KSDF 2026

2. KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU KONGRESİ

22-26 NİSAN 2026

Rixos Sungate, Antalya

BİLİMSEL PROGRAM ve BİLDİRİ ÖZETLERİ KİTABI

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

DAVET

Saygıdeğer Değerli Meslektaşlarımız,

Türkiye genelinde daha önce kurulmuş olan Karadeniz, Ege, Akdeniz, Doğu Anadolu, Güneydoğu Anadolu, Marmara ve İç Anadolu Kadın Sağlığı Derneklerinin bir araya gelmesiyle oluşturulan Kadın Sağlığı Dernekleri Federasyonu (KASDEF), bir meslek örgütü olmanın yanı sıra, kadın sağlığını ilgilendiren tüm alanlarda bilimsel, toplumsal ve etik katkı sunmayı amaç edinmiştir.

2024 yılında ilk kez düzenlediğimiz Kadın Sağlığı Dernekleri Federasyonu Kongresi, beklentilerin ötesinde bir katılım ve ilgiyle gerçekleşmiştir:

- Türkiye'den 200 farklı hastaneden 1300 katılımcı,
- Yurt dışından 100 katılımcı,
- Yurt dışından 50 seçkin konuşmacı,
- Yoğun ilgi gören bilimsel oturumlar ve
- Zengin içerikli sosyal etkinlikler ile

kongremiz ülkemizde kadın sağlığı alanında yeni bir standart oluşturmuştur.

Bu büyük başarının ardından, federasyonumuzu oluşturan bölge dernekleri tarafından 2025'te her bölgede bölgesel kongre ve sempozyumlar düzenlenerek bilimsel faaliyetlere aralıksız devam edilmiştir. Her biri yüksek katılımlı bu etkinlikler, federasyonumuzun sürekli öğrenme ve paylaşım kültürünü pekiştirmiştir.

Bu güçlü ivmeyi daha da ileri taşımak amacıyla 2. Kadın Sağlığı Dernekleri Federasyonu Kongresi (2026) için bir araya geliyoruz. Kongremiz, "Sağlıklı Kadın, Güçlü Toplum, Güvenli Gelecek" mottosuyla; kadın sağlığı alanındaki en güncel gelişmelerin ve araştırmaların paylaşılacağı, bilimsel ve sosyal açıdan zengin bir platform oluşturacaktır.

Sizleri, bilimsel gücümüzü ve toplumsal sorumluluğumuzu birlikte büyütmeye davet ediyoruz.

Sevgi ve Saygılarımızla,



Prof. Dr. Gürkan Uncu
Kadın Sağlığı Dernekleri
Federasyonu Başkanı

KURULLAR

Gürkan Uncu
Kongre Başkanı

BÖLGE DERNEK BAŞKANLARI

Yakup Kumtepe
Doğu Anadolu Kurucu Başkan

Hüsnü Çelik
Akdeniz Kurucu Başkan

Işıl Kasapoğlu
Marmara Kurucu Başkan

Davut Güven
Karadeniz

Erhan Şimşek
Akdeniz

Erbil Doğan
Ege

Bilge Çetinkaya Demir
Marmara

Salih Taşkın
İç Anadolu

Pınar Topdağı Yılmaz
Doğu Anadolu

M. Mutlu Meydanlı
Güneydoğu Anadolu

KONGRE BÖLGE SEKRETERLERI

Recep Erin
Karadeniz

Selen Doğan
Akdeniz

Ahmet Demir
Ege

Kiper Aslan
Marmara

Yavuz Emre Şükür
İç Anadolu

Gamze Cimilli Şenocak
Doğu Anadolu

Neslihan Tepe
Güneydoğu Anadolu

ALAN FİKİR LİDERLERİ

Barış Ata
İnfertilite

Fatih Durmuşoğlu
Menopoz

Recep Has
Perinatoloji

Gürkan Bozdağ
PCOS

Ercan Baştu
Endometriozis

Akın Sivaslıoğlu
Ürojinekoloji

U. Fırat Ortaç
Onkoloji

M. Faruk Köse
Onkoloji-Tarama Önleme

Kemal Özerkan
Endoskopi

Selcen Bahadır
Cinsel Disfonksiyon

Pınar Yalçın Bahat
Jinekolojide Bütüncül Yaklaşım

Ayşe Seyhan
Görüntüleme

Yaprak Üstün
Kontrasepsiyon

Nafiye Karakaş
Onkofertilite

Orhan Orhan
Kozmetik

Özlem Dural
Adolesan

BİRİM SEKRETERLERİ VE KONGRE SÜRECİ YÜRÜTÜCÜLERİ

Nilüfer Cimşit
İnfertilite

İpek Özçivit
Menopoz

Merih Uğur
Cinsel Disfonksiyon

Ediz Güney
Onkoloji

Büşra Şahin
Jinekolojide Bütüncül Yaklaşım

Cansu Kaya
Kozmetik

Arif Can Özsipahi
PCOS

Berican Şahin
Onkoloji-Tarama Önleme

Can Benlioğlu
Görüntüleme

Şeyma Hasköylü
Adolesan

Tansu Bahar Gürbüz
Burslar

Zeynep Kübra Usta
Kurs Yönetimi

Şerife Akbay
Endüstri

Esra Nazlı Döktür
Sosyal Medya

Alev Esercan
Endüstri Kursları

İrem Özcan
Uluslararası Konuşmacılar

İrem Özcan
Uluslararası

Aslışah Çetin
Sosyal Program

Selen Doğan
Canlı Cerrahi

Bahadır Koşan
Genç Adımlar

Ramazan Erda Pay
Mentorla Buluşma

Batuhan Aslan
Endoskopi Eğitimi

Ezgi Ceren Dallı
Sözel Bildiriler

Bulut Varlı
Video Sunumlar

Savcı Telek
Bir Fikrim Var

23 Nisan 2026, Perşembe

	SALON A	SALON B	SALON C	SALON D	SALON E	SALON F
08:30-10:00	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Namık Demir PERİNATOLOJİ OTURUMU	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Faruk Buyru PCOS OTURUMU	İNTERAKTİF OLGU TARTIŞMASI	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI	ENDÜSTRİ DESTEKLİ KURS: CİLTALTI İMPLANT KURSU ORGANON	SÖZLÜ BİLDİRİ SUNUMLARI
	10:00-10:40 - UYDU SEMPOZYUMU MEALIS Ortadoğu Yaşam Bilimleri A.Ş.					
	10:40-11:20 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)					
	11:20-12:00 - UYDU SEMPOZYUMU BAYER Bayer					
12:00-13:00	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Hakan Yaralı İNFERTİLİTE OTURUMU	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Fulya Dökmeci ÜROJİNEKOLOJİ OTURUMU	MENTORLA BULUŞMA	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI		KSDF AKADEMİ: FİKRİNİ GETİR, TARTIŞALIM!
	13:00-14:00 ÖĞLE YEMEĞİ					
14:00-15:30	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. İlkkan Dünder ONKOLOJİ OTURUMU	BÜTÜNCÜL TIP OTURUMU	İNTERAKTİF OLGU TARTIŞMASI	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI	GENÇ ADIMLAR OTURUMU	JİNEKOLOJİK ENDOSKOPİK CERRAHİ VİDEO BİLDİRİ SUNUMLARI
	15:30-15:50 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)					
	15:50-16:30 - UYDU SEMPOZYUMU ITF İLAÇ					
16:30-17:30	PANEL: KOZMETİK JİNEKOLOJİDE NEREDEYİZ, GELECEK NEREYE GİDİYOR?	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Atıl Yüksel PERİNATOLOJİ PANELİ	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Nejat Özgül ONKOLOJİ PANELİ	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Fatih Durmuşoğlu MENOPOZ PANELİ	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Mustafa Bahçeci İNFERTİLİTE PANELİ	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Akın Sivaslioğlu ÜROJİNEKOLOJİ PANELİ
	17:30-18:30 CANLI CERRAHİ mega OLYMPUS Official Distributor					

24 Nisan 2026, Cuma

	SALON A	SALON B	SALON C	SALON D	SALON E	SALON F
08:30-10:00	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Erdoğan Ertüngealp MENOPOZ OTURUMU	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Fuat Demirci ÜROJİNEKOLOJİ OTURUMU	İNTERAKTİF OLGU TARTIŞMASI	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI	ENDÜSTRİ DESTEKLİ KURS: HİSTEROSKOPİ mega OLYMPUS Official Distributor	SÖZLÜ BİLDİRİ SUNUMLARI
	10:00-10:40 - UYDU SEMPOZYUMU MSD INVENTING FOR LIFE					
	10:40-11:20 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)					
	11:20-12:00 - UYDU SEMPOZYUMU Exeltis Rethinking healthcare					
12:00-13:00	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Rıza Madazlı PERİNATOLOJİ OTURUMU	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Fuat Demirkran ONKOLOJİ OTURUMU	MENTORLA BULUŞMA	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI	KSDF AKADEMİ: FİKRİNİ GETİR, TARTIŞALIM!	SÖZLÜ BİLDİRİ SUNUMLARI
	13:00-14:00 ÖĞLE YEMEĞİ					
14:00-15:30	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Cihat Ünlü İNFERTİLİTE OTURUMU	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. U. Fırat Ortaç TARAMA ÖNLEME OTURUMU	İNTERAKTİF OLGU TARTIŞMASI	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI	GENÇ ADIMLAR OTURUMU	JİNEKOLOJİK ENDOSKOPİK CERRAHİ VİDEO BİLDİRİ SUNUMLARI
	15:30-15:50 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)					
	15:50-16:30 - UYDU SEMPOZYUMU Medtronic					
16:30-17:30	PANEL: ENDOMETRİOZİS - ENDOMETRİOMA YÖNETİMİNDE YENİ YAKLAŞIMLAR	PANEL: CİNSEL DİSFONKSİYON - NEDEN ORGAZM OLAMIYORUM?	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Mehmet Ali Vardar ONKOFERTİLİTE PANELİ	PANEL: GÖRÜNTÜLEME - ENDOMETRİOZİS VE ADENOMYOZİS İÇİN DOĞRU TANI VE CERRAHİ YÖNETİMİN OPTİMİZE EDİLMESİ	PANEL: ENDOSKOPİ - ROBOTİK CERRAHİ GEREKLİ Mİ?	PANEL: İNFERTİLİTE - BİRİNCİ BASAMAK İNFERTİLİTE YÖNETİMİ
	17:30-18:30 CANLI CERRAHİ Medtronic					

25 Nisan 2026, Cumartesi

	SALON A	SALON B	SALON C	SALON D	SALON E	SALON F
08:30-10:00	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Ahmet Zeki Işık ENDOMETRİOZİS OTURUMU	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Mete Güngör ONKOFERTİLİTE OTURUMU	İNTERAKTİF OLGU TARTIŞMASI	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI	ENDÜSTRİ DESTEKLİ KURS: SÜTUR EGİTİMİ KURSU doğsan	JİNEKOLOJİK ENDOSKOPİK CERRAHİ VİDEO BİLDİRİ SUNUMLARI
	10:00-10:40 - UYDU SEMPOZYUMU Applied Medical					
	10:40-11:20 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)					
	11:20-12:00 - UYDU SEMPOZYUMU Orthogen					
12:00-13:00	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Acar Koç PERİNATOLOJİ OTURUMU	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Ali Haberal İNFERTİLİTE OTURUMU	MENTORLA BULUŞMA	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI	HEMŞİRELİK OTURUMU	SÖZLÜ BİLDİRİ SUNUMLARI
	13:00-14:00 ÖĞLE YEMEĞİ					
14:00-15:30	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Bülent Urman İNFERTİLİTE OTURUMU	ADOLESAN DÖNEMDE CİNSELLİK VE KORUYUCU YAKLAŞIMLAR OTURUMU	İNTERAKTİF OLGU TARTIŞMASI	GÖRSELLERLE ENDOSKOPİK CERRAHİ OLGU TARTIŞMALARI	HEKİMİN YENİ ASİSTANI: KADIN DOĞUM PRATİĞİNDE YAPAY ZEKÂ İLE DÜŞÜNMEK	OBSTETRİK ULTRASONOGRAFİ BİLDİRİ SUNUMLARI
	15:30-15:50 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)					
	15:50-16:30 - UYDU SEMPOZYUMU TABİLAÇ					
16:30-17:30	PANEL: KONTRASEPSİYON - KİME? HANGİ YÖNTEM?	PANEL: BÜTÜNCÜL YAKLAŞIM - JİNEKOLOJİ VE OBSTETRİDE NELERİ BİLMELİYİZ?	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Sedat Kadanalı PCOS PANELİ	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. M. Faruk Köse ONKOLOJİ PANELİ	İlham Veren, Yol Gösterenlere Saygılarımızla Prof. Dr. Cemal Posacı İNFERTİLİTE PANELİ	PANEL: ÜREME CERRAHİSİNDE TARTIŞILAN BAŞLIKLAR
	17:30-18:30 CANLI CERRAHİ Applied Medical					

