4. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

22-25 Eylül 2022 / Hilton Dalaman Sarıgerme

www.obstetrikjinekolojitartismalikonular.org

BİLİMSEL PROGRAM ve BİLDİRİ ÖZETLERİ KİTABI

İÇİNDEKİLER

HOŞGELDİNİZ

4. Jinekoloji ve Obstetrikte 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.

4. Jinekoloji ve Obstetrikte 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.

4. Jinekoloji ve Obstetrikte 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

Üyeler
Ali Ayhan
Rıfat H. Gürsoy
M. Mutlu Meydanlı
U. Fırat Ortaç
Salih Taşkın

KONGRE EŞ BAŞKANLARI

M. Faruk Köse
Ali Ayhan
Rıfat Gürsoy
Akın Sivaslıoğlu

KONGRE GENEL SEKRETERİ

Nejat Özgül

BİLİMSEL KURUL

Süleyman Engin Akhan
Ragıp Atakan Al
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
Fuat Demirkıran
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
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
M. Murat Naki
Rıza Madazlı
Ramazan Mercan
M. 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
Mehmet Yavuz Salihoğlu
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 Onur Topçu
Tayfun Toptaş
Samet Topuz
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

4. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

22-25 Eylül 2022 / Hilton Dalaman Sarıgerme

BİLİMSEL PROGRAM

22 Eylül 2022, Perşembe

SALON 1	
13:00-14:00	**2021-2022 Yılında yayınlanmış en iyi 3 makale** **Moderatör:** Demir Özbaşar
14:00-15:00	**İnfertilite: Luteal Faz Desteği** **Moderatör:** Rıfat H. Gürsoy **Panelistler:** Esat Orhon, Bülent Urman, Emre Göksan Pabuçcu, Sezcan Mümüşoğlu
	1. Luteal faz ile ilgili bilmediklerimiz veya eksik bildiklerimiz 2. Neden luteal faz bazen yetersiz oluyor? 3. Stimüle siklusların hepsinde luteal faz yetersizliği olur mu? Luteal fazın yetersiz olabileceği siklusları öngörebilir miyiz? 4. Luteal faz desteği için hangi preparat, hangi yol. Oral progestinler yeterli oluyor mu? 5. Luteal faz desteğinde farklılık gösteren özel durumlar var mıdır? Buna göre uygulanacak destek tedavisi değişir mi? -Ovulasyon indüksiyonu+IUI siklusları -Agonist ultra-short, short, long protokoller -Antagonist protokoller -Agonist triggered antagonist protokoller -Donmuş-çözülmüş embriyo transfer siklusları -Dual-trigerred sikluslar -Gamet/Embriyo donasyon siklusları -Ovaryen yanıt derecesi ve hasta yaşı fark yaratır mı?
15:00-16:00	**Jinekoloji ve Obstetrikte Antikoagülan Kullanımı** **Moderatör:** Esat Orhon **Panelistler:** Coşkun Salman, Miğraci Tosun, Burak Karadağ, Emre Göksan Pabuçcu
	1. ERAS protokolleri çerçevesinde jinekolojik kullanımı 2. Obstetrikte kullanımı 3. İnfertilitide yeri 4. ERAS protokolleri çerçevesinde jinekoloiik onkolojide kullanımı
16:00-16:30	**KAHVE ARASI**
16:30-17:30	**Jinekoloji: Progesteron** **Moderatör:** Rıfat H. Gürsoy **Panelistler:** Mehmet Ali Vardar, Rıza Madazlı, Erbil Doğan, Gürkan Bozdağ
	1. Yapısı ve preparatlar 2. Preterm doğumda 3. İnfertilitede 4. Anormal uterin kanamada 5. Onkolojide 6. Düşük riskinde progesteron tedavisi etkili mi?

22 Eylül 2022, Perşembe

17:30-18:30	**Perinatoloji: Pospartum Kanama Paneli** **Moderatör:** Şevki Çelen **Panelistler:** Aykan Yücel, Gülşah Aynaoğlu Yıldız, Gökhan Yıldırım, Sabahattin Altunyurt
	1. Tanım, etiopatogenez,insidans ve risk faktörleri 2. Medikal tedavi yaklaşımı 3. Cerrahi tedavi yaklaşımı 4. Transenamik asid kullanımı 5. Embolizasyon
18:30-18:40	**Açılış Seremonisi**
18:40-19:15	**Kadın Kanserlerinde Organ Koruyucu Yaklaşımlar** Ali Ayhan

22 Eylül 2022, Perşembe

SALON 2

16:30-17:30	**Sözel Sunumlar - 1** **Moderatör:** Pınar Kadiroğulları

SS-01	Trochar site hernia after laparoscopic myomectomy	*Mehmet Musa Aslan*
SS-02	Hysteroscopic Recurrent Isthmocele Repair	*Orhan Orhan*
SS-05	Analysis of 1438 Total Laparoscopic Hysterectomy; Comparison of cohorts with and without uterine manipulator	*Evrim Erdemoğlu*
SS-06	Lymphangioma Circumscriptum of the Vulva: Case Report	*Duygu Lafcı*
SS-07	Giant Condyloma Acuminatum: A Case Report	*Kübra Ak*

17:30-18:30	**Sözel Sunumlar - 2** **Moderatör:** M. Murat Naki

SS-08	Long-term efficacy of ultrasound-guided transcervical radiofrequency ablation in the treatment of symptomatic fibroids	*Mehmet Musa Aslan*
SS-09	Concordance and diagnostic discrepancies in 3D TVUS and MRI of congenital uterine anomalies across the ASRM 2016, ASRM 2021, ESHRE/ESGE 2016, and CUME 2018 classifications	*Cemil Gürses*
SS-10	Laparoscopic myomectomy, benefit or harm?	*Eren Kaya*
SS-11	Hysteroscopic repair of cesarean scar defect: Isthmocele	*Nazlı Albayrak*
SS-12	Maternal serum 25-Hydroxyvitamine D3 level in first-trimester pregnancy loss	*Alev Esercan*
SS-14	The effects of progesterone treatment on nuchal translucency in first and second trimester in pregnency	*Akın Usta*

23 Eylül 2022, CUMA

SALON 1	
09:00-10:00	**İnfertilite: Ovulasyon İndüksiyonu** **Moderatör:** Cihat Ünlü **Panelistler:** Kutay Biberoğlu, Cem Atabekoğlu, Yavuz Emre Şükür, Erhan Şimşek
	1. Anovulasyonun en rasyonel tanısı hangisidir? 2. Tedavi öncesi değerlendirilmesi gereken hususlar var mıdır? (Tiroid fonksiyonları, Hiperprolaktinemi, Glukoz metabolizması, Endometrial patolojiler) 3. Oral preparatların yeri hala var mı? Kime ne zaman, Klomifen mi aromataz inhibitörleri mi? Etki, yan etki ve riskler açısından farklar var mı? 4. Klomifen +Glukokortikoid veya Klomifen + Metformin gereken durumlar hangileridir? Fark yaratır mı? 5. Dopamin agonisti tedavisi gereken durumlar nelerdir? 6. Klomifen ve Aromataz inhibitörleri sikluslarında hCG tetiklemesi gerekli midir? 7. Gonadotropin tedavisi; Ne zaman, hangi hastaya, hangi gonadotropin, hangi protokol? 8. Ovulasyon indüsiyonunda monitorizasyon; Ultrasonogrfi mi, serum estradiol mü, oral preparatlarda da gerekli mi? 9. OHSS ve çoğul gebeliklerden kaçınma stratejileri nelerdir? 10. Ovulasyon indüksiyonu over ve meme kanseri riskini artırır mı?
10:00-10:30	**KAHVE ARASI**
10:30-11:30	**Serviksin Premalign Lezyonları** **Moderatör:** U. Fırat Ortaç **Panelistler:** Macit Arvas, Kunter Yüce, Coşkun Salman, Özcan Balat
	1. Kolposkopi vakaları 2. Eksizyonel prosedürler
11:30-12:15	**Uydu Sempozyumu** **HPV Aşıları HPV Aşılarında Yenilikler** **Konuşmacı:** Nejat Özgül MSD INVENTING FOR LIFE
12:15-13:00	**ÖĞLE YEMEĞİ**
13:00-14:00	**Endoskopi: Laparoskopik Histerektomi** **Moderatör:** Mete Güngör **Panelistler:** Çağatay Taşkıran, M. Murat Naki, Kemal Özerkan, Salih Taşkın

23 Eylül 2022, CUMA

SALON 1	
14:00-15:00	**Jinekoloji: Myomlarda Tıbbi ve Cerrahi Tedavi** **Moderatör:** Suat Dede **Panelistler:** Samet Topuz, Fulya Kayıkçıoğlu, Özgüç Takmaz 1. Tanı 2. Tıbbi tedavi 3. Cerrahi yaklaşım - Endoskopik vs açık - Laparoskopik vs robotik - Açık yaklaşımlar 4. Takipte oluşan gebelikler - Myomektomi sonrası doğum zamanlaması
15:00-15:45	**Uydu Sempozyumu** **Boğmacadan Koruma: Gebelikte Tdap Aşılaması** **Moderatör:** Mete Güngör **Konuşmacı:** Özlem Pata sanofi
15:45-16:15	**KAHVE ARASI**
16:15-17:15	**Onkoloji: Endometrial Patolojiler** **Moderatör:** Ali Ayhan **Panelistler:** Ahmet Göçmen, Hüsnü Çelik, Yavuz Salihoğlu
	1. EIN 2. Erken evre endometrium kanseri 3. Endometrium kanserinde yeni moleküler sınıflamanın kliniğe yansıması
17:15-18:15	**Ürojinekoloji** **Moderatör:** A. Akın Sivaslıoğlu **Panelistler:** Yakup Kumtepe, Yusuf Üstün, Rukset Attar, Derya Kılıç
	1. Antiinkontinans: Kime, hangi cerrahi? 2. Askı cerrahisi komplikasyonları yönetimi 3. L/S Sakrokolpopeksi, lateral süspansiyon, pektopeksi 4. Posterior Intravaginal Slingoplasty (PIVS), Sakrospinöz fiksasyon, İliokoksigeal fiksasyon 5. Sistosel tanısı nasıl konulmalıdır? 6. Rektosel tanısı nasıl konulmalıdır? Etkin tedavi nedir? 7. Vajinal histerektomi'de ip uçları nelerdir?
18:15-19:15	**Endoskopik Cerrahi: Masterclass Video Oturumu** **Moderatör:** Gürkan Uncu **Cerrahlar:** Bülent Urman, Hüsnü Çelik, Evrim Erdemoğlu, M. Faruk Köse, Mete Güngör

23 Eylül 2022, CUMA

SALON 2

09:00-10:00	**Sözel Sunumlar - 3** **Moderatör:** M. Murat Naki

SS-15	Fetuin-A expression in human umbilical vein endothelial cells and amnion cells of patients with gestational diabetes mellitus	*Selim Afşar*
SS-17	Diagnosis of uterus didelphis by cesarean section in a case with normal vaginal delivery at term: A case report	*Dilek Çayırezmez*
SS-18	Smooth muscle tumor of uncertain malignant potential (STUMP): Clinicopathologic and survival analysis of 15 cases	*Ceyda Karadağ*
SS-19	Evaluation of clinical, pathological and genetic data of endometrial cancer cases with microsatellite instability	*Özlem Çelik*
SS-20	Clinical outcomes of ovarian cancer management: A single tertiary referral centre experience	*Onur Can Zaim*
SS-21	Comparison of four different risk of malignancy indexes in the preoperative evaluation of suspected adnexal masses	*Hasan Volkan Ege*

10:30-11:30	**Sözel Sunumlar - 4** **Moderatör:** Mete Güngör

SS-22	Low-Grade endometrial stromal sarcoma(LG-ESS)-case report	*Selim Afşar*
SS-23	Laparoscopic nerve sparing radical hysterectomy	*Evrim Erdemoğlu*
SS-24	Can complete resection in secondary cytoreductive surgical be predicted in epithelial ovarian cancer patients?	*Büşra Şahin*
SS-25	A rare case: Pure sertoli cell tumor with unexpected levels of anti-mullerian hormone	*Nevda Ceren Sonu*
SS-26	Chylous ascites after pelvic para aortic lymph node dissection and anterior resection: A case report	*Şefkat İlayda Embel*
SS-27	Could bisphenol-a have a role in the etiology of neural tube defects?	*Nefise Nazlı Yenigül*
SS-28	Intrauterine pulmonary balloon valvuloplasty: A case report	*Murat Çağan*

23 Eylül 2022, CUMA

SALON 2

14:00-15:00	**Sözel Sunumlar - 5** **Moderatör:** Nejat Özgül

SS-29	Fetal craniorachischisis associated with omphalocele and radial aplasia	*Coşkun Ümit*
SS-30	First trimester screening; an opportunity for an early diagnosis of structural anomalies	*Eren Kaya*
SS-31	Prognosis of cervical cerclage in acute cervical insufficiency	*Eren Kaya*
SS-32	Fetal cardiac rhabdomyoma associated with Tuberous Sclerosis Complex; a case report	*Bilal Esat Temiz*
SS-33	A dedifferentiated retroperitoneal liposarcoma mimicking an adnexial mass	*Gözde Şahin*
SS-34	A case report: Vulvar rejuvenation with mesotherapy application in a patient with atrophic vaginitis	*İsmail Gökbel*
SS-35	A case report: Management of the patient with recurrent vesicovaginal fistula	*Deniz Akın Gökbel*

16:15-17:15	**Sözel Sunumlar - 6** **Moderatör:** Coşkun Salman

SS-36	A process to the couvelaire uterus: ablation placenta	*Mehmet Musa Aslan*
SS-37	Placental site trophoblastic tumor: A pathology to consider in women with pregnancy of unknown location	*Sinem Ertaş*
SS-38	Bloody tears; extremely rare condition ocular vicarious menstruation; a case report	*Gözde Ünsal*
SS-39	A rare uterine tumor; uterine perivascular epithelioid cell tumor (PEComa)	*Çağla Bahar Bülbül*
SS-40	Postoperative sinus thrombosis in a pregnant woman with a history of recurrent preeclampsia	*Mehmet Musa Aslan*
SS-41	Chylous ascites management after abdominal surgery: A case report	*Hasan Volkan Ege*

17:15-18:15	**İlk trimester anöploidi taraması: Ultrasonografiye dayalı tarama testleri vs cfDNA** **Moderatör:** Özlem Pata **Panelistler:** Aytaç Yüksel, İbrahim Kalelioğlu, Seher Başaran, Umut Dilek, Deniz Karçaaltıncaba

24 Eylül 2022, CUMARTESİ

SALON 1	
09:00-10:00	**Menopoz** **Moderatör:** Hakan Seyisoğlu **Panelistler:** Sezai Şahmay, Fatih Durmuşoğlu, Serdar Özşener, Levent Şentürk
	1. Reprodüktif yaşlanma ve güncel terminoloji. Fertilizasyonun korunması açısından bizi yönlendiriyor mu? 2. Over yetmezliğinde fertilizasyon koruyucu önlemler. Kime hangi yöntem? 3. Menopozda ateş basması basit bir semptom mudur? Hangi özellikleri mutlaka tedavi edilmesini gerektirir? 4. Postmenopozal osteoporoz kaçınılmaz ve önlenemez bir durum mudur? 5. Menopozda hormon tedavisi kime, ne zaman, hangi protokol? 6. Hormon kullanılamadığı durumda, diğer seçeneklerin kanıta dayalı sonuçları 7. Menopozal hormon tedavisi ve kanser konusunda son durum nedir? 8. Hormon tedavisinin yararı, olası riskleri göz ardı ettirir mi? 9. Üzerinde çalışılmakta olan gelecek tedavi yöntemleri nelerdir? Ümit veriyor mu?
10:00-11:00	**Türkiye Tarama Programı** **Moderatör:** M. Faruk Köse **Panelistler:** Nejat Özgül, Gökhan Tulunay, Murat Gültekin
11:00-11:30	**KAHVE ARASI**
11:30-12:15	**Keynote Lecture** **Endometriozis Tanısında Gelecek: Serum Biyobelirteç Kullanımı ile Erken Tanı** **Moderatör:** M. Faruk Köse **Konuşmacı:** Engin Oral
12:15-13:15	**Perinatoloji: Gebelikte Hipertansiyon Yönetimi** **Moderatör:** Tamer Mungan **Panelistler:** Esra Büyükbayrak, Şevki Çelen, Bilge Çetinkaya Demir, Mehmet Güney
	1. Gebelik hipertansiyonu tanımı, etiopatogenezi ve prevensiyonu 2. Medikal tedavi 3. HELP send 4. Kronik hipertansif olgularda gebelik yönetimi 5. İntrapartum ve postpartum yönetimi
13:15-14:00	**ÖĞLE YEMEĞİ**
14:00-15:00	**Perinatoloji: Antenatal Fetal İyilik Hali Paneli** **Moderatör:** Rıza Madazlı **Panelistler:** Ali Ergün, Filiz Yanık, Kazım Gezginç, Turhan Çağlar
	1. Riskli bebek kimdir, belirlenebilir mi? 2. Amniyotik sıvı indeksi (ASI) klinik yönetimdeki yeri 3. Biyofizik skorlama 4. Fetal moniterizasyon 5. İnvaziv fetal durumun değerlendirme testleri klinikte yeri var mı?

