UROGYNECOLOGY SOCIETY

ISPP
International Society
Of Pelviperineology

12th International Congress on Pelviperineology and Regenerative Medicine

31 October - 2 November 2025

Lazzoni Hotel, İstanbul / Türkiye

ABSTRACT BOOK

www.pelviperineologycongress.org

Conjoint Congress of the ISPP and Urogynecology Society (Türkiye)

Dear Colleagues,

The 12th International Congress of Pelviperineology and Regenerative Medicine will be held under the joint auspices of the International Society of Pelviperineology (ISPP) and the Turkish Society of Urogynecology from **October 31 to November 2, 2025,** at the **Lazzoni Hotel in Istanbul,** an ancient city located at the crossroads of continents.

Not only all problems of the pelvic floor (urinary incontinence, pelvic organ prolapse, fistulas, etc.), but also female genital aesthetic interventions (surgical and non-surgical), mesh and rope surgeries in prolapse, sexual dysfunction, regenerative medicine applications in gynecology, healthy aging and menopause, postpartum bleeding, laparoscopic urogynecology and vNOTES will be presented by the best foreign / local physicians in the field in course format.

We are expecting a very high number of participants and we highly value the contribution of the industry to our congress. Our companies, which are an important stakeholder of knowledge transfer, will have the opportunity to introduce themselves and explain their products during the flow of our comprehensive scientific program. We hope to see you among us at our congress organized by a team that believes that knowledge flourishes as it is shared.

Stay in good health

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12th International Pelviperineology and Regenerative Medicine Congress,
President

Assoc. Prof. Dr. İbrahim Polat
12th International Pelviperineology and Regenerative Medicine Congress,
President

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Scientific Committee Names are listed alphabetically by last name.

31 October 2025, Friday		Hall 1
09:00-09:30	**Opening**	
	Congress Honorary Presidents: *Paulo Palma, Yakup Kumtepe* **Congress Presidents:** *Tolgay Tuyan İlhan, İbrahim Polat*	
09:30-10:45	**Workshop 1 – Urogynecological Assessment**	
	Moderators: *Volkan Kurtaran, Murat Ekin, Ayşe Rabia Kanbak*	
	Pelvic Anatomy: POP Surgeon Point of View	***A.A.Nikitin***
	Transperineal USG	***Giulio Santoro***
	USG in OASIS	***Giulio Santoro***
	Urodynamics	***Tolga Güler***
10:45-11:00	**Coffee Break**	
11:00-12:30	**Workshop 2 – Anticontinence Surgery**	
	Moderators: *Berna Aslan Çetin, Tolgay Tuyan İlhan, İbrahim Polat*	
	Tension Free Vaginal Tape	***Burak Sezgin***
	Horizontal TOT	***Emmanuel Delorme***
	Urethral Ligament Plication	***Akın Sivaslıoğlu***
	Laparoscopic EUL/PUL Plikasyonu	***Gamze Nur Cimilli Şenocak***
	Periurethral Bulking Agents	***Akın Sivaslıoğlu***
	Perctuaneous Threads for in Office Reinforcement of the Supporting Urethra Ligaments: New Approach for Stress Urinary Incontinence (Online)	***Paulo Palma***
12:30-13:00	**Lunch**	
13:00-13:30	**Lecture 1– Integral Theory**	
	Moderators: *Akın Sivaslıoğlu, Aybüke Tayarer*	
	Integral Theory (Online)	***Peter Petros***

31 October 2025, Friday	Hall 1
13:30-14:00	**Lecture 2 – Trigone Theory on Urinary Incontinence**
	Moderators: *Özlem Evliyaoğlu, Zeynep Yavaş Yücel*
	Trigone Theory — ***Wolfram Jaeger***
14:00-15:30	**Workshop 3 – vNOTES for Urogynecologists**
	Moderators: *Berrin Göktuğ Kadıoğlu, Burcu Kasap, Berna Aslan Çetin*
	Preoperative Setup and Indications — ***Ozan Karadeniz***
	vNOTES Hysterectomy — ***Şükrü Yıldız***
	vNOTES Cystectomy, Oophorectomy, Salpingectomy — ***Eralp Bulutlar***
	vNOTES for POP — ***Kemal Güngördük***
	vNOTES Complications and Management — ***Murat Yassa***
15:30-15:45	**Coffee Break**
15:45-17:00	**Workshop 5 – POP Surgery**
	Moderators: *Akın Sivaslıoğlu, Hakan Timur, Pınar Topdağı Yılmaz*
	Recurrent POP — ***Boris Slobodyanyuk***
	Prolapse Recurrence & Prevention — ***Kirill Ovchinnikov***
	Recurrence After Sacrocolpopexy — ***Kirill Ovchinnikov***
	Vaginal Site-Specific vs Classical Surgery — ***Boris Slobodyanyuk***
	Pelvic Organ Prolapse Repair with Hybrid Titanized Meshes — ***Olesya Snurnitsyna***
	Surgical Options for Recurrent POP After Transvaginal Correction — ***Olesya Snurnitsyna***
	The Efficacy and Safety of One-Stage and Two-Stage Correction of Pelvic Organ Prolapse and Stress Urinary Incontinence — ***Diana Babaevskaya***

31 October 2025, Friday	Hall 1

17:00-18:00	Special Topics	
	Moderators: *Boris Slobodyanyuk, Emmanuel Delorme, İsmet Alkış*	
	Transvaginal Enterocele Repair with One and Two Meshes	***Michail Enikeev***
	Structural and Functional Features of the Sacrospinal Ligament in Cadavers as a Predictor of Pelvic Organ Prolapse Recurrence	***Olesya Snurnitsyna***
	Site-Specific Pelvic Organ Prolapse Repair with Bilateral Sacrospinal Hysteropexy: Long-Term Outcomes	***Anastasia Shpikina***
	Local Microdoses of Estrogens in the Combined Treatment of Chronic Cystitis and Postcoital Dysuria	***Marina Alekseeva***
	Traditional Urethral Transposition or Urethrohymenal Adhesiolysis with Suburethral Filler Injection in Postcoital Dysuria	***Marina Alekseeva***
	Obliterative Vaginal Surgery is not Only for the Frail and Elderly	***Tony Bazi***

31 October 2025, Friday		Hall 2
14:00-15:30	**Oral Presentations -1**	
	Moderators: *Zeynep Yavaş Yücel, Derya Kılıç Güler*	
SS-1	The Effect of Sexual Health Education and Counseling on Sexual Function and Quality of Life in Postpartum Patients with Vaginal and Cesarean Delivery	***Hatun Çolak***
SS-2	A Forgotten but Valuable Surgical Technique: The Manchester-Fothergill Operation in the Management of Isolated Cervical Elongation	***Zeynep Yavaş Yücel***
SS-3	A rare case of laparoscopic excision and mesh repair of a canal of Nuck cyst	***Elif Özden Kural Taşsındıran***
SS-4	Vaginal approach in advanced uterine prolapse associated with a large uterus and pelvic kidney: A rare case report	***Rümeysa Süleyman***
SS-5	Management of Pyometra Complicated by Pelvic Abscess Following Le Fort Colpocleisis: A Case Report	***Nevin Ek***
SS-6	Late-Onset Small Bowel Evisceration Due to Vaginal Cuff Dehiscence: A Rare Case Following Laparoscopic Hysterectomy	***İde Bayır***
SS-8	Relationship between treatment satisfaction and clinical variables among pessary users for more than two years	***Pakize Özge Karkın***
SS-9	Total Vajinal Necrosis After Transobturator Tape(TOT) Procedure	***Nevin Ek***
SS-11	Removal of contralateral tubal occlusion with Nelaton feeding during surgical treatment of ectopic pregnancy (salpingectomy)	***Hatun Çolak***