26 Nisan 2026, Pazar

	SALON A	SALON B	SALON C	SALON D	SALON E	SALON F
08:30-10:00	CİNSEL DİSFONKSİYON OTURUMU - SEKS ACITIRSA	KONTRASEPSİYON OTURUMU	SÖZLÜ BİLDİRİ SUNUMLARI	SÖZLÜ BİLDİRİ SUNUMLARI	SÖZLÜ BİLDİRİ SUNUMLARI	JİNEKOLOJİK ENDOSKOPİK CERRAHİ VİDEO BİLDİRİ SUNUMLARI
10:00-10:45	AKILCI İLAÇ KULLANIMI					

22 Nisan 2026, Çarşamba

A SALONU

13:00-14:00 **Jinekolojide Görüntüleme**
Kurs Yöneticisi: Ayse Seyhan Ata
Oturum Başkanları: Ayse Seyhan Ata, Inga Ludwin

13:00-13:20 2D ve 3D Ultrason Görüntü Kalitesini Arttırma: Ustaların Sırları
Inga Ludwin

13:20-13:40 ART Perspektifinde Uterin Kavite ve Fallop Tüplerinin Değerlendirilmesi
Artur Ludwin

13:40-14:00 İnteraktif Vakalar: Doğuştan Uterin Anomalilerde Tanısal ve Terapötik İkilemler
Inga Ludwin, Artur Ludwin

14:00-14:20 **KAHVE ARASI**
Ultrason Cihazı Üzerinde Çalısma



14:20-15:20 **Oturum Başkanları: Üzeyir Kalkan, Erhan Simsek**

14:20-14:40 Myomların Ultrason Tanısı ve Bulguları Nasıl Tanımlarız, Haritalandırırız?
Üzeyir Kalkan

14:40-15:00 Adenomyozis Tanısı ve Ultrasonografide Karşılaşılabilecek Zorluklar
Sinem Ertas

15:00-15:20 İnteraktif Vakalar: Adenomyosis ve Myomlarda Tanı ve Tedavi İkilemleri
Kiper Aslan

15:20-15:40 **KAHVE ARASI**
Ultrason Cihazı Üzerinde Çalısma



15:40-16:40 **Oturum Başkanları: M. Faruk Köse, Mehmet Ali Vardar**

15:40-16:00 Benign ve Malign Adneksiyal Kitleleri Ayırt Etmek Için "Simple Rules" Kullanımı & İnteraktif Vakalar
Hamdullah Sözen

16:00-16:20 Over Malignitesini Öngörmek için ADNEX ve ORADS Modellerinin Tanıtımı
Çagatayhan Öztürk

16:20-16:40 İnteraktif Vakalar: ADNEX ve ORADS Modellerinin Vakalar Üzerinde Uygulaması
Doğan Vatansever

Kapanış Konuşması
Ayşe Seyhan Ata

**Kurs Türkçe-Ingilizce olarak yapılacaktır. Simültane çeviri yapılmayacaktır.*

B SALONU

13:00-18:00

İlham Veren, Yol Gösterenlere Saygılarımızla
Prof. Dr. Recep Has
Obstetrik Ultrasonografi Kursu
Kurs Yöneticisi: Bilge Çetinkaya Demir
Oturum Başkanları: Serenat Yalçın, Hüseyin Ekici



İlk Trimester Tarama USG: Standart Planlar, Ölçümler ve Kalite Kriterleri
Cem Sanhal
İlk Trimester Fetal Anatomi: "Normal" Gibi Görünen Patolojiler
Nihal Şahin Uysal
Skar Gebeliği Tanısı: Erken Dönemde Ayırıcı Tanı ve Yönetim Algoritmaları
Emel Ebru Özçimen



KAHVE ARASI

Oturum Başkanları: Bilge Çetinkaya Demir, Emel Ebru Özçimen

İkinci Trimester Anatomi Taraması: Temel Planlar ve Zorunlu Görüntüler
Serenat Yalçın
İkinci Trimester Anatomi Taraması: Genişletilmiş İnceleme ve Gri Alanlar
Gülşah Aynaoğlu Yıldız
Servikal Değerlendirme: Kimde, Ne Zaman ve Gerçekten Ne İşe Yarıyor?
Muhammed Hanifi Bademkıran



KAHVE ARASI

Oturum Başkanları: Şevki Çelen, Mehmet Güney

Amniyon Sıvısı ve Plasentanın Ultrasonografik Değerlendirilmesi: Normal mi, Risk mi?
Erkan Çağlıyan
Plasenta Akreta Spektrumu: Prenatal Tanıda Ultrason Nerede Güçlü, Nerede Yetersiz?
Hüseyin Çağlayan Özcan
Fetal Doppler Ultrasonografi Endikasyonları
Hüseyin Ekici

Kapanış Konuşması
Bilge Çetinkaya Demir

22 Nisan 2026, Çarşamba

C SALONU

13:30-18:00

İlham Veren, Yol Gösterenlere Saygılarımızla
Prof. Dr. Hakan Seyisoğlu
Menopoz Yönetimi ve MHT Kursu
Kurs Yöneticisi: Fatih Durmuşoğlu
Oturum Başkanları: Fatih Durmuşoğlu, Elif Akşahin



MHT Endikasyonları
Banu Çiftçi
Kime Verelim?
Kemal Hansu
Ne Zaman Verelim ve Ne Süre?
Telce Ayşen Küçükceran



KAHVE ARASI

Oturum Başkanları: Fatih Durmuşoğlu, İpek Özçivit

Hangi Hormonlar?
Elif Akşahin
Hangi Protokoller?
Hakan Seyisoğlu
Hangi Yol?
Fatih Durmuşoğlu



KAHVE ARASI

Oturum Başkanları: Hakan Seyisoğlu, Telce Ayşen Küçükceran

Obezite-GLP-1 Agonistleri
Şirin Aydın
Non Hormonal Tedaviler
Fatih Aktoz
Biyoözdeş ve Compaunded Bioidentikal Kavramları
İpek Özçivit

Kapanış Konuşması
Fatih Durmuşoğlu

D SALONU

13:30-18:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Esra Kuşçu
HPV ile İlintili Sorunların Tanı ve Yönetimi
Kurs Yöneticisi: M. Mutlu Meydanlı
Oturum Başkanları: M. Mutlu Meydanlı, Mürşide Çevikoğlu



13:00-13:20 HPV Enfeksiyonu: Doğal Seyir ve Klinik Anlamı
İbrahim Yalçın

13:20-13:40 Servikal Kanser Taramasında Güncel Yaklaşımlar
Ahmet Barış Güzel

13:40-14:00 HPV Pozitif Hastaya Yaklaşım: İlk Adım Ne Olmalı?
Şevki Göksun Gökulu



14:00-14:20 **KAHVE ARASI**

14:20-14:40 **Oturum Başkanları: Hüsnü Çelik, Sevda Baş**

14:20-14:40 Kolposkopinin Temelleri: Ne Zaman, Nasıl?
Nejat Özgül

14:40-15:00 CIN Lezyonlarının Yönetimi
Çetin Çelik

15:00-15:20 Tedavi Sonrası İzlem ve Nüks Riski
Seda Yüksel Şimşek



15:20-15:40 **KAHVE ARASI**

14:20-14:40 **Oturum Başkanları: Salih Taşkın, Seda Yüksel Şimşek**

15:40-16:00 HPV ve Özel Hasta Grupları
Hüseyin Akıllı

16:00-16:20 HPV Aşıları: Kime, Ne Zaman?
Nasuh Utku Doğan

16:20-16:40 Günlük Pratikte Sık Yapılan Hatalar & Zor Sorular
Mürşide Çevikoğlu, Sevda Baş, Esra İşçi Bostancı

Kapanış Konuşması
M. Mutlu Meydanlı

E SALONU

13:00-18:00

vNOTES
Kurs Yöneticisi: Kemal Güngördük
Oturum Başkanları: Burcu Kasap, Kübra Baki Erin

vNOTES Cerrahisi: Başlangıç ve Temel İlkeler
Bahadır Koşan
vNOTES Histerektomi
Bulut Varlı
Adneksiyel Cerrahiler ve vNOTES
Gamze Nur Cimilli Şenocak



KAHVE ARASI

Oturum Başkanları: Onur Karaaslan, Süleyman Salman

Acil Jinekolojik Vakalarda vNOTES
Mesut Önal
vNOTES Lateral Süspansiyon Tekniği
Onur Karaaslan
vNOTES Uterosakral Ligament Plikasyonu ve Sakrokolpopeksi
Süleyman Salman



KAHVE ARASI

Oturum Başkanları: Selçuk Erkılınç, Neslihan Bayramoğlu Tepe

Kompleks Olgularda vNOTES
Kemal Güngördük
vNOTES: Jinekolojik Onkoloji Cerrahisindeki Yeri
Ghanim Khatib
vNOTES: Komplikasyonlardan Kaçınma ve Yönetimi
Batuhan Turgay

Kapanış Konuşması
Kemal Güngördük

F SALONU

13:00-18:00

Fonksiyonel ve Kozmetik Jinekoloji Kursu
Kurs Yöneticisi: Orhan Orhan
Oturum Başkanı: Orhan Orhan

A Comprehensive Introduction to Integrative Cosmetic and Functional Gynecology and Learning Objectives of the Day
Orhan Orhan

Functional Pelvic Anatomy: Structural, Muscular and Neurovascular Landmarks Guiding Aesthetic and Reconstructive Procedures
Orhan Orhan

Aesthetic and Functional Correlations: Clinical Assessment, Anatomical Harmony and Patient-Centered Design Principles
Mustafa Aldam

KAHVE ARASI



Oturum Başkanı: Sibel Üstünel

Reconstructive Surgical Techniques: Edge, Wedge and Perineoplasty Approaches for Functional and Cosmetic Optimization
Sibel Üstünel

Labia Majora and Clitoral Hood Procedures: Surgical Techniques, Indications, and Management of Aesthetic and Functional Complications
Mustafa Aldam

Energy-Based Technologies in Gynecology: Clinical Indications, Mechanisms and Evidence-Based Outcomes in Laser and RF Applications
Helia Radnaseri

KAHVE ARASI



Oturum Başkanları: Orhan Orhan, Sibel Üstünel

Regenerative and Rejuvenative Therapies: Fat Grafting, Platelet-Rich Plasma and Hyaluronic Acid Fillers for Tissue Quality Enhancement
Şeyma İlayda Paltacı

Combination Approaches: Synergistic Use of Surgical, Energy-Based and Regenerative Modalities for Optimal Pelvic Restoration
Cansu Kaya

Complication Management and Revision Strategies
Sibel Üstünel

Closing Session: Future Perspectives in Functional and Aesthetic Gynecology
Orhan Orhan

**Kurs Türkçe-Ingilizce olarak yapılacaktır. Simültane çeviri yapılmayacaktır.*

22 Nisan 2026, Çarşamba

G SALONU

13:00-14:30 — **Travay ve Doğum Yönetimi**
Kurs Yöneticisi: Furkan Kayabaşoğlu

Güvenli bir "Travay takibi"
13:00-13:30 Intrapartum Ultrasonografi
Esra Ayanoğlu
13:30-14:00 Fetal İyilik Hali
Emre Erdoğdu
14:00-14:30 Yeni Nesil Partografi
Arzu İlknur Özdemir

14:30-15:00 — **KAHVE ARASI**

15:00-16:30

İdeal "doğum"
15:00-15:30 Doğum nasıl idealize edilebilir? Dikişsiz… Ağrısız…
Furkan Kayabaşoğlu
15:30-16:00 Doğumun olmazsa olmazı: Continous Support!
Hürcan Çit Bayram
16:00-16:30 Epizyotomi! Uygulaması… Onarılması…
Salih Yılmaz

16:30-17:00 — **KAHVE ARASI**

16:00-18:00

Tüm gerçekliği ile "Suda Doğum"
17:00-18:00 Suda Doğum Paneli
Furkan Kayabaşoğlu, Burak Özköse

H SALONU

13:00-18:00 **Histeroskopi Kursu**
Kurs Yöneticisi: Cihan Bademkıran

Histeroskopide Enstrümentasyon, Temel Teknikler
Cihan Bademkıran
Operatif Histeroskopi; Rezektoskop Kullanımı, Polip, Myom, İstmosel, Septum (Video eşliğinde)
Yavuz Tokgöz
Mekanik Doku Çıkarıcı Histeroskopi: Polip, Myom
İhsan Bağlı
Mekanik Histeroskopi Diğer Uygulama Alanları: Histeroskopide Komplikasyonların Önlenmesi, Yönetimi
Cihan Bademkıran

KAHVE ARASI



Maket ve Simülatörler Üzerinde Çalışma
Eğitmenler: Cihan Bademkıran, Yavuz Tokgöz, İhsan Bağlı

KSDF

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

22 NİSAN 2026, ÇARŞAMBA
SALON A / 18:00-19:00

AÇILIŞ TÖRENİ PROGRAMI

Saygı Duruşu

İstiklal Marşı

Açılış Videosu

AÇILIŞ KONUŞMASI

Prof. Dr. Gürkan Uncu

Kadın Sağlığı Dernekleri Federasyonu Başkanı

"KADIN SAĞLIĞINDA İLHAM VEREN, YOL GÖSTEREN HOCALARIMIZA" VEFA OTURUMU

Genç Adımlar Sunuculuğunda

İlham Veren Hocalarımıza Ödül Takdimi

KSDF

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

22 NİSAN 2026, ÇARŞAMBA
SALON A / 18:00-19:00

KADIN SAĞLIĞI: GÖRÜNMEYENİ GÖRMEK

Her Kadın Bir Hikâye, Her Fotoğraf Bir İz..