24 Eylül 2022, CUMARTESİ

SALON 1

15:00-15:30	**KAHVE ARASI**
15:30-16:30	**Vaginit: Genel Bakış** **Moderatör:** Süleyman Engin Akhan **Panelistler:** Esra Kuşçu, Akın Usta, Baki Şentürk, Emine Karabük
	1. 2018 IUSTI / WHO ve 2020 ACOG kılavuzları çerçevesinde vaginit tanı ve tedavisi ana hatları 2. Genital HPV infeksiyonları ve mikrobiyota 3. Genital HPV infeksiyonları ve vaginal mikrobiyota ilişkisi, prekanseröz lezyonlar ile ilişkisi, vaginal infeksiyonlar ile ilişkisi 4. Başımızın derdi kronik vaginitlerde temel yaklaşım ve yeni tedavi modaliteleri 5. Deskuamatif inflamatuar vaginit/ Atrofik vaginit tanımı ve tedavisi: Çocuklukta/ ergenlikte, menopozda, jinekolojik onkolojide tedavi
16:30-17:30	**Perinatoloji: Perinatolojide Tartışmalı Konular Paneli** **Moderatör:** Recep Has **Panelistler:** Ahmet Gül, Selim Büyükkurt, Tuncay Özgün, Ebru Davutoğlu
	1. Gebelikte troid değerlendirmesi gerekli mi? 2. Gestasyonel diabet taraması nasıl olmalı? 3. TORCH taranmalı mı? 4. Tekrarlayan gebelik kaybı olgularında düşük molekül heparin ve aspirin tedavisi: Kime, ne zaman, hangi dozda?
17:30-18:30	**İnfertilite: Preimplantasyon Genetik Test** **Moderatör:** Necat İmirzalıoğlu **Panelistler:** Muhterem Bahçe, Volkan Baltacı, R. Seçkin Özen
	1. Embriyo biopsisi için hangi yöntemler vardır? Polar cisim ve Blastomer biopsiler niçin terk edilmiştir, Trofektoderm biopsisinin avantajları nelerdir? 2. PGD (PGT-M) ve PGS (PGT-A) ne demektir? Aralarında ne gibi farklar vardır? 3. PCD/PGS kimlere uygulanmalıdır? 4. PGD/PGS - Tüp bebek başarı şansını artırır mı? - Çoğul gebelik oranlarını azaltır mı? - Sağlıklı bebek elde etme olasılığını artırır mı? - Tekrarlayan gebelik kayıplarında yararlı olabilir mi? 5. Hangi genetik analiz yöntemleri kullanılmaktadır, avantajları ve dezavantajları nelerdir? 6. Smart-PGT nedir, gerçekten fark yaratıyor mu?

24 Eylül 2022, CUMARTESİ

SALON 2	
09:00-10:00	**Genital Kozmetik - 1** **Moderatör:** A. Akın Sivaslıoğlu **Panelistler:** Kemal Güngördük, Gökmen Sukgen, Esra Özbaşlı
	1. Platelet Rich Plazma (PRP) hazırlanışı, PRP uygulama alanları ve teknikleri, 2. Dolgu malzemeleri, Mikrofat ve Nanofat elde edilmesi-Lipocube 3. Vajinal rejuvenasyon ve Kozmetik jinekolojide dolgu malzemeleri uygulama teknikleri
11:00-11:30	**KAHVE ARASI**
12:15-13:15	**Hormonal Kontrasepsiyon** **Moderatör:** Berna Dilbaz **Panelistler:** Tansu Küçük, Nafiye Yılmaz, Hüseyin Levent Keskin, Nefise Nazlı Yenigül
	1. Oral kontraseptiflerin içindeki estrojen dozu fark yaratır mı? 2. Zaman içinde geliştirilen farklı dört jenerasyon progestinlerin özellikleri nelerdir? 3. Kişiye ve amaca yönelik farklı progestinler olabilir mi? 4. Monofazik mi? Yoksa multifazik preparatlar mı? 5. Konvansiyonel 21 günlük haplar ile 24 günlük uzatılmış rejimler arasında farklar var mı? 6. Günümüzde kullanılan yeni oral kontraseptifler için absolü ve relatif kontrendikasyonlar değişti mi? 7. Yeni jenerasyon oral kontaseptiflerde de meme kanseri ve tromboembolik hastalık riski eski preparatlarla aynı mı? 8. Oral kontraseptif kullanımı menopoz yaşını değiştirir mi? 9. Dismenore, hirsutism, premenstruel sendrom, disfonksiyonel uterin kanama gibi kontrasepsiyon dışı endikasyonlarla kulanımda preparat seçiminin önemi var mı? 10. Transdermal estrojen-progestin kontrasepsiyon daha avantajlı mı? 11. Depo progestinler, aylık enjeksiyonlar ve ciltaltı implantlarla ilgili son durum nedir? 12. Postkoital acil kontrasepsiyonda riskler, olumsuz etkiler, limitasyonlar nelerdir?
13:15-14:00	**ÖĞLE YEMEĞİ**
14:00-15:00	**Jinekoloji: Menstruasyon ve Anormal Uterin Kanama** **Moderatör:** Yaprak Üstün **Panelistler:** Kenan Dolapçıoğlu, Davut Güven, Doğan Vatansever, Özgüç Takmaz
	1. Tanı 2. Tıbbi tedavi 3. Cerrahi yaklaşım
15:00-15:30	**KAHVE ARASI**

24 Eylül 2022, CUMARTESİ

SALON 2	
16:30-17:30	**Genital Kozmetik Cerrahi- 2** **Moderatör:** A. Akın Sivaslıoğlu
	1. Labioplasti& Hudoplasti: **Gökmen Sukgen** 2. Vaginal Gevşeklik Sendromu Yönetimi: **A. Akın Sivaslıoğlu** 3. Kozmetik Jinekolojide Cerrahi Komplikasyon Yönetimi: **Derya Kılıç**
17:30-18:30	**HRT Kanser İlişkisi** **Moderatör:** İlkkan Dünder **Panelistler:** Fuat Demirkıran, Müfit C. Yenen, Ercan Baştu
	1. HRT ve menopoz tedavisi meme kanseri insidansını azaltmak için kişiselleştirilebilir mi? 2. HRT ve kanser survivorlar 3. HRT ve özel popülasyonlar

25 Eylül 2022, PAZAR

SALON 1	
09:00-10:00	**Perinatoloji: İntrapartum Doğum Yönetimi** **Moderatör:** İnanç Mendilcioğlu **Panelistler:** Ayşe Kırbaş, Cem Batukan, Metin İngeç, Miğraci Tosun
	1. Vaginal doğum için optimal şartlar 2. Doğum indüksiyonu nasıl olmalı? 3. Servikal olgunlaştırma yöntemleri 4. İntrapartum ultrasonografi 5. Sezeryan dışı operatif doğum 6. Sezeryan doğum
10:00-11:00	**Onkoloji: Adneksiyel Kitleler** **Moderatör:** Çağatay Taşkıran **Panelistler:** Tayup Şimşek, Nuri Yıldırım, Çetin Çelik, Oğuzhan Kuru
	1. Endoskopik yaklaşımlar 2. Açık yaklaşımlar
11:00	**KAPANIŞ**

4. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

22-25 Eylül 2022 / Hilton Dalaman Sarıgerme

SÖZLÜ BİLDİRİLER

SS-01 [Endoskopi]

Trochar site hernia after laparoscopic myomectomy

Ayşe Sanem Öksüz, Mehmet Musa Aslan
Obstetrics and Gynecology, Sakarya Training and Research Hospital, Sakarya, Turkey

Objective: Trocar site hernias are a complication that develops after laparoscopic surgeries and usually in 10 mm port sites. In the last 10 years, it has become a more common complication as laparoscopic surgery has become a standard method for many surgeries. In our case report, we will discuss the management of trocar site hernia that develops from the 5 mm port site after laparoscopic myomectomy, in the light of the literature.

Method: In the last 10 years, laparoscopic surgery has become the standard method for many surgeries. Its main advantages include being minimally invasive, shortening the hospital stay, reducing the need for painkillers and increasing the speed of returning to daily life. Although it is a rare complication, trocar site hernia should be avoided. Although its incidence varies between 0.6-1%, it is a serious complication in terms of morbidity as it requires surgery as soon as it is noticed.

Case report: A 39-year-old patient applied to our infertility outpatient clinic. An operation was planned for the patient with primary infertility (4 years married), bilateral hydrosalpinx appearance on HSG and myoma uteri on TVUSG. The patient underwent office hysteroscopy, diagnostic laparoscopy, laparoscopic myomectomy and chromopertubation. The patient, who did not develop any complications during the case, was discharged on the 2nd postoperative day due to gas and stool discharge. The patient, who applied to the emergency department with severe nausea and vomiting 48 hours after discharge, was admitted to the ward. In the abdominal CT, the small intestine diameter was measured 5 cm at its widest point, and air-fluid levels are observed in its lumens (ileus?). The tomography result was reported to the general surgery and the patient was taken into operation. Intestinal loop was reduced in the operation.

Conclusion: There are different data on the incidence of trocar site hernia following laparoscopic procedures. In the largest series on this subject in the literature, 10 trocar site hernias were reported among 3600 cases. Based on this, it can be said that trocar site hernia after laparoscopy is a rare complication. However, when complicated cases such as strangulated hernia or intestinal obstruction due to hernia in both series and case reports are considered, it is clear that it can be an important cause of morbidity. Trocar site hernia, which is generally known to develop from a 10 mm trocar site, is quite rare to develop from a 5 mm trocar site. Factors affecting its pathogenesis; trocar size, opening/closing of the fascia, location, open/closed laparoscopy, widening the entrance for specimen collection, intra-abdominal gas pressure, patient's body mass index, and infections. Only 10% of trocar site hernias occurred through 5 mm ports. Trocar site herniation is a complication that can develop even if access to the abdomen is provided with the right techniques. Although it is a rare complication, immediate care should be taken because of its high morbidity. Early diagnosis can provide treatment without the need for bowel resection.

Keywords: lmyomectomy, hernia,laparoscopic surgery complication

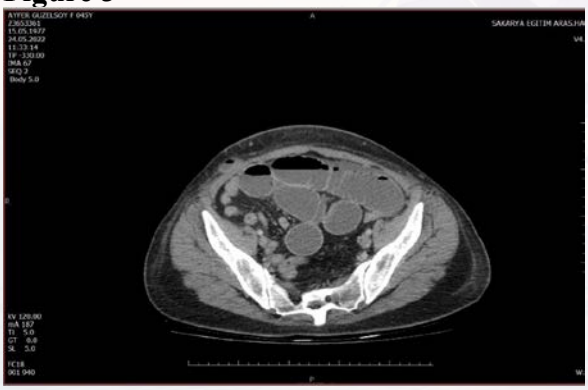
Figure 1

abdominal X-Ray

Figure 2

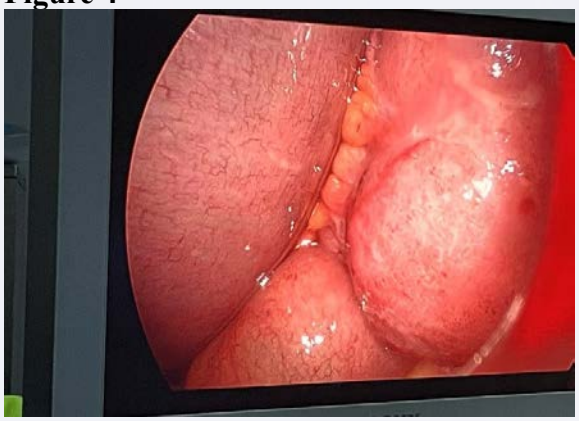
An incarcerated hernia is observed in the upper right part of the patient's abdominal tomography.

Figure 3



An incarcerated hernia is observed in the upper right part of the patient's abdominal tomography.

Figure 4



Perop appearance of the intestine after reduction

Figure 5

Perop appearance of the intestine after reduction

Figure 6

abdominal X-ray of the patient before discharge (air-fluid level is not observed)

SS-02 [Endoskopi]

Hysteroscopic Recurrent Isthmocele Repair

Orhan Orhan
Muayenehane, Bursa, Turkey

An isthmocele appears as a fluid pouchlike defect in the anterior uterine wall at the site of a prior cesarean section and ranges in prevalence from 19% to 84%, a directly proportional to the increase in cesarean sections performed worldwide. In this case a 34 year old woman with a history of a single cesarean delivery in 2008, complained of postmenstrual spotting, brown discharge, pelvic pain and seconder infertility for the past 7 years. She underwent isthmocele repair by laparotomy in 2016 and had recurrence 6 months later. We performed hysteroscopic treatment in 2019 which included resection of fibrotic tissue of the proximal part, distal part and coagulation of niche surface with a rollerball electrode. She became pregnant just two months after surgery and gave live birth in 2020. In conclusion; hysteroscopic isthmocele repair can be minimally invasive and effective treatment option for the symptomatic patients. Keywords; Istmocele, Hysteroscopy,Seconder Infertility, Spotting, Pelvic Pain

Keywords: Istmocele, Hysteroscopy,Seconder Infertility, Spotting, Pelvic Pain

SS-05 [Endoskopi]

Analysis of 1438 Total Laparoscopic Hysterectomy; Comparison of cohorts with and without uterine manipulator

Erdener Karacan[1], Volkan Öztürk[1], İlyas Turan[1], Mehmet Güney[2], Okan Öztürk[2], Evrim Erdemoglu[1]
[1]Jinekolojik Onkoloji BD. Kadın Hastalıkları ve Doğum AD. Süleyman Demirel Üniversitesi
[2]Kadın Hastalıkları ve Doğum AD. Süleyman Demirel Üniversitesi

OBJECTIVE: Uterine manipulators can reduce complications in total laparoscopic hysterectomy (TLH), but opposing views exist regarding the use of uterine manipulators for the treatment of TLH. This study was designed to see whether TLH without uterine manipulator is safe and effective for both benign and malignant cases. This study aimed to analyze the results and complications of TLH with or without manipulator and performed for benign as well as malignant indications. A non-inferiority trial was performed to compare outcomes in TLH without a uterine manipulator.

METHODS: Data from 1438 patients who underwent total laparoscopic hysterectomy were retrieved.Patient characteristics, preoperative features, indications for operation, uterine weight, pre and postoperative hemoglobin levels, blood transfusion, fresh frozen plasma transfusion, intraoperative urinary/intestinal complications, and postoperative complications were analyzed.

RESULTS: A total of 138 laparoscopic hysterectomies were carried out without the use of a manipulator (group A), and 1300 laparoscopic hysterectomies were carried out using a uterine manipulator (Group B). Patient charasterictics and uterine weight were similar. There was a significant hemoglobin drop in group B (1.35 versus 1.50, $p<0.05$). There was no significant difference in the transfusion rates between the two groups. Intraoperative complication rates were 4.3% in group A and 2.8% in group B ($p>.05$). Rates of bladder, ureteral, and intestinal injuries were similar in the two groups, but the rate of conversion to laparotomy was higher in group A (2.3%) than group B (0%). Postoperative complication rates were similar in groups A and B.

CONCLUSION: TLH without the use of a uterine manipulator can be safely performed at experienced referral centers. The use of TLH techniques in educational centers is important so that the trainees' learning curve can be monitored and supported.

Keywords: total laparoscopic hysterectomy, uterine manipulator, complication, non-inferiority

SS-06 [Jinekoloji Genel]

Lymphangioma Circumscriptum of the Vulva: Case Report

Duygu Lafcı, Gülay Turan, Selim Afşar, Akın Usta
Department of Obstetrics & Gynecology, Balıkesir University Faculty of Medicine, Balıkesir,Turkey

INTRODUCTION: Lymphangiomas are benign proliferations of the lymphatic system that rarely affects vulva. There are three known types of lymphangiomas: circumscriptum, cavernous, and cystic. Based on the etiopathogenesis, lymphangioma circumscriptum (LC) can be either primary or secondary, with the secondary form being relatively more common in vulva. LC is commonly found in chest, mouth, axilla and tongue. Vulva is an uncommon site for LC. Acquired vulvar LC is known to occur after radical hysterectomy with or without adjuvant radiation therapy for cervical cancer. Clinically, it is characterized by persistent clusters of thin-walled vesicles filled with clear fluid. The diagnosis is usually made by biopsy, as these lesions often mimic such infectious diseases as molluscum contagiosum and vulvar condyloma.

CASE: A 67-year-old woman admitted our outpatient clinic with chronic grey-colored cauliflower-like papules on both labia majora, edema in this area, and oozing of clear fluid. Approximately ten years after radical abdominal hysterectomy, lymph node dissection, and subsequent irradiation for cervical cancer, the cutaneous symptoms started. The patients' history revealed that the lesions developed during the last 4-5 years and the patient tried a myriad of therapy options such as intermittent corticosteroid creams and antihistaminics based on the pathology result which concluded as dermal hyperplasia. Clobetasol propionate cream was tried topically for final medical option to follow-up, but this treatment was also unsuccessful. So that, simple vulvectomy was performed, since no regression was observed in the lesions. The final pathology of vulvectomy specimen was lymphangioma circumscriptum.

RESULT: The main pathologic criteria for LS is dilated lymphatics in dermal papilla and whose endothelium is immunostained for CD31 and CD2-40. LS of the vulva rarely develops after postoperative pelvic irradiation. Clinically, LS of the vulva is not easily indistinguishable from molluscum contagiosum, genital warts or tuberculosis verrucosa cutis. Biopsy is essential to confirm the diagnosis. There is no standard management for vulvar LS. The various treatments range from conservative treatment with decongestive physiotherapy, such as manual lymph drainage, exercise, and compression, to abrasive therapy, sclerotherapy, electrocoagulation, laser-therapy with CO2, and surgical excision depending on the patients' conditions. Simple vulvectomy is a valid option for the treatment of vulvar LS which is resistant to medical therapy options.

Keywords: lymphangioma circumscriptum, pruritus vulvae, external-beam radiotherapy

SS-07 [Jinekoloji Genel]

Giant Condyloma Acuminatum: A Case Report

Kübra Ak[1], Gülay Turan[1], Duygu Lafcı[1], Çağla Bahar Bülbül[2], Ceyda Sancaklı Usta[1], Selim Afşar[1], Akın Usta[1]
[1]Department of Gynecology and Obstetric,Balıkesir University Health Practice Research Hospital,Balikesir,Turkey
[2]Department of Gynecology and Obstetric,Balikesir Ataturk City Hospital,Balikesir,Turkey

AIM: Genital condyloma, also known as condyloma acuminatum, represent a skin infection caused by sexual transmission of the human papilloma virus (HPV)(1). There are several subtypes and type 6 and 11 are associated with genital warts, while other subtypes like 16 or 18 are prone to malignant transformation (2-3) Genital warts can frequently resolve without medical and surgical treatment in an immunocompetent host (2). However, persistent and recurrent infection require medical and/or surgical

procedures (2-4-5). Giant condyloma, also known as Buschke-Lowenstein tumor (BLT), is a rare disease that present in the the anogenital region (6). BLT is considered a locally aggressive tumor of benign histological appearance, however some of the BTL have a potential for destructive growth and high recurrence rates especially in immunocompromised patients (6). Local cellular immun response to HPVs plays a crucial role in the natural control of various HPV-induced lesions. Giant condyloma acuminata are mostly reported in patients with primary (e.g., DOCK8 or SPINK5 deficiencies) and secondary (e.g., AIDS, solid organ transplantation) immune deficiency. We present a case of overwhelming gaint condyloma acuminata that was treated successful surgery.