1 November 2025, Saturday		Hall 1
09:00-10:30	**Workshop 6 – Anterior, Posterior & Apical Compartment Defects**	
	Moderators: *Süleyman Salman, Melike Nur Akın, Zeynep Kamalak*	
	Posterior IVS	***Akın Sivaslıoğlu***
	Plication of RVF to USLs	***Esra Özbaşlı***
	Sacrocolpopexy / Pectopexy	***Yakup Kumtepe***
	SS Fixation	***Çetin Kılıççı***
	Trapezoidal Repair	***Derya Kılıç Güler***
10:30-11:30	**Round Table** **ULP Surgery: Tips and Tricks** **Speakers:** *Akın Sivaslıoğlu, Alev Esercan*	
11:30-13:00	**Workshop 7 – Featured Topics in Pelviperineology**	
	Moderators: *Ateş Karateke, M. Murat Naki, Çağrı Gülümser*	
	Partial LeFort Colpocleisis	***Akın Sivaslıoğlu***
	Vaginal Hysterectomy	***Boris Slobodyanyuk***
	Management of Chronic Pelvic Pain	***Tolgay Tuyan İlhan***
	ICS terminology as: Bladder Pain Syndrome / IC	***Tufan Tarcan***
	Recurrent UTI	***Tony Bazi***
	Genitourinary Syndrome of Menopause	***Banu Çiftçi***
13:00-13:30	**Lunch**	
13:30-15:00	**Workshop 8 – Pelviperineological Care & Management**	
	Moderators: *Yakup Kumtepe, Adnan Budak, Bora Coşkun*	
	Native Tissue Repair	***Elvira Brătilă / co-author Ciprian Coroleuca***
	Sacropexy Anatomical Landmarks	***Elvira Brătilă***
	Mesh Surgery for POP	***Burak Karadağ***
	High Uterosacral Ligament Plication	***Burak Sezgin***
	Management of Vulvodynia	***Alev Esercan***
	Perioperative Management of the Urogynecologic Patient	***Akın Sivaslıoğlu***

1 November 2025, Saturday	Hall 1
15:00-15:15	**Coffee Break**
15:15-17:00	**Workshop 9 – Functional Female Genital Esthetics Interventions (FFGEI-Surgical)**
	Moderators: *Paşa Uluğ, Nil Atakul*
	Edge Labioplasty — ***Ali Doğukan Angın***
	Wedge Labioplasty — ***Berkay Yüksel***
	Complications of Labiaplasty — ***Irina Mayskova***
	Revirginization — ***Akın Sivaslıoğlu***
	Vaginoplasty — ***Hanifi Şahin***
	Perineoplasty — ***Asiye Uzun***
	Monsplasty — ***Ozan Doğan***
	Immediate Post-op Care — ***İmran Ayhan***
	Complications of Genital Esthetic Interventions — ***Özlem Evliyaoğlu***

1 November 2025, Saturday		Hall 2
10:30-12:00	**Oral Presentations -2**	
	Moderators: *Ömer Tolga Güler, Irina Mayskova*	
SS-22	Long term results of surgeon-tailored transobturator tape operation for female stress urinary incontinence	***Alev Esercan***
SS-23	Clinical Significance of Coexistence of HPV Types	***Nilda Nalbant***
SS-24	Interpretation of the relationship between bladder neck descent and nocturia	***Gamze Elçi Uysal***
SS-25	Periurethral malignant melanoma: A rare case report	***Hilal Özen***

2 November 2025, Sunday	Hall 1
09:00-10:30	**Workshop 10 – FFGEI (Non-Surgical)**
	Moderators: *Mete Güngör, Emine Karabük*
	Vulvar Bleaching — ***Burak Karadağ***
	Genital PRP — ***Burak Karadağ***
	Genital Mesotherapy — ***Berkay Yüksel***
	Genital Exosomes Applications — ***Süleyman Eserdağ***
	Genital Fillers — ***Nida Bayık***
	Laser in Functional Female Genital Esthetics — ***Hacer Sadıkoğlu***
10:30-10:45	**Coffee Break**
10:45-12:30	**Workshop 11 – Postpartum Hemorrhage (PPH)**
	Moderators: *M. Faruk Köse, Nejat Özgül, Eray Çalışkan*
	Diagnosis & Management — ***Yusuf Üstün & Yaprak Üstün***
	Surgery — ***Eray Çalışkan***
12:30	**Closing Ceremony**

SÖZLÜ BİLDİRİLER

SS-01

The Effect of Sexual Health Education and Counseling on Sexual Function and Quality of Life in Postpartum Patients with Vaginal and Cesarean Delivery

Hamza Yıldız[1], Hatun Çolak[2]
[1]Mersin Tarsus State Hospital, Department of Gynaecology and Obstetrics Mersin, TURKEY
[2]Osmaniye Education and Research Hospital, Department of Gynaecology and Obstetrics Osmaniye, TURKEY

AIM: The postpartum period is characterized by significant physical and psychological changes, with sexual health issues being common and negatively affecting women's quality of life. This study aimed to compare the effects of vaginal and cesarean delivery on women's sexual health and physical recovery

METHODS: A prospective, comparative, quasi-experimental study included 332 patients at their 6-week postpartum check-up between April and August 2025. The sample included 145 patients with vaginal deliveries and 187 with cesarean deliveries. Participants received personalized counseling and education on postpartum sexual health from a specialized professional. The education was supported by face-to-face sessions and digital health technologies. The Female Sexual Function Index (FSFI) and the World Health Organization Quality of Life Scale (WHOQOL-BREF) were used to evaluate their sexual function and quality of life. RESULTS: There was no statistically significant difference in the demographic characteristics of the two groups. A statistically significant increase in sexual function scores was observed in both groups after the sexual health education and counseling ($p<0.05$). However, this increase was more pronounced in the vaginal delivery group compared to the cesarean delivery group. After the intervention, 72% of vaginal delivery patients and 65% of cesarean patients reported a positive impact on their sexual life. Episiotomy and perineal trauma were the most common causes of sexual dysfunction in the vaginal delivery group, while pain and wound healing were the primary factors in the cesarean group.

CONCLUSION: This study demonstrates that sexual health education and counseling provided at the 6-week postpartum mark are an effective method for improving women's sexual function and overall quality of life, regardless of the mode of delivery. The findings suggest that women who have had a vaginal delivery may benefit more rapidly and significantly from this education. It is therefore recommended that personalized and mode-of-delivery-specific sexual health counseling programs be integrated into routine postpartum care for all women.

Keywords: Vaginal delivery, cesarean section, sexual health education, postpartum, sexual dysfunction.

SS-02

A Forgotten but Valuable Surgical Technique: The Manchester-Fothergill Operation in the Management of Isolated Cervical Elongation

Zeynep Yavaş Yücel, Yağmur Solak
Clinic of Obstetrics And Gynecology, University of Health Sciences Türkiye, İstanbul Training and Research of Hospital

AIM: To present a case of isolated cervical elongation without uterine prolapse successfully managed with the Manchester-Fothergill operation, emphasizing the importance of uterine-preserving surgical techniques in selected patients.

CASE: A 40-year-old woman, gravida 4, para 4 (vaginal delivery), presented with complaints of a sensation of pelvic heaviness. She had no history of any surgery.

Speculum examination revealed marked cervical elongation. The cervix extended beyond the hymenal ring. Bimanual examination confirmed the absence of uterine descent. POP-Q assessment demonstrated grade 3–4 cervical elongation without uterine prolapse. No otherl symptoms were reported.

Transvaginal ultrasonography showed a normal anatomical appearance. Pap smear was negative. Considering the isolated cervical elongation and the patient's strong preference to preserve her uterus, a Manchester-Fothergill (MF) operation was performed.

The surgical steps included cervical amputation, anterior plication of the uterosacral ligaments for additional support. Histopathology of the excised cervix revealed benign.

