of the sigmoid is barely visible for inexperienced ones.

Figure 1 B



Three consecutive slices of T2W MRI examination with MT in the sagittal plane of the same patient in figure 1A. The abnormality, which is demonstrative with the Indian headdress sign, is visible even for inexperienced ones.

Table 1:

	No of patients	No of patients with bowel findings	No of findings in patients by TVUS	No of confirmation of TVUS bowel findings by ST MRI	No of confirmation of TVUS bowel findings by MT MRI	Percentage (%) of the bowel findings confirmed by MRI
Group A	41	24	29	1		3,4
Group B	27	18	25		23	79,3
Group C	11 in group A	6	10	1		10,0
Group C	11 in group B	7	13		13	100,0

The number of patients, bowel findings and the percentage of confirmations by ST and MT MRI.

SS-05

Effects of estrogen use following operative hysteroscopy on IVF outcomes in cases with T-shape uterus

Ahmet Emin Mutlu
Hüma Obstetrics and Gynecology Hospital, IVF Center, Kayseri, Turkey

OBJECTIVE: The aim of the study was to evaluate effects of estrogen use following operative hysteroscopy on IVF (in vitro fertilization) outcomes in patients with T-shape uterus.

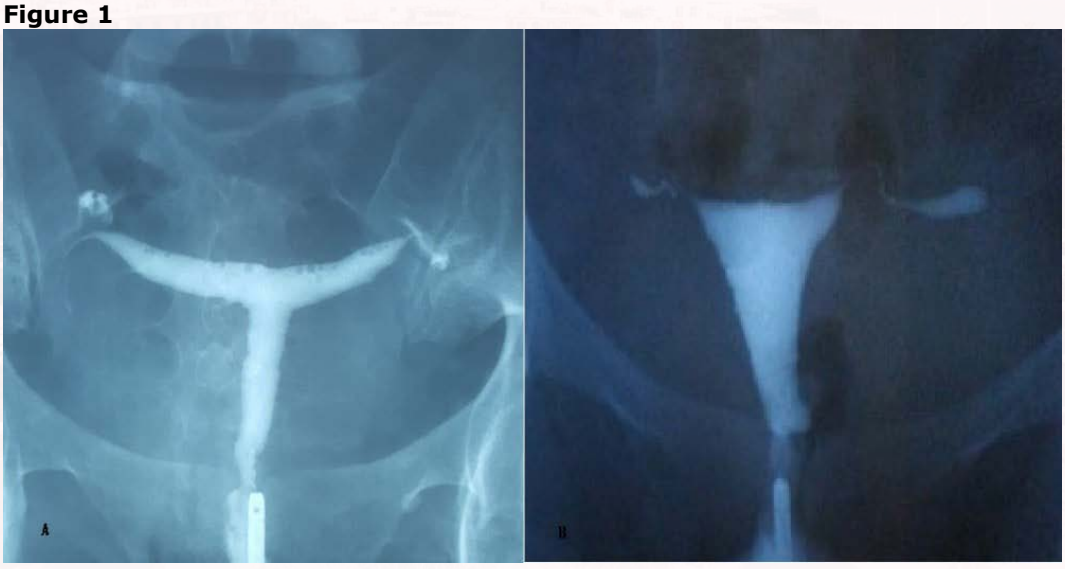
METHODS: This retrospective observational study included 91 patients who presented to IVF unit of Huma Obstetrics and Gynecology Hospital with primary infertility and diagnosed as T-shape uterus on hysterosalpingography between January, 2018 and January, 2021. All patients underwent operative hysteroscopy under general anesthesia. At surgery, uterus was exposed using bipolar cautery to a level where lateral walls of uterine cavity and tubal ostium could be seen. After surgery, 46 patients were given oral estradiol valerate 2 mg (Cyclo-progynova tablet, Bayer, Turkey), over one month; while no medication was given to 45 patients. The patients were included to IVF program 2 months after surgery. Frozen embryo (aged 5 days) was transferred to all patients. Two groups were compared regarding total number of pregnancy, abortion, ongoing pregnancy and live birth rate.

RESULTS: The mean age was 30.4 (min:20 max:39). Pregnancy was achieved in 28 (60.8%) of 46 patients underwent hysteroscopy and given estrogen therapy. In estrogen group, pregnancy outcomes included spontaneous abortion in 6 (21.4%), ongoing pregnancy in 6 (21.4) and live birth in 16 (57.2%). Pregnancy was achieved in 13 (28.8%) of 45 patients not received estrogen therapy. In this group, pregnancy outcomes included spontaneous abortion in 8 patients (61.5%), ongoing pregnancy in 2 (15.3%) and live birth in 3 patients (23%).

CONCLUSION: Hysteroscopic repair is feasible and effective method to correct T-shape uterus. We think that estrogen therapy given at early postoperative period has positive effect on endometrium thickness and width uterine cavity. In particular, we detected that estrogen following hysteroscopic treatment but before IVF improved live birth rates and decreased abortion rate. However larger studies are needed to evaluate long-term results of this treatment. A prospective, randomized and controlled study is necessary to support these results.

Keywords: estrogen, IVF outcome, T-shaped uterus, operative hysteroscopy

Figure 1



A-T Shaped Uterus HSG İmage B- After Operative Hysteroscopy HSG İmage

SS-06

Rare cases of ectopic molar pregnancy

Nazlı Aylin Vural[1], Ezgi Ceren Dallı[2]

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INTRODUCTION: Partial or complete molar hydatiform pregnancies are seen rate of 1-2 per-1000 among all pregnancies. it is seen that ectopic molar pregnancy cases are rarely observed ranging from 1/200000 to 1/10000. Ultrasound and bhcg follow-up give us an idea in the follow-up and diagnosis, but the definitive diagnosis is made histopathologically. The final pathology results of 4 patients whom were operated for ectopic pregnancy were molar pregnancy.

Case-1; A 28-year-old patient who referred to the emergency department with abdominal pain and general condition disorder was evaluated. She was pregnant for 7w4d according to her last menstrual period, gravida 4, parity 1, ectopic pregnancy number 1. bhcg value during hospitalization 3950, perineum, vulva, vagina were observed naturally in her vaginal examination and spotting was observed. During ultrasound examination, intrauterine gestational sac was not observed, coagulum was seen in the abdomen and perihepatic areas. Laparoscopic right salpingectomy was performed. Pathology result; tubal grosses were histopathological findings compatible with molhidatiform. Bhcg-follow-up was performed, bhcg became negative, and became pregnant 2 years after, and she gave birth in a healthy way.

Case-2; A 35-year-old G3P2 patient was admitted with complaints of spotting and abdominal pain for 10 days. She was 5w5d pregnant according to menstruel period. Hospitalization bhcg value:>15000.00, no pathologhical findings were seen in pelvic-examination and spotting was observed. In ultrasound; 84x55 mm coagulum was observed in the left adnexal area, and 67 mm fluid was observed in the deepest pocket in the abdomen. The patient underwent laparoscopic right salpingectomy. Final pathology was early partial hydatiform mole. The patient did not come for follow-up, was phoned from the system, but could not be reached.

Case-3;36 years old G3P2 patient with previous tubal ligation history was diagnosed with ectopic pregnancy at external center. She has 7w pregnancy. Hospitalization bhcg value 13658, no pathological findings was evaluated during vaginal examination and no bleeding was observed. In ultrasound examination, right ovary crown-rump length compatible with 6w4d, ectopic focus was seen but fetal heart rate not clearly evaluated. The patient underwent laparoscopic bilateral salpingectomy. Pathology result; right tubal grosses was early partial hydatiform mole. Patient did not come for follow-up.