MATERIAL-METHODS: a 32-year-old female patient was referred to our clinic from external center due to giant conduloma in vulva, perineum and perianal region. In the medical history the patient have had chronic kidney diseases. There was no pregnancy and delivery history. There was no known immunodeficiency or genetic disease. Genital examination revealed that large genital warts was present in the vulva, perineum and perianal region. Skinning vulvectomy was planned for the treatment of the lesions.

RESULTS: All genital lesions were removed by skinning vulvectomy. After the surgery, the patient was discharged without any postoperative complication. Excised materials was undervent pathological examination. The pathology result was reported as genital condyloma acuminatum due to HPV.

CONCLUSION: Large genital condylom can be successfully treated surgery with no postoperative complication.

Keywords: Gaint condyloma,Immundeficiency,HPV

Giant condyloma acuminatum

Giant condyloma acuminatum

Giant condyloma acuminatum

SS-08 [Jinekoloji Genel]

Long-term efficacy of ultrasound-guided transcervical radiofrequency ablation in the treatment of symptomatic fibroids

Mehmet Musa Aslan[1], Arif Serhan Cevrioğlu[2]
[1]Department of Obstetrics and Gynecology, Sakarya Training and Research Hospital, Sakarya, Turkey
[2]Department of Obstetrics and Gynecology, Sakarya University School of Medicine, Sakarya, Turkey.

OBJECTIVE: Myoma is the most common benign tumor of the uterus and is seen in 20-30% of reproductive age and 70-80% of women over 50 years of age. Treatment of fibroids with ultrasound-guided radiofrequency ablation (RFA) has some advantages over conventional surgery. It is aimed to shrink myoma volume and to make myoma asymptomatic within months after myolysis. In appropriately selected cases, an average of 70-90% reduction in myoma size was observed in 3-12 months of follow-up after the procedure. The aim of this study was to examine the efficacy of RFA in the treatment of symptomatic uterine fibroids.

METHODS: RFA was performed to 15 women with symptomatic uterine fibroids. Under the guidance of transvaginal USG, the needle electrode passed through the attachment on the USG probe was placed in the body of the myoma. At the end of the 24-month follow-up, reductions in myoma diameter and volume were evaluated.

RESULTS: The characteristics of the patients included in the study are shown in Table 1. The mean age of the patients was 42 + 3.8. At the end of the 24th month, an average of 54.7% reduction was observed in myoma diameters compared to basal, while 88.6% reduction was observed in myoma volumes (Table 2).

DISCUSSION: Ultrasound-guided RFA is one of the methods used in the treatment of fibroids. According to the results of the Fibroid Ablation Study-EU (FAST-EU), in which 50 premenopausal women were examined, an average of 67% reduction was found in myoma volumes as a result of 12-month follow-up after the RFA. In the Sonography-Guided Transcervical Ablation of Uterine Fibroids (SONATA) trial study, which included 147 premenopausal women, an average of 62% reduction in fibroid volumes was observed in the 12-month follow-up after the RFA. In our study, 85% reduction in fibroid volumes at the end of 12-month follow-up and 88.6% reduction at the end of 24 months was observed.

CONCLUSION: Ultrasound-guided RFA may be a safe and effective minimally invasive alternative in the treatment of patients with symptomatic fibroids.

Keywords: Myoma uteri,radiofrequency ablation,treatment of fibroids,transcervical ablation

Table 1

Subjects treated	n = 15
Age, years	42 ± 3.8
Gravida	2.2 ± 2.8
Parity	1.35 ± 1.39
Abortion	0.85 ± 1.95
Ectopic pregnancy, %	-
Survivor, %	1.35 ± 1.39
Myomectomy cs history, %	%33.3

Baseline subject characteristics

Table 2

	Baseline	3rd month	6th month	12 months	24th month
Largest diameter (mm)	32.3 ±12.7	21.8 ± 12.7	20.4 ± 12	15.6 ± 9.1	14.6 ± 8.3
Volume (mm3)	26917±22847	11727±18421	9175±13985	3846±4687	3048±3620

Changes in myoma diameter and volume over time

SS-09 [Jinekoloji Genel]

Concordance and diagnostic discrepancies in 3D TVUS and MRI of congenital uterine anomalies across the ASRM 2016, ASRM 2021, ESHRE/ESGE 2016, and CUME 2018 classifications

Cemil Gürses, Koray Kaya Kılıç
University of Health Sciences, Antalya Education and Research Hospital, Department of Radiology, Antalya / Turkey

PURPOSE: Congenital uterine anomalies classifications are based on coronal imaging of the uterus through 3D transvaginal ultrasound and MRI. The purpose was to examine the diagnostic concordances between two diagnostic imaging techniques or the conformance between the ASRM, ESHRE/ESGE and CUME systems for each imaging modality.

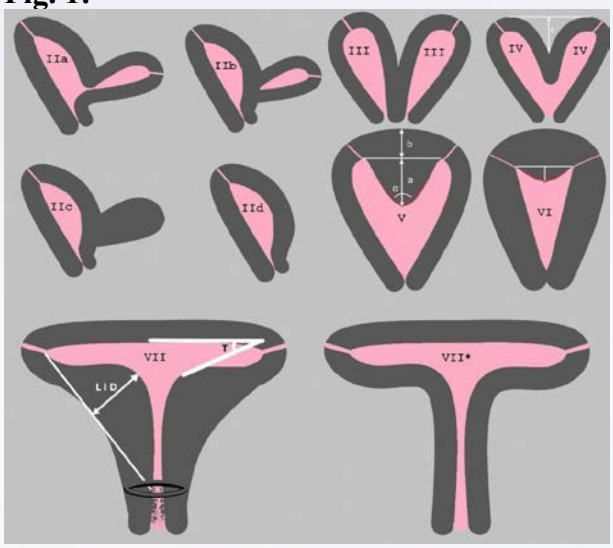
METHODS: 94 patients were accused of having congenital uterine anomalies (Fig.1). 67 attendees were reviewed with 3D TV US prospectively. 53 patients were assessed with MR retrospectively. Thirty-four participants were examined using the two techniques. An ASRM, ESHRE/ESGE and CUME cross table (Table 1) and flowchart diagram were used to arrive at the final diagnostic for each system (Fig.2). The type and prevalence of abnormalities in the study group were calculated as a percentage by the system. Fleiss' Kappa is used to evaluate for agreement level determination.

RESULTS: The Class VI arcuate uterus was the most common form of CONUTA according to the ASRM 2016 and 2021. The partially-septated uterus was the most prevalent form in CUME 2018 and ESHRE/ESGE 2016 classification systems.

CONCLUSION: There is no discrepancy between classification systems for all fusion defects and the complete type of septated uterus of absorption defects. However, the CUME, proposed as an alternative system, was disappointing to differentiate between normal and arcuate uteruses. It was almost impossible to diagnose a uterus as normal/arcuate in ESHRE/ESGE system and nearly half of the abnormal uteruses were partially septated types.

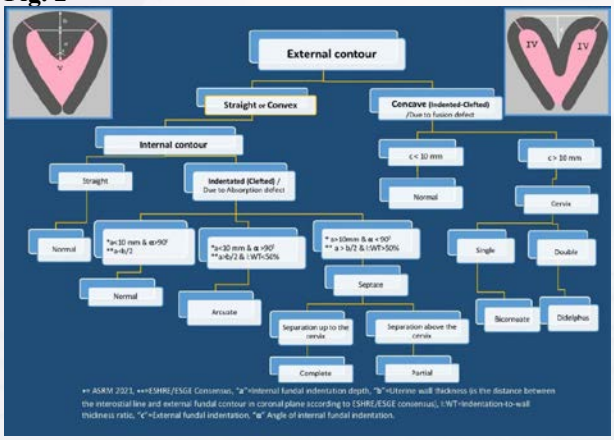
Keywords: Congenital, MRI, Uterine anomalies, Three-dimensional ultrasonography

Fig. 1:



Drawings for a schematic representation of congenital uterine anomalies, labelled in Roman numerals according to ASRM classification. Class I hypoplasia/agenesis was not included.

Fig. 2



A flowchart of stages to reach a final diagnosis for each system.

Table 1

		ASRM Uterus	ESHRE-ESGE Uterus		
Normal / Arcuate	Normal / Arcuate Uterus	Straight, convex fundal contour. Internal indentation depth <1 cm. Angle of the indentation >90 degrees. External cleft < 1 cm	Straight, curved interstitial line. Internal indentation < 50% myometrial thickness. Normal outline or external cleft < 50% of uterine wall thickness.	Normal Uterus	U0 Normal Uterus
Class I Hypoplasia/ Agenesis	a Vaginal	PEERLESS in ASRM	V1 Longitudinal non-obstructing vaginal septum V2 Longitudinal obstructing vaginal septum V3 Transverse vaginal septum and/or imperforate hymen V4 Vaginal aplasia	V0 Normal	Vagina
	b Cervical	PEERLESS in ASRM	C1 Septate cervix C2 Double Normal cervix C3 Unilateral cervical aplasia C4 Cervical aplasia	C0 Normal	Cervix
	c Fundal		Bi- or unilateral horn	U5a With rudimentary functional cavity	U5- Aplastic or dysplastic uterus Uterus
			Bi- or unilateral uterine remnant / aplasia	U5b Without functional rudimentary cavity	
	d Tubal e Combined		PEERLESS in ESHRE/ESGE		
Class II Unicornuate	a Communicating	Single well-formed uterine cavity with a single tubal ostium. Asymmetric ellipsoidal shape ('banana-shaped'). External cleft >1 cm dividing the two horns.	With communicating or non-communicating functional contralateral horn of cavity	U4a With functional rudimentary cavity	U4- Hemi Uterus- Unilateral formed uterus (formation defect)
	b Non Communicating				
	c No Cavity		Without functional contralateral horn of cavity	U4b Without functional rudimentary cavity	
	d No Horn				
Class III Didelphys	Didelphys	Two separate unicornuate uterine cavities with double cervix.	Midline fundal indentation>150% uterine wall thickness (average myometrial thickness). External cleft>50% myometrial thickness.	U3c Bicorporeal septate	U3- Bicorporeal Uterus- Dysfused uterus (fusion defect)
Class IV Bicornuate	a Complete	Internal indentation ≥1.5 cm. External fundal indentation ≥1 cm single normal cervix.	Division up to or above of the internal cervical os. External cleft >50% myometrial thickness.	U3b Complete	
	b Partial			U3a Partial	
Class V- Septate	a Complete	Internal indentation depth ≥1.5 cm ASRM 2016. (According to CUME 2018 ≥1.0 cm). Angle of the indentation < 90 degrees. External indentation cleft <1 cm.	Division up to or above of the internal cervical os. Internal indentation >50% myometrial thickness. Normal outline or external cleft <50% of uterine wall thickness.	U2b Complete	U2- Septate Uterus- Absorption defect
	b Partial			U2a Partial	
Class VI Arcuate	Arcuate	Straight, convex fundal contour. Internal indentation depth <1 cm; ≤1.5 cm. External cleft < 1 cm. Angle of the indentation >90 degrees.		U2a Partial	
Class VII DES drug related		Uterb drug related.	Abnormal narrow cavity; thickened lateral walls; Normal outline or external cleft <50% of uterine wall thickness	U1a I-shaped	U1- Dysmorfic Uterus
	I shaped uterine cavity.	PEERLESS in ASRM		U1b Infantilis	
		PEERLESS in ASRM		U1c Others	
Class VIII Unclassified	Anomaly without classification.	Hybrid form, non-characteristic conjunction of uterine, cervical and vaginal malformations.	Infrequent anomalies, subtle changes, or combined anomalies	Malformations	U6- Still unclassified

The cross-listing table provides the synonyms across ASRM and ESHRE/ESGE classifications.

SS-10 [Jinekoloji Genel]

Laparoscopic Myomectomy, Benefit or Harm?

Eren Kaya[1], Mustafa Deveci[2], Emine Karabuk[1]
[1]Acibadem MAA University, Department of Obstetrics & Gynecology
[2]Acibadem University Atakent Hospital, Department of Obstetrics & Gynecology

Introduction: Uterine leiomyoma (fibroma) is one of the most common benign tumors in gynaecology. The decision of treatment depends on the size, location, symptoms and radiologic characteristics of the fibroma. Treatment options include hysterectomy or myomectomy with either conventional or minimally invasive techniques. There are also numerous studies on non-surgical methods for the treatment of leiomyomata such as medical suppression and ablation. In this video, we aim to demonstrate laparoscopic myomectomy and intraperitoneal morcellation of a fibroma which has a rather difficult access laparoscopically.

Methods: We present a 45-year-old primigravida patient with a history of c/section and has a long history of uterine leiomyoma. The patient is discussed with the options of hysterectomy and myomectomy and the patient preferred myomectomy. The patient did not have any findings suspicious for malignancy in both ultrasonography and MRI and we decided to perform laparoscopic myomectomy. We performed intraperitoneal morcellation without protective bag because the patient had a long history of leiomyoma with minimal enlargement of the tumor and no radiological findings suggesting a malignant tumor.

Results: The patient was discharged in post operative day-1 without any complications and the pathology reported leiomyoma with hyaline degeneration.

Discussion: Minimally invasive myomectomy has been a controversial technique due to risk of implantation of potential leiomyosarcoma. The risk is believed to be especially elevated in older patients as well as with the use of morcellator without protective bag. However with long history of leiomyoma without progression and with detailed physical examination and imaging techniques we can minimize the risk of spilling of potential leiomyosarcoma during myomectomy.

Keywords: leiomyoma, fibroma, myomectomy, uncontained power morcellation

SS-11 [Jinekoloji Genel]

Hysteroscopic repair of cesarean scar defect: Isthmocele

Nazlı Albayrak, Ozguc Takmaz
Acibadem MAA University, Istanbul, Turkey

Uterine isthmocele or uterine niche is on of a late complication of cesarean section[1] which may present with postmenstrual spotting, and infertility. Myometrial thinning after cesarean section is seen as pouch-like diverticulum during ultrasonographic examination years after the delivery. There are three defined methods of isthmocele reparation:(1) hysterescopic resection, (2) laparotomic repairment, and (3) laparoscopic repairment. There are not any data about the superiority any of these three among them in the literature.

Case Report: 36-year old patient admitted to our gynecology clinic with the complaint of postmentrual bleeding. During the ultrasonographic examination, uterus is retrovert, and it is realized that there is 8*9mm pouch on the anterior wall of the uterus right above the cervix where the cesarean section's Kerr incision was performed. The patient had singleton delivery by cesarean section four years ago with an embryo obtained via in vitro fertilization. After the delivery, her complaints got started. Regarding to our examination, and the patient's anamnesis, hysterescopic isthmocele surgery is performed. During the surgery, cervix is dilated with Hegar dilators, then operative hysterescopy is used. When it is entered to the uterine cavity, after visualizing the uterine fundus and two cornii, isthmocele defect is detected. With the use of loop resectoscope, the cesarean defect on the anterior wall of the uterus is resected. After the hemostasis, the operation is ended. 2 weeks later, the patient is invited to the physician's office for the post operative follow-up where there is no pouch recognized via ultrasonography.

Reference

[1] Rupa, R., et al. "Uterine Isthmocele—a Frequently Overlooked Complication of Cesarean Sections." Indian Journal of Radiology and Imaging, vol. 31, no. 03, 2021, pp. 601–604., https://doi.org/10.1055/s-0041-1736393.

Keywords: isthmocele, scar, cesarean scar

SS-12 [Obstetri Genel]

Maternal serum 25-Hydroxyvitamine D3 level in first-trimester pregnancy loss

Alev Esercan[1], Tufan Arslanca[2], Tayfun Gungor[3]
[1]Department of Obstetrics and Gynecology, Sanliurfa Education and Training Hospital,Sanliurfa,Turkey
[2]Department of Obstetrics and Gynecology, Ufuk University, Ankara, Turkey
[3]Women's Health and Gynecologic Oncology Private Clinic, Ankara, Turkey

OBJECTIVE: Pregnancy loss (abortus) is defined as loss of fetal cardiac beat or expulsion of pregnancy material before 20 weeks. It has many causes such as chromosomal abnormalities, uterine anomalies, infections, and unknown causes. Vitamin D has become one of the new topics of research in many medical fields, as it has relations with other diseases besides bone diseases. In some studies of recurrent pregnancy loss, a low vitamin D level was found. In our study, vitamin D levels were measured in the first-trimester pregnancy loss and normal pregnancy group.

Material METHOD: Patients, single pregnancies with a positive fetal heartbeat, who applied to the pregnant outpatient clinic for the first examination of pregnancy were included in the study, and vitamin D levels were measured at this time. The patients were followed up to the 12th gestational week using the hospital automation system. The groups of normal pregnancy

and abortus groups were determined. 25(OH)D levels between 2-96 ng/ml can be detected, while over 30 ng/ml is sufficient, 20-29.99 ng/ml is insufficient, and <20 ng/ml is defined as a low 25(OH)D3 level.

RESULTS: 66 patients were included in the pregnancy loss group, in the follow-up, 63 patients were in the normal pregnancy group. The mean vitamin D level of the individuals included in the study was measured as 7.45±4.64 ng/ml. Levels of vitamin D were 10.04±6.19 in the normal course group and 4.8±1.73 ng/ml in the intrauterine exitus group($p<0.05$). At a vitamin D level of 6,87 ng/ml, pregnancy loss was expected with 90% sensitivity and 64% specificity.

CONCLUSION: It is still an important issue to determine the most appropriate level and preconceptional starting and the appropriate dose for maximum benefit for mother and baby, especially in the reproductive period and pregnant. Therefore, large-scale randomized controlled studies of high quality are needed.