In 6-months-follow-up, she remained symptom-free and expressed high satisfaction with both the outcome and the recovery process.

DISCUSSION: The Manchester-Fothergill (MF) operation, first described over a century ago, has regained clinical interest in the context of uterus-preserving pelvic reconstructive surgery. Archibald Donald from Manchester, England, was the first to combine the components of this operation for the treatment of genital prolapse in 1888.

Pelvic organ prolapse (POP) refers to the descent of one or more pelvic organs beyond their normal anatomical positions due to weakening of the pelvic floor support structures. It may involve the anterior, apical, or posterior vaginal compartments. [1]

While hysterectomy remains a standard surgical option for uterine prolapse, cervical elongation without uterine descent represents a distinct clinical entity. In these cases, uterine support is preserved, and the pathology is limited to hypertrophy or elongation of the cervix. Performing a hysterectomy in such cases may represent overtreatment, especially in women who wish to preserve the uterus for reproductive, psychological, or cultural reasons.

The MF procedure combines cervical amputation with uterosacral ligament plication, effectively restoring apical support

while maintaining uterine integrity. This approach provides excellent anatomical correction and functional outcomes, with shorter operative time and fewer complications compared with vaginal hysterectomy.

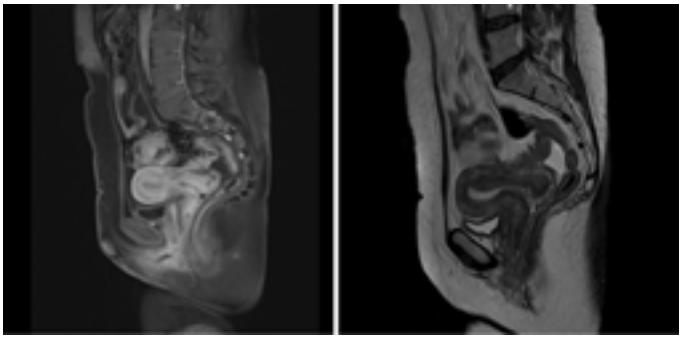
Historical data support its efficacy: Conger and Keettel [2] reported favorable long-term outcomes in over 960 patients, and subsequent studies by Marquini et al. [3] and Enklaar et al. [4] demonstrated low recurrence rates and high patient satisfaction.

In our case, the MF operation achieved complete resolution of the patient's symptoms. Therefore, in well-selected patients with confirmed cervical elongation but intact uterine support, the Manchester-Fothergill operation remains a reliable, safe, and effective surgical option.

CONCLUSIONS: The Manchester-Fothergill operation represents a valuable uterus-preserving technique for the management of cervical elongation without uterine prolapse. Accurate differentiation between cervical elongation and true uterine descent is essential to avoid unnecessary hysterectomy and to offer a conservative, functionally effective surgical alternative for women desiring uterine preservation.

Keywords: cervical elongation, pelvic organ prolapse, uterus-preserving surgery, Manchester-Fothergill operation

Figure: mr before surgery



SS-03

A rare case of laparoscopic excision and mesh repair of a canal of Nuck cyst

Elif Özden Kural Taşsındıran, Berna Aslan
Department of Obstetrics and Gynecology, Başakşehir Çam and Sakura City Hospital, İstanbul, Türkiye

OBJECTIVE: Canal of Nuck cysts are rare entities in women and can be misdiagnosed as inguinal hernias or adnexal pathologies. This report presents a case of a patient with pelvic pain who underwent laparoscopic excision and mesh repair of a canal of Nuck cyst.

METHODS: A 47-year-old multiparous woman (G3P3) with a history of ankylosing spondylitis (not on treatment) presented with pelvic pain.

Gynecological examination showed normal vulva, vagina, and cervix.

Transabdominal ultrasonography (TAUSG) revealed a 5.3 × 4.8 cm cystic lesion in the right inguinal canal that moved with the Valsalva maneuver.

Transvaginal ultrasonography (TVUSG) demonstrated a thin endometrium without adnexal pathology.

Tumor markers (CA-125, CA19-9, CEA) were within normal limits.

Pelvic magnetic resonance imaging (MRI) showed a 42 × 27 mm thin-septated cystic lesion between the rectus sheath and internal oblique muscle in the right inguinal canal, with mild contrast enhancement consistent with a canal of Nuck cyst.

No femoral hernia was detected.

Based on these findings, laparoscopic excision and mesh repair were performed.

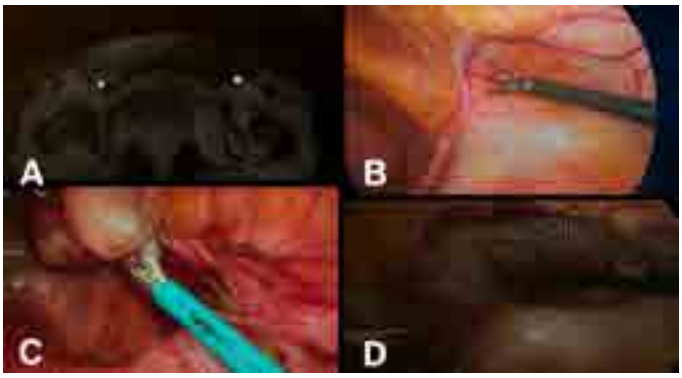
Intraoperatively, both adnexa were normal. The cyst was carefully dissected from surrounding tissues and removed intact. A mesh prosthesis was placed over the defect to reinforce the canal and prevent recurrence, and the peritoneum was closed with a V-Loc suture. The procedure was completed without bleeding, and the postoperative course was uneventful.

RESULTS: Histopathological examination revealed a 3.5 × 2.5 × 2 cm benign cystic lesion containing serous fluid, consistent with a canal of Nuck cyst.

CONCLUSIONS: Canal of Nuck cysts are rare and can be mistaken for inguinal or adnexal masses.Imaging modalities such as ultrasonography and MRI are crucial for accurate diagnosis.Laparoscopic excision with mesh repair is a minimally invasive, safe, and effective surgical option that prevents recurrence and ensures excellent cosmetic outcomes. This case highlights the importance of considering canal of Nuck cysts in the differential diagnosis of pelvic pain and inguinal cystic lesions.

Keywords: Canal of Nuck cyst, laparoscopy, pelvic pain, inguinal mass, minimally invasive surgery, mesh repair

Figure 1.



(A) Pelvic MRI showing a thin-septated cystic lesion within the right inguinal canal (canal of Nuck cyst). (B) Laparoscopic view demonstrating dissection of the canal of Nuck cyst in the right inguinal region. (C) Intraoperative appearance during cyst excision. (D) Placement of mesh over the defect after cyst excision.

SS-04

Vaginal approach in advanced uterine prolapse associated with a large uterus and pelvic kidney: A rare case report

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Department of Obstetrics and Gynecology, Başakşehir Çam and Sakura City Hospital, Istanbul, Türkiye;

PURPOSE: Pelvic organ prolapse (POP) is a common condition among multiparous women that adversely affects quality of life due to urinary, sexual, and pelvic symptoms. The coexistence of pelvic kidney and uterine prolapse is extremely rare. This case report presents the surgical management and early postoperative outcomes of a patient diagnosed with grade 3–4 uterine prolapse and grade 3 cystocele, who underwent vaginal hysterectomy, anterior colporrhaphy, and sacrospinous fixation.