Case-4; A 40-year-old patient applied to us with complaints of abdominal pain and delayed menstruation for 1.5 months. G4P3Y3 is the patient with unknown period. Hospitalization bhcg value:>15000. No pathological findings during vaginal examination and no bleeding was observed. During ultrasound no gestational sac, an appearance compatible with 70x35 mm coagulum around the uterus, perihepatic 41 mm free fluid was observed. The patient underwent laparoscopic left salpingectomy. Final pathology result was early partial hydatiform mole. The patient did not come for follow-up.

CONCLUSION: When the pathology results of the patients who were operated for 590 ectopic pregnancies in our clinic within 7 years were evaluated, it was observed that it was compatible with gestational trophoblastic disease in 4 patients. In patients who were operated for ectopic pregnancy, the final pathology results should be followed and it should be kept in mind that molar pregnancy may occur.

Keywords: ectopic pregnancy, molar pregnancy, tubal pregnancy

SS-07

Laparoscopic Repair of Isthmocele With Hysteroscopic Assistance, a Simple Technique with Marking Sutures

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1istanbul University-Cerrahpasa, Cerrahpasa Faculty Of Medicine, Department Of Obstetrics And Gynecology

Aim. To demonstrate a clinical case of laparoscopic repair of isthmocele facilitated with hysteroscopic assistance and marking sutures on the edges of uterine defect.

Method. A 30 year-old woman, without any comorbidities, gravidity 4 parity 4, complaining about abnormal uterine bleeding and pelvic pain for 14 years was examined. At transvaginal ultrasound examination, at the superior of cervical canal a cesarean scar defect of 7*5mm was identified, with a residual myometrial thickness of 4.5 mm over the defect. Laparoscopic isthmocele excision with hysteroscopic approach and myometrial repair were planned under general anesthesia. During the surgery, after the placement of Clermont-Ferrand manipulator, using bipolar and monopolar scissors visceral peritoneal layers over isthmic region were dissected. Vesico-uterine space was developed and bladder was dissected 2 cm below the uterine defect. The bulge of isthmocele wasn't visible at laparoscopy. Therefore, the laparoscopic light intensity was decreased and the light of hysteroscopy was used for the visualization of dehiscence at the anterior wall of uterus. Hysteroscopic transillumination helped the identification of the exact position and the edges of isthmocele. The edges of isthmocele was marked by 1-0 Vicryl stitches. The fibrotic tissue was removed by monopolar hook until the reddish healthy myometrium was visualized. Before suturing the myometrial defect, Hegar dilator was inserted from the cervical canal as a guide to maintain the continuity between cervical canal and endometrium. The myometrial repair was done with 2-layered continuous 1/0 Monocryl suture.

Results. The patient was discharged on the 3rd postoperative day. At the 1-week and 1-month follow-up, the incision site was observed to be intact at transvaginal ultrasound. After the patient had her menstrual period, at 1st month follow up, the endometrium was observed 5.59 mm at transvaginal ultrasound and the uterine defect was completely repaired (Figure 1, Figure 2). The patient was satisfied with the result of the surgery, her complaint of postmenstrual bleeding and pelvic pain were resolved.

Conclusion. Laparoscopic approach with hysteroscopic assistance is a safe and minimally invasive method which enables the identification and marking of the edges of isthmocele adequately and the restoration of normal thickness of myometrium.

Keywords: Isthmocele, Laparoscopy, Suturing

SS-08

Giant Borderline Musinous over tumor determined insidentally during caserian

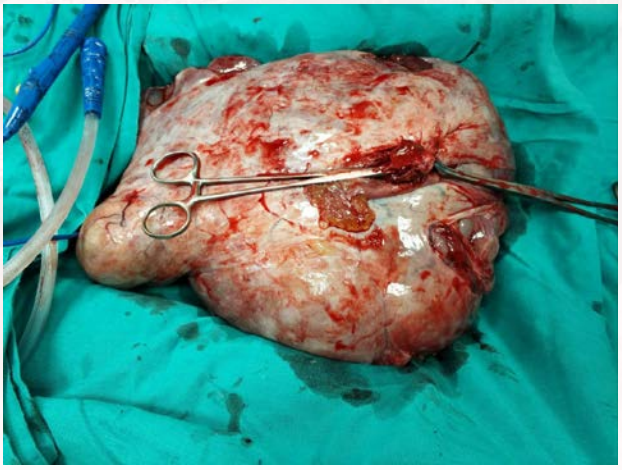
Şeyma Dağlıtuncezdi Çam, Mehmet Ak
Kayseri Şehir Hastanesi

İncrease in the incidence of adnexal masses during pregnancy is detected with the widespread use of ultrasonography. Adnexal mass is seen in approximately 1% of pregnancy. Borderline ovarian tumors; Moderate nuclear atypia is characterized by increased mititoc activity, but they do not exhibit stromal invasion or rapid infiltrative growth. Surgical pre-diagnosis was difficult and depends on the pathologist's experience on frozen. Treatment is generally similar to invasive ovarian cancer, but there are differences of opinion on lymphadenoctomy and hysterectomy. (6-7) An extremely large case of mucinosis borderline ovarian tumor detected incidentally during cesarean delivery is presented in the light of the literature.

Thirty-four-year-old, 3 of whom had 3 pregnancies, and 38 weeks of gestation, applied to the emergency department due to pain. The patient, whose other deliveries were also cesarean, was taken to emergency cesarean. In the abdominal exploration performed after the uterus was closed, a mass of approximately 35 cm originating from the left ovary was observed. The mass was then removed by left salpingooophorectomy. The mass was not likely to be frozen due to the operation being performed under emergency conditions. Pathology result in the control examination of the patient; Atypical proliferative (Borderline) Mucinous Tumor, left ovary, Tumor capsule integrity has been reported. In the laboratory tests of the patient; CA 125: 15.94, CA15-3: 21.93, CA19-9: 10.71. With the development of ultrasonography, the frequency of diagnosing adynxial masses during pregnancy has increased. It is easier to diagnose, especially in the first trimester. In our case, the diagnosis could not be made because the pregnancy did not come to routine follow-up in the early period. The most common masses during cesarean section; functional cysts, mature cystic teratoma and cystadenomas. (8-9). In our case, the prominent borderline mucinosis tumor is much less common and there are fewer literature examples on this subject because we randomly diagnosed during cesarean section. Borderline tumors are neoplasms that exhibit biological behavior between benign and malignant. Treatment approach in adnexal masses in pregnant women is controversial. 90% of the masses are unilateral non-complex and smaller than 5 cm. (3). Torsion and rupture are common in complex masses larger than 5 cm, and malignancy is observed at a rate of 1-8%. (6-11) It is known that these operations performed during pregnancy may cause maternal and fetal complications. Borderline mucinosis tumor during pregnancy is extremely rare and a giant mass of 35 cm in size was found in our case. Since the patient was not followed up in the early weeks of pregnancy, the diagnosis could not be made during pregnancy. For this reason, intra-abdominal exploration is important, especially during cesarean operations, following the birth of the baby. It will provide early diagnosis and treatment in andexial masses that can be detected indiscriminately.