Keywords: abortus, 25-Hydroxyvitamine D3, pregnancy loss

Descriptive values of study groups

Study groups	Healthy group n=63	Healthy group n=63	Pregnancy loss group (n=66)	Pregnancy loss group (n=66)	
Variables	Mean	Min-Max	Mean	Mıx-Max	p
Age (year)	26.58±4.01	19-34	24.12±3.89	18-33	NS
Gravidity	1.57±0.75	1-3	1.41±0.7	1-5	NS
Body mass index (kg/m²)	25.09±3.42	18-33	24.96±4.46	19-42	NS
Smoking status	61 non-smoker	2 smoker	62 Non-smoker	4 smoker	NS
Full covered Clothing	22 full-covered	41 none	21 full-covered	45 none	NS

The relationship between the outcome of pregnancy follow-up and vitamin D levels

Level of vitamin D (ng/ml)	Normal course	Intrauterine exitus
Low (<20)	56	57
Deficiency(20-29.99)	5	8
Sufficient(>30)	2	1

Cut-off values of vitamin D levels in pregnancy loss group

Cut-Off	Sensitivity	Spesificity
6,78	0,892	0,644
6,87	0,908	0,644
6,96	0,908	0,630

SS-14 [Obstetri Genel]

The effects of progesterone treatment on nuchal translucency in first and second trimester in pregnency

Akın Usta[1], Ceyda Usta[1], Kübra Ak[1], Çağla Bahar Bülbül[2], Nevroz Alış Söyleyici[3]
[1]Department of Gynecology and Obstetric,Balıkesir University Health Practice Research Hospital,Balikesir,Turkey
[2]Department of Gynecology and Obstetric,Balikesir Ataturk City Hospital,Balikesir,Turkey
[3]Department of Histology and Embryology.Uludağ University,Bursa,Turkey

AIM: In the literature, there are studies related to the fact that the use of progesterone in the first trimester increases the NT measurement.

We aimed to investigate the effect of progesterone use on NT measurement in the first trimester and NF measurement in the second trimester due to threatened abortion in our pregnant population.

MATERIAL-METHODS: In this retrospective study, we evaluate a total of 130 pregnant women who applied to our clinic for routine pregnancy follow-up. It was determined that 35 of them used vaginal progesterone due to the threatened abortion. NT

and NF thicknesses of 130 pregnant women were compared with those who used progesterone (n = 35) and those who did not (n = 95). In addition, demographic data such as age, body mass index (BMI), NT, NT MoM, free beta human chorionic gonadotropin (free B-hCG), pregnency associated plasma protein-A (PAPP-A) values in the first trimester aneuploidi screening and alpha feto protein (AFP) values in the second trimester aneuploidi screening, B-hCG, Estradiol (E2) values were also recorded.

RESULTS: There was no statistically significant difference between the NT values in the first trimester of the pregnant women who used progesterone due to threatened abortion and those who did not use progesterone (p = 0.1142). Considering the NF measurements, it was found that the NF thickness was significantly less in pregnant women using progesterone in the first trimester (p = 0.0268).

CONCLUSION: Although the use of progesterone in the first trimester due to threatened abortion does not affect NT values, it may be associated with lower NF values measured in the second trimester.

Keywords: progesterone,nuchal translucency,nuchal fold

Clinical and Laboratory results all the groups

Variable	Control Group (n = 95)	Progesterone Group (n = 35)	P Value
Age,Year (average±SD)	28.40±5.71	30.97±5.32	0.0222*
VKI, kilo/tall 2 (average±SD)	25.92 ±5.33	25.61 ±3.89	0.7669*
CRL, mm (average±SD)	60.80±9.38	59.97±8.89	0.6477*
Gestational age, week (average±SD)	12.4±0.6	12.4±0.7	0.9020*
NT, mm (average±SD)	1.27±0.31	1.37± 0.32	0.1142*
NT, MoM (average±SD)	0.81±0.18	0.84±0.23	0.6071*
NF, mm median (min-max)	0.43 (0.24-0.76)	0.41 (0.27-0.57)	0.0268 #
AFP, ng/mL (average±SD)	44.72 ±23.75	32,19 ±10.36	0.1836*
ß-Hcg, mlU/mL (average±SD)	21616.5±10564.3	23596.6±8079.1	0.6453*
E 2, pg/mL (average±SD)	0.71±0.34	0.71±0.26	0.9925*
Free B-hCG, mlU/mL (average±SD)	51.59±53.21	54.54±33.99	0.7828*
PAPP-A, ng/mL (average±SD)	2.76±1.83	2.68±1.50	0.8324*

SS-15 [Obstetri Genel]

Fetuin-A expression in human umbilical vein endothelial cells and amnion cells of patients with gestational diabetes mellitus

Selim Afşar[1], Ayşe Yiğit[3], Ruhşen Özçağlayan[2], Ceyda S Usta[1], Çağla B Bülbül[4], Gulay Turan[5]
[1]Department of Obstetrics & Gynecology, Balıkesir University Faculty of Medicine, Balıkesir,Turkey
[2]Department of Internal Medicine, Balıkesir University Faculty of Medicine, Balıkesir,Turkey
[3]Department of Obstetrics & Gynecology, Yureğir State Hospital, Adana, Turkey
[4]Department of Obstetrics & Gynecology,Cıty Hospital,Balıkesir, Turkey
[5]Department of Pathology,Balıkesir University Faculty of Medicine, Balıkesir,Turkey

INTRODUCTION: Gestational diabetes mellitus is seen with a prevalence of 5-10% of all pregnancies. The inability to overcome this insulin resistance despite pancreatic B-cell hyperplasia leads to GDM. Fetuin-A (α2 - Heremans-Schmid glycoprotein) which was first isolated from fetal bovine serum. Fetuin-A is an inhibitor of insulin receptor tyrosine kinase and also it is associated with insulin resistance, type 2 diabetes and metabolic syndrome. On the other hand, in another meta-analysis; it was speculated that fetuin-A levels in patients with GDM were not significantly different from those in the control group during the first or early second trimester of pregnancy.

However, the role of fetuin-A in the placenta is obscure. In literature, there are myriad papers which explores the correlation of serum fetuin-A levels and GDM, however; data is limited on the tissue expression of this molecule, especially on placental subunits of patients with GDM.

Our purpose was to delineate the correlation between fetuin-A expressions in human umbilical vein endothelial cells (HUVECs) and amnion cells (ACs) in patients with GDM and clinicopathological variables of those patients and neonates.

METHODS: This retrospective cohort study was carried out between January 2019 and January 2022. The design of the study in parallel with the requirements of the Helsinki Committee essentials and it was approved by the Local Ethical Committee of the Balikesir University, School of Medicine, Balikesir, Turkey, and the informed consent was obtained from all participants. Women who had singleton pregnancy underwent the 2-step approach to detect GDM and they were followed until delivery. Based on glucose challenge test (GCT) or oral glucose tolerance test (OGTT) results 82 age-matched patients were included into the study as GDM group (n=40) or control group (n=42) and placental tissue and amnion membranes were retrieved after delivery. Patients with pregestational diabetes, multiple pregnancies, history of hypertension, other chronic systemic diseases, intrauterine infections, and fetal anomaly were excluded from the study. After placental specimens were assessed morphologically for placental weight and cord insertion site, those were fixed and embedded in paraffin for detailed histopathological examination. The expression of fetuin-A in the GDM and control group was compared.

RESULTS: In our study, there is a correlation between fetal macrosomia, neonatal hypoglycemia, placental weight, and fetuin-A expression of HUVECs in GDM patients. Additionally, an excursion on fetuin scores can be conferred in both ACs and HUVECs of GDM patients. The expression of fetuin might be linked in the development of GDM.

Keywords: gestational diabetes, fetuin-A, human umbilical vein endothelial cell, amniotic membrane

SS-17 [Obstetri Genel]

Diagnosis of Uterus Didelphis by Cesarean Section in a Case with Normal Vaginal Delivery at Term: A Case Report

İrem Küçükyıldız[1], Songül Varış Tuncay[2], Dilek Çayırezmez[3]
[1]Department of obstetrics, Sivas Cumhuriyet University,Sivas,Turkey
[2]Department of obstetrics, Sivas Cumhuriyet University Hospital,Sivas,Turkey
[3]Department of delivery room,Sivas Cumhuriyet University Hospital,Sivas,Turkey

Müllerian duct anomalies (0.5-6.7%) are common and these anomalies are usually accompanied by uterine diphdelphis (UD) at a rate of 5%.Uterine didelphis is a rare uterine anomaly and reproductive results are better in patients with uterine didelphis compared to other anomalies.In this case, a case with a normal vaginal delivery at 3 terms was taken to a cesarean section due to premature water arrival and non-progressive action.During the operation, she was diagnosed with uterine didelfis. The aim of this case is to conduct a literature review on the complications of uterine anomalies during pregnancy

Keywords: Uterus didelphis,,uterin anomaly, pregnancy, complication

SS-18 [Onkoloji]

Smooth muscle tumor of uncertain malignant potential (STUMP): clinicopathologic and survival analysis of 15 cases

Saliha Sağnıç, Ceyda Karadağ, Hasan Aykut Tuncer, Selen Doğan, Tayup Şimşek
Department of Gynecology and Oncology, Akdeniz University, Antalya, Turkey

Smooth muscle tumors of undetermined malignant potential (STUMP) in the uterus are one of the rare gynecologic neoplasms. These tumors do not meet the current histologic criteria for a specific malignant or benign tumor. Due to the rarity of these tumors, their clinical behavior is poorly understood. AIM: To investigate the clinicopathologic features, treatment methods, recurrence rate and survival outcomes of patients diagnosed with STUMP. METHODS: The clinical and pathologic data of STUMP patients diagnosed in Akdeniz University Faculty of Medicine Hospital from 2014 to 2022 were collected. The patients' electronic medical files were reviewed. Data including age at the time of diagnosis, clinical characteristics, tumor size, tumor localization, treatment modality, pathological findings, recurrence rate and overall survival were retrospectively analyzed. RESULTS: Fifteen patients with STUMPs were included in the study. The mean age of the patients at the time of diagnosis was 44 with a range of 32 to 54 years, 12 (80%) patients were of reproductive age. The median parity was 2 (0-3) The most common clinical presentation was abdominal pain (53,3%). Other clinical symptom was abnormal vaginal bleeding and one patient was asymptomatic. The most common localization of tumor was in the uterus (80%), other localizations were cervix (13.3%) and broad ligament (6,7%).The mean tumor diameter was 6.8 cm (range 3-11,3 cm). 5 cases underwent myomectomy and 10 cases underwent hysterectomy; in addition to various operations. 6,7% of patients showed high mitotic index (10/10 HPF). While 53.3% of patients showed modarate atypia index; 40% of patients showed significant atypia index.and only two patients showed necrosis. Most tumors carried Ki-67 index ranging from 3% to 30%. With a mean follow up of 53 months no recurrence was seen. All patients are alive. CONCLUSION: STUMPs are considered as low malignant potential tumors since recurrent cases were reported in the literature although we did not detected any relaps. Fertility-sparing approaches are feasible in patients desiring fertility but close follow up is essential.

Keywords: Clinicopathologic characteristic, Recurrence, Smooth muscle tumor of uncertain malignant potential (STUMP), Survival outcome.

SS-19 [Onkoloji]

Evaluation of Clinical, Pathological and Genetic Data of Endometrial Cancer Cases with Microsatellite Instability

Özlem Çelik, Nejat Özgül, Murat Gültekin, Mehmet Coşkun Salman, Utku Akgör, Alp Usubütün
Hacettepe Üniversitesi Tıp Fakültesi

Endometrial cancer, the most common gynecological cancer; In 2013, the Cancer Genome Atlas (TCGA) analyzed the molecular genetic basis of endometrial cancer development and identified four molecular subclasses based on mutation load and copy number changes. Studies have shown that molecular markers in these subgroups are stronger prognostic markers than the histopathological features of the tumor. The aim of this study was to determine the frequency of MSI in the tumor tissues of patients who underwent hysterectomy at Hacettepe University, Department of Obstetrics and Gynecology between January 1, 2019 and March 30, 2021 and whose pathology resulted in endometrial cancer, and to examine the effects of treatments applied on patients with MSI tumors on the prognosis; It is aimed to evaluate patients who meet the test criteria in terms of LS and to contribute to the literature by combining clinical, pathological and genetic data. There were 174 patients in total in the study group. MMR deficiency was detected in 61 (35.1%) of these patients, and no deficiency was observed in 112 (64.4%) patients. When the effect of deficiency of MMR on treatment was examined, no independent variable that made a statistically significant difference was observed. Lynch Syndrome

was detected in 4 patients in total. Genetic counseling was offered to these patients. As a result, molecular classification will become the basis of molecular subgroup adjuvant treatment approaches and individualized treatments in the coming years.

Keywords: Endometrial Cancer, Molecular Classification, Mismatch Repair, Lynch Syndrome

Clinicopathological and Molecular Characteristics of MMR Patients

Patients with MMR Deficiency	Result
MMR deficiency (Number, %) Deficiency Non Deficiency	61 (35,1) 112 (64,4)
Average Age (SD) MMR deficiency ones MMR non deficiency ones	59,5(±10,7) 60,1 (±10,4)
MMR Proteins (Number) Having deficiency of MSH2 Having Deficiency MSH6 Having Deficiency PMS2 Having Deficiency of MLH1	9 12 51 42
MLH1 Methylation (Number, %) MLH1 Methylation Not Detected MLH1 Methylation Detected MLH1 Mertilation Insufficient	3 (7,1) 37 (88) 2 (4,7)

SS-20 [Onkoloji]

Clinical Outcomes of Ovarian Cancer Management: A Single Tertiary Referral Centre Experience

Onur Can Zaim[1], Mehmet Coşkun Salman[2], Nejat Özgül[2], Hasan Volkan Ege[2], Murat Gültekin[2]
[1]Department of Obstetrics and Gynecology, Hacettepe University, Ankara, Turkey
[2]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Hacettepe University, Ankara, Turkey

INTRODUCTION: High grade serous carcinomas are the most common subtype of ovarian cancer. Mostly the patients diagnosed with advanced stage disease. The main approach for management consists of primary debulking surgery (PDS). However, some patients cannot be good candidates for primary surgery, and neoadjuvant chemotherapy (NACT) followed by interval debulking surgery (IDS) emerges as an alternative strategy. In our study, it was aimed to show that both strategies applied in our clinic are similar in terms of effectiveness.

METHODOLOGY: Our study retrospectively included 151 patients who were treated between January 2014 and May 2021 in Hacettepe University, Gynaecological Oncology Clinic with a diagnosis of advanced stage high-grade serous carcinoma. These patients were divided into two groups by their strategies as 77 patients for PDS and 74 patients for NACT/IDS groups in terms of 1:1 ratio. Two groups were comparatively investigated for patient characteristics, staging, recurrence and survival rates, and follow up outcomes. $p<0,05$ was considered to be statistically significant.

RESULTS: The importance of performance status ($p=0,003$) and the clinical stage of patients ($p=0,001$) were shown regarding to patient selection for the appropriate strategy. Direct effect of “no residual tumour after surgery” on overall survival rates was determined by multivariate analysis (HR: 0,57 [95% CI 0,34 - 0,96]; $p=0,034$). In terms of overall survival (HR: 0,74 [95% CI 0,45 - 1,22]; log rank $p=0,234$) and progression-free survival (HR: 0,728 [95% CI 0,50 - 1,06]; log rank $p=0,083$), it was shown that both of strategies were similar for effectiveness. There was no impact of pandemic on strategy selection ($p=0,073$).

CONCLUSION: NACT/IDS and PDS strategy have the same effectiveness, in terms of surgical complications, recurrence and survival rates. However, if it is envisaged that no residual disease after surgery with appropriate patient selection for strategy, PDS strategy can be considered as leading option.

Keywords: Ovarian cancer, Neoadjuvant therapy, Gynaecologic surgical procedures

Figure 1

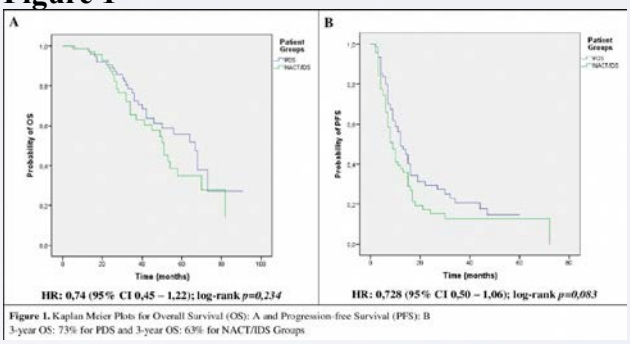


Figure 1. Kaplan Meier Plots for Overall Survival (OS): A and Progression-free Survival (PFS): B
3-year OS: 73% for PDS and 3-year OS: 63% for NACT/IDS Groups

Kaplan Meier Plots for Overall Survival (OS): A and Progression-free Survival (PFS): B 3-year OS: 73% for PDS and 3-year OS: 63% for NACT/IDS Groups

Table 1

Table 1. Cox Proportional Hazard Regression Model for OS and PFS

Overall Survival (OS)		**Multivariate analysis**	
Parameter	**HR**	**%95 CI**	***p value***
Patient groups*	1,12	0,64 – 1,96	*0,688*
Age	0,99	0,95 – 1,03	*0,573*
ECOG Score	1,43	0,82 – 2,52	*0,207*
CA125 at diagnosis	1,00	0,99 – 1,01	*0,218*
Stage	1,13	0,81 – 1,59	*0,453*
Degree of cytoreduction **	0,57	0,34 – 0,96	***0,034***
Progression-free Survival (PFS)		**Multivariate analysis**	
Parameter	**HR**	**%95 CI**	***p value***
Patient groups*	1,25	0,83 – 1,88	*0,286*
Age	0,99	0,97 – 1,02	*0,727*
ECOG Score	1,18	0,76 – 1,82	*0,453*
CA125 at diagnosis	1,00	0,99 – 1,01	*0,055*
Stage	0,99	0,82 – 1,22	*0,984*
Degree of cytoreduction **	0,73	0,49 – 1,08	*0,113*

HR: Hazard ratio, CI: Confidence interval
*PDS vs. NACT/IDS
** No residual gross tumor vs. R>0

Cox Proportional Hazard Regression Model for OS and PFS

SS-21 [Onkoloji]

Comparison of Four Different Risk of Malignancy Indexes in the Preoperative Evaluation of Suspected Adnexal Masses

Hasan Volkan Ege[1], Ayşe Filiz Yavuz[2], Gökçen Ege[3], Onur Can Zaim[4], Hüseyin Levent Keskin[5]
[1]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Hacettepe University, Ankara, Turkey
[2]Department of Obstetrics and Gynecology, Yıldırım Beyazıt University Faculty of Medicine, Ankara, Turkey
[3]Department of Obstetrics and Gynecology, University of Health Sciences Etlik Zübeyde Hanım Women's Health Care, Training and Research Hospital, Ankara, Turkey
[4]Department of Obstetrics and Gynecology, Hacettepe University, Ankara, Turkey
[5]Department of Obstetrics and Gynecology, University of Health Sciences Ankara City Hospital, Ankara, Turkey

AIM: Risk of malignancy index (RMI) is a combined parameter which is simple, practical and highly sensitive, and more specific to predict the malignancy potential of suspected adnexal masses preoperatively. RMI is calculated with a simplified regression equation obtained from the product of menopausal status score (M), ultrasonographic score (U), and absolute value of serum CA-125. Various combined methods for evaluating the risk of ovarian cancer have been proposed. The aim of this study was to evaluate the performances of 4 RMI to discriminate benign from malignant pelvic masses in Turkish population.