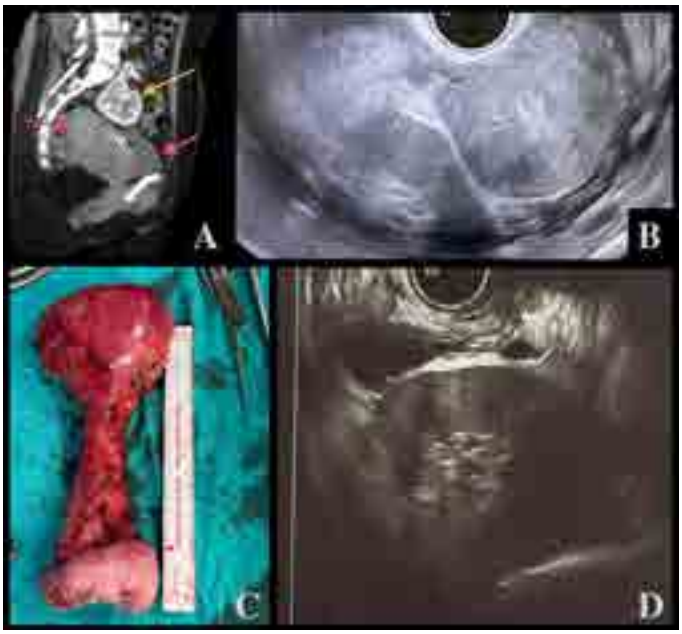
METHODS: A 45-year-old woman (G3P2A1) presented with complaints of a palpable vaginal mass and pelvic discomfort. Her medical history revealed the insertion of a Levonorgestrel intrauterine device (IUD) two years earlier for abnormal uterine bleeding. Gynecological examination demonstrated grade 4 uterine descent and grade 3 cystocele. Pelvic ultrasonography revealed an anteverted uterus with an intrauterine device in situ and no adnexal pathology. The patient had no systemic comorbidities; however, a pelvic ectopic kidney was identified on previous contrast-enhanced abdominal CT imaging. Under combined general and spinal anesthesia, vaginal hysterectomy, anterior colporrhaphy, and sacrospinous ligament fixation were performed. The intraoperative and postoperative courses were uneventful.

RESULTS: No intraoperative or postoperative bleeding or complications occurred. Postoperative hemoglobin was 10.9 g/dL, and there were no signs of infection, urinary retention, or hemorrhagic complications. The patient was mobilized within 24 hours, and bowel function returned promptly. Pathological evaluation revealed a uterus measuring 14×8×6 cm and a cervix measuring 4 cm in length. Histopathological analysis demonstrated chronic cervicitis with Nabothian cysts, decidualized endometrium under progesterone effect, and adenomyosis within the myometrium.

CONCLUSIONS: Vaginal hysterectomy accompanied by anterior colporrhaphy and sacrospinous fixation is a safe and effective surgical approach for managing advanced uterine prolapse with cystocele. This approach provides successful anatomical correction, minimal morbidity, rapid postoperative recovery, and high patient satisfaction. Preoperative recognition of pelvic anatomical variations, such as a pelvic ectopic kidney, is crucial for individualized surgical planning and achieving optimal clinical outcomes.

Keywords: uterine prolapse, cystocele, vaginal hysterectomy, sacrospinous fixation, adenomyosis, pelvic kidney

figure 1



(A) Sagittal contrast-enhanced pelvic CT showing the pelvic ectopic kidney (orange arrow), uterus (pink arrow), and anteriorly displaced bladder (red arrow). (B) Preoperative transvaginal ultrasound demonstrating the prolapsed uterus and the hypoechoic appearance of the adjacent pelvic kidney cortex (anterosuperior to the uterus). (C) Gross appearance of the excised uterus and cervix obtained during vaginal hysterectomy. (D) Postoperative transvaginal ultrasound showing the pelvic kidney in similar location and morphology compared to the preoperative period.

SS-05

Management of Pyometra Complicated by Pelvic Abscess Following Le Fort Colpocleisis: A Case Report

Nevin Ek, Nil Atakul
Department of Obstetrics and Gynecology, Istanbul Training and Research Hospital, University of Health Sciences

PURPOSE: Le Fort colpocleisis is a safe and effective surgical method applied to elderly and sexually inactive women in the treatment of advanced pelvic organ prolapse. However, in the postoperative period, infectious complications such as pyometra and pelvic abscess may rarely develop. In the literature, treatment approaches related to these complications have been reported very rarely. In this study, a rare case of pyometra complicated by pelvic abscess that developed after Le Fort colpocleisis and was successfully treated with a conservative method is presented.

METHODS: A 73-year-old, G3P3 patient with additional comorbidities presented with suspected prolapse. On physical examination, stage 3 pelvic organ prolapse (POP) was detected, and the stress test was negative. Speculum examination revealed a normal cervix. Ultrasonographic findings were consistent with age. The postmenopausal patient, not sexually active, underwent Le Fort colpocleisis under spinal anesthesia and was discharged on postoperative day 2.On the 8th postoperative day, the patient presented with complaints of fever (39°C), abdominal pain, inability to pass gas or stool, and foul-smelling vaginal discharge. Laboratory examinations revealed WBC 14,700/µL, CRP 78 mg/L, and PCT 1.54 mg/dL. Computed tomography showed a loculated fluid collection associated with the uterine cavity extending posteriorly to the cervix and compressing the rectum. The patient was hospitalized and intravenous piperacillin/tazobactam therapy was started.

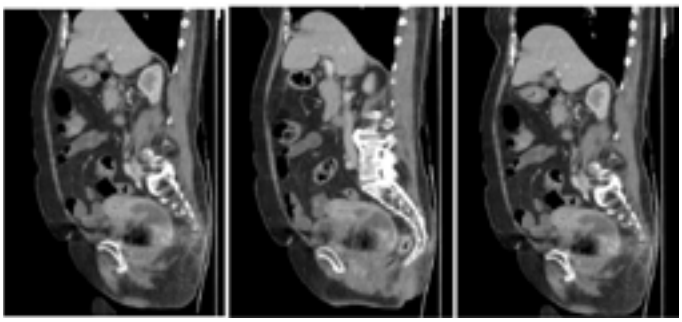
FINDINGS: During follow-up, as WBC increased to 24,100/µL and CRP to 157 mg/L, incision and drainage were performed in the operating room. Previous sutures were opened until the cervical os became visible, and yellow-green purulent material was drained. Under ultrasound guidance, the pus inside the uterus and the abscess extending posteriorly to the cervix were drained using an endometrial biopsy cannula and a 14F pediatric catheter. The operative area was irrigated with saline and gentamicin, the cervix was sutured to the lateral vaginal wall, and a minivac drain was placed. ESBL-producing Escherichia coli grew in the abscess culture.After 5 days of intravenous imipenem therapy, CRP decreased to 38 mg/L and WBC to 9,200/µL. The patient improved clinically and was discharged with oral antibiotics according to the antibiogram. At the three-month follow-up, no prolapse recurrence or other complications were observed.

CONCLUSIONS: The development of pyometra and pelvic abscess after Le Fort colpocleisis is extremely rare but can have a serious course. Early diagnosis, appropriate antibiotic therapy, and vaginal drainage with a conservative approach

can provide safe and effective results. This case demonstrates that conservative treatment can be a successful alternative in the management of infectious complications after Le Fort colpocleisis.

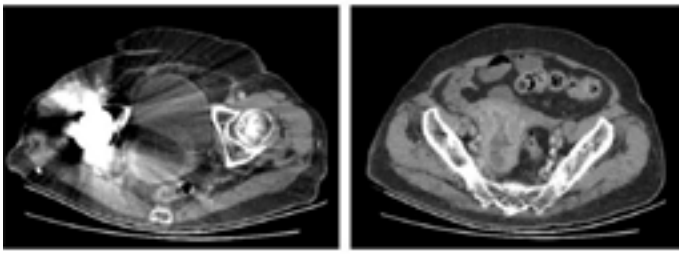
Keywords: Le Fort colpocleisis, pelvic organ prolapse, pyometra, pelvic abscess

CT



Sagittal CT: A 46×45×50 mm loculated fluid collection associated with the uterine cavity.

CT



Axial CT: A 46×45×50 mm loculated fluid collection associated with the uterine cavity.