Keywords: borderline, musinous, ovar tumor, caesarian

Ovarian mass



SS-09

Application of Bakri Balloon in postpartum hemorrhage after cesarean section: A tertiary center experience

Anil Ertürk[1], Nergis Ertürk[2]
[1]Gemlik State Hospital
[2]Bursa Yuksek Ihtisas Educational and Research Hospital

INTRODUCTION: Postpartum hemorrhage (PPH) is defined as a blood loss of >1000 mL and the appearance of symptoms of hypovolemia in the first 24 hours after birth, regardless of the mode of delivery.

The most common cause of PPH is uterine atony, followed by placental location and invasion anomalies. Although the first-line treatments of PPH are uterine massage and uterotonic agents, intrauterine balloon tamponade is also used. Intrauterine balloon tamponade is preferred in hemorrhage due to both atony and placental invasion anomalies. The aim of our study is to evaluate the effectiveness of the Bakri balloon, which is an intrauterine balloon tamponade, in PPH developing after cesarean section, according to the experiences of a tertiary center.

METHOD: 115 patients who had a Bakri balloon inserted after cesarean section due to PPH between 2017-2021 were retrospectively analyzed. Demographic data of the patients, laboratory results before and after the procedure, indications for cesarean section and PPH etiologies were recorded and evaluated.

RESULTS: The mean age of the patients was 31.32±5.64. Emergency cesarean section was performed in 42 patients with the indications of acute fetal distress, ablatio or bleeding, and elective cesarean section was performed in 73 patients. PPH developed due to atony in 35 (30.4%) patients and due to invasion anomaly in 80 (69.6%) patients. Ablatio was detected in 17 (14.8%) of the patients. Bakri balloon was applied to all patients and inflated with a mean of 241.21±61.80 mL of water. According to placental anomaly, the patients were grouped as no placental anomaly (n=29), only location anomaly (n=66 (marginal or total), and those with invasion anomaly in addition to location anomaly (n=20)) (placenta accreta spectrum-PAS). It was found that preoperative hemoglobin values were similar between the three groups (p>0.05), and post-procedure hemoglobin values were higher in the group without anomaly (p=0.038). Fibrinogen support was needed only in the PAS group. Hysterectomy was performed in 5 patients based on intraoperative bleeding follow-up, while 110 patients were followed up with Bakri balloon postoperatively, and relaparotomy and hysterectomy were required in only 4 (3.6%) patients.

CONCLUSION: In cases of postpartum hemorrhage after cesarean section, even if the etiology is due to placental location and/or invasion anomaly, Bakri balloon application can be seen as an effective treatment in preventing postpartum hemorrhage.

Keywords: postpartum hemorrhage, intrauterine balloon tamponade, cesarean section

SS-10

Gynecologic Mullerian Anomalies: Unicorn Uterus

Gazi Güner
Department of Gynecologic Oncology, Başakşehir Çam ve Sakura State Hospital; İstanbul

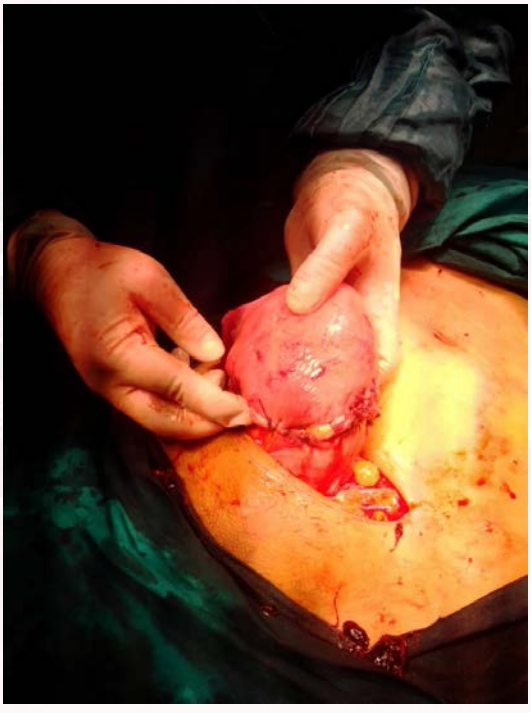
Object: Unicorn Uterus is a Class 2 mullerian anomaly and is usually characterized with the presence of 1 fallopian tube and 1 ovary in the patient. These uterine anomalies represents for 10% (6-13%) among mullerian anomalies. Infertility is seen in 12.5% of these patients. The physiopathology of the right side being the dominant side in both those and our patients is still unexplained. Renal abnormalities accompany to those patients. In this case, we will explain the unicorn uterus that was detected during a cesarean section in an infertile patient.

Results: Our 32-year-old primigravida patient was married for 5 years and conceived at the end of 5 years with clomen treatment. The patient did not apply to the obstetrician, however she was prescribed clomen in a health centre and used the calendar method for 4 years. She applied for pregnancy follow-up at 12th weeks of gestation. Double-test and routine laboratory tests were performed and those where resulted as normal. The patient's perinatology follow-up was normal, and her pains started at the 30th week of gestation. Betamethasone was administered to the patient. The patient's pains were decreased and high-amplitude pains started at the 37 weeks, and she was admitted to our hospital. The patient was underwent to cesarean section because the patient's water broke and dark meconium was observed. A healthy female baby with Apgar 7/8 was delivered. A unicorn uterus was observed during the operation. The operation was successful. The baby was referred to the neonatal team, was hospitalized in the neonatal intensive care unit for 7 days, and was discharged with recovery.

Discussion: Müllerian anomalies may be presented as asymptomatic, therefore an obstetric examination is essential in the reproductive age. Uterine shape and both ovaries must be examined by pelvic ultrasound. This anomaly should be kept in mind in cases with primary infertility. In addition, renal screening should be performed in patients with Müllerian anomaly.

Keywords: Unicorn, Anomaly, Mullerian

Unicorn Uterus



SS-11

Twin pregnancy in rudimentary horn

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INTRODUCTION: The unicornuate uterus with a rudimentary horn is the rarest of the Mullerian anomalies of the female genital tract, with an incidence of 1/100000-140000. The risk of developing complications such as rupture, abortion, ectopic pregnancy, preterm labor, intrauterine growth retardation. Malpresentation increases in rudimentary horn pregnancies.

The standard treatment is the surgical removal of the rudimentary horn.

In our case report, we aimed to present the dichorionic twin rudimentary horn ectopic pregnancy, which was diagnosed by transvaginal ultrasonography, was not ruptured, and was treated with laparoscopy excision first-trimester fetal cardiac activity was detected.

Case: A 28-year-old patient applied to our hospital with a complaint of pelvic pain.

His anamnesis; She had gravida 4, parity 3 (vaginal delivery), regular menstrual cycle (once in 28 days), previous operation history, and no known disease. The patient's vital signs were stable. Abdominal examination revealed no signs of rebound or defense.

In her gynecological examination, vagina and cervix were normal, uterus was normal size, retroverted mobile on palpation, and a mobile well-circumscribed mass of approximately 5-6 cm in diameter was palpated in the left adnexal region. There was no tenderness in the uterus and collum movements. In transvaginal ultrasonography, an adnexal mass between the left ovary and the uterus is separated from the uterus, with fine myometrium, 55x64 mm in size, and two embryos with fetal cardiac activity consistent with CRL at 7 weeks s and 8 weeks.