Materials-METHODS: Four different RMI scores of 703 patients who were operated in a tertiary hospital on with the diagnosis of adnexal mass were calculated retrospectively. RMI 1 =U x M x CA-125 level; a total US score of 0 yielded U =0, a score of 1 yielded U =1, and a score of ≥2 yielded U =3. Premenopausal status yielded M =1, postmenopausal

=3. RMI 2 =U x M x CA-125; with the differences from RMI 1 of total US score of ≥2 yielded U=4 and postmenopausal =4. RMI 3 =U x M x CA-125 with the differences from RMI 1 of a total US score of 0 or 1 yielded U =1. RMI 4 =U x M x S x CA-125, where a total US score of 0 or 1 yielded U =1 and a score of ≥2 yielded U =4. Premenopausal status yielded M =1, postmenopausal =4. A tumor size (single greatest diameter) of < 7 cm yielded S =1 and ≥7 cm S =2. Postoperative final pathology reports of the subjects were recorded and the diagnostic performances of preoperative RMI scores were calculated.

RESULTS: The mean age of the subjects were 48.0 and 42.2% were postmenopausal. In the ultrasonographic examination solid papillary structure (n=283), multilocular (n=246), bilaterally adnexal mass (n=97), ascites (n=59) and metastatic mass (n=59), which are accepted as malignancy criteria, were detected. %62,6% of the patients had an ultrasonographic finding. The final histopathologic diagnoses were malignant in 137 (19,5%) and borderline ovarian tumor in 23 (%3,3) cases. The predictive power of 4 different RMIs for malignant masses is shown in Table.

CONCLUSION: Different RMIs do not have significant superiority over each other. The RMI method is a valuable and applicable method in diagnosing adnexal masses with high risk of malignancy and a simple technique that can be used in daily practice in gynecology clinics without any additional workload and cost.

Keywords: Risk of malignancy index, Adnexal mass, Ovarian cancer

Table

RMI	Sensitivity	Specificity
RMI1	%74.4	%91.3
RMI2	%80.6	%86.2
RMI3	%75.6	%90.1
RMI4	%78.8	%89.9

Preoperative diagnostic performances of different RMI to predict malignancy potential of suspected adnexal masses (n=703)

SS-22 [Onkoloji]

Low-Grade Endometrial Stromal Sarcoma(LG-ESS)-Case Report

Selim Afşar[1], Gülay Turan[2], Akın Usta[1], Duygu Lafcı[1]
[1]Department of Obstetrics & Gynecology, Balıkesir University Faculty of Medicine, Balıkesir,Turkey
[2]Department of Pathology,Balıkesir University Faculty of Medicine, Balıkesir,Turkey

INTRODUCTION: Endometrial stromal tumors (ESS) are rare uterine neoplasms, accounting for approximately 0.2% of all genital tract malignancies. ESS most often affects postmenopausal women whose median age between 45 and 57 years. ESS could be misdiagnosed as leiomyoma. Its differential diagnosis may be challenging and generally it is done postoperatively based on histopathological examination. The cornerstone of treatment of LG-ESS is surgery (TH and BSO), however the role of lymphadenectomy is uncertain. Generally, hormone receptors (estrogen receptor [ER] and progesterone receptor [PR]) are positive for LG-ESS, which unveils the hormonal therapy (HT) option. LG-ESS pose a risk of late recurrence which necessiates a long-term

follow-up. It is uncertain how long the progestin therapy can be used to achieve the sustained protection. CASE: A 51 year old patient admitted to our clinic with a history of abdominal mass and abnormal bleeding. Her past medical record and gynecologic history was otherwise unremarkable. The US examination was revealed a 11 cm mass which was thought as a leiomyoma. The results of preoperative laboratory testing, serum electrolyte levels, biochemical tests, and tumor markers such as carbohydrate antigen 125 (CA 125) were within normal limits. Endometrial curettage result was normal. So that total abdominal hysterectomy and bilateral salpingoophorectomy were performed. The final pathology was revealed as LG-ESS. The immunohistochemical study showed that CD 10 and SMA were positive, and also estrogen and progesterone receptors were positive. The patient was followed up. RESULT: Uterine sarcomas comprise a rare group of cancers that mostly affect postmenopausal women. Endometrial stromal sarcoma is often diagnosed postoperatively on hysterectomy specimens taken from patients initially thought to have a benign condition such as leiomyoma. The recommended treatment is total hysterectomy with bilateral salpingo-oophorectomy, and lymphadenectomy is rarely performed. LGESS could be detected coincidentally after myomectomy operation and the surgical treatment should be individualized according to the grade and invasion of myometrium by tumour.

Keywords: Endometrial stromal sarcoma, Uterine sarcoma, Leiomyoma

SS-23 [Onkoloji]

Laparoscopic Nerve Sparing Radical Hysterectomy

Evrim Erdemoglu, İlyas Turan, Volkan Öztürk
Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, Suleyman Demirel University

AIM: Cervical cancer patients not only care about their oncological outcomes, but also their quality of life. Therefore, laparoscopic surgery can provide an optimized view of pelvic nerves and structures, allow for early ambulation and discharge, and reduce the need for analgesics. Nerve-sparing radical hysterectomy technique can improve surgical outcomes and minimize pelvic dysfunction rates. The aim of this presentation is to demonstrate that laparoscopic nerve-sparing radical hysterectomy can be performed in cases of recurrent/persistent locally advanced cervical cancer after chemo-radiation. METHOD: A step-by-step guide to the technique shown in a surgical video. RESULTS: A type C radical hysterectomy can be performed laparoscopically while preserving the nerves in the pelvis, including the hypogastric nerve, the sacral plexus, and the splanchnic nerves traveling to the bladder and rectum. CONCLUSION: Laparoscopic nerve-sparing radical hysterectomy is a feasible option for experienced centers, even in patients who have been previously irradiated.

Keywords: laparoscopy, nerve sparing radical hysterectomy, cervical cancer, radiation, recurrence

SS-24 [Onkoloji]

Can complete resection in secondary cytoreductive surgical be predicted in epithelial ovarian cancer patients?

Büşra Şahin, Derman Başaran, Fulya Kayıkçıoğlu
SBÜ Ankara Etlik Zübeyde Hanım Kadın Hastalıkları Eğitim ve Araştırma Hastanesi

AIM: Epithelial Ovarian Cancer (EOC) is the most mortal gynecological malignancy. The most important problem for EOC is the recurrence of the disease and the lack of curative treatment in relapsed patients. Therefore, the treatment strategy in relapsed patients is to prolong survival without impairing quality of life. One of the important topics of discussion for relapsed patients is the place of secondary cytoreductive surgery (SCS) in the treatment. The aim of this study is to investigate the parameters to be used to predict complete resection (CR) in patients undergoing SCS in our clinic and to analyze the effects of complete resection and survival when classified according to the AGO score. METHODS: There are 326 patients who were diagnosed with EOC, completed their primary treatment and had recurrence information in Etlik Zübeyde Hanım Gynecology Training and Research Hospital Gynecological Oncology Clinic between 2006-2020 were analyzed retrospectively. Forty-two patients who underwent SCS at their first recurrence were included in the study. According to the results of SCS, the patients were divided into two groups; CR and residual tumor group. Two group analyzes were performed in terms of demographic characteristics of the patients, intraoperative findings at the first surgery and recurrence pattern. In addition, patients were classified according to the AGO scoring system (Platinium free interval >6 months, complete resection at first surgery, good performance status, <500 cc acid) and its effect on survival outcomes was investigated. RESULTS: CR was achieved in 29 (69%) of 42 patients included in the study. While the SCS-CR rate was 20% in patients who underwent splenectomy at the first surgery, the SCS-CR rate was 80% in patients who did not undergo splenectomy ($p<0.05$). When evaluated intraoperatively during SCS, the rate of CR was found to be higher in the group with recurrence as a discrete lesion (up to three nodules) compared to the group with recurrence as diffuse disease (more than three nodules and/or peritoneal carcinomatosis) ($p<0.05$). When the patients were analyzed according to their compliance with the AGO scoring, no significant difference was found in the rate of CR between the groups. The mean survival rate in the group with CR after SCS was 102 months, with a survival advantage of 38 months. Also, the compliance of the patients with the AGO score did not affect the survival results. CONCLUSION: The addition of SCS to treatment in suitable patients in the treatment of relapsed patients improved survival outcomes. In the DESKTOP III study, when the patient was selected according to the AGO score, CR was achieved in 76% of the patients. We found a CR rate of 69% for SCS in our clinic. Candidates for SCS were determined by the gynecological oncology council, taking into account clinical-surgical experience, regardless of AGO score. The pattern of the disease at the time of relapse can be a guide in patient selection. There is a need for studies with a large patient population to determine the parameters that can be used to determine patients suitable for SCS.

Keywords: Ovarian cancer, recurrent epithelial ovarian cancer, secondary cytoreduction surger

Comparison of surgical outcomes in patients undergoing secondary cytoreduction surgery

Variables	Total Patients n: 42 (%100)	Complete Resection n:29 (%69)	Presence of residual tumor n: 13 (%31)	p
Age				0,641
< 65	37	26 (70,3)	11 (29,1)	
> 65	5	3 (60,0)	2 (40,0)	
FIGO Stage				0,686
I-II	8	6 (75)	2 (25)	
III - IV	34	23 (67,6)	11 (32,4)	

Histopatho-logy				0,460
High Grade Serous Carcinoma	13	10 (76,9)	3 (23,1)	
Other	29	19 (65,5)	10 (34,5)	
Diffuse peritoneal carcinoma-tosis (at first diagnosis)				0,323
No	33	24 (72,7)	9 (27,3)	
Yes	9	5 (69)	4 (31)	
Splenec-tomy (in the first operation)				0,05
No	35	28 (80)	7 (20)	
Yes	5	1 (20)	4 (80)	
Acid				0,616
< 500 cc	25	18 (72)	7 (28)	
> 500 cc	17	11 (64,7)	6 (35,3)	
AGO score				0,588
Available	20	13 (65)	7 (35)	
Not Avai-lable	22	16 (72,7)	6 (27,3)	
Recurrence Pattern (intraopera-tive)				0,002
1 nodule	10	10 (100,0)	0	
2-3 nodules	10	9 (90,0)	1 (10,0)	
>3 nodules and/or peritoneal carcinoma-tosis	22	10 (45,5)	12 (54,5)	
In Preopera-tive Imaging				0,091
< 3 nodules	30	23 (76,7)	7 (23,3)	
> 3 nodules and/or peritoneal carcinoma-tosis	12	6 (50)	6 (50)	

Chi-Square Test(x2), FIGO:International Federation of Gynaecology and Obstetrics.

Survival results of the patients

Variables	Median survival (months)	95% CI		p
		Min	Max	
SCS				0,011
Complete Resection	102,0±17,9	66,826	137,174	
Residual Tumor Present	64,0±6,9	50,471	77,529	
AGO score				0,758
Available	68,0±14,6	39,372	96,628	
Not Available	85,0±4,1	76,942	93,058	

Kaplan-Meier analysis. Log-rank test was used for comparisons. CI: Confidence interval. SCS: Secondary Cytoreduction Surgery

SS-25 [Onkoloji]

A rare case: pure sertoli cell tumor with unexpected levels of anti-mullerian hormone

Nevda Ceren Sonu[1], Hasan Volkan Ege[2], Şefkat İlayda Embel[1], Nejat Özgül[2]
[1]Hacettepe University Faculty of Medicine Department of Department of Obstetrics and Gynecology, Ankara, Turkey
[2]2. Hacettepe University Faculty of Medicine, Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Ankara, Turkey

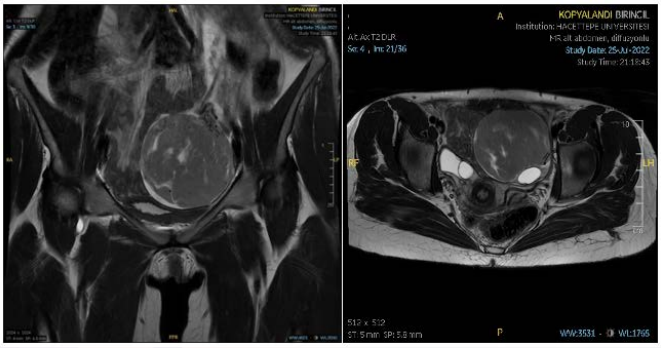
INTRODUCTION: Ovarian Sertoli-Leydig cell tumors are rare type of tumors which belong to the group of sex cord stromal tumors. As a rare conditon these tumors are accounting for less than 0.5% of the all ovarian tumor patients. Pure ovarian Sertoli cell tumors are more rare than both Sertoli-Leydig cell tumors. They are usually in benign nature. They

diagnosed at early stages and their prognosis are usually good (ten years survival of %92). They can accompany Peutz-Jeghers Syndrome and should be investigated when diagnosed in case of the patients with Peutz-Jeghers syndrome are at risk for a variety of other gynecologic and non-gynecologic malignancies.These tumors can be associated with increased Serum CA 125(cancer antigen 125), AMH (anti-müllerian hormone), AFP(alpha-fetoprotein), inhibin levels. These patients frequently present with abdominal pain,swelling and menstural abnormalities. These tumors are hormone functional in %50 of patients and also can present with excess estrojen and anrojen related symptoms (abnormal uterine bleeding, menorrhagia, virilization, oligomenorrhea, amenorrhea etc.).

Case Presentation: A 30 years old woman was presented with lower pelvic pain and secondary amennorhea. She had no additional medical or familial history. Her body mass index was 18 kg/m2. At follow-up 25/07/2022 in Pelvic ultrasonography 82x50 mm right sided adnexial mass was reported.25/07/2022 in Lower abdominal Manyetic resonance imaging (MRI) a right pelvic mass measured as 7.6x7 cm and additionally another right sided multiseptated cyctic appearence measured as 5.2 x 3 cm was reported (Figure-1). Tumor markers were found within normal ranges after these imagings had made.Anti-mullerian hormone level was found as more than 723 µg/L and Estradiol (E2) level was found as 445 pg/mL. By these findings first left unilateral salphingooforectomy performed and the specimen was intraoperatively consulted to the pathology department. They couldn't make a definitive diagnosis. Then right ovarian cystectomy+ cytology+ omental biopsy was added to the operation and ceased at this point considering the intraoperative pathology consultation result. The final pathology was reported as pure Sertoli cell tumor. In follow up the patient informed about the relation between pure Sertoli cell tumors and Peutz Jeghers sydrome.In case of this situation, genetic testing was recommended to the patient. DISCUSSION: Pure Sertoli cell tumor is a rare condition which is a type of sex cord stromal tumor. It usually has a benign character,but also it may be related to Peutz Jeghers syndrome.We should be careful about the other gynecologic and non-gynecologic malignancies and direct these patients to genetic testing. The reported Pure sertoli cell Anti-mullerian hormone levels are ranged mostly between 100 µg/L and 200 µg/L. In our case the level of anti-mullerian hormone was unexpectedly high (>723 µg/L).Very high levels of anti mullerian hormone are associated with the tumor mass in some clinical studies but it is still under discussion.

Keywords: Anti-mullerian hormone, Peutz-Jeghers Syndrome, Sertoli cell tumor

figure 1



Pelvic mass in MRI at diagnosis

SS-26 [Onkoloji]

Chylous Ascites After Pelvic Para Aortic Lymph Node Dissection and Anterior Resection: A Case Report

Şefkat İlayda Embel[1], Onur Can Zaim[1], Nevda Ceren Sonu[1], Hasan Volkan Ege[2], Nejat Özgül[2]
[1]Department of Obstetrics and Gynecology, Hacettepe University Faculty of Medicine, Ankara, Turkey
[2]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Hacettepe University Faculty of Medicine, Ankara, Turkey

INTRODUCTION: Chylous ascites is the build-up of lymphatic fluid in the peritoneal cavity. The etiologies of chylous ascites can be classified as traumatic, congenital, infectious, neoplastic, postoperative, cirrhotic, or cardiogenic. It is a rare situation following surgery, but may result from injury to lymphatic vessels during retroperitoneal surgery. It can also be observed after gynecologic, urologic, and pancreatic surgeries. Diagnosis of chylous ascites was based on the noninfectious milky or creamy peritoneal fluid with a volume of ≥100 mL/day and with a triglyceride concentration of ≥110 mg/dL. Main object for treatment is decreasing chyle formation. Treatment methods may involve a low-fat diet with medium-chain triglycerides, total parenteral nutrition. For patients who are refractory to these methods medical or surgical treatments can also be usefull. Also lymphangiography is a proven beneficial diagnostic tool for these patients. We describe the case of a patient with ovarian cancer who developed severe chylous ascites following pelvic-para aortic lymph node dissection and anterior resection. Case Presentation: A 58 years old woman who had major abdominal surgery for ovarian cancer presented with abdominal distension and shortness of breath. She had total abdominal hysterectomy, bilateral salpingooophorectomy, total omentectomy, pelvic-para aortic lymph node dissection, cytology gathering, anterior resection and anostomosis for ovarian cancer (June 2022). She only had hypertension as a medical background. Body mass index was 23. At follow-up in August 2022, she had severe abdominal distension and shortness of breath.

By these symptoms the patient hospitalized and peritoneal fluid drainage (4000 cc) performed. The sample had milky whitish color. As an indicating laboratory finding triglyceride level was 1539 mg/dL for ascites. There was no infectious or malignant proof in fluid assesment. At the time after drainage, the recommended diet for chylous ascites and total parenteral nutrition ordered. After this regimen the patient still had growing abdominal distension. Subcutaneous administration of the somatostatin analogue (octreotide) at a dose from 100 µg, 3 times daily added to treatment. At the 11th day lymphangiography was performed to the patient. After these medical procedures the patient's amount of abdominal distension decreased.