- **Doç. Dr. Üzeyir Kalkan**
  Moderatör



- **Duygu Nazire Kaşıkcı, "*Yakından*" başlıklı gösterimi ile**
  Akademisyen, Fotoğraf Eğitmeni (FSK, KASK)



- **Dr. Sefa Ulukan - "*Santo Niño*" sunumu ile**
  Tıp Doktoru, ESFIAP, EFIAP, TFSF Onur Yıldızı, FIAP Uluslararası Medikal Fotoğrafçılar Derneği (IMPC), Kurucu Dünya Başkanı

A SALONU

08:30-10:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Namık Demir Oturumu
Oturum Başkanları: Atıl Yüksel, Rıza Madazlı



Anomali Taramasında Ultrason ve NIPT'nin Kombinasyonu
İbrahim Kalelioğlu
Diagnostic Accuracy of First Trimester Ultrasound to Detect Fetal Anomalies and How to Improve the Accuracy
Daniele di Mascio
3. Trimester Ultrasonu
İnanç Mendilcioğlu
Management of Early and Late FGR
Daniele di Mascio
Tartışma

10:00-10:40 **UYDU SEMPOZYUMU**
HPV Enfeksiyonlarında Tedavi Mümkün mü?
Moderatör: İlkkan Dünder
Konuşmacı: Nejat Özgül

MEALIS ORTADOĞU YAŞAM BİLİMLERİ A.Ş.



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

11:20-12:00 **UYDU SEMPOZYUMU**
Anormal Uterin Kanama ve Primer Dismenore Tedavisinde Kombine Oral Kontraseptiflerin Yeri
Moderatör: Gürkan Uncu
Konuşmacı: Kiper Aslan, Ayşe Telce Küçükceran

Bayer

12:00-13:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Hakan Yaralı Oturumu
Tedavi Seçiminde AMH
Moderatör: Mustafa Bahçeci



12:00-12:20 Pro: AMH Tedavi Seçimini Belirlemeli
Kiper Aslan
12:20-12:40 Con: Hayır, AMH Tedavi Seçimini Belirlememeli
Sezcan Mümüşoğlu
12:40-13:00 Tartışma



13:00-14:00 **ÖĞLE YEMEĞİ**

A SALONU

14:00-15:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. İlkkan Dünder Oturumu
Oturum Başkanları: U. Fırat Ortaç, M. Mutlu Meydanlı



Erken Evre Serviks Kanseri Cerrahisinde MIS Yeniden Popülarite Kazanabilir mi?
M. Murat Naki
High-Risk Endometrium Kanserinde Sentinel Nod Mapping Yeterli midir?
Hamdullah Sözen
"Neoadjuvan Kemoterapi + İnterval Cerrahi" vs. "Primer Sitoredüksiyon" TRUST Çalışması Soruyu Cevaplayabildi mi?
Christina Fotopoulou
Epitelyal Over Kanserinde Genomik Profillemeye Göre Güncel Tedavi Seçenekleri
Esra Kuşçu
Tartışma



15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

15:50-16:30 **UYDU SEMPOZYUMU**
Menopozun Genitouriner Sendormunda Etkili ve Güvenli Tedavi: Blissel
Moderatör: Fatih Durmuşoğlu
Konuşmacı: Selcen Bahadır

16:30-17:30 **Panel: Kozmetik Jinekolojide Neredeyiz, Gelecek Nereye Gidiyor?**
Moderatör: Orhan Orhan
Panelistler: Sibel Üstünel, Telce Ayşen Küçükceran, Bahadır Koşan, Cansu Kaya

Tartışılacak Konular:
- Fonksiyonel Jinekoloji ile Kozmetik Uygulamaların Kesişim Alanları
- Güncel Uygulamalar: Hangi İşlemler Rutinleşti, Hangileri Tartışmalı?
- Hasta Beklentileri, Memnuniyet ve Psikososyal Boyut
- Enerji Temelli Teknolojiler, Dolgu ve Rejeneratif Tedavilerde Güncel Durum
- Etik Sınırlar ve Medikolegal Sorumluluklar
- Standartlar, Sertifikasyon ve Eğitim İhtiyacı
- Kozmetik Jinekolojide Gelecek Trendler ve Teknolojik Gelişmeler

17:30-18:30 **CANLI CERRAHİ** LIVE
Moderatör: Çağatay Taşkıran

Pelvik Anatomi - Retroperiton Diseksiyonu - Histerektomi
Cerrah: Salih Taşkın (Akdeniz Üniversitesi Hastanesi'nden Canlı Aktarım)
Histeroskopik Myomektomi
Cerrah: Erhan Şimşek (Akdeniz Üniversitesi Hastanesi'nden Canlı Aktarım)
Histereskopik Skar Onarımı
Cerrah: Selen Doğan (Akdeniz Üniversitesi Hastanesi'nden Canlı Aktarım)

B SALONU

08:30-10:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Faruk Buyru Oturumu
Oturum Başkanları: Gürkan Bozdağ, Murat Özekinci



PCOS Etiopatogenezinde Güncel Durum ve Klinik Önemi
Cem Atabekoğlu
Adölesanlarda PCOS Tanısı ve Yönetim Güçlükleri
Ümran Küçükgöz Güleç
PCOS Metabolik Riskler ve Kadın Doğum Uzmanının Rehberliği; Kimi, Ne Zaman ve Nasıl İzlemeliyiz?
Pınar Çağlar Aytaç
İnfertilite Yönetimi; Güncel Kanıtlar
Gürkan Bozdağ
Tartışma



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Fulya Dökmeci Oturumu
Apikal Prolapsus Yönetimi Abdominal Yoldan Olmalı
Moderatör: Emsal Pınar Topdağı Yılmaz



12:00-12:20 Pro
Tommaso Simoncini
12:20-12:40 Con
Gülin Feykan Yeğin
12:40-13:00 Tartışma



13:00-14:00 **ÖĞLE YEMEĞİ**

14:00-15:30 **Bütüncül Tıp Oturumu**
Oturum Başkanları: Pınar Yalçın Bahat, Orhan Orhan

Üreme Sağlığında Mikrobiyata
Meltem Yalınay
Oosit ve Sperm Kalitesi Gerçekten Artabilir mi?
İdil Bozkurt
ART Tedavisinde Takviye Seçiminde Dikkat Edilmesi Gerekenler
Çiğdem Yayla Abide
ART Öncesi Detoks Nasıl Olmalı?
Zühal Dilek Şanlı
Tartışma

B SALONU



15:30-15:50 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)

16:30-17:30

İlham Veren, Yol Gösterenlere Saygılarımızla
Prof. Dr. Atıl Yüksel Paneli
Preterm Doğumun Önlenmesi, Progesteron, Serklaj, Tokolitikler
Moderatör: Recep Has
Panelistler: Tuğba Saraç Sivrikoz, Şevki Çelen, Oya Demirci



Tartışılacak Konular:

- Preterm Doğum Riskinin Öngörülmesinde Güncel Yaklaşımlar
- Serklaj Endikasyonları
- Serklaj Sonrası Takip, Komplikasyonlar ve Başarısızlık Nedenleri
- Tokolitik Ajanların Yeri, Etkinliği ve Güvenliği: Kime, Ne Zaman, Ne Kadar?
- Tokoliz İle Antenatal Kortikosteroid ve Magnezyum Sülfat Uygulamalarının Zamanlaması
- Farklı Klinik Senaryolarda (Çoğul Gebelik, Önceki Preterm Doğum, Kısa Serviks) En Uygun Yaklaşım
- Güncel Kılavuzlar Işığında Tartışmalı Alanlar ve Pratikte Karşılaşılan İkilemler

C SALONU

08:30-10:00 **İnteraktif Olgu Tartışması**
Konu: Doğum Eylemi
Olgu Sunumu: Tansu Bahar Gürbüz
Yönetici: Pınar Tokdemir Çalış
Tartışmacı Hocalar: Furkan Kayabaşoğlu, Mehmet Murat Işıkalan, Ragıp Atakan Al

- İndüksiyon Başarısızlığı
- Operatif Vajinal Soğum ve Distoşi Yönetimi
- Fetal Gelişim Kısıtlılığı Olan Olguda Doğum İndüksiyonu

Bu oturumda genç bir jinekolog tarafından sunulan 3 olgu , kıdemli hocaların katkılarıyla interaktif olarak tartışılacak; tanısal yaklaşımlar, tedavi seçenekleri ve klinik karar süreçleri güncel bilgiler ışığında değerlendirilecektir



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **Mentorla Buluşma**

Konu: Over Kist Endometriomlarının Yönetimi
Mentor: Ludovico Muzii
Konu: Over Kanseri Yönetimi: ESGO Akreditasyonuna Sahip Üçüncü Basamak Bir Merkezde – Berlin Charité Üniversitesi'nden İçgörüler
Mentor: Emel Canaz
Konu: Kompleks Cerrahi İşlemlerin Güvenli Yönetimi İçin Retroperitoneal Anatominin Ustalıkla Öğrenilmesi
Mentor: Mohamed Achour
Radikal Sitoredüktif Prosedürler İçin Öğrenme Eğrileri
Mentor: Christina Fotopoulou



13:00-14:00 **ÖĞLE YEMEĞİ**

C SALONU

14:00-15:30 **İnteraktif Olgu Tartışması**
Konu: Adneksiyal Kitle Yaklaşımı
Olgu Sunumu: Arif Can Özsipahi
Yönetici: Yakup Yalçın
Tartışmacı Hocalar: Tufan Öge, Selçuk Erkılınç, Serhat Ege, Ediz Güney

- Seröz Borderline Over Tümörü
- Retroperitoneal Anjiyolipoleiomyom

Bu oturumda genç bir jinekolog tarafından sunulan 2 olgu , kıdemli hocaların katkılarıyla interaktif olarak tartışılacak; tanısal yaklaşımlar, tedavi seçenekleri ve klinik karar süreçleri güncel bilgiler ışığında değerlendirilecektir



15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

16:30-17:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Nejat Özgül Paneli
Olgularla Adneksiyel Kitle
Moderatör: Mehmet Ali Vardar
Panelistler: Işın Üreyen, Kemal Güngördük, Utku Akgör, Mehmet Sait Bakır



Tartışılacak Konular:

- Adneksiyel Kitlelerde İlk Değerlendirme ve Risk Sınıflaması
- IOTA Simple Rules, ADNEX ve O-RADS Sınıflamalarının Olgu Bazında Kullanımı
- Tümör Belirteçlerinin (CA-125, HE4 Vb.) Tanı ve Karar Sürecindeki Yeri
- Minimal İnvaziv Cerrahi mi, Laparotomi mi? Olgu Bazında Cerrahi Yol Seçimi
- Şüpheli Adneksiyel Kitlelerde Evreleme Cerrahisi Endikasyonları
- Minimal İnvaziv Cerrahi mi, Laparotomi mi? Olgu Bazında Cerrahi Yol Seçimi
- Benign Düşünülen Ancak Malign Çıkan Olgularda Yönetim Stratejileri

D SALONU

08:30-10:00 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: İlkkan Dünder

Eğiticiler:
Ameliyat: Myomlu Uterusu ve Çoklu Sezaryen Öyküsü Olan Hastada Laparoskopik Histerektomi
Çağrı Ateş
Ameliyat: İntrauterin Adhezyonlara Histeroskopik Yaklaşım
Abdullah Tok
Ameliyat: vNOTES Histerektomi ve Apikal Prolapsus Önleyici Cerrahiler
Ahkam Göksel Kanmaz

Bu oturumda, üç kıdemli öğretim üyesi kendi endoskopik cerrahi ameliyatlarını video kayıtları eşliğinde sunarak, cerrahi teknikleri, kritik aşamaları ve klinik deneyimlerini katılımcılarla paylaşacaktır.

10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**



12:00-13:00 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: Üzeyir Kalkan

Eğiticiler:
Ameliyat: Laparoskopik Histerektomi Basit ve Komplike Olgular
Deha Denizhan Keskin
Ameliyat: Videolar Eşliğinde Minimal İnvaziv Ürojinekolojik Yaklaşım Algoritması
Ömer Lütfi Tapısız
Ameliyat: Laparoskopide Komplikasyonlar ve Perop Yönetimi
Yağmur Minareci

Bu oturumda, üç kıdemli öğretim üyesi kendi endoskopik cerrahi ameliyatlarını video kayıtları eşliğinde sunarak, cerrahi teknikleri, kritik aşamaları ve klinik deneyimlerini katılımcılarla paylaşacaktır.