In the laparoscopic pelvic observation, an appearance compatible with a rudimentary non-communicating horn, approximately 6-7 cm in size and connected to the uterus by a fibrous band, was observed in the left adnexal area, and the left ovary and tuba, which were not connected with the uterus, were also observed; right ovary and tuba were normal, uterus was unicornuate. The fibrous connections between the rudimentary horn and the left round ligament, the proprium of the ligamentum ovarium, the left tuba, and the pelvic side wall were excised with a ligasure and removed from the abdomen with the help of an endobag. After the bleeding control, the procedure was terminated.

DISCUSSION: Often, the diagnosis is missed and may present as an emergency with hemoperitoneum. Therefore, early diagnosis of these pregnancies is very important for possible maternal mortality.

Keywords: pregnancy, dichorionic twin, rudimentary horn, unikollis uterus, ultrasonography

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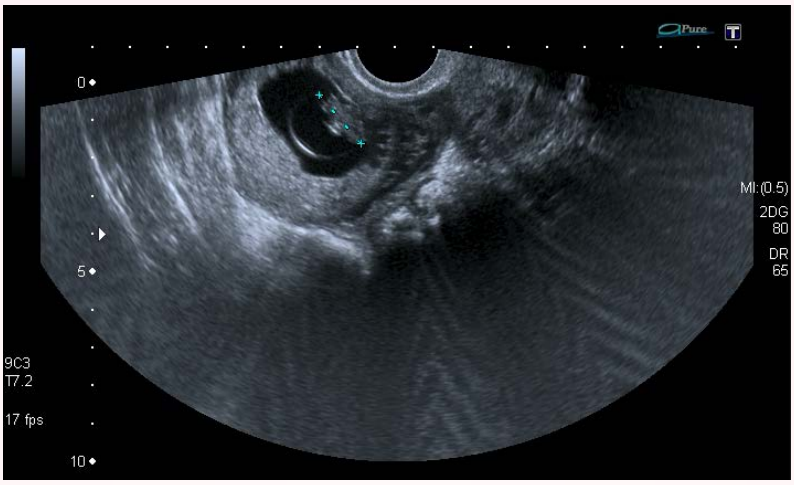

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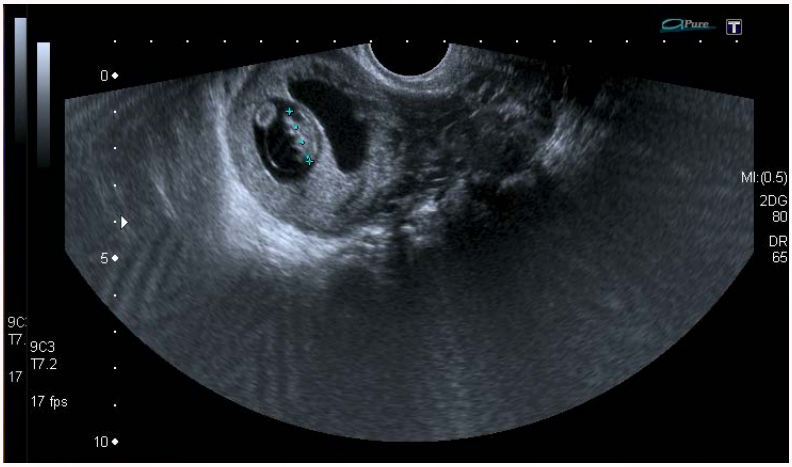

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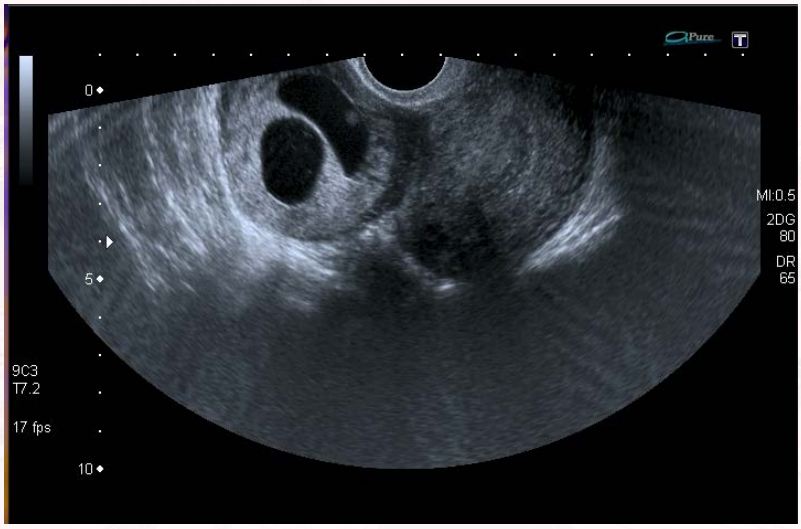

SS-12

Concurrent endometrial cancer in women with atypical endometrial hyperplasia

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BACKGROUND: Endometrial hyperplasia(EH) is an abnormal proliferation of endometrial glands and stroma. World Health Organization (WHO) divided endometrial hyperplasia into two groups based on nuclear atypia. Non-atypical EHs are defined as benign, while Atypical EHs have been considered as precursors of endometrial cancer (EC). Different rates of concurrent EC has been reported in patients with atypical endometrial hyperplasia. Identifying patients more likely to have concurret EC to avoid suboptimal surgical treatment may allow for optimum management.

AIM: To evaluate the risk of concurrent endometrial cancer in patients diagnosed with atypical endometrial hyperplasia (AEH) prior to hysterectomy and to determine the ability of preoperative characteristics to predict which patients may have a risk of occult malignancy.

METHODS: Medical records of 110 patients who underwent hysterectomy within 3 months after a diagnosis of AEH were retrospectively reviewed. Data on age, body mass index, menopause status, details of endometrial sampling, interval between endometrial biopsy and hysterectomy and final pathologic findigs of hysterectomy specimens were collected. Associations between variables and occult EC were analyzed with independent sample t-test and chi square test.

RESULTS: Among 110 patients, 46 (41,8%) had occult EC, and 8 of them were stage II endometrial cancer in final pathologic examination of hysterectomy specimens. In the group with occult EC, the patients were older (58,8 ±9,9 vs 51,7±7,8;p<0,001), BMI was higher (30,8±3,8 vs 28,6 ±3,5;p=0,003), and parity numbers were lower(2,4±1,1 vs 3,1±1,4;p=0,007). Occullt EC was found to be higher in postmenopausal patients (9/40 vs 37/70 p=0,002). There was no difference between the groups in terms of interval from diagnosis to hysterectomy.

Cocnlusion: It is not always easy to separate AEH, which is a precursor for endometrial cancer, from well-differentiated endometrial carcinoma. Older age, higher body mass index, lower parity number and postmenopausal status are risk factors for coexitence of endometrial cancer with AEH. A surgical planning that will be made by considering the preoperative characteristics of the patients diagnosed with AEH will contribute to the implementation of the optimum treatment in these patients.