DISCUSSION: Postoperative chylous leakage is an uncommon but established complication that occurs following abdominal surgical procedures. Chylous ascites may occur due to conditions such as filariasis, tuberculosis, trauma, hepatic cirrhosis, malignancies and complications associated with surgery. In our case both gynecological pelvic-para aortic lymph node dissection and anterior resection may contribute to cylous ascites. Chylous leakage is potentially fatal due to the large amount of fluid, plasma protein, fat and immunoregulatory lymphocyte loss. Furthermore, affected patients exhibit clinical symptoms of severe malnutrition, hyponatremia, acidosis, hypocalcemia and susceptibility to infection. Our case showed that in patients whose abdominal distension is not reduced by diet and total parenteral nutrition, somatotsatin analogues appears to be an effective therapy available for the treatment of chylous ascites.

Keywords: chylous ascites, ovarian cancer, somatostatin analogue

SS-27 [Perinatoloji]

Could Bisphenol-A have a role in the etiology of neural tube defects?

Nisa Aytac Bektas[1], Nefise Nazlı Yenigül[1], Kaan Pakay[2], Burcu Dincgez[1], Yasemin Budak[3], Emin Ustunyurt[4]
[1]Department of Obstetrics and Gynecology, Bursa Yuksek Ihtisas Research and Training Hospital
[2]Department of Obstetrics and Gynecology, Division of Perinatology, Bursa Yuksek Ihtisas Research and Training Hospital
[3]Department of Biochemistry, Bursa Yuksek Ihtisas Research and Training Hospital
[4]Department of Obstetrics and Gynecology, Bursa City Hospital

AIM: In this study, we aimed to evaluate BPA levels in the maternal serum and amniotic fluid of patients diagnosed with NTD. In addition, we wanted to investigate the relationship between neurodevelopmental defects, such as neural tube defects (NTD), and BPA levels. METOD: This prospective observational study was carried out at Bursa Yüksek İhtisas Training and Research Hospital between April 15, 2021, and April 15, 2022. The study consisted of 92 patients between the ages of 18-45 who had an amniocentesis at 15-22 weeks of gestation.The patients were divided into two groups according to the indications of amniocentesis. Group 1 contained the patients with abnormal maternal serum screening results or cell-free DNA results and abnormal ultrasonography findings (45 patients). Group 2 contained the patients with a pre-diagnosis of NTD (47 patients). The first 5 cc fluids and maternal serum samples taken during the amniocentesis procedure of all patients were delivered to the biochemistry laboratory. The BPA values between groups were compared. RESULT: A statistically significant difference was found between the two groups in terms of amniotic fluid BPA levels (36.66(19.00:82.00) and 39.62(19.02-73.87)) and maternal blood BPA levels (22.26 (12.60-228) and 47.81(12.89-228.39)). In cases with NTD, amniotic fluid BPA levels and maternal blood BPA levels were significantly higher than the control group.When AUC values were compared, the AFP numerical value was higher than the amniotic fluid and maternal blood BPA levels. CONCLUSION: Plastic, which is indispensable for modern life, may negatively affect fetal development in intrauterine life. The data in this study says that high maternal blood BPA may be associated with NTD.

Keywords: Bisphenol-A, neural tube defects, plastic, amniocentesis.

SS-28 [Perinatoloji]

Intrauterine pulmonary balloon valvuloplasty: A case report

Murat Çağan, Özgür Özyüncü, Özgür Deren
Division of Perinatology, Department of Obstetrics and Gynecology, Faculty of Medicine, Hacettepe University, Ankara, Turkey

Background and AIM: Critical pulmonary stenosis has a poor prognosis with high mortality and morbidity rates. With the demonstration of the feasibility of intrauterine balloon valvuloplasty to achieve biventricular circulation, interest in these procedures has increased worldwide. In this study, we aim to share one of our fetal cardiac interventions (FCI) targeting to relieve the obstruction of the pulmonary valve (PV) before the development of irreversible damage to the right ventricle in a patient diagnosed with critical pulmonary stenosis. Case presentation: A 32-year-old, primigravid pregnant woman was referred to the Division of Maternal-Fetal Medicine, Hacettepe University due to critical pulmonary stenosis detected in a detailed ultrasound examination. The fetus had a thick dysplastic pulmonary valve with antegrade jet flow and hypertrophic hypoplastic right ventricle (Figure 1). The pulmonary annulus was measured as 3.7 mm (z score, -2.7) and the peak systolic velocity

(PSV) at the level of the PV was 3.2 m/s. The procedure was planned after a rigorous evaluation with a multidisciplinary approach including Perinatology, Pediatric Cardiology, Anesthesiology, and Neonatology. In-utero pulmonary balloon valvuloplasty was conducted under general anesthesia and ultrasound guidance via an 18-gauge needle inserted through the maternal abdominal wall into the uterine cavity and reaching the fetal heart at the 28th gestational week. In the right ventricle outflow tract view, after insertion of the needle into the right ventricle, the coronary guidewire was viewed at the right ventricle, at the level of the pulmonary valve, and in the main pulmonary artery, respectively (Figure 2). The non-compliant percutaneous transluminal coronary angioplasty balloon (4 mm x 12 mm) was inflated 3 times in a row at the level of the PV. As the PSV decreased to 1.6 m/s after the procedure, the FCI was considered technically successful. However, hemopericardium requiring immediate percutaneous drainage developed at the end of the procedure. No other complications related to the procedure, such as laceration of maternal vessels, premature rupture of membranes, placental abruption, preterm delivery, fetal injury, and infection were observed. At the time of this report, the pregnancy follow-up was uneventful and delivery is planned at term. We expect a biventricular outcome after postnatal balloon valvuloplasty of residual stenosis.

CONCLUSION: Fetal cardiac interventions may improve the likelihood of a biventricular outcome for fetuses with critical valvular stenosis. Careful selection of patients and centralization of experience in highly technically skilled medical institutions are essential for obtaining favorable perinatal outcomes of fetal cardiac interventions. Improved procedural techniques with a lower complication rate will be achieved through advanced medical technology and specific balloon catheters.

Keywords: balloon valvuloplasty, critical pulmonary stenosis, fetal cardiac intervention

Figure 1

Four chamber view showing hypertrophic hypoplastic right ventricle.

Figure 2

Ultrasonographic view showing balloon catheters passing through the stenotic pulmonary valve.

SS-29 [Perinatoloji]

Fetal craniorachischisis associated with omphalocele and radial aplasia

Coşkun Ümit, Gulsah Aynaoglu Yildiz, Acar Koç
Department of Obstetrics and Gynecology, Ankara University, Ankara, Turkey

Fetal craniorachischisis is a rare congenital anomaly characterized by the combination of anencephaly contiguous with a bony defect of the cervical spine. The defect occurs with the failure of neural tube to close within 28 days after conception. Fetal craniorachischisis may be associated with omphalocele and cardiac, facial and skeletal

abnormalities. An omphalocele is a median abdominal wall defect of different size, with the herniated abdominal organs covered by a membrane. It occurs at the base of the umbilical cord. The incidence of omphalocele is nearly 1/5000 live births. Due to the high risk of chromosomal abnormalities, karyotyping is mandatory. Radial ray anomalies comprise of a large spectrum of upper limb anomalies which range from partial (radial hypoplasia) to a complete (radial aplasia) deficiency of the radius with or without accompanying deficiency of the thumb bones. We reported here a 13 weeks male fetus with craniorachischisis, omphalocele and bilateral radial aplasia. A chorionic villus sampling was performed immediately, and the karyotype was normal (46,XY). After informing the parents about the lethal nature of the abnormalities, pregnancy was terminated by induction with misoprostol and the diagnosis was confirmed on clinical, radiographic examination of the fetus. Major congenital anomalies affect 2-3% of all pregnancies. Although second trimester ultrasound screening has routinely been used for anomaly screening all around the world, it is widely accepted that most anomalies can be detected earlier by the advanced ultrasound technologies. Moreover, early detection of lethal anomalies protects mother from obstetric complications and psychological trauma of advanced gestational weeks pregnancy termination.

Keywords: craniorachischisis, omphalocele, prenatal diagnosis, radial aplasia, termination, ultrasound

craniorachischisis and radial aplasia

post termination photo

craniorachischisis posterior aspect

post termination photo

omphalocele

post termination photo

SS-30 [Perinatoloji]

First Trimester Screening; an opportunity for an Early Diagnosis of Structural Anomalies

Talat Umut Kutlu Dilek[1], Eren Kaya[4], Elif Ganime Aygun[2], Ozlem Pata[3]
[1]Halic University, Department of Obstetrics & Gynecology
[2]Acibadem University Atakent Hospital, Department of Obstetrics & Gynecology
[3]Acıbadem MAA University, Department of Obstetrics & Gynecology, Branch of Perinatology
[4]Acibadem MAA University, Department of Obstetrics & Gynecology

Introduction: A newly diagnosed pregnancy has a 2-3% risk of major structural anomaly. The primary imaging tool to screen and diagnose structural anomalies is ultrasound. In this retrospective study, we wanted to share our data in a tertiary center on ultrasonographic evaluation of fetal anatomy in the first trimester and pregnancy follow-up.

Method: This retrospective study was carried out in the Acibadem Mehmet Ali Aydinlar University Atakent Hospital Prenatal Diagnosis Unit between April 2015 and December 2019. The study group consisted of 3000 patients who were referred for the first-trimester aneuploidy screening and anomaly survey. Total 1872 cases had follow-up data including second trimester examination and pregnancy follow-up data.

Results: 51 of 1872 cases have pathologic ultrasound findings including enlarged NT (NT>95 percentile). NT value was over 95 percentile in 14 fetuses (42 %) with structural anomaly. When we exclude cases with only enlarged NT, 24 cases had only isolated and 9 cases had multiple congenital anomalies. An invasive genetic test was performed on to total of 13 cases (CVS for 8 cases and amniocentesis for 5 cases). Prevalence of major fetal structural anomaly was 1,7% (33/1872) for the first-trimester exam including high-risk pregnancies and 0,59 % (11/1839) for the second-trimester exam. However, following the exclusion of cases with increased NT (NT>95 percentile), it was 0,9 % for the first trimester and 0,6 % for the second trimester respectively.

Discussion: The first trimester combined test replaced the second-trimester serum screening test to screen for common aneuploidies in the early 1990s. High-frequency ultrasound probes including transvaginal techniques and increased operator experience contributed to a better and earlier definition of fetal anatomy in the late first trimester. Despite the progress in first trimester ultrasonographic screening, the principal option in prenatal structural and genetic screening remains to be the second trimester ultrasonography

Keywords: prenatal screening, prenatal diagnosis, obstetric ultrasonography, congenital anomaly screening

Table 1

Region	Examination Plane	Details
Head	Transverse-sagittal	Cranial bones Midline Falx Choroid plexus filled ventricles Fourth ventricle, intracranial translucency Midbrain
Neck	Sagittal	Nuchal translucency
Face	Transverse-sagittal-coronal	Eyes with pair of lenses Nasal bone Profile view with palate Retronasal triangle
Chest and heart	Transverse	Symmetrical lung fields Four symmetrical chambers Outflow tracts Three-vessel trachea view Rule out effusions and masses
Abdomen	Transverse-sagittal-coronal	Stomach (fluid filled and left upper quadrant location) Urinary bladder Kidneys
Abdominal wall	Transverse-sagittal	Normal cord insertion Rule out abdominal wall hernias
Extremities		Four limbs each with three symmetrical segment Hand and feets with normal orientation
Spina	Sagittal	Vertebra and intact overlying skin
Placenta		Size, location, proximity to cervical os
Uterine arteries		Bilateral uterine artery pulsatility index
Umblical cord	Transverse	Three-vessel cord

Checklist for the first trimester exam

Table 2

Fetal Structural Anomaly	First trimester	Second trimester
Acrania-exencephaly	4	
Alobar holoprosencephaly	1	
Posterior fossa cyst	2	
Ventricular septal defect (VSD)	3	
Atrioventricular septal defect (AVSD)	4	
Tetralogy of Fallot	1	
Double outlet right ventricle	1 coexisted with VSD	
Transposition of great arteries	2	1
Absence of ductus venosus	1	
Hypoplastic left heart	3	
Abdominal cyst	1	
Pleural effusion	1	
Pes equinovarus	0	2
AVSD+Pes equinovarus	1	
AVSD+Maxillary Gap+Cleft lip and palate	1	
VSD+Extremity contractures	1	
VSD+Omphalocele	2	
VSD+Posterior fossa cyst+Hypertelorism	1	
Posterior fossa cyst+Hypoplastic left heart	1	
Pes equinovarus+Extremity contractures	1	
Atrial septal defect+unilateral pyelectasis+single umbilical artery	1	
Total	33	

Summary of fetal structural anomalies and distribution by trimesters

Table 3

Karyotype	N
Trisomy 13	1
Trisomy 18	2
Trisomy 21	0
Turner Syndrome	0
Triploidy	2
Noonan Syndrome	1
46; t13;14 (Balanced)	1
46; t17;13 (Unbalanced)	1
Normal constitutional karyotype	6

Karyotype results of fetuses with congenital anomalies which underwent invasive genetic diagnosis in the first trimester

SS-32 [Perinatoloji]

Fetal cardiac rhabdomyoma associated with Tuberous Sclerosis Complex; a case report

Bilal Esat Temiz[1], Umutcan Kayikci[2], Murat Cagan[2], Kader Karli Oguz[3], Kadri Safak Gucer[4], Ozgur Deren[2]
[1]Department of Obstetrics and Gynecology, Faculty of Medicine, Hacettepe University, Ankara, Turkey
[2]Division of Perinatology, Department of Obstetrics and Gynecology, Faculty of Medicine, Hacettepe University, Ankara, Turkey
[3]Department of Radiology, Faculty of Medicine, Hacettepe University, Ankara, Turkey
[4]Division of Pediatric Pathology, Department of Pediatrics, Faculty of Medicine, Hacettepe University, Ankara, Turkey

Introduction: Tuberous Sclerosis Complex (TSC) is an autosomal dominant disease, presenting with widely variable clinical manifestations such as seizures, mental retardation, skin lesions, cardiac rhabdomyomas and hamartomas. The prevalence of TSC varies between 1/6,000-1/60,000. Rhabdomyomas are the most common cardiac tumors. It characteristically appears in late pregnancy and commonly regress spontaneously in neonatal period. While 20-40% of single rhabdomyomas are accompanied by TSC, this rate rises up to 95% when they are multiple. In this report, we have presented a case of fetal cardiac rhabdomyoma diagnosed with TSC.

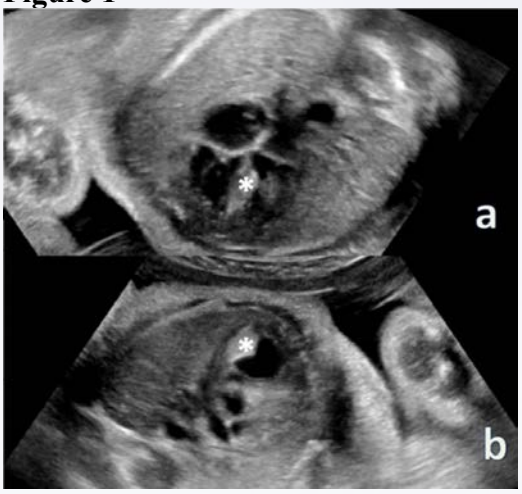
Case Presentation: A 34-year-old, primigravid woman with no significant history was referred to the Division of Perinatology, Hacettepe University due to cardiac mass. There was no consanguinity between spouses. During the detailed anatomical scan performed at 21st gestational week (gw), a 5 mm single hyperechoic mass was observed in the left ventricle (LV). The patient was admitted to our clinic at 29th gw, with a delay due to social reasons. Ultrasonography revealed multiple well-circumscribed hyperechoic masses of 10 mm in size in the LV lateral wall and interventricular septum (Figure1). The masses were not leading outflow obstruction, and cardiac function was normal. Since the masses suggested rhabdomyoma, meticulous evaluation of other fetal structures, including the brain and kidney, was performed. Fetal neurosonography revealed suspected cortical tubers. In the fetal Magnetic Resonance Imaging (MRI), subependymal nodules in the lateral ventricles and small nodular lesions in the cerebral white matter were observed. The diagnosis was thought to be TSC and the termination of pregnancy was offered. Within consent, the pregnancy was terminated at the 33rd gw and fetal autopsy was performed. Multiple cardiac rhabdomyomas and cortical tubers were observed in fetopsy (Figure 2, and 3), and a “de novo” heterozygous TSC-2 mutation was detected in the whole genome sequencing.

Discussion: Fetal cardiac tumors are rare conditions with an estimated prevalence of 0.08-0.2% and are usually diagnosed at late second trimester. Most cardiac masses in fetuses are rhabdomyomas and differential diagnosis includes teratoma, fibroma, hemangioma, and myxoma. Although the definitive diagnosis is histopathological, myocardial location without pericardial extension and multiple masses are in favor of rhabdomyoma. Rhabdomyomas tend to grow slowly in the antenatal period, and show a high rate of association with TSC, especially when multiple as in our case. Clinical manifestations of rhabdomyomas include outflow obstructions, heart failure, arrhythmia, hydrops fetalis, and stillbirth. In our case, no additional cardiac pathology was observed. Since USG is not sensitive for brain evaluation, it is recommended to perform fetal MRI as a complementary tool in suspicious cases. In our case, multiple cerebral tubers were observed in the autopsy, which was also consistent with the MRI findings. The TSC1–9q34 and TSC2–16p13.3 gene mutations have been identified in the presence of TSC. Two-third of these mutations are known to be “de novo”. In our case, a heterozygous mutation was detected in the TSC-2 gene. In conclusion, it should be kept in mind that cardiac

rhabdomyomas, especially when multiple, may be the earliest manifestation of tuberous sclerosis.

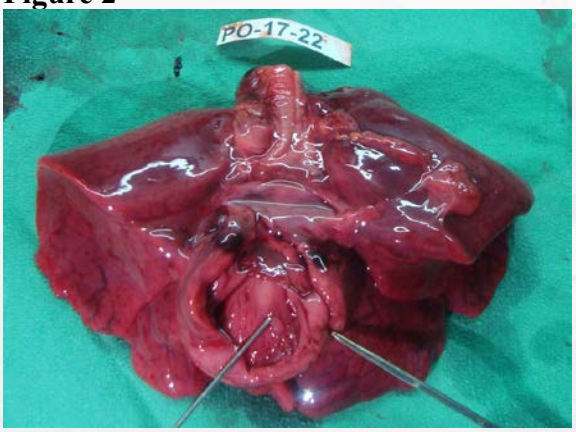
Keywords: Cardiac tumor, Prenatal diagnosis, Rhabdomyoma,Tuberous Sclerosis Complex

Figure 1



Ultrasonographic views showing cardiac masses (*) in the interventricular septum (a) and lateral wall of left ventricle (b).