SS-06

Late-Onset Small Bowel Evisceration Due to Vaginal Cuff Dehiscence: A Rare Case Following Laparoscopic Hysterectomy

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INTRODUCTION: Hysterectomy has been performed through vaginal and abdominal approaches since the 19th century. After 1989, laparoscopic hysterectomy was introduced into surgical practice and has become widely used today. Compared to the abdominal approach, laparoscopic hysterectomy is preferred in suitable cases due to its lower morbidity, shorter hospital stay, and faster recovery. Vaginal cuff dehiscence (VCD), although rare, is a serious complication associated with high morbidity and mortality. Following dehiscence, severe complications such as peritonitis, bowel injury, necrosis, and sepsis may occur. In this report, we present a late-onset case of vaginal cuff dehiscence that developed six months after a total laparoscopic hysterectomy (TLH) performed at an external center.

CASE PRESENTATION:A 49-year-old woman with known hypothyroidism, heart failure, and a history of three cesarean sections, who had undergone TLH for treatment-resistant abnormal uterine bleeding at an external center six months earlier, presented to our emergency department with a complaint of a mass protruding from the vagina. On examination, ileal loops were observed prolapsing through the introitus, maintaining both vascularization and peristalsis. The patient underwent emergency laparotomy, which revealed a full-thickness dehiscence at the vaginal cuff line. The prolapsed ileal loops were replaced into the abdominal cavity, and evaluation by the General Surgery team revealed no necrosis, infection, or need for bowel resection in either the small intestine or colon.

Approximately 1 cm of tissue was excised from the cuff margins, and the defect was closed continuously using delayed-absorbable sutures (polydioxanone). The postoperative period was uneventful, and the patient was discharged on postoperative day 5 without complications.

DISCUSSION: Vaginal cuff dehiscence is a rare but potentially life-threatening complication that may occur at any time following hysterectomy. In premenopausal women, it most commonly appears in the early postoperative period, typically within 2–5 months after surgery.

According to the literature, the incidence is highest after robotic surgery (0.7%), followed by laparoscopic hysterectomy (0.5%), and is lower after abdominal (0.3%) and vaginal approaches (0.12%).

The most commonly reported precipitating factor is vaginal sexual intercourse; however, heavy physical activity, constipation, smoking, and low body mass index have also been identified as risk factors. Early diagnosis and a multidisci-

plinary surgical approach are crucial for preventing serious complications such as bowel necrosis, peritonitis, and sepsis. In this case, timely intervention and collaboration with the General Surgery team allowed for successful management without the need for bowel resection.

CONCLUSIONS: Although laparoscopic and robotic surgeries offer lower comorbidity and higher patient satisfaction compared to abdominal and vaginal approaches, the incidence of vaginal cuff dehiscence has been reported to be higher with these minimally invasive techniques. When evisceration accompanies dehiscence, it constitutes a surgical emergency that can be potentially life-threatening. Therefore, early recognition, prompt surgical repair, and multidisciplinary collaboration play a decisive role in reducing morbidity and mortality.

Keywords: Vaginal cuff dehiscence, laparoscopic hysterectomy,emergency laparotomy

picture 1

ileal loops protruding from the vagina.

picture 2

dehiscence at the vaginal cuff

picture 3

dehiscence at the vaginal cuff

SS-08

Relationship between treatment satisfaction and clinical variables among pessary users for more than two years

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PURPOSE: Pelvic organ prolapse is a common condition mostly among elderly women. Although surgical treatment exists, also there are options to reduce prolapse with nonsurgical treatments including pessaries. Pessary is an effective nonsurgical treatment for the ones who wish not to undergo surgery or who are not recommended. We aimed to find out the patient satisfaction of pessary users longer than two years.

METHODS: The urogynecology repository was scanned to find the pessary users more than two years duration. Pessary users solely for urinary incontinence and users less than two-year period were excluded. The volunteers asked for fill out the P-QOL and PGI-I questionnaires and demographic and clinical variables were obtained. The data were analyzed by SPSS 27.0 statistical program. The value of p ≤0.05 deemed statistically significant.

FINDINGS: The mean age of the pessary users was 74±14.7, and the median was 78.5 (min 42-max 98). One patient was premenopausal (6.25%) and 15 were postmenopausal (93.75%).

All patients were using 1 mg/g estriol topically. The mean duration of pessary use was 3.625±2.2 years (min 2-max 10).

Whole study population had normal vaginal delivery and the mean of birth number was 5.25±2.08.

Of the study population, six patients (37.5%) had cuff prolapse, eight patients (50%) had uterine prolapse, one patient (6.25%) had cystocele, and one patient (6.25%) had rectocele indications for pessary treatment. Four patients who used pessaries for uterine descent opted for vaginal hysterectomy within the past year. While two of these patients were satisfied with the pessary, they opt to undergo surgery maybe due to their relatively young age (min42 -max49).

Patients who use pessary longer than 2 years appear to have high satisfaction with the treatment. 62.5% of patients reported being satisfied with the treatment, subjectively. Using the PGI-I score 1–2 as threshold, satisfaction rate was significantly higher in the group reporting improvement ($p<0.05$). PGI-I 1–2 threshold is discriminatory in terms of satisfaction (Table 1).

The mean of P-QOL total score is 20.71±17.03 for all pessary users. P-QOL strongly discriminates against overall satisfaction (AUC=0.93). Best threshold value for P-QOL ≤ 17.45; sensitivity 0.80 (95% CI 0.49-0.94), specificity 1.00 (95% CI 0.61-1.00); PPV 1.00 (95% CI 0.68-1.00), NPV 0.75 (95% CI 0.41-0.93). A 10 point increase in total score on the P-QOL tended to decrease the likelihood of satisfaction (Figure 1, Table 2).

There was no statistical significant association between satisfaction and age, obesity, indications, or new-onset vaginal discharge ($p>0.05$) (Table 3). There were no complaints of de-novo urinary incontinence after pessary treatment.

P-QOL and PGI-I scores are the primary measure reflecting patient satisfaction in pessary treatment; lower P-QOL scores and PGI-I score 1-2 are associated with higher satisfaction. Demographic and clinical variables (age, obesity, indication, and new onset of posttreatment discharge) were not found to be associated with satisfaction (Figure 1). Among behavioral indicators, desire for surgery correlates more strongly with dissatisfaction (83.3%), while undergoing surgery, being multifactorial, is a weaker predictor of dissatisfaction ($p=0.604$). The findings are exploratory due to the small sample size and should be confirmed with larger series.

CONCLUSIONS: P-QOL and PGI-I scores are the primary measure reflecting patient satisfaction in pessary treatment; lower P-QOL scores and PGI-I score 1-2 are associated with higher satisfaction. Demographic and clinical variables (age, obesity, indication, and post-treatment new onset discharge) were not found to be associated with satisfaction. Our findings are consistent with recent literature reporting positive effects of pessary treatment on quality of life and symptoms. A retrospective cohort study of premenopausal Thai patients reported 90.1% symptom improvement in the surgical group and 82.63% in the pessary group at 2-year follow-up [1]. In our patients, P-QOL-based discriminability was high, consistent with low satisfaction scores. A recent study indicating that pain is the primary reason for discontinuation supports our findings that pessary treatment improves long-term quality of life [2]. In conclusion, pessary treatment for pelvic organ prolapse is an effective, nonsurgical treatment with a high subjective satisfaction rate, regardless of indication.

References

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2) Ozdogar ON, Ertas IE. The Long-Term Effects of Pessary Treatment on Quality of Life, Symptoms, Sexual Function, and the Urinary System in Women with Pelvic Organ Prolapse. Int Urogynecol J. 2025 Aug 26. doi:10.1007/s00192-025-06291-y.