13:00-14:00 **ÖĞLE YEMEĞİ**



D SALONU

14:00-15:30 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: Yaşam Kemal Akpak

Eğiticiler:
Ameliyat: Jinekolojik Kanserlerde Floresan Booya ve ICG
Çağatayhan Öztürk
Ameliyat: vNOTES POP Cerrahisi
Berican Şahin Uyar
Ameliyat: vNOTES
M. Ferdi Kıncı

Bu oturumda, üç kıdemli öğretim üyesi kendi endoskopik cerrahi ameliyatlarını video kayıtları eşliğinde sunarak, cerrahi teknikleri, kritik aşamaları ve klinik deneyimlerini katılımcılarla paylaşacaktır.

15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**



16:30-17:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Fatih Durmuşoğlu Paneli
Kime MHT? Nasıl MHT? Ne Kadar Süre?
Moderatör: Fatih Durmuşoğlu
Panelistler: Hakan Seyisoğlu, İpek Özçivit, Dilşad Sindel, Serdar Özşener



Tartışılacak Konular:
- MHT için Doğru Hasta Seçimi: Fayda–Risk Dengesi
- Başlama Zamanı: "Window of Opportunity" Kavramı
- Östrojen Türleri ve Dozları: Oral vs Transdermal
- Progestojen Seçimi: Kime, Hangisi, Ne Kadar?
- Kardiyovasküler, Tromboembolik ve Meme Kanseri Riskleri Işığında MHT
- Ne Kadar Süre MHT? Uzatma ve Kesme Kriterleri

E SALONU

08:30-10:00 **Endüstri Destekli Kurs: Ciltaltı İmplant Kursu** ORGANON

Eğiticiler:
Nefise Nazlı Yenigül
Selin Özaltın
Şebnem Alanya Tosun
Nefise Tanrıdan Okçu



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**



13:00-14:00 **ÖĞLE YEMEĞİ**

14:00-15:30 **Genç Adımlar Oturumu**
Malpraktis Baskısı Altında Kanıta Dayalı Obstetri
Oturum Başkanları: Rıza Madazlı, İlkin Acar Açıkgöz

İndüksiyon Endikasyonları: Kılavuzlar Ne Diyor, Pratikte Ne Yapıyoruz?
Büşra Şahin
Latent Faz Yönetimi: Beklemek mi, Müdahale mi? Güncel Tanımlar ve Sınırlar
Ebru Yücel
Fetal Monitörizasyon Günümüzde Hala Güvenilir mi?
Şerife Akbay
Operatif Vajinal Doğum; Doğru Araç, Doğru Hasta, Doğru Zaman
Cansu Kaya
Tartışma



15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

16:30-17:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Mustafa Bahçeci Paneli
Zor IVF Hastası: Ne Zaman Israr, Ne Zaman Yön Değiştirmeli?
Moderatör: Gürkan Uncu
Panelistler: Erhan Şimşek, Erbil Doğan, Neslihan Bayramoğlu Tepe, Alev Özer



Tartışılacak Konular:
- IVF: Protokolde Neyi Değiştirmeliyiz?
- Beklenmeyen Kötü Over Yanıtı: İlk Siklusta Hata Nerede?
- PGT-A Ne Zaman Faydalı, Ne Zaman Gereksiz?
- Tekrarlayan İmplantasyon Başarısızlığında Uterin Faktörler ve Değerlendirme Stratejileri
- Ne Zaman "Dur" Demeli?
- Etik Sınırlar ve Gerçekçi Beklenti Yönetimi

F SALONU

08:30-10:00 **Sözlü Bildiri Sunumları**
Oturum Başkanları: Fatma Devran Bıldırcın, Sema Baki Yıldırım
Detaylar için QR okutunuz!

10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**



12:00-13:00 **KSDF Akademi: Fikrini Getir, Tartışalım!**
Yorumlayıcılar: Faruk Buyru, Rıza Madazlı, Sedat Kadanalı

Preeklampsi Öyküsü Olan Gebelerde Gebelik Kesesi Görüldüğü Anda Başlanan Vajinal Progesteron Tedavisinin Rekürren Preeklampsi Riskine Etkisinin Değerlendirilmesi - **Ece İrem Özcan**
Gebelik Öncesi FSH, LH, Progesteron ve AMH Düzeylerinin Plasentasyon ve Preeklampsi Gelişimi ile İlişkisi - **Ece İrem Özcan**
Antenatal Multivitamin Kullanımı ve Fetal Büyüme Arasındaki İlişkinin Maternal Metabolik Faktörlerle Birlikte İncelenmesi - **Defne Sayici**
Ergen Polikistik Over Sendromu Hastalarında Probiyotik Tedavisinin Metabolik ve Hormonal Parametreler Üzerine Etkisi - **Furkan Turan**

Bu oturumda genç araştırmacılar kendi fikirlerini sunacaklar ve kıdemli hocalar fikrin olgunlaşmasını sağlayacaklar ve yorum yapacaklardır.

13:00-14:00 **ÖĞLE YEMEĞİ**



14:00-15:30 **Jinekolojik Endoskopik Cerrahi Video Bildiri Sunumları**
Oturum Başkanları: Ramazan Erda Pay, Cihan Bademkıran
Detaylar için QR okutunuz!

15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**



16:30-17:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Akın Sivaslıoğlu Paneli
Askı Ameliyatları Teknikleri Çok Şeyi Değiştiriyor mu?
Moderatör: Emsal Pınar Topdağı Yılmaz
Panelistler: Fuat Demirci, Derya Kılıç Güler, Bulut Varlı, Gamze Nur Cimilli Şenocak



Tartışılacak Konular:
- Stres Üriner İnkontinansta Askı Cerrahilerinin Yeri ve Güncel Endikasyonları
- Teknik Farklılıkların Başarı Oranları ve Hasta Memnuniyetine Etkisi
- Komplikasyon Profilleri: Ağrı, Mesh Erozyonu, İşeme Disfonksiyonu
- Hasta Seçimi: Primer vs Rekürren Olgular, Eşlik Eden Pelvik Organ Prolapsusu
- Askı Cerrahilerinde Cerrah Deneyimi ve Öğrenme Eğrisi
- Başarısız Askı Cerrahisi Sonrası Revizyon ve Alternatif Tedavi Seçenekleri
- Güncel Kılavuzlar Işığında Teknik mi, Hasta mı Sonucu Belirler?

A SALONU

08:30-10:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Erdoğan Ertüngealp Oturumu
Oturum Başkanları: Fatih Durmuşoğlu, Şirin Aydın



Black Box Ne Diyor?
Fatih Durmuşoğlu
Premature Ovarian Insufficiency: Fertility and Beyond, a Comprehensive Challenge in Women's Health
Antonio Cano Sanchez
VMS ve Uyku Bozuklukları
Hakan Seyisoğlu
Postmenopozal Osteoporoz ve Kas-Eklem Ağrıları
Serdar Özşener
Tartışma

10:00-10:40 **UYDU SEMPOZYUMU**
HPV, HPV İlişkili Hastalıklar ve Kanserlerin Önlenmesinde HPV Aşıları
Konuşmacı: Çağatay Taşkıran

MSD



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

11:20-12:00 **UYDU SEMPOZYUMU**
Gebelik Öncesinden Emzirmeye Kesintisiz Destek: Regenesis Max Plus
Moderatör: Recep Has
Konuşmacı: Pınar Yalçın Bahat

Exeltis
Rethinking healthcare

12:00-13:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Rıza Madazlı Oturumu
NIPT ile Nadir Otozomal Trizomileri, Mikrodelesyon ve Duplikasyonları Taramalı mıyız?
Moderatör: Acar Koç



12:00-12:20 Pro
Ebru Davutoğlu
12:20-12:40 Con
Özlem Pata
12:40-13:00 Tartışma



13:00-14:00 **ÖĞLE YEMEĞİ**

A SALONU

14:00-15:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Cihat Ünlü Oturumu
Oturum Başkanları: Davut Güven, Mete Işıkoğlu



Yüzeysel Endometriozisin Görüntülenmesindeki Zorluklar, Yenilikler
Işıl Kasapoğlu
Ultrason Bazlı Endometriozis Evreleme Sisteminin (UBESS) Laparoskopik Endometriozis Cerrahisinin Zorluk Düzeyini Tahmin Etme Performansı
Bülent Urman
Endometriozisin ve Endometriomaların Doğal Seyri Nedir: Ultrason ile İzlemeli miyiz?
Yavuz Emre Şükür
İnsidental Ultrason Bulgusu Olan Adenomyozis: Hastalarımızı Nasıl Bilgilendirmeliyiz?
Ayşe Seyhan Ata
Tartışma



15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

15:50-16:30 **UYDU SEMPOZYUMU**
Jinekolojide Hassas Enerji: LigaSure XP'nin Klinik Kanıtları ve Uygulamaları
Moderatör: Yaşam Kemal Akpak
Konuşmacı: Ahkam Göksel Kanmaz

Medtronic

16:30-17:30 **Panel: Endometriozis - Endometrioma Yönetiminde Yeni Yaklaşımlar**
Moderatör: Cihat Ünlü
Panelistler: Yavuz Emre Şükür, Şule Yıldız, Davut Güven, Ahmet Demir, Lütfi Cem Demirel

Tartışılacak Konular:
- Endometriomada Tanısal Yaklaşım: USG, MR ve Takip Stratejileri
- Bekle–Gör mü, Müdahale mi? Hangi Hastada, Ne Zaman?
- Cerrahi Endikasyonlar: Ağrı, İnfertilite, Malignite Şüphesi
- Endometrioma Cerrahisinde Over Rezervine Etkiler ve Koruyucu Stratejiler
- Kistektomi, Ablasyon, Skleroterapi ve Kombine Tekniklerin Karşılaştırılması
- Fertilite İsteyen Hastada Önce Cerrahi mi IVF mi?
- Rekürrens Riski ve Uzun Dönem Yönetim Stratejileri

17:30-18:30 **CANLI CERRAHİ**
Moderatörler: Gürkan Uncu, İdris Koçak

LIVE

Laparoscopic Mymektomi
Cerrah: Rajesh Modi (Hindistan'dan Canlı Aktarım)
Laparoskopik Endometriozis Cerrahisi
Cerrah: Kiper Aslan (Bursa Uludağ Üniversitesi Hastanesi'nden Canlı Aktarım)

Medtronic

B SALONU

08:30-10:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Fuat Demirci Oturumu
Oturum Başkanları: Yakup Kumtepe, Ulaş Çoban



Non-Mesh Prolapse Repair
Aethele Khunda
Örgüsüz İnkontinans Cerrahisi: ULP Cerrahisi
Akın Sivaslıoğlu
Pelvik Taban Bozuklukları için Laparoskopik Girişimler
Yakup Kumtepe
Sexual Function and Incontinence
Aethele Khunda
Parsiyel Kolpokleizis Tekniği
Tolgay Tuyan İlhan
Tartışma



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Fuat Demirkıran Oturumu
İleri Evre Epitelyal Over Kanseri Yönetiminde HIPEC
Moderatör: Samet Topuz



12:00-12:20 Pro
Çağatay Taşkıran
12:20-12:40 Con
Christina Fotopoulou
12:40-13:00 Tartışma



13:00-14:00 **ÖĞLE YEMEĞİ**

14:00-15:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. U. Fırat Ortaç Oturumu
Oturum Başkanları: M. Faruk Köse, Emine Karabük



HPV İlişkili Hastalıklar Epidemiyolojisinde Değişiklik Var mı?
Hamdullah Sözen
En Uygun Serviks Kanseri Taraması Nasıl Olmalı?
Yakup Yalçın
Kolposkopik Değerlendirme Kriterleri Nelerdir?
Nejat Özgül
Servikal Preinvaziv Lezyonların Medikal Tedavileri Nelerdir?
İlkbal Temel Yüksel
Tartışma

B SALONU



15:30-15:50 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)

16:30-17:30

Panel: Cinsel Disfonksiyon - Neden Orgazm Olamıyorum?
Moderatör: Zühal Dilek Şanlı
Panelistler: Annamaria Giraldi, Selcen Bahadır, Ali Doğukan Ağın

Tartışılacak Konular:

- Kadın Orgazm Bozukluğunun Tanımı ve Sınıflandırılması
- Anatomik, Nörolojik ve Hormonal Faktörlerin Rolü
- Psikolojik Etkenler: Anksiyete, Depresyon, Travma ve İlişki Dinamikleri
- Pelvik Taban Disfonksiyonu ve Orgazm İlişkisi
- Partner Katılımı ve Çift Odaklı Yaklaşımlar
- Kültürel, Sosyal ve İletişim Bariyerleri
- Gerçek Yaşamdan Olgu Örnekleri

C SALONU

08:30-10:00 **İnteraktif Olgu Tartışması**
Konu: Düzensiz Kanama
Olgu Sunumu: Aslışah Çetin Tırınk
Yönetici: Müfit C. Yenen
Tartışmacı Hocalar: Kenan Dolapçıoğlu, Aslıhan Yurtkal, Neşe Yücel

- Ovulatuar Disfonksiyon
- Adenomyozis

Bu oturumda genç bir jinekolog tarafından sunulan 2 olgu , kıdemli hocaların katkılarıyla interaktif olarak tartışılacak; tanısal yaklaşımlar, tedavi seçenekleri ve klinik karar süreçleri güncel bilgiler ışığında değerlendirilecektir



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **Mentorla Buluşma**

Konu: Ürojinekolojide İlginç Olgular: Aşırı Aktif Mesane, Obstrüktif Defekasyon ve Tanımlanması Güç İnkontinans
Mentor: Aethele Khunda
Her Bir Prolapsus İçin Doğru Cerrahi Nasıl Seçilir?
Mentor: Tommaso Simoncini
Cinsel Tıp - Kişisel Bir Yolculuk
Mentor: Annamaria Giraldi
MHT ve Kardiyovasküler Spektrum
Mentor: Antonio Cano Sanchez



13:00-14:00 **ÖĞLE YEMEĞİ**

C SALONU

14:00-15:30

İnteraktif Olgu Tartışması
Konu: İnfertilite
Olgu Sunumu: Şerife Akbay
Yönetici: Melike Aslan
Tartışmacı Hocalar: Didem Alkaş Yağınç, Mehmet Tunç, Berrin Göktuğ Kadıoğlu

- Adenomyozis
- Uterin Septum

Bu oturumda genç bir jinekolog tarafından sunulan 2 olgu , kıdemli hocaların katkılarıyla interaktif olarak tartışılacak; tanısal yaklaşımlar, tedavi seçenekleri ve klinik karar süreçleri güncel bilgiler ışığında değerlendirilecektir.