Keywords: atypical endometrial hyperplasia, endometrial carcinoma, risk factors

Table 1. Preoperative characteristics of the groups according to the presence of EC in patients with AEH

	Non- occult EC	With occult EC	p-value
Age (years)	51,78±7,8	58,8±9,9	<0,001
BMI(kg/m2)	28,6±3,5	30,8±3,8	0,003
Parity	3,1±1,4	2,4±1,1	0,007
Interval (days)	39,7±13	41±16	0,641
Menopause status Premonopausal (n=40) Postmenopausal(n=70)	 31 (77,5) 33 (47,1)	 9(22,5) 37(52,8)	0,002a

Independent sample t-test a:chi square, values are expressed as numbers (with percentages) EC: Endometrail cancer AEH: Atypical endometrial hyperplasia BMI: Body mass index

SS-13

The effect of anesthesia mode on maternal and neonatal outcomes in placenta previa cases

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BACKGROUND: Placenta previa(PP) is defined as the precense of the placenta at the level of the uterine cervical os. The incidence increases in parallel with increasing cesarean rates and in addition, with the increasing number of cesarean sections, invasion anomalies of the placenta also increase. PP is associated with maternal and neonatal morbidity and mortality due to massive antepartum and peripartum hemorrhage. The principal causes of neonatal morbidity and mortality are related to preterm birth. There is not enough evidence to support the choice of anaesthetic technique for caesarean section in women with placenta previa and plasenta accreta spektrum (PAS).

AIM: To compare the maternal and neonatal outcomes in plasenta previa cases with or without PAS according to the anesthesia mode performed.

METHODS: 363 PP cases delivered in our clinic between May 2016 and May 2021 were retrospectively reviewed. Patients demographic data, obstetric characteristics, anesthetic management, intraoperative complications, blood transfusion requirement, maternal and neonatal outcomes were extracted from the hospital's computerized database. Categorical variables was assessed by the χ2-test. Student ' s t -test was used for normally distributed continuous variables, and the Mann – Whitney U test was used for non-normally distributed variables.

RESULTS: General anesthesia(GA) was performed on 162 of the 363 patients (44.6%), remaining 201 patients (%55,4) were given spinal anesthesia (SA). It was observed that the number of previous cesarean sections (0 (0-4) vs 1 (0-5); p<0,001) and the rates of PP with PAS (14/201 (7%) vs 46/162 (29,4%) p<0,001) and emergency cesarean section (71(35.3%) vs 95(58.6%)) were higher in the GA group. While there was no significant difference between the two groups in terms of intraoperative complications, statistical results indicated that GA was associated with significantly worse maternal outcomes (higher hysterectomy rates, more perioperative red blood cell and Fresh- frozen Plasma transfusion and longer hospital stay). In multiple lineer regression analysis; GA was significantly independent risk factor for blood transfusion in PP cases (p=0,043). Also GA was found to be associated with worse neonatal outcomes (lower gestational age and birth weight at delivery, lower APGAR scores and more intensive care administration.)

CONCLUSION: Although spinal anesthesia was our prefered anesthesia mode for plasenta previa cases, general anesthesia was performed more in patients who were estimated to have massive blood loss and prolonged operation time and in emergency cesarean sections. Management of PP cases requires a multidisciplinary team to coordinate planned delivery. It may be an appropriate approach for the anesthesia mode to be decided by the anesthesiologist according to the maternal volume status.

Keywords: anesthesia mode, maternal outcome, neonatal outcome, placenta previa

Table 1: Demographics and baseline characteristics

	Spinal anesthesia (n:201)	General anesthesia (n:162)	p
Materal age (year)	32 (18-45)	32 (16-44)	0.313
BMI (kg/m2)	25.05(18-41.5)	24.95(16.5-42)	0.946
Gravity	3(1-14)	3(1-10)	0.686
Parity	2 (0-7)	2 (0-6)	0.487
No. of curretage	0 (0-6)	0 (0-6)	0.667
Comorbidity None GDM GHT Hypothyroidy Hydronephrosis Hearth Disease Preeclampcia Covid-19	191(95) 2(2) 4(4) - 1(1) 1(1) 1(1) 1(1)	153 (94.4) 4 (2.5) 3(1.9) 1 (0.6) 0 0 1(0.6) 0	0.675
No. of cesarean	0 (0-4)	1 (0-5)	<0.001
Previous myomectomy Yes No	6 (3) 195 (97)	7 (4.3) 155 (95.7)	0.496
Mode of cesarean delivery PCD ECD	130(64.7) 71(35.3)	67(41.14) 95(58.6)	<0.001
Plasenta invazyonu Plasenta previa (none) Acreata Increata Percreata	187(93) 8(4) 2(1) 4(2)	116(71.6) 26(16) 2(1.2) 18(11.1)	<0.001

Data presented as n (%) or median (min-max). P value<0.05 was statistically significant. BMI: body mass index; GDM: Gestational Diabetes Mellitus; GHT: Gestational Hypertension; ECD: emergent cesarean delivery; PCD: planned cesarean delivery.

Table 2: Neonatal outcomes

	Spinal anesthesia (n:201)	General anesthesia (n:162)	p
Gestational age	37 (25-40)	36 (25-40)	<0.001
Birth weight (g)	2910 (650-4080)	2685(595-4100)	0.001
1-min Apgar	9 (6-9)	9 (2-9)	<0.001
5-min Apgar	10 (7-10)	10 (5-10)	<0.001
Admission to NICU Yes No	22 (10.9) 179 (89.1)	45 (27.8) 117 (72.2)	<0.001

Data presented as n (%) or median (min-max). P value<0.05 was statistically significant. NICU: Neonatal intensive care unit.

Table 3: Operative approach and maternal outcomes

	Spinal anesthesia (n:201)	General anesthesia (n:162)	p
B-Lynch suture Yes No	3 (1.8) 198 (98.2)	1 (0.6) 161 (99.4)	0.427
Bakri balloon Yes No	79 (39.3) 122 (60.7)	58 (35.8) 104 (64.2)	0.494
Hysterectomy Yes No	10 (2) 191 (98)	11 (6.8) 151(93.2)	<0.001
Blood transfusion	0 (0-7)	2 (0-12)	<0.001
Fresh-frozen Plasma	0(0-4)	2(0-20)	<0.001
Bladder injury Yes No	2 (1) 199 (99)	5 (3.1) 157 (96.9)	0.150
Bowel injury Yes No	0 201	1(0.6) 161(99.4)	0.265
Hospital stay after delivery (day)	3 (1-19)	3 (1-19)	<0.001

Data presented as mean ± SD, n (%) or median (min-max).
P value<0.05 was statistically significant. SD: standard deviation; PAS: Placenta accrete spectrum; ECD: emergent cesarean delivery; PCD: planned cesarean delivery.

SS-14

Genital ulcer in adolescent

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AIM: Acute genital ulcer (AGU) in the adolescent age group is a rare condition that clinicians may misdiagnose. The purpose of this article is to discuss and present a case of adolescent AGU.

CASE: A 14-year-old virgin girl was admitted to our clinic due to a painful wound in the genital area. In the gynecological examination, there was a 2 cm ulcerated lesion in the right lower labium majus and 0.5 cm kissing ulcers on the bilateral labium majus. There were no other skin or mucosal lesions. No vaginal discharge was observed. There was tenderness and pain over the lesions, but no fever. The general condition of the patient was good. In laboratory examination, C-reactive protein was 2 mg/dL and there was no leukocytosis. Herpes simplex virus type 1 and 2, Cytomegalovirus, Treponema pallidum (VDRL), Chlamydia trachomatis, Epstein Barr virus and human immunodeficiency virus (HIV) serologies were negative. Bacterial lesion culture was also negative. Topical anesthetic cream (EMLA,Eutectic Mixture of Local Anesthetics) and topical antibacterial cream (Nitrofurazone) were applied. She had received ivimipenem (1g/dose/day iv). She was discharged one week later The lesion was completely healed 20 days.