Keywords: pelvic organ prolapse, pessary, satisfaction

Figure 1. Forest Plot – OR and %95 CI

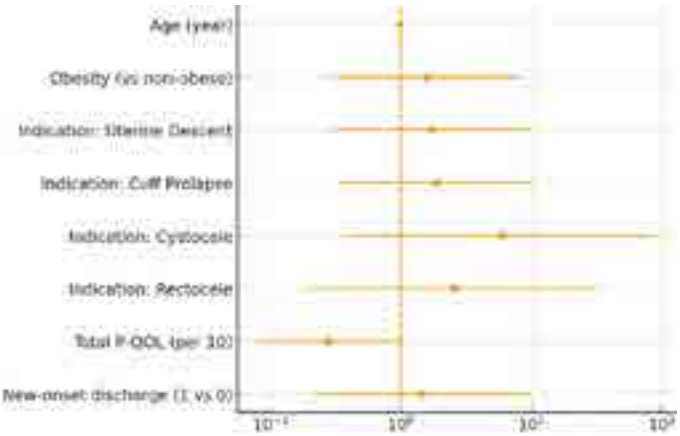

Table 1. PGI-I and satisfaction

PGI-I score range	n	%
[1-2]	20	62.5
[3]	4	25
[4-7]	2	12.5

PGI-I scores	Satisfied n	Dissatisfied n	Satisfaction rate	p
1–2	9	1	90%	0.008
3–7	1	5	16.7%	

Table 2. Total P-QOL Scores and satisfaction

Satisfied	n	P-QOL total score (mean ± SD)	P-QOL total score (mean ± SD) for whole study population
yes	10	12.1 ± 10.4	20.71±17.03
no	6	35.1 ± 16.7	

Table 3. Logistic Regression Results

Table 3. Logistic Regression Results

Variable	Coefficient (β)	Odds Ratio (OR)	95% CI	p-value
Age	-0.02	0.98	0.92–1.05	0.62
Obesity	0.43	1.57	0.31–7.89	0.58
Indication: Uterine Prolapse	0.55	1.73	0.30–9.95	0.49
Indication: Cuff Prolapse	0.65	1.91	0.34–10.65	0.45
Indication: Cystocele	1.80	6.05	0.40–90.12	0.19
Indication: Rectocele	0.95	2.58	0.20–32.89	0.48
Total P-QOL Score (per 10-point increase)	-1.27	0.28	0.079–1.000	0.050

SS-09

Total Vajinal Necrosis After Transobturator Tape(TOT) Procedure

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Midurethral slings (MUS) are the gold standard surgical treatment for stress urinary incontinence, with a well-established safety profile. We present a rare case of total vaginal necrosis following a transobturator tape (TOT) procedure in a 51-year-old postmenopausal woman. She presented on postoperative day 24 with vaginal and perineal pain, discharge, and fever. Examination revealed extensive necrosis from the periurethral area to the anterior and posterior fornices. Laboratory findings included elevated CRP and WBC. Empiric intravenous antibiotics were initiated, and prompt surgical debridement with mesh excision was performed. Tissue culture grew Candida albicans, and systemic antifungal therapy was added. The patient showed significant improvement by day 10 and was discharged on day 18. At 8 weeks, marked secondary healing and granulation tissue formation were observed. Mild urinary incontinence persisted, managed with anticholinergic therapy, and vaginal stenosis developed in the sexually inactive patient who did not use a vaginal mold.

This case highlights the importance of early recognition and timely multidisciplinary intervention to prevent progression of tissue loss. In postmenopausal patients, careful assessment of vaginal trophism, estrogen supplementation when indicated, and strict adherence to aseptic techniques are critical for optimal outcomes.

Keywords: Total Vajinal Necrosis, TOT, İnkontinas

SS-11

Removal of contralateral tubal occlusion with Nelaton feeding during surgical treatment of ectopic pregnancy (salpingectomy)

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Osmaniye Training and Research Hospital

OBJECTIVE: A 33-year-old woman, G2A1, who had been trying to conceive for approximately 2 years, presented to the emergency department with a gestational age of 6 weeks and 2 days based on her last menstrual period and a β-hCG level of 7523 IU/L. Physical examination revealed no defense or rebound; the abdomen was soft, BP: 110/70 mmHg, pulse: 90/min, and the patient was assessed as hemodynamically stable. Transvaginal ultrasound showed a gestational sac and yolk sac in the right tube. A curettage had been performed the day before, and the β-hCG value was 7900 IU/L.

METHOD: The patient was informed about medical and surgical treatment options. The patient accepted the risk of salpingectomy and requested evaluation of the other tube, and surgical treatment was preferred.

FINDINGS: Diagnostic laparoscopy revealed findings of pelvic inflammatory disease (chlamydial infection). An ectopic focus extending to the mesentery was observed in the proximal part of the right tube. The right tube was clamped with a LigaSure device and dissected stepwise; a right salpingectomy was performed to remove the ectopic focus. The adhesions on the side wall of the left tube were opened. A Nelaton feeding catheter was inserted through a 5 mm trocar and advanced from the left tubal fimbria to the ostium, and isotonic irrigation was performed; fluid movement was observed.

No passage of methylene blue was observed from the right uterine stump or the left tube. Following the resolution of the tubal occlusion, methylene blue was administered again, and passage of dye through the left tube was subsequently observed. Figure 9 demonstrates methylene blue emerging from the tubal fimbria over the sigmoid colon.

The patient was informed. At 3 months postoperatively, the patient became spontaneously pregnant; CRL: 8 weeks 4 days, fetal heartbeat was observed.

CONCLUSIONS: Medical treatment is usually the first option in ectopic pregnancy1. However, the success rate decreases when β-hCG >5000 IU/L, the focus >3–4 cm, or fetal cardiac activity is present. Multiple doses of methotrexate and salpingostomy show similar efficacy2. Surgical treatment (salpingostomy or salpingectomy) is similar in terms of fertility and recurrent ectopic pregnancy rates3. Salpingectomy eliminates the risk of residual trophoblastic tissue, thereby reducing the need for additional treatment3. In hemodynamically stable cases, evaluation of the contralateral tube during surgery is recommended.

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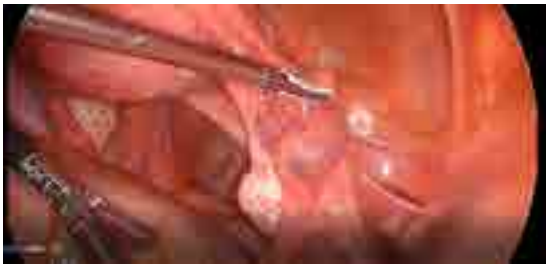
Keywords: Ectopic pregnancy, infertility, salpingectomy

Resim 1



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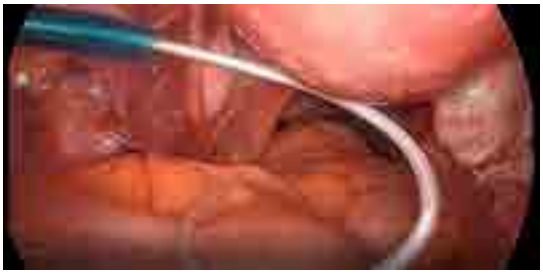

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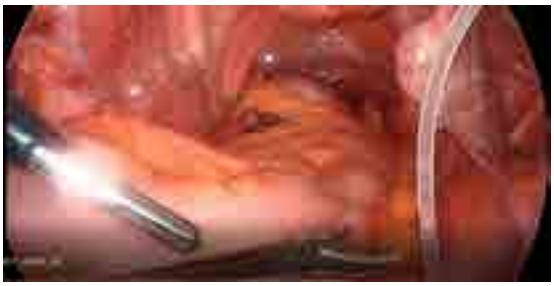