15:30-15:50 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)



16:30-17:30

İlham Veren, Yol Gösterenlere Saygılarımızla
Prof. Dr. Mehmet Ali Vardar Paneli
Yeni Gelişen Alt Uzmanlık Neleri Nasıl Değiştiriyor?
Moderatör: Mete Güngör
Panelistler: U. Fırat Ortaç, Fuat Demirkıran, Fatih Köse, M. Ali Narin, Hüsnü Çelik



Tartışılacak Konular:

- Onkofertilitenin Tanımı, Kapsamı ve Multidisipliner Yapısı
- Kanser Tanısı Alan Üreme Çağındaki Hastalarda Fertilite Koruma İhtiyacının Erken Değerlendirilmesi
- Oosit, Embriyo ve Over Doku Kriyoprezervasyonu: Endikasyonlar ve Zamanlama
- Jinekolojik Kanserlerde Fertilite Koruyucu Cerrahinin Güncel Sınırları
- Onkofertilitede Etik, Hukuki ve Bilgilendirilmiş Onam Süreçleri
- Gebelik, Sağkalım ve Uzun Dönem Üreme Sonuçları
- Gelecekte Onkofertilitenin Standart Bakımın Bir Parçası Olma Potansiyeli

D SALONU

08:30-10:00 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: Gürkan Kıran

Eğiticiler:
Ameliyat: Laparoskopik Serklaj
Betül Kalkan
Ameliyat: Laparoskopik Lateral Süspansiyon
Cengiz Şanlı
Ameliyat: Zor Vakalarda Laparoskopik Histerektomi
Emrah Töz



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: Paşa Uluğ

Eğiticiler:
Ameliyat: Laparoskopik Adneksiyel Kitle Yönetimi
Şevki Göksun Gökulu
Ameliyat: Laparoskopik Sakrohisteropeksi
Murat Seval
Ameliyat: Laparoskopik Ürojinekolojik Ameliyatlar
Mustafa Gazi Uçar



13:00-14:00 **ÖĞLE YEMEĞİ**

D SALONU

14:00-15:30 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: Erhan Şimşek

Eğiticiler:
Ameliyat: Kompleks Laparoskopik Histerektomi Olguları ve Müllerian Anomalilerde Laparoskopik Yaklaşım
Onur Yavuz
Ameliyat: Laparoskopik Myomektomi
Recep Erin
Ameliyat: Histeroskopik Fertilite Cerrahileri
Ramazan Erda Pay

15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**



16:30-17:30 **Panel: Görüntüleme - Endometriozis ve Adenomyozis İçin Doğru Tanı ve Cerrahi Yönetimin Optimize Edilmesi**
Moderatör: Bülent Urman
Panelistler: Ayşe Seyhan Ata, Hilal Şahin, Can Benlioğlu

Tartışılacak Konular:
- Transvajinal USG ve MR: Ne Zaman, Hangisi, Kime?
- Derin İnfiltratif Endometriozisin Görüntüleme Kriterleri ve Sınıflandırılması
- Adenomyoziste Ultrasonografik Tanı Kriterleri ve Ayırıcı Tanı
- Görüntüleme Bulgularının Cerrahi Planlamaya Katkısı
- Cerrahi Öncesi Lezyon Haritalaması ve Multidisipliner Yaklaşım
- Güncel Kılavuzlar Işığında Tanısal ve Cerrahi Stratejilerin Optimizasyonu

E SALONU

08:30-10:00 **Endüstri Destekli Kurs: Histeroskopi**

Eğiticiler:
Erhan Şimşek
Levent Keskin
Bahadır Koşan
Orhan Orhan
Serhat Ege



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **KSDF Akademi: Fikrini Getir, Tartışalım!**
Yorumlayıcılar: Yakup Kumtepe, İlkkan Dünder, Akın Sivaslıoğlu

Endometriosis, Fallop Tüp Fimbriayı Tutmuyorsa, Fimbrial Özellikli İlaç Endometriosisi Tedavi Edebilir - **Esra Nazlı Döktür**
Preeklampside İnflamasyon ve Endotel Disfonksiyonunu Yansıtan İndekslerin Makine Öğrenmesi Modellerine Entegrasyonu: Maternal ve Perinatal Sonuçların Öngörülmesi **Libasen Yüce**
Jinekolojik Cerrahide Öğrenme Eğrileri: Çok Merkezli Prospektif Analiz - **Asya Turhan**

Bu oturumda genç araştırmacılar kendi fikirlerini sunacaklar ve kıdemli hocalar fikrin olgunlaşmasını sağlayacaklar ve yorum yapacaklardır.



13:00-14:00 **ÖĞLE YEMEĞİ**

E SALONU

14:00-15:30

Genç Adımlar Oturumu
Yeni Nesil Kadın, Yeni Nesil Jinekoloji: Obezite, İlaçlar ve Modern Yaşamın Kadın Sağlığına Etkisi
Dünya Hızla Değişiyor Ama Biz Hazır mıyız?
Oturum Başkanları: Batuhan Aslan, Gürkan Uncu

Obezite ve Yeni Nesil Metabolik Tedaviler (GLP-1 Analogları)
Aylin Tunalı
Modern Yaşamın Görünmeyen Yükü
Nilüfer Cimşit
Modern Kadın ve Modern Hastalıklar; Modern Yaşamın Sessiz Pandemisi: Stres, İnflamasyon ve Hormonal Disfonksiyon
Merih Oğur
Longevity ve Kadın Sağlığı; Kadın Sağlığında Biyolojik Saati Yavaşlatmak ve Sağlıklı Yaşlanma Stratejileri
Seray Kaya Topdağı

16:30-17:30

Panel: Endoskopi - Robotik Cerrahi Gerekli mi?
Moderatör: Salih Taşkın
Panelistler: Ahmet Göçmen, Zeliha Fırat Cüylan, Ali Küçükmetin

Tartışılacak Konular:

- Robotik Cerrahinin Laparoskopi ile Karşılaştırmalı Avantaj ve Sınırlılıkları
- Hangi Jinekolojik Olgularda Robotik Cerrahi Gerçekten Fark Yaratır?
- Onkolojik, Benign ve Kompleks Cerrahilerde Robotik Yaklaşımın Yeri
- Komplikasyon Oranları ve Hasta Sonuçları Açısından Kanıta Dayalı Veriler
- Maliyet–Etkinlik ve Sağlık Sistemleri Açısından Sürdürülebilirlik
- Robotik Cerrahinin Geleceği: Yapay Zekâ, Görüntü Entegrasyonu ve Yeni Platformlar
- Robotik Cerrahiye Ne Zaman İhtiyaç Var, Ne Zaman Gereksiz?

F SALONU

08:30-10:00

Sözlü Bildiri Sunumları
Oturum Başkanları: Özcan Balat, Sinem Ertaş
Detaylar için QR okutunuz!



10:40-11:20 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)

12:00-13:00

Sözlü Bildiri Sunumları
Oturum Başkanları: Şule Yıldız, Sakine Ocakoğlu
Detaylar için QR okutunuz!



13:00-14:00 ÖĞLE YEMEĞİ

14:00-15:30

Jinekolojik Endoskopik Cerrahi Video Bildiri Sunumları
Oturum Başkanları: M. Murat Naki, Emre Biton
Detaylar için QR okutunuz!



15:30-15:50 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)

16:30-17:30

Panel: İnfertilite - Birinci Basamak İnfertilite Yönetimi
Moderatör: Faruk Buyru
Panelistler: Gürkan Bozdağ, Sefa Arlıer, Bülent Yılmaz, Sabri Çolak, Selçuk Yetkinel

Tartışılacak Konular:

- Primer Workup'da Neler Olmalı?
- HSG Herkese Çekilmeli mi?
- Rezerv Belirteçleri mi? Yaş mı Önemli?
- Basamak Tedavi Zaman Kaybı mıdır?
- IUI Bir Tedavi Seçeneği midir?
- Elimizde IVF Varken Neden Başka Çözümler?
- Cerrahi İşin Neresinde?

A SALONU

08:30-10:00

İlham Veren, Yol Gösterenlere Saygılarımızla
Prof. Dr. Ahmet Zeki Işık Oturumu
Endometrioma ve İnfertilite
Oturum Başkanları: Ercan Baştu, Üzeyir Kalkan



Endometriozis İnfertilite Tedavisinde Cerrahi İyi Yapıldığında Halen Uygun Bir Seçenektir
Mohamed Achour
Cerrahi Öncesi Oosit / Embriyo Dondurup Sonra Ameliyat Yapmak
Ercan Baştu
Adenomyozis Birlikteliğinde Yönetim Stratejileri
Ludovico Muzii
Derin Endometriozis Cerrahisi Fertiliteyi Artırır mı?
Üzeyir Kalkan
Tartışma

10:00-10:30

UYDU SEMPOZYUMU
Farklı Fonksiyonlar, Ortak Hedef: Entegre Sistemlerle Optimal Sonuçlar
Moderatör: Gürkan Uncu
Cerrahi Enerji Modaliteleri: Bipolar Teknoloji ile Optimal Doku Yönetimi
Konuşmacı: Yakup Kumtepe
vNOTES Cerrahide Cihazların Uyumu
Konuşmacı: Kemal Güngördük

10:30-10:45

Konferans: Her Kadın Bir Hikâye, Her Fotoğraf Bir İz..
Moderatör: Gürkan Uncu
Constipation Blues-Kabız
Digital Çağda Reklam Fotoğrafı
Konuşmacı: Fethi İzan

10:45-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**



11:20-12:00

UYDU SEMPOZYUMU
Servikal Rejenerasyon ve Enflamasyon Yönetiminde Cerviron'un Rolü
Moderatör: Mete Güngör
Konuşmacı: Zeliha Fırat Cüylan

12:00-13:00

İlham Veren, Yol Gösterenlere Saygılarımızla
Prof. Dr. Acar Koç Oturumu
Tekrarlayan Gebelik Kayıplarında Herediter Trombofililer Taranmalı ve Düşük Molekül Ağırlıklı Heparin ile Profilaksi Yapmalı mıyız?
Moderatör: Namık Demir



12:00-12:20 Pro
Cenk Sayın
12:20-12:40 Con
Bilge Çetinkaya Demir
12:40-13:00 Tartışma

13:00-14:00 **ÖĞLE YEMEĞİ**

A SALONU

14:00-15:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Bülent Urman Oturumu
IVF-ET
Oturum Başkanı: Ahmet Zeki Işık



The Efficiency of Ovarian Stimulation; Real World Evidence
Dominic Stoop
Endometrium, Embryo and Illusions: What Truly Matters in IVF?
Barış Ata
Overtreatment in IVF: Are We Doing Too Much?
Dominic Stoop
Simplification of IVF
Gürkan Bozdağ
Tartışma



15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

15:50-16:30 **UYDU SEMPOZYUMU**
Demir Eksikliğinde Yeni Nesil Çözüm - Feritinol
Moderatör: Davut Güven
Konuşmacı: Ayda Yılmaz

TABİLAÇ

16:30-17:30 **Panel: Kontrasepsiyon - Kime? Hangi Yöntem?**
Moderatör: Yaprak Üstün
Panelistler: Yusuf Üstün, Pınar Çağlar Aytaç, Levent Keskin, Hüsnü Görgen, Hatice Çelik

Tartışılacak Konular:
- Hormonal Kontrasepsiyon Öncesi Hastaların Değerlendirmesi
- Sistemik Hastalıklar Varlığında (MEC Kriterlerine Göre Uygun) Kontrasepsiyonun Seçimi Nasıl Olmalı?
- Oral Hormonal Kontrasepsiyonda Yenilikler
- Hormonal, Non-Hormonal ve Uzun Etkili Geri Dönüşümlü Yöntemlerin (LARC) Karşılaştırılması
- Adölesanlarda ve Nullipar Hastalarda Kontrasepsiyon
- Acil Kontrasepsiyonun Yeri ve Güncel Uygulamalar
- Güncel Kılavuzlar Işığında Klinik İkilemler