CONCLUSION: Acute genital ulcers are rare, especially in sexually inactive girls, and there are few cases reported in the medical literature (1). Acute genital ulcers (AGUs) are known as acute vulvar ulcers or "Lipschutz" ulcers (LUs). It usually has an acute onset in prepubertal and pubertal girls. In the differential diagnosis, sexually transmitted infections, autoimmune conditions, drug eruptions and local findings of systemic diseases are considered (2). However, in many cases the cause cannot be determined and these lesions are classified as idiopathic aphthae (3,4). The purpose of the treatment; to reduce pain, facilitate healing and prevent scarring. AGU can be perceived as a sign of sexually transmitted diseases and even sexual abuse. This can cause great anxiety for both the patient and family members. Considering this preliminary diagnosis by gynecologists will prevent the family and the patient from experiencing stress about sexual abuse.

Keywords: Genital ulcer, Adolescent, Lipschutz ulcer.

SS-15

Can laboratory findings and symptoms predict ovarian torsion in patients presenting with ovarian masses and pelvic pain?

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Introduction: Ovarian torsion is defined as the complete or partial bending of the ovaries on the ovarian ligaments and disrupting its' circulation. Ultrasound and normal Doppler flow does not necessarily exclude an ovarian torsion; in fact, it can lead to missed diagnosis and has been shown to delay management. Therefore, our aim was to investigate the determination of the symptoms and laboratory findings of the patients at the time of admission in the diagnosis of torsion.

Material and Methods: Between January 2015 and December 2020, patients who applied to Ankara Training and Research Hospital Gynecology and Obstetrics Clinic due to pelvic pain and were diagnosed with ovarian torsion, were included as the study group. The files and records of the patients who were operated with the preliminary diagnosis of ovarian torsion and whose intraoperative torsion was confirmed were reviewed retrospectively. Patients who were not diagnosed with ovarian torsion during this period and who applied to the clinic due to ovarian cyst and pelvic pain were included as the control group. Age, gravida and parity, body mass index (BMI), complaints, gynecological and abdominal examination, radiological findings at the time of admission and laboratory findings (hemogram parameters, C-Reaktive Protein) were recorded retrospectively. The difference between the numerical variables of the two groups was analyzed using the t-test as a parametric test and the Mann-Whitney U test as a non-parametric test. The difference between two or more groups was analyzed using the Chi-square test and Fisher's exact test. Logistic regression analysis was performed using age, size of the ovarian cyst measured on USG, and hemogram parameters

Results: Sixty-two patients treated for ovarian torsion were included in the study group, and 126 patients admitted to the hospital with ovarian mass and pelvic pain were included in the control group. There was no significant difference between the ages of both groups (27.42±8.79 years in tortion group and 29.68±8.88 years in control group) ($p>0.05$). The ovarian masses of the patients diagnosed with torsion were significantly larger than the control group (5.27±1.92 cm vs 3.90±1.57 cm respectively, $p=0.017$)., White blood cell counts, neutrophil/leukocyte ratios were significantly higher, and basophil and eosinophil counts were significantly lower in patients diagnosed with torsion compared to those without tortion (Table 1). The presence of nausea and vomiting was significantly higher in the torsion group ($p<0.05$), but there was no significant difference between the two groups in terms of abdominal examination findings ($p>0.05$). In the logistic regression analysis, low eosinophils and the size of the ovarian cyst were factors that significantly affected the presence of torsion (Eosinophil count, OR: 0.001, 0.000-0.080 %95 CI, $p=0.002$; the size of ovarian mass, OR: 2.851, 1.972-4.120 %95 CI, $p<0.001$) (Table 2).

Conclusion: Although the low eosinophil level and the large size of the ovarian mass at admission are the most effective factors in predicting ovarian torsion, clinical and laboratory findings and imaging results should be used together in the diagnosis of ovarian torsion.

Keywords: Ovarian Tortion, Ovarian cyst, Hemogram parameters

Table 1

	Tortion Group N= 62	Control Group N=126	p
Age (years)	27.42±8.79	29.68±8.88	0.766
Gravida	1.37±1.35	1.68±1.37	0.821
Parity	0.95±1.09	1.36±1.11	0.979
BMI (kg/m2)	25.71±3.79	25.65±3.59	0.439
Presence of Nausea n(%)	20 (32.3)	24 (19)	0.044
Presence of Vomiting n(%)	7 (11.3)	4 (3.2)	0.026
Size of Ovarian Mass (cm)	5.27±1.92	3.91±1.57	0.017
White Blood Counts (10^9/L)	11.70±4.34	9.66±2.50	<0.001
Hemoglobin (g/dL)	12.24±1.51	12.64±1.81	0.065
Platelets (10^9/L)	294.87±78.98	284.33±70.63	0.319
Eosinophil (10^9/L)	0.084±0.068	0.199±0.169	0.003
Basophile (10^9/L)	0.030±0.015	0.047±0.043	0.007
Monocytes (10^9/L)	0.593±0.271	0.773±0.752	0.529
Neutrophil/lymphocyte ratio	7.02±6.98	2.79±2.17	<0.001
C-Reactive Protein (mg/L)	11.11±4.71	12.33±8.33	0.099
Sedimentation (mm/h)	17.46±16.34	17.20±13.11	0.614

Demographics, symptomes at admission and laboratory findings of the patients of two groups.

Table 2

	OR (%95CI)	P
White Blood Counts	0.965 (0.824-1.131)	0.661
Eosinophil	0.001 (0.000-0.080)	0.002
Basophile	0.001 (0.000-4.804)	0.084
Neutrophil/lymphocyte ratio	1.119 (0.976-1.283)	0.108
Size of Ovarian Mass	2.851 (1.972-4.120)	<0.001
Presence of Nausea	0.434 (0.159-1.185)	0.151
Presence of Vomiting	0.996 (0.148-6.718)	0.996

Logistic regression analysis of ovarian tortion with hemogram parameters, size of ovarian mass and presence of nasuea and vomiting

SS-16

Extraperitoneal lymph Node Dissection in Cervical Canser: Laparoscopic Paraaortik Bulky Lymph Node Dissection

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Introduction: Servical Canser that mainly affects sexually active woman aged between 30 and 45, is the fourth common canser in woman. Cervical canser has usullay no symptoms. If cervical canser Show symptoms, these are bleedin, pain after sexual activity. Almost all cases of cervical canser are cused by Human Papilloma Viruses (HPV) that women is infected during sexual acitivity. Treatment of cervical canser is depends on early or late stage. If cervical canser is diagnosed at en aerly stage, the primary treatment is surgery or radiotherapy. More advanced cases are usually terated with combination therapy. Our case which was advanced stage had bulky lymph node five centimeters in size.

Results: 41-year-old women with vaginal bleeding after sexual activity had applied our gynecologic oncology polyclinics. We examined the patient. We saw cervical mass six centimeters in size with speculum and vaginal palpation. There was six centimeters cervical mass in examine of our transvaginal ultrasound screeningThe patient was tested laboratory and PET-CT screening. On PET-CT report, there were parametrial invasion and cervical mass 6 centimeters in size. We had decided to Laparoskopic extraperitoneal bulky Lymph Node Dissection operation. The patient was operated successfully in one hour with laparoscopic balloon trocars. Amount of bleeding was only about 50 cc. The patient had no serıous pain. We discharged the patient second day of operation. The patient is following successfully on the clinics radiation oncology and medical oncology.