Figure 2



Multiple cardiac tumors observed at autopsy

Figure 3

Tubers in the formalin-fixed brain tissue

SS-33 [Vaka Bildirileri]

A dedifferentiated retroperitoneal liposarcoma mimicking an adnexial mass

Gözde Şahin[1], Tufan Gümüş[2]
[1]Gynecologic Oncology Clinic,Basaksehir cam and sakura city hospital,İstanbul,Turkey
[2]General Surgery Department, Ege University,İzmir,Turkey

OBJECTIVE: Liposarcomas are soft tissue sarcomas of adipose tissue origin.Even liposarcoma is the most common type of sarcoma in retroperiton, retroperitoneal sarcoms are very uncommon with insidance of %0.07 %0.2. Liposarcomas are divided into 5 types according to their pathological features. These types are 1- well-differentiated liposarcoma,2-dedifferentiated liposarcoma, 3- myxoid/round cell liposarcoma; 4- pleomorphic liposarcoma; and 5-mixed liposarcoma. Dedifferentiated liposarcomas are one third of all liposarcomas. And they have a worse prognosis than other types.Retroperitoneal liposarcoma should be separated from renal, pancreas, gis, and ovarian tumours, so as not to cause diagnostic confusion. In this case, we will present a case of retroperitoneal dedifferentiated liposarcoma giving the image of an adnexial mass.

METHOD: A 43-year-old female patient was admitted

to our gynecologıc oncology policlinic with complaints of abdominal pain and swelling in the abdomen. As a result of the patient's abdominal MRI, a solid adnexial mass of approximately 30x25x17 cm with lobulated contours was observed, heterogeneously hypointense on T1a images and heterogeneous hyperintense on T2a images, extending from the epigastric region to the pelvis. The patient's routine blood tests and tumor markers were normal except for LDH elevation.(LDH:332). The patient was operated with a preliminary diagnosis of ovarian tumor. In the operation,there was a huge retroperitoneal mass, invading inferior mezenteric artery, on the aort, independent from uterus and ovaries. General surgery was included in the operation. The inferior mesenteric artery was ligated and the mass was excised with a negative surgical margin

RESULTS: In microscopic sections, large hyperchromatic atypical neoplastic cells with irregular nuclear contours and multinucleated giant cells were detected between adipocytes in lipamatous areas, while eosinophilic spindle cells with coarse chromatin were detected in sarcomatous areas. Mitosis 23/10 large magnification field. The final pathological diagnosis was reported as dedifferentiated liposarcoma

CONCLUSION: Dedifferantiated retroperitoneal liposarcomas are very rare tumors and should be differentiated from other gastrointestinal and adnexial tumors to avoid diagnostic confusion.

Keywords: retroperitoneal dedifferentiated liposarcoma, adnexial mass, mitosis,

SS-34 [Vaka Bildirileri]

A case report: vulvar rejuvenation with mesotherapy application in a patient with atrophic vaginitis

İsmail Gökbel[1], Deniz Akın Gökbel[2], Ahmet Akın Sivaslıoğlu[2]
[1]Department of Gynecology and Obstetrics, Mentese State Hospital, Mugla, Turkey
[2]Department of Gynecology and Obstetrics, Mugla Sitki Kocman University, Mugla, Turkey

OBJECTIVE: A 47-year-old female patient with diffuse pruritus in the vulvar region was admitted to the outpatient clinic of our hospital. Vulvar rejuvenation with mesotherapy application was planned for the patient.

METHOD: The mesotherapy solution was injected intradermally into the vulva at 0.04 cc/ 10 millimeter intervals.

RESULTS: No complications were observed in the patient in the early period. The itching, which the patient described as quite common in the vulva before the application, improved after the application.

CONCLUSION: Atrophic changes in the vulva are seen due to thinning of the epithelium. Atrophic vulvitis due to these changes seen with advancing age; It is a common problem after menopause. These patients may present with itching, tenderness, dyspareunia or bleeding. The application of mesotherapy to our case provided improvement in the symptoms of this patient due to vulvar atrophy.

Keywords: mesotherapy,vulvar atrophy, vulvar rejuvenation

first day after the procedure

first day after the procedure

SS-35 [Vaka Bildirileri]

A case report: management of the patient with recurrent vesicovaginal fistula

Deniz Akın Gökbel[1], İsmail Gökbel[2], Ahmet Akın Sivaslıoğlu[1]
[1]Department of Gynecology and Obstetrics, Mugla Sitki Kocman University, Mugla, Turkey
[2]Department of Gynecology and Obstetrics, Mentese State Hospital, Mugla, Turkey

OBJECTIVE: Most of the vesicovaginal fistulas are observed especially in the vaginal vault after hysterectomy. Patients often present with the complaint of persistent urinary incontinence. In surgical treatment, there are different treatment options as vaginal and abdominal. Another surgical treatment option is the technique called the Latzko procedure, which is also done vaginally. In this case, we aimed to describe the management of a patient who underwent abdominal and vaginal vesicovaginal fistula repair and whose complaints did not regress.

METHOD: A 37-year-old female patient who underwent laparoscopic hysterectomy in another hospital applied to our hospital's outpatient clinic with the complaint of persistent urinary incontinence after the operation. As a result of the evaluations, abdominal vesicovaginal fistula repair was planned for the patient. As the patient's complaints continued, cystoscopy was planned. A fistula tract was observed on cystoscopy. Fistula repair was performed vaginally in the patient who developed recurrence after abdominal repair. The patient, whose complaints did not resolve after vaginal repair, was followed up with bladder catheterization for 20 days.

RESULTS: After the patient was followed up with bladder catheterization, secondary healing was observed in the fistula tract.

CONCLUSION: The surgical approach in the treatment of vesicovaginal fistula repair is vaginal or abdominal repair. However, it should not be forgotten that follow-up with bladder catheterization is also a treatment option in these patients.

Keywords: bladder catheterization, vesicovaginal fistula, vesicovaginal fistula repair

SS-36 [Vaka Bildirileri]

A process to the couvelaire uterus: ablation placenta

Sait Talha Özkan, Mehmet Musa Aslan
Obstetrics and Gynecology, Sakarya Training and Research Hospital, Sakarya, Turkey

Objective: After the 20th week of pregnancy, the separation from the placenta before it will come (partial abruption) or completely (complete abruption) is called "placental abruption". This situation is seen in one of the pregnancy. The placenta is school-paired with the umbilical cord to the baby for its tendency in the mother's womb. Extremely in the appearance of a baby happily to grow up healthy in birth. This is called the "stage of birth". The placenta will be separated from the uterus (placenta uterus) wall and separated from the uterus wall before birth, training the blood vessels that are open in the muscle and will be designed in this way. Couvelaire uterus is also known as uteroplacental apoplexy. A life threatening reproductive site in which the use of the placenta (ablation placenta) forces the myometrium into the peritoneal spaces where these mechanisms exist. This condition makes the uterus very tense and rigid. The movements into the decidua basalis eventually divide the decidua and the hematoma may be in the decidua or extravasation may be made to the myometrium (the uterine muscle is designed). Due to uterine surgeries, myometries that are weak due to weak intrauterine and rupture may occur. This can lead to an obstetric emergency that threatens the immediate delivery of the fetus.

Case report: A 29-year-old female patient was admitted to the Gynecology and Obstetrics Emergency Service with the complaint of bleeding and pain. Detachment was suspected in the ultrasound and fetal bradycardia was observed in the NST, manual contraction and contraction were continuous. USG measurements were consistent with 37W. The abdomen was entered with a Phannensteil incision. Approximately 300 cc of bleeding fluid was aspirated in the abdomen. The uterus was then entered with a Kherr incision. Head presentation 2930 g girl baby with 7-8 was delivered. Placenta was observed as 100% detached. Approximately 2000 cc of blood and fibrin fragments were aspirated from the abdomen and uterus. Diffuse Couvelaire sign was observed in uterus.

Conclusion: Placental abruption is one of the important emergencies that can develop many complications in terms of obstetrics. Depending on the amount of bleeding, the patient may enter the picture of disseminated intravascular coagulation. May experience hypovolemic shock. Due to tissue perfusion damage, multiple organ failure may occur, and even maternal and infant death may occur. If the patient describes bleeding at the time of admission or if bleeding is detected during the examination, it should always be kept in mind that placental abruption may occur. In addition, not every case of abruptio placentae may present with bleeding. If the bleeding does not extend to the cervix, there may be bleeding between the placenta and the uterus and this bleeding may not be observed in the vaginal examination. In such a case, the placenta should be especially evaluated for ablatio placentae, fetal heartbeat should be monitored, and clinical findings such as continuous uterine contractions should raise suspicion for placental abruption.

Keywords: ablatio placenta, couvelaire uterus, bleeding

Figure 1

couvelaire uterus

Figure 2

couvelaire uterus

Figure 3

couvelaire uterus

SS-37 [Vaka Bildirileri]

Placental site trophoblastic tumor: a pathology to consider in women with pregnancy of unknown location

Sinem Ertaş, Bülent Urman
Kadın Sağlığı ve Tüp Bebek Bölümü, Amerikan Hastanesi, İstanbul, Türkiye

Introduction: The vast majority of pregnancies of unknown location (PUL) are failing intrauterine or ectopic implantations. These are pregnancies not visible to ultrasound examination and beta hCG levels do not increase appropriately. Very rarely, a positive pregnancy test in the presence of a negative ultrasound scan may be due to gestational trophoblastic diseases (GTDs). We herein report a case of Placental site trophoblastic tumor (PSTT) misdiagnosed as ovarian ectopic pregnancy and review the literature.

Case: A 41-year-old woman, gravida 1 para 1 (caesarean section-18 months ago), presented with amenorrhea, slightly high level of beta-hCG and suspected ectopic pregnancy. She was followed up for 1 month in another hospital and the level of beta-hCG ranged from 26 to 67 mIU/mL. Ultrasound examination showed a thin endometrial echo, a normal sized uterus, and a suspicious left intraovarian gestational sac suggestive of an ovarian pregnancy. Beta-hCG levels did not change despite the administration of Methotrexate (MTX) (Figure 1). 10 mg MTX was also injected into the left ovary locally and during the procedure endometrial sampling was performed with vacuum aspiration. Histology revealed proliferation of intermediate trophoblastic cells with a presumptive diagnosis of PSTT. Pelvic MRI (magnetic resonance imaging) showed a fundal uterine mass measuring 4,5x4x3.5 cm that was consistent with PSTT (Figure 2). Chest X-Ray, thorax CT (Computed tomography) and total abdominal MRI were performed that were all normal. There were no metastatic lesions nor enlarged lymph nodes. After extensive counseling, we performed a total extra-facial hysterectomy with bilateral salpengectomy. The final histological examination confirmed of FIGO grade I PSTT. Two years of clinical and laboratory follow-up has been normal.

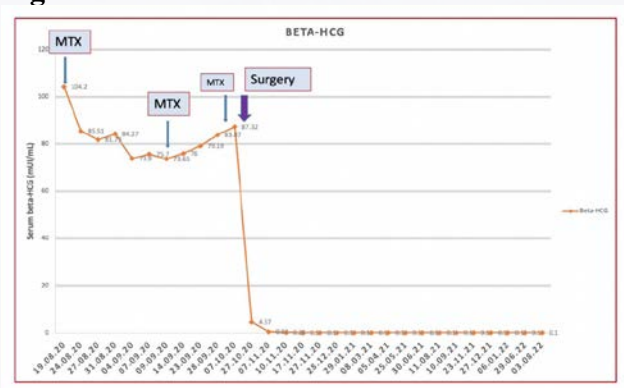
Discussion: PSTT is a very rare malignant tumor that belongs to a family of pregnancy-related diseased. Less than 300 cases of PSTT have been reported in literature, with an incidence of » 1/50,000-100,000 pregnancies representing only the 0.23%to 3.00% of all GTDs. PSTT differ from other GTDs as they are slower growing, produce less hCG for the volume of disease present, metastasize later and less chemo-sensitive. For the management of PSTT not only FIGO scoring system but also independent poor prognostic factors (female age >35, long interval since the antecedent pregnancy, deep myometrial invasion, invasion of serous membrane, vascular invasion, extensive coagulative necrosis, high mitotic index, cells with clear cytoplasm, persistent high postoperative beta hCG levels) are important. Mostly, lymph node sampling is recommended because PSTT has a significant tendency to metastasize through

lymphatic vessel but this topic is still controversial. We avoided lymph node surgery and adjuvant chemotherapy because the good prognostic factors outweighed the poor ones as recommended by the newest guidelines.

Conclusion: Ectopic pregnancy is the one of the most leading causes of PUL. However, clinicians should also carefully evaluate their patients for possible PSTT.

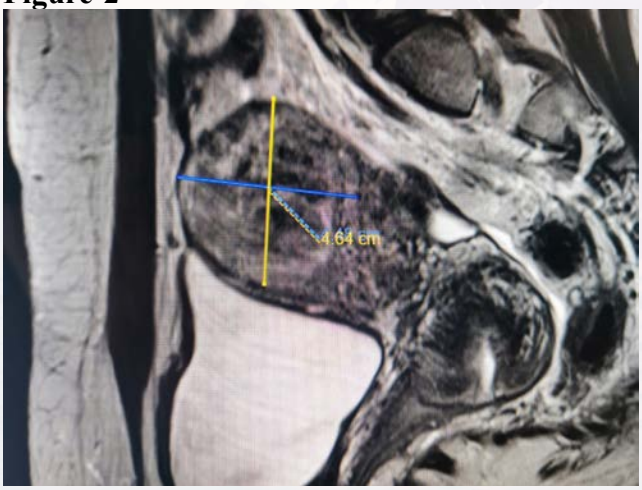
Keywords: Placental site trophoblastic tumors, Pregnancy of unknown location, Beta hCG, Ectopic pregnancy

Figure-1



Serum Beta hCG level during follow up

Figure-2



MRI image of the patient

SS-38 [Vaka Bildirileri]

A case report; endometriosis on both eyeballs; bloody tears

Gozde Unsal, Emine Karabuk
Department of Obstetrics and Gynecology, Acibadem University, Istanbul, Turkey

AIM: To present a case of cyclical episodes of bloody tears with menstrual period in a 12-year-old adolescent female patient

METHODS-MATERIALS: Physical examination records, blood tests, video record and other medical records of a 12-year-old case who has cyclical episodes of bloody tears with menstrual period

RESULTS: Patient is 12-year-old and The patient has had menstrual bleeding for 18 months and her first bloody tears episode occurred with menstrual period. It lasts about 2 days. On ophthalmologic examination, there was black coloured focus suggesting endometriosis on both eyeballs. Physical and gynecologic examination was normal.

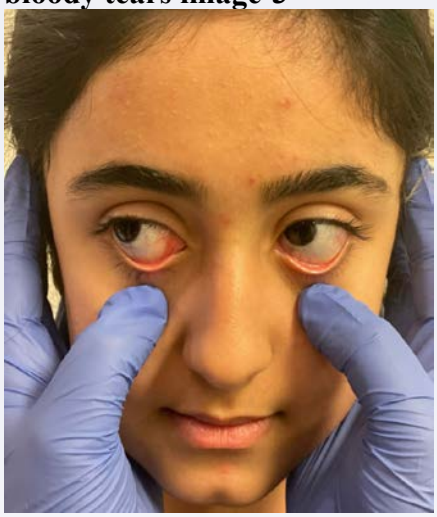
CONCLUSION: Vicarious menstruation is defined as cyclical bleeding in extrauterine organs during menstruation. Ocular vicarious menstruation is an extremely rare condition. Bleeding in the eyes with the menstrual period helps the diagnosis. There is no consensus on diagnosis and treatment approaches. Treatment should be decided on a case-by-case

Keywords: Bleeding tears, endometriosis, menstrual cycle, vicarious menstruation

bloody tears ımage-1

bloody tears ımage-2

bloody tears ımage-3



bloody tears ımage-4

bloody tears video

SS-39 [Vaka Bildirileri]

A rare uterine tumor; Uterine Perivascular Epithelioid Cell Tumor (PEComa)

Cagla Bahar Bulbul[1], Gulay Turan[2], Kübra Ak[3], Ceyda Sancakli Usta[3], Selim Afşar[3], Akin Usta[3]
[1]Department of Obstetrics & Gynecology, Balikesir Atatürk State Hospital, Balikesir, Turkey
[2]Department of Pathology, Balikesir University, School of Medicine, Balikesir, Turkey
[3]Department of Obstetrics & Gynecology, Balikesir University, School of Medicine, Balikesir, Turkey

BACKGROUND: Perivascular epithelioid cell tumors (PEComa) are rare mesenchymal neoplasms that can be benign or malignant and have an aggressive clinical course. The uterine corpus is the most common site of gynecological PEComas; however, it has also been reported in the cervix, vagina, broad ligament, ovary, and rarely in the vulva. Most gynecological PEComas occur in women in the fifth to sixth decades. Although there are no specific symptoms of the disease, PEComa patients usually present with abnormal uterine bleeding or pelvic pain or with the identification of a mass such as myoma on imaging. The standard treatment for localized disease is surgery. In addition, mTOR inhibitors are currently the most active agents used in the treatment of advanced PEComa. In this case report, a patient who underwent hysterectomy due to myoma detected in lower pelvic MR (Magnetic Resonance) and whose pathology result was reported as PEComa will be discussed.

Case presentation: A 60-year-old gravida 2, parity 2 female patient, who has been in menopause for 9 years, was referred to our clinic because of the 8.5 cm myoma in the MR imaging performed in an external center. She had no active complaints. In the preoperative smear examination, intraepithelial lesion-malignancy was negative, HPV sampling was negative, and endometrial sampling was reported as mucoid material. The MR result of the patient was evaluated as a mass lesion in favor of degenerated myoma at the level of the uterus fundus, approximately 83x78 mm in size, with well-delimited borders and cystic degeneration areas, which did not show pathological contrast enhancement in contrast-enhanced images. The preoperative diagnostic hypothesis was of a smooth muscle tumor of uncertain malignant potential. The patient underwent total laparoscopic hysterectomy and bilateral salpingoooophorectomy. In the pathological examination of the surgical material, a tumoral structure with a vascular stroma and necrosis in large areas was detected in the sections examined in the uterine corpus. The tumor was oval or round, with uniform nuclei, pink cytoplasm, and monotonous appearance, consisting of palisades of cells, usually around vascular structures. In immunohistochemistry examination, CD10 focal (+) positive, Kappa (+) positive, Lambda (+) positive, Ki-67 proliferation index 1%, SMA (-), CD3(-), LCA(-), CD20 (-), Estrogen (-), Progesterone (-), CD19 (-), Beta-catenin (-), HMB-45 (-), MelenA (-), MUM-1 (-). With these findings, the lesion was diagnosed as PEComa.