17:30-18:30 **CANLI CERRAHİ**
Moderatörler: Fulya Dökmeci, Ahkam Göksel Kanmaz

LIVE

Laparoskopik Askı Ameliyatı
Cerrah: Yakup Kumtepe (Akdeniz Üniversitesi Hastanesi'nden Canlı Aktarım)
vNOTES Histerektomi
Cerrah: Kemal Güngördük (Akdeniz Üniversitesi Hastanesi'nden Canlı Aktarım)

Applied Medical

B SALONU

08:30-10:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Mete Güngör Oturumu
Oturum Başkanları: Murat Sönmezer, İbrahim Polat



Kanser Hastalarında Fertilite Koruyucu Yaklaşımlar
Emel Canaz
Kanser Hastalarında Oosit, Sperm ve Over Doku Dondurma
Işıl Kasapoğlu
Kanser Hastalarında Ovarian Stimülasyon Protokolleri
Nafiye Karakaş Yılmaz
Over Transplantasyonu
Murat Sönmezer
Tartışma



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Ali Haberal Oturumu
Endometrioma ve İnfertilite
Moderatör: Gürkan Uncu



12:00-12:20 Pro: Üçüncü Basamak Cerrahi ile Mekanik Engelin Kaldırılması
Mesut Önal
12:20-12:40 Con: Over Rezervine Zarar, Gecikme, IVF'in Doğrudan Uygulanması
Mete Işıkoğlu
12:40-13:00 Tartışma



13:00-14:00 **ÖĞLE YEMEĞİ**

14:00-15:30 **Adolesan Dönemde Cinsellik ve Koruyucu Yaklaşımlar Oturumu**
Oturum Başkanları: Nafiye Karakaş Yılmaz, Alper Başbuğ

Adolesan Dönemde Cinsellik ve Koruyucu Yaklaşımlar
Özlem Dural zoom
Normal Pubertal Gelişim ve Puberte Bozukluklarına Yaklaşım
Özlem Dural zoom
Adolesanlarda PCOS Tanısı, Metabolik Problemler ve Semptomların Yönetimi
Nafiye Karakaş Yılmaz
Ergenlerde Müllerian Anomalilere Yaklaşım ve Yönetim
Kiper Aslan
Tartışma



15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

B SALONU

16:30-17:30

Panel: Bütüncül Yaklaşım - Jinekoloji ve Obstetride Neleri Bilmeliyiz?
Moderatör: Pınar Yalçın Bahat
Panelistler: Meltem Yalınay, İdil Bozkurt, Zühal Dilek Şanlı

Tartışılacak Konular:

- Jinekoloji ve Obstetride Bütüncül Yaklaşımın Tanımı ve Önemi
- Beslenme, Yaşam Tarzı ve Mental Sağlığın Jinekolojik ve Obstetrik Sonuçlara Etkisi
- Alternatif ve Tamamlayıcı Yaklaşımlar: Kanıt mı, Beklenti mi?
- Üremeye Faydası Ne Kadar?
- İnflamasyonu Nasıl Etkiliyor?
- Endometirozis Olgularında Nasıl Etkiliyor?
- Bütüncül Yaklaşımın Gelecekteki Yeri ve Sınırları

C SALONU

08:30-10:00 **İnteraktif Olgu Tartışması**
Konu: İnfertilite
Olgu Sunumu: Esra Nazlı Döktür
Yönetici: Cemal Posacı
Tartışmacı Hocalar: Funda Göde, Yavuz Tokgöz, Göğşen Önalan, İsmet Gün

- Endometriosis Hastasında İnfertilite
- PCOS Hastasında İnfertilite

Bu oturumda genç bir jinekolog tarafından sunulan 2 olgu , kıdemli hocaların katkılarıyla interaktif olarak tartışılacak; tanısal yaklaşımlar, tedavi seçenekleri ve klinik karar süreçleri güncel bilgiler ışığında değerlendirilecektir.



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **Mentorla Buluşma**

Birleşik Krallık'ta Kadın Hastalıkları ve Doğum Uzmanı Olarak Kariyer Planlamak
Mentor: Ali Küçükmetin
Konu: ESHRE-ESGE, ASRM ve CUME'nin Farklı Tanı Kriterleri Bağlamında Septat Uterus Yönetimi
Mentor: Artur Ludwin
Hasta Dostu Over Stimülasyon Protokolleri
Mentor: Dominic Stoop
Konu: Tübal Geçirgenlik Testinin Optimize Edilmesi: İpuçları, Püf Noktaları ve Dikkat Edilmesi Gerekenler
Mentor: Inga Ludwin
Fetal Büyüme
Mentor: Daniele di Mascio



13:00-14:00 **ÖĞLE YEMEĞİ**

C SALONU

14:00-15:30

İnteraktif Olgu Tartışması
Konu: Üreme Endokrinolojisi
Olgu Sunumu: Ömer Faruk Öz
Yönetici: Veli Mihmanlı
Tartışmacı Hocalar: Aslı Akdöner, Ebru Şahin Güleç, Funda Cevher Akdulum

- Azalmış Over Rezervinde Tek Oosit ile Canlı Doğum: Bir IVF Olgusu
- Hipo-Hipo ve Düşük Rezerv: Zor Bir Olguda Gebeliğe Giden Yol

Bu oturumda genç bir jinekolog tarafından sunulan 2 olgu , kıdemli hocaların katkılarıyla interaktif olarak tartışılacak; tanısal yaklaşımlar, tedavi seçenekleri ve klinik karar süreçleri güncel bilgiler ışığında değerlendirilecektir.



15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

16:30-17:30

İlham Veren, Yol Gösterenlere Saygılarımızla
Prof. Dr. Sedat Kadanalı Paneli
PCOS'da Değişen Neler Var?
Moderatör: Gürkan Bozdağ
Panelistler: Sezcan Mümüşoğlu, Nafiye Karakaş Yılmaz, Nafiye Helvacı, Onur İnce



Tartışılacak Konular:

- Patogenez Alanlarında Güncel Durum: Ne Kadar İlerledik?
- Bireysel Bir Sorun mu? Nesiller Arası Aktarılan Bir Miras mı?
- Metabolik Riskler: Kimi, Ne Zaman ve Nasıl İzlemeliyiz?
- İnfertilite Yönetimi: Güncel Kanıtlar Bizi Nereye Götürüyor?
- Fenotip Yaklaşımı: Klinik Yönetimi Nasıl Etkiliyor?
- Ovulasyon İndüksiyonunda Letrozolün Artan Rolü ve Güncel Kanıtlar
- Adölesanlarda PCOS: Tanı ve Aşırı Tanı Sorunu

D SALONU

08:30-10:00 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: Ahkam Göksel Kanmaz

Eğiticiler:
Ameliyat: Laparoskopik ULP
Alev Esercan
Ameliyat: Laparoskopik Histerektomi
Süleyman Salman
Ameliyat: Laparoskopik Myomektomi
Selen Doğan



10:40-11:20 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

12:00-13:00 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: Ahmet Göçmen

Eğiticiler:
Ameliyat: Özerkan Modifikasyonu
Kemal Özerkan
Ameliyat: Laparoskopik Sentinel Lenf Nodu Diseksiyonunda Temel Noktalar
Seda Yüksel Şimşek
Ameliyat: Laparoskopik Zor Histerektomiler
Nasuh Utku Doğan



13:00-14:00 **ÖĞLE YEMEĞİ**

D SALONU

14:00-15:30 **Görsellerle Endoskopik Cerrahi Olgu Tartışmaları**
Oturum Başkanı: Hüsnü Çelik

Eğiticiler:
Ameliyat: Laparoskopik Adenomyozis Cerrahisi
Yılmaz Güzel
Ameliyat: Robotik Zor Histerektomilerde İndosiyanin Yeşili Eşliğinde İntraoperatif Floresan Üreter Görüntüleme ve Cerrahi Basamaklar: Sezaryen Sonrası Gelişen Vezikouterin Yapışıklık Olgusu
Zeliha Fırat Cüylan
Ameliyat: Laparoskopik Rektopeksi
Ulaş Çoban



15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**

16:30-17:30



İlham Veren, Yol Gösterenlere Saygılarımızla
Prof. Dr. M. Faruk Köse Paneli
Jinekolojik Kanser Önleme - Servikal Preinvaziv Hastalıkların Sitolojik ve Histopatolojik Yönetiminde Önemli Noktalar Nelerdir
Moderatör: Nejat Özgül
Panelistler: Coşkun Salman, Kemal Özerkan, Doğan Vatansever

Tartışılacak Konular:
- Servikal Kanser Taramasında Sitoloji, HPV Testleri ve Ko-Tarama Yaklaşımları
- Anormal Sitoloji Sonuçlarının (ASC-US, LSIL, HSIL vb.) Klinik Yorumu
- HPV Pozitif Hastada Risk Temelli Yönetim ve Takip Algoritmaları
- Kolposkopi Endikasyonları, Biyopsi Stratejileri ve Yeterlilik Kriterleri
- Eksizyonel ve Ablasyonel Tedavi Yöntemlerinin Endikasyonları ve Sınırları
- Tedavi Sonrası Takip ve Nüks Riskinin Yönetimi
- Güncel Kılavuzlar Işığında Pratikte Sık Yapılan Hatalar

E SALONU

08:30-10:00 **Endüstri Destekli Kurs: Sütur Eğitimi Kursu**
Kurs Yöneticisi: M. Murat Naki

doğsan

Eğiticiler:
Deha Denizhan Keskin
Ömer Lütfi Tapısız
Gülin Feykan Yeğin
Zeliha Fırat Cüylan
Orhan Orhan
Ayşenur Yapar
M. Ali Narin
Hüsnü Görgen



10:40-11:20 KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)

12:00-13:00 **Hemşirelik Oturumu**
Oturum Başkanı: Can Benlioğlu, Savcı Bekir Telek

ÜYTE Merkezinde Hemşirenin Yeri
Tülay Karataş
ÜYTE Hemşireliğinde Sık Karşılaşılan Sorunlar
Seda Soyer
Endoskopik Cerrahide Ekip olmak
Fatma Gülşah Çaylak
Klinik Hemşirelikte Kalite, Güvenlik ve Hasta Odaklı Bakım
Tülay Çıkrık
Tartışma



13:00-14:00 ÖĞLE YEMEĞİ

E SALONU

14:00-15:30 **Hekimin Yeni Asistanı: Kadın Doğum Pratiğinde Yapay Zekâ ile Düşünmek**
Oturum Başkanı: Bülent Urman

Okurken, Yazarken, Karar verirken… Nerede Durmalı, Nasıl Kullanmalı?
Emre Biton
Hekimlikte Üretken Yapay Zekâ ve Prompt Engineering
Şeyma Hasköylü Şahin
Karmaşık Hastayı Değerlendirirken Yapay Zekâ; Klinik Sezgiye Rakip mi? Dijital Konsültan mı?
Savcı Bekir Telek
Makale Okurken Yapay Zeka Literatür Okuryazarlığı Güçleniyor mu? Zayıflatıyor mu?
Arif Caner Erdoğan
İstatistikten Makale Yazımına Yapay Zekâ ile Akademik Üretimin Sınırları
Ece İrem Özcan
Tartışma

15:30-15:50 **KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)**



16:30-17:30 **İlham Veren, Yol Gösterenlere Saygılarımızla**
Prof. Dr. Cemal Posacı Paneli
İnfertilite: Ovulasyon İndüksiyonu Standartlaştı mı?
Moderatör: Ahmet Zeki Işık
Panelistler: Ahmet Erdem, Kubilay Vicdan, Gülşen Doğan Durdağ, Süleyman Güven



Tartışılacak Konular:
- Ovulasyon İndüksiyonunda Güncel Kılavuzlar ve Önerilen Standartlar
- Ovulasyon İndüksiyonunda Başarıyı Belirleyen Faktörler
- IUI'da Kullanılan Ovulasyon İndüksiyon Ajanları (Letrozol, Klomifen, Gonadotropinler)
- IVF ve KOH'da Güncel Kılavuzlar Gerçekten Standart Oluşturuyor mu?
- Hasta Fenotipine Göre KOH Protokolü Seçimi (PCOS, Düşük Over Rezervi, İleri Yaş)
- LH Desteği Gerekli mi, Kimde?
- Tetikleme Stratejileri: hCG, GnRH Agonist veya Dual Trigger

F SALONU

08:30-10:00 — **Jinekolojik Endoskopik Cerrahi Video Bildiri Sunumları**
Oturum Başkanları: Murat Gözüküçük, Aslı Akdöner
Detaylar için QR okutunuz!



10:40-11:20 — KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)

12:00-13:00 — **Sözlü Bildiri Sunumları**
Oturum Başkanları: Ezgi Ceren Dallı Alper, Anıl Ertürk
Detaylar için QR okutunuz!



13:00-14:00 — ÖĞLE YEMEĞİ

14:00-15:30 — **Obstetrik Ultrasonografi Bildiri Sunumları**
Oturum Başkanları: Selahattin Kükner, Tansu Bahar Gürbüz
Detaylar için QR okutunuz!