Disscussion: The patients who are aptopriate for only lymph node dissection should operatewith laparoscopic extraperitoneal way. This way advantage for surgery time, bleeging during surgery and hospitalised time. So, Morbidy and mortality have decrease for patient with cervical canser.

Keywords: Canser, Lymph Node, Laparoscopic, Extraperitoneal

SS-17

diagnosing ovarian torsion in female patients admitted to a training and research hospital

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Ovarian torsion is the fifth most common gynecological surgery in the world.In clinical presentation, medical history and physical examination should always be the first priority, and the medical history should include a recent diagnosis of any adnexal mass,recurrent abdominal pain, and low-grade fever.Serum human chorionic gonadotropin, hematocrit, white blood cell count, and electrolyte panel should then be included in the laboratory evaluation. Currently, no serum marker for the diagnosis of adnexal torsion has been found. Imaging studies are the most important when evaluating a pelvic mass.Ultrasonographic evaluation is the first step diagnostic evaluation.Torse ovary may be round and larger than the contralateral ovary due to edema or vascular and lymphatic engorgement. Doppler flow in the vessels of the torched ovary may be decreased or absent.However, MRI is expensive but helpful in diagnosing ovarian torsion if ultrasound findings are in doubt.The most important of all direct visualizations is necessary for the definitive diagnosis of ovarian torsion.Therefore, the diagnosis must be surgically proven for early recovery of ovarian function.Surgery is the gold standard for treating ovarian torsion.There are two surgical methods, laparoscopy and laparotomy.The laparoscopic approach has become a popular procedure. During the surgery, ovarian viability should be evaluated and its function should be preserved.Visual inspection is the only way to determine the viability ofa twisted ovary during surgery. From the conventional point of view,dark and enlarged ovaries may have vascular and lymphatic obstruction and appear lifeless. However, numerous studies have suggested that even black or blue-like ovaries can preserve ovarian function after detorsion.Patients admitted to the hospital with the diagnosis of ovarian torsion in the Education and Research Hospital were retrospectively screened.Patients under the age of 18 and over the age of 45 and who were pregnant when diagnosed with ovarian torsion were not accepted.Not only transabdominal sonography was applied tothe patients using a 2-5 MHZ probe, but also 4-9 MHZendocavity probes by a gynecologist.We included 264 patients in our study.The mean ageof our patients was 31.97±8.66 years.Pregnancy was associated in 44 patients.The mean age of the patients diagnosed with ovarian torsion was 32.07±8.69 years and the mean age of the patients not diagnosed with ovarian torsion was 31.78±8.65 years,and there was no statistically significant difference between the two values.Of these,16 were diagnosed with ovarian torsion and 28were diagnosed with another disease by surgery.When we performed surgery on the patients, we got the diagnosis of study participants:171 torsion (64.78%),ovarian cyst/ruptured ovarian cysts/hemorrhagic cyst 56,endometrioma/ruptured endometrioma10,appendicitis 9,pelvic/adnexal mass2.65%,elvic inflammatory disease1.89%,omental torsion1.13%,ectopic pregnancy1.13%.In conclusion, we can say that transvaginal ultrasonography has higher accuracy in detecting ovarian torsion.There were 36.47% false negatives in ultrasonography performed by a gynecologist (transvaginal or transabdominal). However, radiologists had 12.28% false negatives and there was a statistically significant relationship between the two groups.Of all surgically diagnosed ovarian torsions, 82 were detected on the right side and 89 on the left side. The mean diameter of the torsion-affected ovaries was significantly higher than that measured innormal ovaries. According to notonly transvaginal butalso transabdominal sonography findings,bloodflow wasnot detected in8.5% ofthe affected ovaries.

Keywords: OVARIAN TORSION,DIAGNOSIS,surgical observation

SS-18

Endometrıum changes after delivery

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Today, ultrasonography is an increasingly used tool in the evaluation of postpartum hemorrhage. The thickness of the endometrium can give an idea about postpartum hemorrhage in the evaluation made via ultrasound. There is no consensus on the normal values of postpartum endometrial thickness. In our study, we aimed to examine the difference in endometrial thickness between puerperium of vaginal and cesarean delivery.

METHODS: In this study, endometrial thickness was measured by ultrasonography in each volunteer 2 and 7 days after birth. Inaddition, breastexaminationwasalsoperformed, and no significant difference was found between the diseases accompanying the pregnancies of the volunteers and postpartum mastitis.

RESULTS: While the mean endometrial thickness on the 2nd day after cesarean delivery was 12,1 mm, this value wasmeasured as 12,4 mm in those who delivered vaginally. On the 7th day after birth, the endometrial thickness of the volunteers who gave birth by cesarean section was measured as 11,0 mm, while those who had vaginal delivery weremeasured as 10,3 mm. No significant relationship was found between the diseases accompanying the pregnancy of the volunteers and postpartum mastitis.

CONCLUSION: When the endometrial thickness of the puerperant women was measured twice, it was observed that there was no difference between vaginal delivery and cesarean section groups. Among the parameters examined, it was seen that the main factor affecting postpartum endometrial thickness was labor induction and it was concluded that endometrial thicknesses were thinner on both the 2nd and the 7th days of the puerperium in induced deliveries.

Keywords: ENDOMETRIUM,ENDOMETRIUM CHANGES,cesarean delivery,vaginal delivery

SS-19

Analyse of the ce¬sarean birth rate according to Robson ten groups classification system.

Ali Buhur, Necdet Öncü, Çetin Şamiloğlu

Analyse of the cesarean birth rate according to Robson ten groups classification system.

OBJECTIVE: The aim of this study is to analyse the ce¬sarean birth rate according to Robson ten groups classification system.

MATERIALS-METHODS:. TheRobson classification objectively categorises women into ten groups on the basis of parity (nullipara/multipara), previous CS (previous CS/no previous CS), plurality (single/multiple), presentation (cephalic/breech/transverse), labour (spontaneous/induced c/s with no labour), and mode of delivery (CS/no CS). in this system woman fits into only one group All deliveries above 500 grams or gestational age ≥ 20 weeks were included in the study). For each group, the CS rate (number of CSs/total number of deliveries), relative size (total deliveries in each group/total deliveries), and absolute contribution to the total CS rate (CS deliveries in each group/ total deliveries) were.calculated The history, type and cesarean indications of these births and the ages of the pregnant women were recorded using patient files. To analyze the data, descriptive statistical methods (Frequency, Percentage, Mean, and Standard deviation), Pearson Chi-Square test and Fisher Exact test were used. For statistical significance, $p<0.05$ was accepted.