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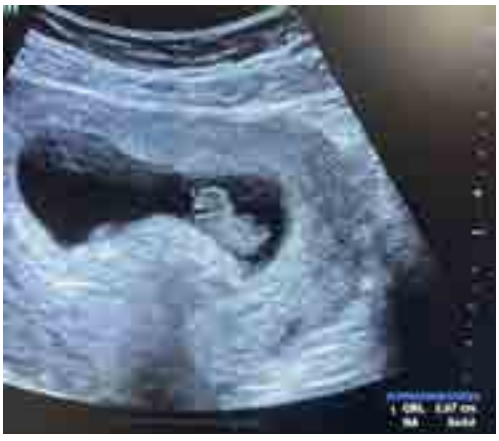

SS-22

Long term results of surgeontailored transobturator tape operation for female stress urinary incontinence

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PURPOSE: Stress urinary incontinence (SUI) is on the rise due to longer life expectancy, numerous pregnancies, and obesity. It is still under treated and under diagnosed. Surgeries with and without mesh can be chosen for treatment. Trans obturator tape operation (TOT) is a mid-urethral sling surgery. New surgeries are emerging daily because of the occurrence of mesh-related complications. In addition, in trans obturator tape surgery has disadvantages as groin pain, bladder injury, and various ranges of success rates for SUI. Our study aimed to evaluate the ten-year outcomes of patients who had trans obturator tape surgery (TOT) for SUI performed by the same surgeon at a single center.

METHODS: This prospective study included patients who underwent TOT surgery at Şanlıurfa Training and Research Hospital. Patients in their tenth postoperative year were queried regarding their latest incontinence status, their use of medication for incontinence, and the development of any complications. This study had included patients who had TOT surgery with surgeon-tailored mesh due to a diagnosis of SUI between August 2015 and January 2025. The exclusion criteria for patients were pregnancy, breastfeeding, acute infection, malignancy, TOT with concomitant pelvic floor surgery (anterior or posterior repair, para vaginal repair, Le Fort operation, and vaginal hysterectomy), had a history of previous anti-incontinence surgery or a diagnosis of any neurologic disease. This surgeon-tailored polypropylene mesh is a non-absorbable, monofilament, macro porous structure with standard features. This standard mesh measuring 15 × 15 cm was cut to form a conical shape at the ends of 7.5 × 1 cm, and a No. 1 polyglactin 910 suture was fixed to both ends of the created mesh. All patients underwent a standard preoperative evaluation, medical history, gynecological examination, and routine abdomino pelvic ultrasonography (US). A previously validated Turkish version of the IIQ-7 was used in this study for the effects of SUI, which the patient rates from 0 (not at all affected) to 3 (greatly affected). SUI definition was made by tap test positivity and subjective complaints SUI. All of the patients had conventional TOT operation. The study was approved by the regional ethics committee of The Harran University Ethics Committee, decision number: HRU/24.03.08.

FINDINGS: The ten-year surgical results of 209 patients who had TOT operations were evaluated. The mean age of the patients was 45.95 10.62 (25–72) years. 52.2% of patients were postmenopausal. The cure rate was 89.5% (one hundred eighty-seven patients) at tenth year. Nineteen patients (9.1%) had de novo urgency, which was defined as failure. Three patients (1.4%) had still incontinent as before, which was defined as failure. Leg pain was seen in 2.9%, dyspareunia in

1%, and mesh erosion in 5.3% of patients. Cystoscopy was not routinely used unless hematuria occurred. None of the patients had bladder perforation. The relationships between de novo urgency and postmenopausal status or grand multiparity were not statistically significant, with p values of 0.31 and 0.40, respectively. A total of 2.9% of patients had leg pain in the right leg. There was no neurological deficit in any patient. When the mesh was loosened, leg pain disappeared in one patient. The mesh was loosened but not removed at the first postoperative day by local anesthesia, through the interrupted sutures on the incision. Patients were still urinary continent.

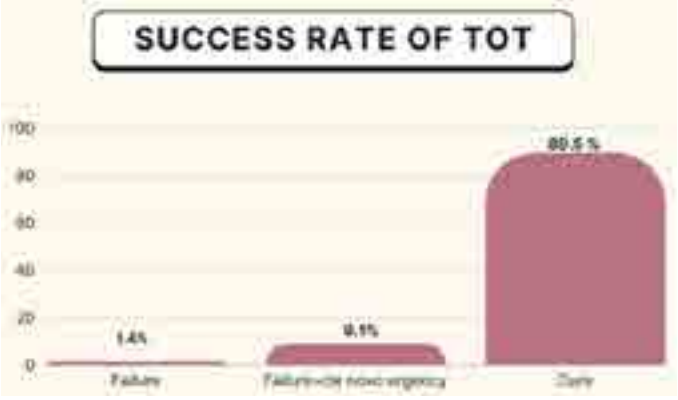
The advantages of the TOT are minimally invasiveness, has lower costs than laparoscopic surgery as Burch colpo-suspension. While DynaMesh costs approximately 59 US dollars, the surgeon tailored mesh costs about 7.5 US dollars for each surgery. It can be an advantage for usage in low-income countries.

In the literature, two-year results of TOTs by surgeon-tailored meshes revealed that the cure rate was approximately 100%. In a Chinese study the success rate of the TOT was 96% at first year. In our study, the cure rate was 89.5%. We followed the patients for ten years, therefore, our results are more realistic than data from other similar studies. In a prospective study, that included five years of follow-up, the objective and subjective cure rates were 91.0% and 82.8%, respectively.

CONCLUSIONS: Although surgeon-tailored mesh is a cheap and practical method for places that do not have the opportunity to buy traditional mesh, its chance of success in the long term remains lower than that of traditional mesh, and the risk of mesh erosion and the de novo urgency it causes should not be ignored.

Keywords: De novo urgency, integral theory, mid-urethral sling, stress incontinence, trans-obturator tape

Figure 1: Success rate of trans-obturator tape operation after ten years



SS-23

Clinical Significance of Coexistence of HPV Types

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BACKGROUND: Cervical cancer is the fourth most common malignancy among women worldwide (1). Almost all cases are attributed to Human Papillomavirus (HPV) infection, with approximately 70% caused by HPV types 16 and 18 (2). However, data remain limited regarding whether concurrent infection with HPV 16 and other genotypes further increases cervical cancer risk. This study aimed to evaluate the association between combined HPV infections and the presence of high-grade squamous intraepithelial lesions (HSIL).

MATERIAL-METHODS: Medical records of HPV-positive women who underwent colposcopic examination were retrospectively reviewed. Women aged 25–65 years were included, while those with a history of malignancy, autoimmune disease, or immunosuppressive therapy were excluded. Data regarding HPV genotype, colposcopic findings, and histopathological results were collected from medical records.

RESULTS: A total of 107 patients met the inclusion criteria; 69 (64.5%) had HPV 16 alone, and 38 (35.5%) had HPV 16 with other genotypes. Basal charateristics of these groups are summarized in Table 1. Both groups showed similar baseline characteristics.

We then evaluated the relationship between HPV 16 infection, alone or combined with other types, and the presence of HSIL lesions.

When pathology results were compared according to HPV types, 27 patients (33.8%) without HSIL had combined HPV types, whereas 11 patients (40.7%) with HSIL had both HPV 16 and other types detected (p =.512) (Table 2).

CONCLUSION: In our study, the combination of HPV 16 with other HPV types was not found to confer an additional risk for the development of HSIL lesions. Khan et al. reported a 17% incidence of HSIL among HPV 16–positive women, compared with 3% for other high-risk types. In another cohort of approximately 20,500 women, isolated HPV 16 infection was associated with a significantly higher 10-year risk of HSIL or cervical cancer (3,4). Therefore, colposcopic evaluation should be performed in all patients with HPV 16 positivity, even in the absence of coexisting HPV types.