15:30-15:50 — KAHVE MOLASI (ENDÜSTRİ İLE BULUŞMA)

16:30-17:30 — **Panel: Üreme Cerrahisinde Tartışılan Başlıklar**
Moderatör: Bülent Berker
Panelistler: Elif Aylin Taşkın, Abdullah Karaer, Hale Göksever Çelik, İsmet Gün

Tartışılacak Konular:
- Üreme Cerrahisinin İnfertilite Tedavisindeki Güncel Yeri
- Hidrosalpenks Yönetimi
- Septum Rezeksiyonu: Kime, Ne Zaman Gerçekten Faydalı?
- İntramural Myomlar: Cerrahi Endikasyonların Sınırları
- Dismorfik Uterus
- İstmosel ve İnfertilite İlişkisi
- Laparoskopk Serklaj Kime Ne Zaman?

A SALONU

08:30-10:00 **Cinsel Disfonksiyon Oturumu - Seks Acıtırsa**
Oturum Başkanları: Selcen Bahadır, Telce Ayşen Küçükceran

Kılavuzlara Göre Kadında Cinsel Ağrı Bozukluğu
Annamaria Giraldi
Cinsel Tıp Yaklaşımı ile Ağrılı Cinsellik
Selcen Bahadır
Vajinismusa Bütüncül Yaklaşım
Zühal Dilek Şanlı
Cinsel Ağrı Bozukluklarında Rejeneratif Yaklaşımlar
Ali Doğukan Angın
Tartışma

10:00-10:45 **Akılcı İlaç Kullanımı**
Bahadır Koşan

B SALONU

08:30-10:00 **Kontrasepsiyon Oturumu**
Oturum Başkanları: Yaprak Üstün, Selin Özaltın

Kombine Oral Kontraseptif Seçiminde Doğru Tercih
Şebnem Alanya Tosun
Progestin Only Pill ve Intrauterin Araç Kullanımı
Nefise Tanrıdan Okçu
Hormonal Kontraseptifler ve Malignite İlişkisi
Emre Mat
İmplant Kontraseptiflerin Kullanımı
Nefise Nazlı Yenigül
Tartışma

C SALONU

08:30-10:00 **Sözlü Bildiri Sunumları**
Oturum Başkanları: Serkan Karaşin, Burcu Kasap
Detaylar için QR okutunuz!

D SALONU

08:30-10:00

Sözlü Bildiri Sunumları
Oturum Başkanları: Işın Üreyen, Gökalp Şenol
Detaylar için QR okutunuz!

E SALONU

08:30-10:00

Sözlü Bildiri Sunumları
Oturum Başkanları: Burcu Dinçgez, Erkan Çağlıyan
Detaylar için QR okutunuz!

F SALONU

08:30-10:00

Jinekolojik Endoskopik Cerrahi Video Bildiri Sunumları
Oturum Başkanları: Nergis Kender Ertürk, Büşra Şahin
Detaylar için QR okutunuz!

SÖZLÜ BİLDİRİLER

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

SS-002

The Role of Vaginal Natural Orifice Transendoscopic Surgery in Gynecological Emergencies

Furkan Karaöz, Kemal Güngördük
Muğla Sıtkı Koçman University

Background and OBJECTIVES: Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) represents an innovative and minimally invasive surgical technique that is increasingly recognized across various gynecological applications. While the body of evidence regarding vNOTES is currently more limited compared to traditional laparoscopy, this technique presents distinct benefits, such as reduced blood loss, shorter operative times, lower postoperative pain, faster recovery and hospital discharge, improved aesthetic outcomes, and fewer postoperative complications. Despite the growing support for vNOTES in the management of elective adnexal conditions, its application, safety, and efficacy in emergency settings remain insufficiently studied. This report aims to detail our clinical experience and provide insights into employing vNOTES for managing gynecological emergencies.

METHODS: A retrospective analysis was conducted by evaluating data from patients who underwent vNOTES for gynecological emergencies in two gynecology centers between January 2023 and December 2025. Relevant demographic information and perioperative outcomes were collected and analyzed.

RESULTS: A total of 40 patients were enrolled in this study. The procedures were performed to manage gynecological emergencies, including suspected ectopic pregnancies in 19 patients (47.5%), suspected adnexal torsion in 6 patients (15.0%), hemoperitoneum post-hysterectomy in 5 patients (12.5%), pelvic abscess in 4 patients (10.0%), and ruptured ovarian cysts in 6 patients (15.0%). Surgical interventions included unilateral salpingectomy (47.5%), ovarian cystectomy (12.5%), adnexal detorsion (10.0%), oophorectomy (7.5%), hemoperitoneum evacuation (15.0%), and combined abscess drainage with appendectomy (7.5%). The median operative time was 39 minutes, ranging from 24 to 72 minutes. Median estimated blood loss was 150 mL, with a range of 30 to 350 mL, and no intraoperative complications were reported. All surgeries were successfully completed using vNOTES, with no need for conversion to standard laparoscopy or open surgery. The median hospital stay post-surgery was 2 days, varying between 1 and 5 days. Postoperative pain, evaluated using the visual analog scale, indicated a median score of 2 (range: 1-5) at the 24-hour mark. No procedure-related complications were identified.

CONCLUSIONS: This study showcases the clinical applicability of vNOTES procedures for addressing emergency gynecological conditions, such as tubal ectopic pregnancy, adnexal torsion, painful ovarian disorders, post-hysterectomy hemoperitoneum, and severe uterine bleeding. Supported by existing literature, our findings suggest vNOTES may offer certain benefits when compared to conventional laparoscopy in managing these conditions.

Keywords: Minimally invasive surgery, Laparoscopy, Transvaginal natural orifice transluminal endoscopic surgery

SS-003

Fertility and delivery outcomes after surgical treatment of ovarian dermoid cysts

Hatice Banu Atay, Ronak Mohamad,
Sevki Goksun Gokulu
Mersin üniversitesi Tıp Fakültesi

OBJECTIVE: Mature cystic teratoma (dermoid cyst) is the most common benign ovarian tumor in reproductive-age women, accounting for 70% of premenopausal and 20% of postmenopausal benign lesions. Surgical treatment is performed via laparotomy (LT) or laparoscopy (LS). This study evaluates fertility and delivery outcomes of patients operated for dermoid cysts in light of clinical data and current literature.

METHODS: The study included 155 patients operated between January 2015 and June 2024 with uterus and at least one ovary preserved. Clinical data and surgical records were retrieved from the NUCLEUS XCE system, while postoperative follow-up was obtained from hospital files, the e-health system, and phone interviews. The mean age of the 155 patients with preserved reproductive function included in the study was 29.2±8.1 years. 60.6% (n=94) of the patients were married, and 46.52% (n=72) had given birth at least once. The rate of uterine torsion within the patient group was 3.9% (n=6). Dermoid cysts were detected incidentally in nearly half of the patients (49%) (n=76), and the most common complaint was pelvic pain in 25% (n=39). 52% (n=81) of the patients underwent laparotomy, and 48% underwent laparoscopy.

FERTILITY STATUS: Fertility information was unavailable for 6 patients. Thirteen of the 149 patients (8.7%) had a desire for children. All 13 patients had a pre-existing diagnosis of infertility. No newly developed infertility problems were detected in any patient after surgery.

METHOD OF DELIVERY: Postoperative delivery information was unavailable for 8 patients. Of the 147 patients, 16% (n=24) gave birth in the postoperative period. Of these deliveries, 13 (54.2%) were by cesarean section(CS) and 11 (45.8%) were vaginal(VD). The significance of the difference between the known CS rate from the reference population and the rate obtained from the sample was evaluated using a two-way one-sample z-test at a 5% significance level. Compared to the reported CS rate in Turkey in 2024 (61.5%) [1], the rate in the sample patient group did not show a statistically significant difference ($z = -0.738$; $p>0.05$; two-way z-test).

The total number of births was observed as n=14 (19%) in the LT group and n=10 (14%) in the LS group. No statistically significant difference was found between the two groups in terms of the total number of births (P=0.656).

In the LT group, the number of CS was n=7 (54 %), the number of VD was n=7 (64%), and in the LS group, the number of CS was n=6 (46%), and the number of VD was n=4 (36%). No statistically significant difference was found between the two groups in terms of the method of birth (P=0.723) (Figure 1).

CONCLUSION: Infertility rates remained unchanged before and after surgery, and most patients conceived naturally. Literature on fertility after dermoid cyst surgery is limited [2], but evidence shows pregnancy rates are preserved when ovarian reserve is maintained, especially with minimally invasive techniques [3]. Our findings confirm that laparoscopic or open dermoid cyst surgery does not adversely affect fertility or delivery method.

Keywords: Fertility outcomes, Infertility, Mode of delivery, Ovarian dermoid cyst surgery

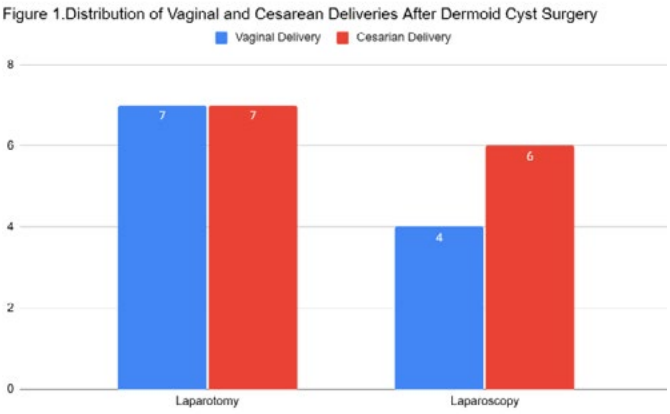
Figure 1.Distribution of Vaginal and Cesarean Deliveries After Dermoid Cyst Surgery

Table 1. Clinical Caharacteristics of women operated for Dermoid Cyst (n=155)

Variable	Value*
Age	29.2±8.1
Married	94 (60.6)
Parous	72 (46.5)
Torsion	6 (3.9)
İncidental	76 (49)
Pelvic pain	39 (25.2)
Mean cyst diameter (cm)	7.0±3.1
Laparotomy	81(52.23)
Laparoscopy	74(47.7)

*Data are presented as mean ± standard deviation or No. (%) of participants

Table 1. Clinical Caharacteristics of women operated for Dermoid Cyst (n=155)



SS-004

Estimated prevalence of adenomyosis among infertile women: a retrospective screening study

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[2]Department of Obstetrics and Gynecology, Akhisar State Hospital, Manisa, Turkiye
[3]Department of Obstetrics and Gynecology, Izmir Demokrasi University, Izmir, Turkiye

OBJECTIVE: Adenomyosis is a benign uterine disorder. Studies investigating the prevalence of adenomyosis among women with infertility are limited. This study was designed to determine the prevalence of adenomyosis in infertile women using ultrasound imaging.

METHODS: This retrospective cross-sectional screening study included 615 infertile women who were eligible and presented for the first time to the infertility clinic of our hospital between 2020 and 2025. All women were referred for transvaginal ultrasonography before initiation of treatment. Exclusion criteria were defined as women older than 45 years, those with multiple or large uterine fibroids, patients with vaginismus, and those unwilling to participate in the study. Participants were divided into two groups: women with adenomyosis and women without adenomyosis.

RESULTS: The overall prevalence of adenomyosis was found to be 16%, of which 52% were classified as severe adenomyosis. The mean age was significantly higher in the adenomyosis group compared with the non-adenomyosis group (33.12 ± 5.58 vs. 29.88 ± 5.46 years, P < 0.001). Among women with adenomyosis, the prevalence of concomitant fibroids and ovarian endometrioma was 22.66% and 9.12%, respectively. According to multivariable logistic regression analysis, age, type of infertility, presence of ovarian endometrioma, presence of fibroids, and causes of infertility were significantly associated with adenomyosis.

CONCLUSION: Adenomyosis appears to be a clinical condition with a relatively high prevalence among infertile women. This finding highlights the importance of routine myometrial evaluation during infertility assessment and suggests that it may contribute to improved patient counseling and management.

Keywords: Adenomyosis, Female Infertility, Prevalence, Transvaginal Ultrasound, Uterine Disorders

SS-005

Comparison of Vascularity Pattern and Uterine Artery Resistance Index Changes on Doppler Ultrasonography According to Myoma Types

Belma Gözde Özdemir, Gizem YÜKSEK,
Nur Dilara Sarıhan, Ahmet Bilgi, Çetin Çelik
Selçuk University Faculty Of Medicine, Obstetrics And Gynecology Department, Konya,Turkey

BACKGROUND-AIM: Uterine myomas may exhibit different vascular and hemodynamic characteristics depending on their type and location. Doppler ultrasonography is a widely used noninvasive method for evaluating myoma vascularity and uterine artery blood flow. The aim of this study was to compare vascularity patterns and changes in uterine artery resistance index (RI) on Doppler ultrasonography according to different myoma types.

MATERIALS-METHODS: Patients diagnosed with uterine myomas who underwent transvaginal Doppler ultrasonography were included in the study. Myomas were classified based on their type. Vascularity patterns were assessed using color Doppler imaging, and resistance index measurements were obtained from both uterine arteries. The collected data were analyzed statistically to evaluate differences among myoma types.