Robson10 group clasification system
1. Nullipara, single, cephalic, ≥37 gestastional age spontaneous labour
2. Nullipara, single, cephalic, birth weight ≥37 gestastional age induced labour or elective CS
3. Multipara, no previous CS, single, cephalic, 37 gestastional age, spontaneous labour
4. Multipara, no previous CS, single, cephalic, birth weight ≥37 gestastional age induced labour or elective CS
5. Previous CS, single, cephalic, birth weight ≥37 gestastional age
6. Nullipara, single, breech
7. Multipara, single, breech
8. Multiple pregnancies Previous CS,or no. Previous CS
9. Single, transverse or oblique lie
10. Single, cephalic, birth weight < 37 gestastional age

RESULTS: The data obtained from 7437 births that took place in the Gynecology and obstetrics clinic of İstanbul Kanuni Sultan Süleyman Training and Research Hospital between January 1, 2020 and december 31, 2020 were analysed retrospectively through the hospital data processing center and patient files. Approximately half of the pregnant women ((47.72%) had vaginal delivery and (52.28%) had cesarean section. İn terms of the actual contribution of the total C/S ratio of pregnant women who had cesarean section,the highest rates (26.88)were composed of the patients in fifth groupand the patients in the first group (8.18%)İn the cesarean indi,cations of women the highest rate was found to be previous cesarean section (26.89%)and the second highest rate was fetal distress (5.44%)

Conclusion The study demonstrated that the most frequent cesarean section indication in the study was previous uterine surgery. There are some methods that can be reduce the cesarean rate such as to control primary cesarean rates, it is also important to educate women about the benefits of normal birth and to support and encourage them for pain control during birth,
Keywords: Robson Ten-Group Classification System, ce¬sarean section, labour. pregnancy

Keywords: Robson Ten-Group Classification System, ce¬sarean section, labour. pregnancy

SS-20

Analyse of the cesarean birth rate according to Robson 10 groups classification system

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OBJECTIVE: The aim of this study is to analyse the ce¬sarean birth rate according to Robson ten groups classification system.

MATERIALS-METHODS:. TheRobson classification objectively categorises women into ten groups on the basis of parity, (nullipara,multipar, previous cesarean), plurality,(single/multiple), presentation,(cephalic/breech/transverse), onset of labour, (spontaneous,induced, cesarean before labour starts) and gestational age (less than 37weeks preterm,37 weeks at term and above) in this system woman fits into only one group. All deliveries above 500 grams or gestational age ≥ 20 weeks were included in the study). For each group, the cesarean rate (number of cesarean section /total number of deliveries), relative size (total deliveries in each group/total deliveries), and absolute contribution to the total cesarean section rate (deliveries in each group/total deliveries) were.calculated The history, type and cesarean indications of these births and the ages of the pregnant women were recorded using patient files. To analyze the data, descriptive statistical methods (Frequency, Percentage, Mean, and Standard deviation), Pearson Chi-Square test and Fisher Exact test were used. For statistical significance, $p<0.05$ was accepted.

Robson10 group clasification system
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2. Nullipara, single, cephalic, birth weight ≥37 gestastional age induced labour or elective CS
3. Multipara, no previous CS, single, cephalic, 37 gestastional age, spontaneous labour
4. Multipara, no previous CS, single, cephalic, birth weight ≥37 gestastional age induced labour or elective CS
5. Previous CS, single, cephalic, birth weight ≥37 gestastional age
6. Nullipara, single, breech
7. Multipara, single, breech
8. Multiple pregnancies Previous CS,or no. Previous CS
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Keywords: Robson Ten-Group Classification System, ce¬sarean section, labour. pregnancy

Keywords: Robson Ten-Group Classification System, ce¬sarean section, labour. pregnancy

SS-21

Early Postoperative CT at Primary Cytoreductive Surgery

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Cytoreductive surgery provides increased survival in gynecological cancers, especially in ovarian malignancies. In ovarian cancer, minimizing the residual tumor to microscopic size followed by chemotherapy is the basis of treatment.

OBJECTIVE: The purpose of this article is to investigate the role of early postoperative Computerized Tomography (CT), which provides postoperative information in patients with ovarian carcinoma after primary cytoreductive surgery.

MATERİAL- METHOD: We retrospectively analyzed 28 patients with advanced stage ovarian cancer who have been performed primary cytoreductive surgery and underwent CT scan 3–90 days after operation during 2019-2021 years at Acibadem Mehmet Ali Aydinlar University Atakent Hospital. Abdominal CT scans were performed using 256-slice multislice CT device; Starting from the xiphoid process to the symphysis pubis; it was performed with intravenous and orally contrast administration. Post-operative complications were recorded by an abdominal radiologist with 5 years of experience.

RESULTS: Mean age of 28 patients was 51,64 and mean BMI was 27,6. Average operation time is 6,02 hours and average count of total dissected pelvic paraaortic lymph node was 79,2. Primary cytoreductive surgery was performed in 27 patients out of 28 patients. USO+Omentectomy+PPLND was performed in one patient with fertility desire. We performed bowel resection 12 patients, in two out of these patients we detected bowel anastomotic leakage postoperatively. Additionally, 25 patients required appendectomy, 18 patients required diaphragm peritonectomy, 13 patients required liver stripping, 4 patients required cholecystectomy and 7 patients were performed splenectomy. Histologically, serous carcinoma was detected in 17, clear Cell in 4, mixed type in 3, endometrioid in 2, mucinous in 1 and undifferentiated in 1 patient. In term of stage, advanced stage (Stage 3,4) was detected in 24 patients and early stage (Stage 1,2) in 4 patients. Pelvic lymph node involvement was observed in 13 patients and paraaortic lymph node involvement was observed in 13 patients.

Abdominal CT scans of the cases in post-operative period showed that most common finding was intra-abdominal free fluid (20/27). Lymphocele in 4 cases, ileus in 2 cases, seroma in 1 case, hematoma in the splenic area in 1 case and evisceration in 1 case were observed, respectively. No residual lesion was observed in the postoperative period on radiological imaging. Pneumonic infiltration was detected in 1 patient who underwent thorax CT. Bilateral pleural effusion was observed in other 2 cases, no infection or pulmonary embolism was detected.

CONCLUSION: CT scan is a fast, reliable and easily accessible imaging method compared to other radiological examinations in the evaluation of postoperative patients and detection of complications in cases who had performed cytoreductive surgery.

Keywords: Ovarian cancer, Cytoreductive Surgery, CT

SS-22

Analysis of the pregnancy outcomes in pregnant women with COVID-19

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Coronaviruses are crucial pathogen of human and animal. At the late 2019, a new type of coronavirus was determined as the cause of pneumonia cases in Wuhan, China. Then it got spread quickly in other countries around the world. Pregnant women are at a higher risk for severe illness from COVID-19 than nonpregnant women. Additionally, pregnant women with COVID-19 are at a higher risk for preterm birth and might have a higher risk for other adverse pregnancy outcomes.

OBJECTIVE: To investigate the effect of COVID-19 on pregnancy and neonatal outcome in our clinic, Acibadem University Atakent Hospital.

METHOD: A retrospective comparison of the pregnancy outcomes was done between 29 women with COVID-19 and 36 women without COVID-19.

RESULTS: The birth weight between two groups were similar as 3311gr for negative group and 3281gr for positive group(P:0.811). APGAR scores for 1. and 5. minute were also similar between two groups (P:0.64 for APGAR1, P:0.66 for APGAR5). There was significant difference for delivery route; c-section rate was %52 for negative group and %86 for positive group. When we compared negative group with woman who has infected in her 3. trimester; we found significant difference in delivery route (%100 in positive group) and no significant difference in APGAR scores and birth weight. Gestational age in negative group was 273days (39w0d) and 267days(38w1d) in positive group; and these are significantly different (P<0.05).

CONCLUSION: Despite the increasing number of published studies on COVID-19 in pregnancy, there are insufficient data to draw unbiased conclusions regarding the severity of the disease or specific complications of COVID-19 in pregnant women. In our small group study, being infected with COVID-19 in pregnancy doesn't seem to effect birth weight and APGAR scores of newborns; however large group studies showed contrary results, especially in third trimester pregnancy.

Keywords: COVID-19 in pregnancy, neonatal outcome, pregnancy outcome

4. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

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