Keywords: HPV (Human Papillomavirus), HGSIL (High Grade Squamous Intraepithelial Lesion), Cervical Cancer

Table 1. Characteristics of the study population

Parameter	HPV 16 (n=69)	HPV 16 + Other (n=38)	p value
Yaş (mean ± SD)	46.7 ± 11.5	42.9 ± 12.8	.114
Gravida (mean ± SD)	2.8 ± 1.8	2.3 ± 1.7	.206
First intercourse age (mean ± SD)	20.5 ± 4.1	20.6 ± 3.4	.889
More than one partner (%)	30 (%43.5)	22 (%57.9)	.153
Smoker (n, percentage)	26 (%37.7)	20 (%52.6)	.135
IUD (n, persentage)	32 (%46.4)	17 (%44.7)	.871
OC (n, percentage)	22 (%31.9)	10 (%26.3)	.547
IUD: Intrauterine device, OC: oral contraceptive			

Table 2. Histopathological results in HPV 16 and HPV16 + Other groups

Parameter	< HGSIL (n=80)	HGSIL (n=27)	p value
HPV 16	53 (%66.2)	16 (%59.3)	.512
HPV 16 + Other	27 (%33.8)	11 (%40.7)	
HGSIL:Hıgh Grade Squamous Intraepithelial Lesion			

SS-24

Interpretation Of The Relationship Between Bladder Neck Descent And Nocturia

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BACKGROUND: Transperineal ultrasonography (TPUS) in a non-invasive office procedure sensitive for assessing dynamic changes related with urethral mobility besides from examining pelvic floor structures (1). Several parameters have been proposed to be related with urinary symptoms (2). In this study we aimed to compare bladder neck descent measured by TPUS between women with and without nocturia.

MATERIAL-METHODS: Patient files of women assessed with TPUS were retrospectively analyzed. Bladder neck descent were compared against age, BMI and D point distance matched women with and without nocturia. Bladder neck descent was measured during resting and maximum valsalva according to a standardized method described previously (3). Distance of the bladder neck from symphysis were noted in both conditions. Bladder neck descent was calculated by calculating the difference of these distances.

RESULTS: There were total 86 women who met the inclusion criteria. Basal characteristics of the two groups are summarized in Table 1. Bladder neck descent measurements in women with nocturia, urge incontinence and stress incontinence symptoms were also investigated. Only nocturia was found to be associated with bladder neck descent in this study population (1.51 vs. 2.32, p=0.008) (Figure 1).

CONCLUSIONS: The observed association between bladder neck descent (BND) and nocturia in women with similar degrees of apical prolapse highlights a potentially underrecognized mechanical component in the pathophysiology of nocturnal voiding symptoms. Further studies with larger sample sizes are warranted to understand the role of perineal ultrasonography in the evaluation of the underlying dynamic anatomical mechanisms linking to specific LUTS profiles.

Keywords: Female urinary incontinence, Pelvic floor, Transperineal ultrasonography,

Figure 1. Bladder neck descent measurements in women with nocturia

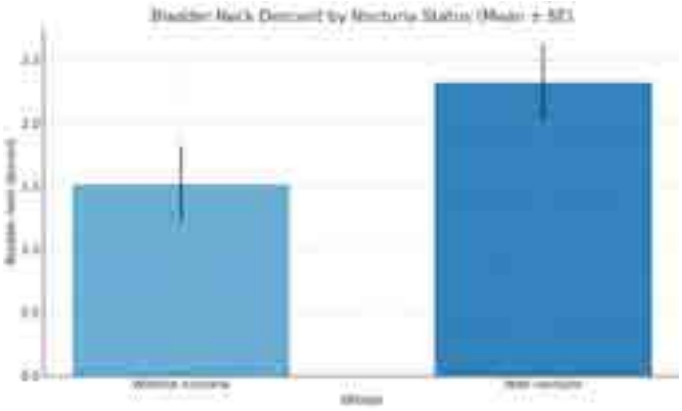

Table 1. Characteristics of the study population

Parameter	Women without nocturia (n=46)	Women with nocturia (n=40)	p value
Age (mean ± SD)	46.8 ± 8.1	49.8 ± 9.3	.106
BMI (mean ± SD)	27.8 ± 3.9	29.0 ± 4.5	.231
D point in POP-Q	-6.48 ± 2.747	-5.42 ± 3.929	.166

SD: Standard deviation, POP-Q: Pelvic Organ Prolapse Quantification system

SS-25

Periuretral Amelanotic Malignant Melanoma: A Rare Case Report

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BACKGROUND: Primary urethral melanoma is a rare and aggressive malignancy, accounting for less than 1% of all melanomas. It occurs predominantly in elderly women and is often diagnosed late due to nonspecific symptoms. Amelanotic variants are even rarer and, lacking characteristic pigmentation, frequently lead to diagnostic delays. Early recognition and accurate histopathological evaluation are essential for improving outcomes.

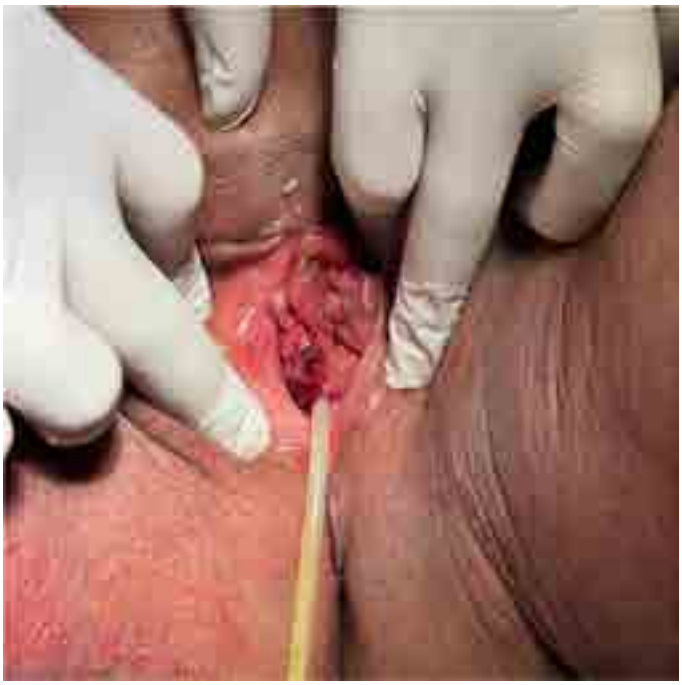
CASE: A 67-year-old female presented with groin pain and vaginal bleeding. Gynecological examination revealed a non-pigmented periurethral mass measuring 3 × 4 cm, nearly obstructing the urethral orifice, and palpable left inguinal lymph nodes (Figure 1). Vaginal or urethral squamous cell carcinoma (SCC) was initially suspected; however, histopathological and immunohistochemical findings confirmed malignant melanoma. PET-CT showed no additional lesions except the periurethral mass and left inguinal lymphadenopathy. Compared with a PET-CT performed one year earlier, these findings were newly developed, consistent with the aggressive biological behavior of melanoma.

DISCUSSION: Optimal management of primary urethral melanoma remains controversial due to its rarity. Wide local excision with negative margins is the preferred treatment, often combined with lymph node dissection. Adjuvant therapies such as radiotherapy, chemotherapy, and immunotherapy may be considered, though their efficacy is uncertain. Nivolumab-based immunotherapy has shown benefit in cutaneous melanoma and may offer promise in periurethral cases given biological similarities.

CONCLUSION: This case highlights the importance of including malignant melanoma in the differential diagnosis of periurethral masses, even without pigmentation, and emphasizes that early diagnosis, histopathological confirmation, and surgical resection are vital for achieving better clinical outcomes.

Keywords: amelanotic melanoma, periurethral mass, primary urethral melanoma,

Figure 1: periurethral malignant melanoma



A periurethral mass was observed on gynecological examination.

Organization Secretariat

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