CONCLUSION: PEComa is defined by the presence of perivascular epithelioid cells that co-express both muscle and melanocytic markers. Even though they are rarely seen in the differential diagnosis of uterine pathologies, PEComas should also be kept in mind.

Keywords: uterine perivascular epithelioid cell tumor, PEComa, Magnetic Resonance imaging

SS-40 [Vaka Bildirileri]

Postoperative sinus thrombosis in a pregnant woman with a history of recurrent preeclampsia

Ayşe Sanem Öksüz, Özgür Çot, Mehmet Musa Aslan
Department of Obstetrics and Gynecology, Sakarya Training and Research Hospital, Sakarya, Turkey

Objective: Preeclampsia is a cause of maternal morbidity and mortality. It is seen 4.1% in the first pregnancy and 1.7% in other pregnancies. It increases to 14.7% in women who had preeclampsia in their first pregnancy. The puerperium period has an increased risk for sinus vein thrombosis and venous thromboembolism. In this presentation, we will discuss the management of postoperative sinus thrombosis in pregnant women with a history of recurrent preeclampsia, in the light of the literature.

Method: Neurological complications of preeclampsia and eclampsia play a major role in the morbidity and mortality of women and newborns. The puerperium period has an increased risk of hypercoagulation. Follow-up of the patient with a multidisciplinary approach in the postoperative period has an important place in its early diagnosis and treatment. In this case, we will talk about the diagnosis, treatment and multidisciplinary management of sinus thrombosis after recurrent preeclampsia.

Case report: A 22-year-old g2p2y2(c/s) female patient was rushed to the emergency department after having a seizure at home on the 6th postoperative day. After the patient had a seizure in the emergency room, the patient was consulted to the Obstetrics and Gynecology department. Preeclampsia was considered in the preliminary diagnosis and the patient was hospitalized. When the patient was 28w+6d pregnant, she was taken to the obstetrics emergency with headache. Due to her high blood pressure, she was hospitalized with a prediagnosis of preeclampsia. When her medical history was questioned she told that she had preeclampsia in the first pregnancy (32 w) in 2018 and there were no complications in the postoperative period. In the second pregnancy the patient underwent a C-section due to preeclampsia and was followed up postoperatively. The patient received magnesium sulfate treatment for 24 hours postoperatively. Adalat 60 mg 2x1 was started after the end of the magnesium treatment after receiving the cardiology's opinion. MRI of the patient was evaluated as sagittal sinus thrombosis. (Picture 1) Thrombectomy was performed by interventional radiology, levetiracetam and enoxaparin were started by neurology. Coumadin was also added to his treatment with the aim of keeping the INR level between 2-3.

Conclusion: Pregnancy is a period prone to hypercoagulation. Although the risk of thromboembolism in young women is small, it is an important problem as it can cause serious maternal and fetal consequences. Severe preeclampsia and eclampsia are often associated with ischemic and hemorrhagic stroke, but should not be considered the only cause in pregnant and new-born women. Magnesium sulfate is the treatment of choice to prevent eclampsia.Sinus vein thrombosis is responsible for 6-64% of pregnancy-related strokes. Risk factors for sinus vein thrombosis include pregnancy, infection, trauma, and dural tears during spinal anesthesia. Although sinus vein thrombosis is maximum in the first 6 weeks postpartum, it can be seen up to the 12th week. Although sinus vein thrombosis is rarely seen after preeclampsia, early diagnosis and treatment are important because it causes life-threatening maternal complications.

Keywords: hypercoagulation, preeclampsia, sinus vein thrombosis

SS-41 [Vaka Bildirileri]

Chylous Ascites Management After Abdominal Surgery: A Case Report

Hasan Volkan Ege[1], Onur Can Zaim[2], Mustafa Onur Kamani[2], Nezih Akkapulu[3], Nejat Özgül[1]
[1]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Hacettepe University, Ankara, Turkey
[2]Department of Obstetrics and Gynecology, Hacettepe University Faculty of Medicine, Ankara, Turkey
[3]Department of General Surgery, Hacettepe University Faculty of Medicine, Ankara, Turkey

INTRODUCTION: Chlyous ascites is one of the least common clinical situation which is defined as lipid rich lymphatic fluid accumulated in abdominal cavity. As a rare outcome it is accounting for less than 1% of the patients. Leading etiologic factors can be given as neoplasia, abdominal surgery, trauma, inflammatory processes and infectious conditions. Triglyceride levels and appearance of ascites fluid obtained from paracentesis are crucial for diagnostic studies also protein level, glycose level and cell count can be used for contributing diagnostic parameters. Initial treatment is dietary management which contains high protein with low fat intake – including medium chain triglycerides – can be enteral and/or parenteral. Drainage (if necessary), pharmacologic agents (somatostatin or octreotid), shunts and lymphangiography (with or without embolisation) can be considered as alternative treatment options. Case Presentation: A 46 years old woman was presented asymptomatically with ascites. She had cholecystectomy (1987), total abdominal hysterectomy and bilateral salpingooophorectomy for endometrium cancer (2017), sleeve gastrectomy (2019) and gastric bypass surgery (January 2022) as previous medical history. Her body mass index was 36. At follow-up in April 2022, Ca125 level was found as 837,7 U/mL (Previous level: 5,0 U/mL [November 2021]). Abdominal computed tomography (CT) imaging was peritoneal carcinomatosis with ascites (Figure-1). By these findings peritoneal fluid drainage and peritoneal biopsy performed. As an indicating laboratory finding triglyceride level was 1832 mg/dL for ascites. There was no infectious or malignant proof in fluid assesment. After the diagnosis of chylous ascites the initial intervention was drainage of ascites fluid (first day 3500cc, second day 2400cc, third day 2500 cc obtained.). At the time of hospitalization the recommended diet for chylous ascites was ordered. Because of gastric surgery history, a multidisciplinary approach was performed for patient evaluation. At the 14th day lymphangiography and 18th day lymphoscintigraphy was performed and there was no obvious leakage for both studies. At the 20th and 21st day of treatment drainage fluid amount was relieved to 100 cc. At the 26th day of hospitalization patient was discharged. In June 2022 at follow-up, control CT was performed and the amount of ascites has been found totally relieved (Figure-2).

DISCUSSION: Chylous ascites is a rare condition which can be seen after abdominal surgical procedures. However malignancy is another etiologic factor and sometimes the leading cause cannot be revealed. In our case diagnostic studies and management were compatible with current literature. However there was a contradiction for underlying cause between general surgery and obstetrics and gynecology department. It couldn't be enlighted that the condition was caused by whether gastric surgery or the lymphatic involvement of endometrium cancer. However there were not any pathologic findings that contributingmalignant involvement. Also the patient had an gastric bypass surgery in June 2022 was a supporting factor for etiologic assesment. Therefore it was considered that abdominal surgery could be the leading cause. After the appropriate diagnostic studies regarding to underlying cause, multidisciplinary approach for management is essential for treatment chylous ascites. The treatment period can be relatively long and complex for professional healthcare providers.

Keywords: Chylous ascites, endometrial neoplasms, gynecologic surgical procedures, bariatric surgery

Figure 1

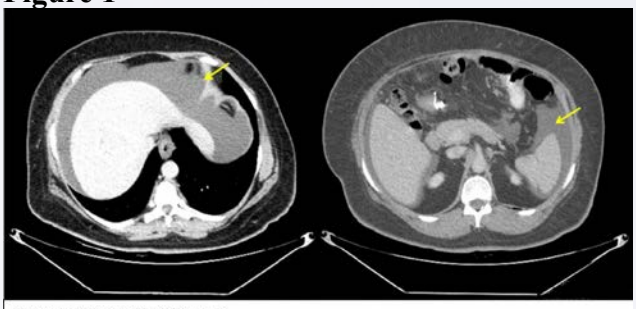


Figure-1: Ascites in CT at diagnosis

Figure 2

Figure-2: Follow-up CT after treatment

SS-42 [İnfertilite]

Is it possible to have artificial sperm and oocyte? Where are we today?

Elif Ganime Aygün[1], Nazlı Albayrak[2], Raife Dilek Turan[3], Ercüment Ovalı[3]
[1]Acıbadem Atakent Hospital
[2]Acıbadem Mehmet Ali Aydınlar University, Department of Obstetrics& Gynecology
[3]Acıbadem Labcell, Center of Cell therapies

AIM: Nowadays, it is not possible to prevent gamete cell loss due to advanced age and choronic disease. Gamete cells are found only in special tissues, however would it be possible to obtain gamete cell from somatic cells? What kind of pathway should we follow? Would it be possible to produce fusion gamete cell? Is additional mithochondrial load the eseential way to obtain gamete cell after the fusion?

METHOD: In this study, fibroblasts obtained from skin tissue are used. A precursor group of fibroblast cells are cultured by marking with GFP(green florescent protein), then squent cells are cultured after they are marked with q-dat(quantum dat). These two groups of cells are exposed to fusion agent allen PEI(polythyleimine). After the fusion islet-cells are formed, flow and FISH analysis of isolated cells are performed. The set up is repeated by creating three seperate cell cultures.

RESULTS: At the end of the 14th day green(GFP) and red(Q-dat) marked cells are seen to be fused, and fused areas are seen in yellow in color under the microscope. When the flow analysis of the cells are done, 4n and n choromosome cells are increased in number, and 2n, 3n chromosome cells are present as well. In FISH analysis, cells in nature of monozomy are detected. Cells in nature of monozomy are significantly similar to gamete cells.

CONCLUSION: There are seen cells with different number of chromosemes after the fusion. The reason behind this particular group of cells is the division of fused cells due to mitochondrial burden. It is thought that after the division cells with n=23 number of chromosome is consistent with gamete cells. However, in order to be certain on this statement, there should be cell colonies generated by transferring mitochondria, and X and Y chromosome percentages should be detected via repeating FISH analysis. This study throw light on obtaining gamete cells rather than reproductive organs.

SS-43
Pinpoint Eşliğinde Sentinel Lenf Nodu Biyopsisi
Pinpoint Guided Sentinel Lymph Node Biopsy

Mehmet Faruk Köse[1], Mustafa Deveci[2]
[1]Acıbadem Mehmet Ali Aydınlar Üniversitesi, Atakent Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, İstanbul, Türkiye
[2]Acıbadem Atakent Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, İstanbul Türkiye

Sentinel pelvik lenf nodu, erken evre endometrium kanserlerinde sıklıkla uygulanan bir cerrahi yöntemdir. Sentinel lenf nodu, muhtemel tümörün drene olduğu ilk lenf nodu olup, pozitifliği bize hastalığın evresi ve prognozu konusunda fikir vermekte ve tedavi şemamızı belirlememize destek olmaktadır. Kliniğimizde, operasyona başlarken serviks saat 3 ve 9 hizasından, önceden hazırladığımız ICG (indocyanine green) solusyonunu serviks yüzeyinin 1 cm ve 5mm derinine 0,5cc olmak üzere enjekte edilerek uygulanmaktadır. Operasyon başlangıcında histerektomi öncesi pelvik periton açılıp paravesikal alanlar oluşturulmakta ve sentinel lenf nodu tespit edilmektedir. Tamamen intakt, parçalamadan ve bütün olarak diseke edilen lenf nodumuz, anatomik (inguinal,obturator, internal iliak vs) lokasyonu da belirtilerek patolojiye gönderilmektedir. Video sunumumuzda, erken evre endometrium kanseri tespit edilen hastamızda Pinpoint kullanılarak sentinel lenf nodu diseksiyonunu göstermeyi amaçladık.

Keywords: sentinel lenf nodu, endometrium kanseri, pinpoint

SS-44
Y Meş ile Laparoskopik Sakroservikopeksi
Laparoscopic Sacrocervicopexy with Y Mesh

Mehmet Faruk Köse[1], Aysel Nalçakan[2]
[1]Acıbadem Mehmet Ali Aydınlar Üniversitesi, Acıbadem Atakent Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, İstanbul, Türkiye
[2]Acıbadem Atakent Hastanesi Kadın Hastalıkları ve Doğum Kliniği, İstanbul, Türkiye

Pelvik organ prolapsusu, pelvik organların normal pozisyonunu kaybedip vajinal duvarlar dışına herniasyonudur ve birçok kadının hayat kalitesini önemli derecede azaltan jinekolojik bir patolojidir. Kadınların %11-19'u 80'li yaşlara gelene kadar pelvik organ prolapsusu nedeniyle operasyon geçirmektedir ve kadınların yaklaşık üçte biri için yeniden cerrahi gerekmektedir. Pelvik organ prolapsusunun tedavisinde amaç normal pelvik anatomiyi sağlamak, üriner ve bağırsak fonksiyonlarını normalleştirmek, cinsel fonksiyonları düzeltmek, semptomların etkilerini azaltmak ve hayat kalitesini düzeltmektir. Cerrahi metodlar arasında abdominal (açık, laparoskopik veya robotik) veya vajinal yöntemler mevcuttur. Bu yöntemlerin bazılarında meş, bazılarında ise doğal doku kullanılmaktadır. Meş ile pelvik organ prolapsusu tamirinde cerrahi teknik, diseksiyon ve seçilen meş materyalinin tipi de önem arz etmektedir.
Video sunumumuzda, evre 3 pelvik organ prolapsusu olan hastamızda makroporlu, polipropilen Y meş kullanılarak laparoskopik sakroservikopeksi tekniğini göstermeyi amaçladık.

Keywords: Pelvik organ prolapsusu, sakroservikopeksi, Y meş

SS-45
Lymhoceles Following Lymphadenectomy in Postoperative Patients with Advanced Stage Ovarian Carcinoma
İleri Evre Over Kanseri Hastalarında Lenfadenektomi Sonrası Lenfosel

Aylin Altan Kuş[1], Edis Kahraman[2]
[1]Acıbadem Atakent Hastanesi, Radyoloji Kliniği
[2]Acıbadem Atakent Hastanesi, Kadın Hastalıkları ve Doğum Kliniği

OBJECTIVE: The purpose of this research is to identify lymphocele, a common postoperative finding following lymphadenectomy, using early postoperative Computerized Tomography (CT) in ovarian cancer patients who have undergone primaryl cytoreductive surgery.

MATERİAL- METHOD: We retrospectively analyzed patients with advanced stage ovarian
cancer who have been performed primary cytoreductive surgery and underwent CT scan
5–90 days after operation during 2019-2022 years at Acibadem Mehmet Ali Aydinlar University Atakent Hospital.
CT imaging was performed using 256-multislice CT device (Siemens SOMATOM Definition); with intravenous and and orally contrast administration. The location, Hounsfield Unit, size of lymphoceles were recorded by an abdominal radiologist. And the number of lymph nodes that were dissected was compared with these outcomes.

RESULTS: Mean age of 47 patients was 52,48 (min: 29 max:77). Primary cytoreductive surgery was performed. Histologically, serous carcinoma was detected in 31, clear Cell in 4, mixed type in 1, endometrioid in 3, mucinous in 4, undifferentiated in 3 and carcinocarcoma in 1 patient. Peritoneal serous fluid and plaural effusion were the most common findings in the post operative CT imaging (41 of 47 patients). The average Hounsfield Unit (HU) of free fluid was 18 ± 2 HU. The most common site of lymphocele was between left iliac vessels while the least common site was paraaortic region. The largest lesion size was 80x50 mm. 4 of 41 patients were examined by Abdominal Ultrasound and 2 of them were reported abcess. The lesions were thin-walled simple fluid collections with minimal wall enhancement after intravenous contrast administration. The average HU of lymphoceles was 15 ± 3. Figure 1 demonstrates bilaterally lymphoceles in iliac regions with 16 and 19 HU. Additionally intraperitoneal free fluid is seen. In the time following surgery, there was no sign of a residual lesion.

CONCLUSION: Ovarian malignancies are treated with pelvic lymphadenectomy, which is frequently accompanied by complications like hemorrhage or hematoma, postoperative ileus, and lymphocele. CECT scan is a quick, trustworthy, and convenient imaging technique for evaluating postoperative patients and identifying consequences in cases involving cytoreductive surgery.

Keywords: Ovarian cancer, Lymphadenectomy, CECT, Lymphocele

SS-46

Endoskopik Bag İçerisinde Over Kisti Diseksiyonu
Ovarian Cystectomy In Endoscopic Bag

Esra Özbaşlı
Acıbadem Mehmet Ali Aydınlar Üniversitesi, Acıbadem Maslak Hastanesi, Kadın Hastalıkları ve Doğum Kliniği

Dermoid kist, overin en sık görülen germ hücreli tümörleridir. Her yaşta görülmekle beraber, reprodüktif çağda daha sık görülmektedir. Her üç germ hücre tabakasından hücre içermesinden dolayı tanıda ultrasonografi en faydalı metotdur. Malignite transformasyonu ihtimali az olsa da, reprodüktif çağda görülmesi, torsiyon ve rüptür ihtimalinin olması nedeniyle tedavisi fertilite koruyucu minimal invazif cerrahidir. Over dokusu korunarak kist eksizyonu sırasında ince cidarlı kist yapısı perop rüptüre olduğu durumda, yoğun kist içeriği batında yayılmakta, postoperative ağrı, batın içi koleksiyon, yapışıklık riski doğurmakta ve operasyon süresini uzatmaktadır. Kliniğimizde uygun vakalarda kist eksizyonunu batın içi torba içerisinde yapmakta ve olası rüptürde batın içine yayılımı durdurmaya çalışmaktayız. Bu video sunumda, genç bir hastanın dermoid kist eksizyonunu endobag içerisinde diseke ediş yolumuzu paylaşmayı amaçladık.

Keywords: Dermoid kist, Laparoskopi, Endobag

ORGANİZASYON SEKRETARYASI

FİGÜR
KONGRE & ORGANİZASYON

19 Mayıs Mah. 19 Mayıs Cad. Nova Baran Center No:4, 34360 Şişli / İstanbul
Tel: 0 212 381 46 00 - Faks: 0 212 258 60 78
E-posta: obstetrikjinekolojitartismalikonular@figur.net

www.obstetrikjinekolojitartismalikonular.org