RESULTS: When comparing patients presenting with AUB and CPP, the mean RI values were 0.29 ± 0.13 and 0.25 ± 0.18, respectively, and no statistically significant difference was found between the groups (p = 0.42). Similarly, PI values were 1.84 ± 0.75 in the AUB group and 1.88 ± 0.77 in the CPP group, with no significant difference observed (p = 0.85). In the analysis performed according to the FIGO classification, RI values were found to be 0.32 ± 0.24 in the FIGO 0–4 group and 0.26 ± 0.10 in the FIGO 5–6 group (p = 0.32), while PI values were 2.04 ± 0.73 and 1.79 ± 0.76, respectively, and no statistically significant difference was found between the groups (p = 0.23).

DISCUSSION: In this study, Doppler parameters in patients with uterine fibroids were evaluated according to presenting symptoms and the FIGO classification. When comparing patients presenting with abnormal uterine bleeding (AUB) and chronic pelvic pain (CPP), no statistically significant difference was found between the groups in terms of resistance index (RI) and pulsatility index (PI) values. Although RI values were numerically higher in the AUB group, this difference did not reach statistical significance. Similarly, no significant difference was observed between the two groups in terms of PI values.

CONCLUSION: In conclusion, Doppler

ultrasonography can provide information about the vascular characteristics of uterine myomas. However, in this study, uterine artery RI and PI values were not significantly associated with presenting symptoms or FIGO classification. These findings suggest that Doppler indices should be interpreted together with clinical and anatomical findings rather than used as independent diagnostic markers. Larger prospective studies are needed to further clarify the clinical role of Doppler parameters in uterine myomas.

1. Pritts, E. A., Parker, W. H., & Olive, D. L. (2009). Fibroids and infertility: an updated systematic review of the evidence. Fertility and sterility, 91(4), 1215–1223. https://doi.org/10.1016/j.fertnstert.2008.01.051

2. Murase, E., Siegelman, E. S., Outwater, E. K., Perez-Jaffe, L. A., & Tureck, R. W. (1999). Uterine leiomyomas: histopathologic features, MR imaging findings, differential diagnosis, and treatment. Radiographics: a review publication of the Radiological Society of North America, Inc, 19(5), 1179–1197. https://doi.org/10.1148/radiographics.19.5.g99se131179

Keywords: Uterine Myoma, Doppler Ultrasonography, Vascularity Pattern, Uterine Artery, Resistance Index

SS-006

Independent risk factors for pelvic lymph node metastasis in endometrial carcinoma

Yakup Yalcin
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OBJECTIVE: Pelvic lymph node metastasis is one of the most important prognostic factors in patients with endometrial carcinoma and plays a crucial role in determining disease stage, adjuvant treatment decisions, and survival outcomes. Identifying clinicopathologic factors associated with pelvic lymph node metastasis may help guide surgical staging strategies and optimize patient management. Therefore, the aim of this study was to evaluate the clinicopathologic risk factors associated with pelvic lymph node metastasis in patients with endometrial carcinoma.

METHODS: This retrospective study included patients diagnosed with endometrial carcinoma who underwent surgical treatment at the Department of Gynecologic Oncology, Bursa Uludağ University Faculty of Medicine, between January 2000 and May 2025. Clinical and pathological data were obtained from medical records. Patients with FIGO stage IV disease, those with isolated para-aortic lymph node metastasis, and those who did not undergo pelvic lymphadenectomy were excluded from the analysis. Demographic characteristics, tumor size, histological subtype, tumor grade, myometrial invasion, lymphovascular space invasion (LVSI), cervical stromal invasion, surgical approach, and lymphadenectomy status were evaluated. Pelvic lymph node metastasis was defined based on pathological evaluation. Continuous variables were presented as median (range) and compared using the Mann–Whitney U test, whereas categorical variables were expressed as frequencies and percentages and compared using the chi-square test. Univariable and multivariable regression analyses were performed to determine independent predictors of pelvic lymph node metastasis.

RESULTS: A total of 711 patients were included in the study. The median age was 62.5 years (range, 27–90). Pelvic lymph node metastasis was detected in 85 patients (11.9%), while 626 patients (88.1%) had no evidence of nodal involvement. Patients with pelvic lymph node metastasis had significantly larger tumor size (median 5 cm vs. 3.5 cm, $p<0.001$) and a higher number of harvested pelvic and para-aortic lymph nodes ($p=0.005$ and $p=0.008$, respectively). Non-endometrioid histology was significantly more common in the metastatic group compared with the non-metastatic group (33.7% vs. 14.7%, $p<0.001$). Similarly, grade 3 tumors, deep myometrial invasion (≥50%), LVSI positivity, and cervical stromal invasion were significantly associated with pelvic lymph

node metastasis (all p<0.001). Age, body mass index, and surgical approach were not significantly associated with nodal metastasis. In univariable analysis, non-endometrioid histology, grade 3 disease, deep myometrial invasion, LVSI, cervical stromal invasion, tumor size, and the number of removed lymph nodes were significantly associated with pelvic lymph node metastasis. However, multivariable analysis demonstrated that non-endometrioid histology (HR:2.145, 95%CI 1.712–3.234, p<0.001), grade 3 tumor (HR:1.587, 95%CI 1.124–2.240, p=0.009), deep myometrial invasion (HR:2.082, 95%CI 1.227–3.533, p=0.007), LVSI positivity (HR:2.864, 95%CI 1.599–5.131, p<0.001), and cervical stromal invasion (HR:3.607, 95%CI 1.923–6.768, p<0.001) were independent predictors of pelvic lymph node metastasis.

CONCLUSION: Pelvic lymph node metastasis in endometrial carcinoma is strongly associated with several adverse clinicopathologic features. Non-endometrioid histology, high tumor grade, deep myometrial invasion, LVSI, and cervical stromal invasion were identified as independent predictors of nodal metastasis. These findings may contribute to improved preoperative risk stratification and may help guide the decision-making process regarding lymphadenectomy during surgical staging in patients with endometrial carcinoma.

Keywords: Clinicopathologic predictors, Endometrial carcinoma, Lymphadenectomy, Pelvic lymph node metastasis, Risk factors

Table 1. Comparison of Clinicopathologic Characteristics of Patients According to Pelvic Lymph Node Metastasis Status

Variables	Total (n=711, %100)	Non-metastatic group (n=626, %88,1)	Metastatic group (n=85, %11,9)	p value
Age, years, median (range)	62.5 (27.0-90.0)	62 (27–90)	65 (41–83)	0.192
BMI, kg/m², median (range)	34.9 (18.0-65.3)	35 (18–65.3)	34.5 (23–51)	0.235
Tumor size, cm, median (range)	3.9 (0.2-15.3)	3.5 (0.2–15.3)	5 (0.8–14)	**<0.001**
Number of pelvic lymph nodes harvested, median (range)	21.0 (1.0-82.0)	20 (1–82)	23 (6–55)	**0.005**
Number of para-aortic lymph nodes harvested, median (range)	12.0 (1.0-51.0)	11 (1–46)	15 (1–51)	**0.008**
Histological type, n, (%)				**<0.001**
Endometrioid	591 (83.1%)	535 (85.3%)	56 (66.3%)	
Non-endometrioid	120 (16.9%)	91 (14.7%)	29 (33.7%)	
Grade, n, (%)				**<0.001**
Grade 1	306 (%43.0)	289 (%46.0)	17 (%20.5)	
Grade 2	206 (%29.0)	180 (%28.9)	26 (%28.9)	
Grade 3	199 (%28.0)	157 (%25.1)	42 (%50.6)	
FIGO stage, n, (%)				**<0.001**
IA	396 (%55.6)	396 (%55.6)	-	
IB	148 (%20.9)	148 (%20.9)	-	
II	53 (%7.5)	53 (%7.5)	-	
IIIA	27 (%3.8)	27 (%3.8)	-	
IIIB	2 (%0.5)	2 (%0.5)	-	
IIIC1	38 (%5.2)	-	38 (%44.7)	
IIIC2	47 (%6.5)	-	47 (%55.3)	
Myometrial invasion, n, (%)				**<0.001**
No invasion	50 (%7.0)	49 (%7.8)	1 (%1.2)	
<50%	419 (%58.9)	390 (%62.3)	29 (%33.7)	
≥50%	242 (%34.1)	187 (%29.9)	55 (%65.1)	
LVSI, n, (%)				**<0.001**
Absent	529 (%74.5)	495 (%79.1)	34 (%38.6)	
Present	182 (%25.5)	131 (%20.8)	51 (%61.4)	
Cervical stromal invasion, n, (%)				**<0.001**
Absent	620 (%87.2)	566 (%90.4)	54 (%62.7)	
Present	91 (%12.8)	60 (%9.6)	31 (%37.3)	
Surgical approach, n, (%)				0.139
Laparoscopy	123 (%17.3)	113 (%18.1)	10 (%10.8)	
Laparotomy	588 (%82.7)	513 (%81.9)	75 (%89.2)	
Para-aortic lymphadenectomy, n, (%)				**0.015**
Yes	577 (%81.2)	498 (%79.6)	79 (%92.8)	
No	134 (%18.8)	128 (%20.4)	6 (%7.2)	

Table 2. Univariable and Multivariable Analysis of Clinicopathologic Risk Factors for Pelvic Lymph Node Metastasis

Variables	Univariate HR (95% CI)	p value	Multivariate HR (95% CI)	p value
Age	1.014 (0.989-1.039)	0.281	-	
BMI	0.976 (0.947-1.007)	0.184	-	
Tumor size	1.265 (1.152-1.390)	**<0.001**	1.062 (0.944-1.196)	0.315
Number of pelvic lymph nodes harvested	1.028 (1.008-1.049)	**0.007**	1.015 (0.986-1.045)	0.318
Number of para-aortic lymph nodes harvested	1.031 (1.008-1.054)	**0.008**	1.028 (0.998-1.058)	0.662
Histological type Endometrioid Non-endometrioid	 1.00 (–) 3.022 (2.018-3.756)	**<0.001**	 1.00 (–) 2.145 (1.712-3.234)	**<0.001**
Grade Grade 1-2 Grade 3	 1.00 (–) 2.121 (1.587-2.835)	**<0.001**	 1.00 (–) 1.587 (1.124-2.240)	**0.009**
Myometrial invasion <%50 ≥50%	 1.00 (–) 3.968 (2.514-6.265)	**<0.001**	 1.00 (–) 2.082 (1.227-3.533)	**0.007**
LVSI Absent Present	 1.00 (–) 6.290 (3.867-10.229)	**<0.001**	 1.00 (–) 2.864 (1.599-5.131)	**<0.001**
Cervical stromal invasion Absent Present	 1.00 (–) 5.644 (3.361-9.476)	**<0.001**	 1.00 (–) 3.607 (1.923-6.768)	**<0.001**
Surgical approach Laparoscopy Laparotomy	 1.00 (–) 1.824 (0.887-3.750)	0.102	 -	
Para-aortic lymphadenectomy No Yes	 1.00 (–) 0.881 (0.646-1.011)	0.232	 -	

SS-008

Clinicopathologic Comparison of Breast Cancer Diagnosed During Pregnancy Versus Lactation: A Single-Center Retrospective Cohort

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OBJECTIVE: Pregnancy-associated breast cancer encompasses breast malignancies diagnosed during pregnancy and the postpartum period. Although these tumors are often considered a single clinical entity, it remains uncertain whether breast cancers diagnosed during pregnancy and those diagnosed during lactation differ in their clinicopathologic characteristics and outcomes. This study aimed to compare the clinical presentation, pathologic features, treatment patterns, and oncologic outcomes of breast malignancies diagnosed during pregnancy versus lactation.

METHODS: We retrospectively reviewed patients with pregnancy-associated breast malignancy who underwent surgery at a tertiary referral center between January 1989 and March 2021. Patients were categorized according to timing of diagnosis as pregnancy-associated or lactation-associated. Demographic characteristics, family history, clinical tumor and nodal stage, histopathologic findings, receptor status, Ki-67, treatment variables, and survival outcomes were analyzed comparatively.

RESULTS: A total of 29 patients were included, of whom 13 were diagnosed during pregnancy and 16 during lactation. The median age was 36 years. Overall, most patients presented with clinically advanced disease; 69% had cT2–3 tumors and 51.7% had clinically node-positive disease. Invasive ductal carcinoma was the predominant histologic subtype. Hormone receptor positivity was observed in a substantial proportion of cases, while high proliferative activity was common, with most tumors demonstrating elevated Ki-67 levels. Luminal tumors constituted the majority, although non-luminal HER2-positive and triple-negative subtypes were also frequently observed. Patients diagnosed during lactation were significantly more likely to have a family history of breast cancer, whereas multifocal or multicentric disease was significantly more frequent among patients diagnosed during pregnancy. Other clinicopathologic variables, including tumor stage, nodal status, grade, estrogen receptor, progesterone receptor, HER2 status, and receipt of neoadjuvant chemotherapy, were comparable between the two groups. Most patients underwent mastectomy. During follow-up, no local or regional recurrence was observed. Five-year disease-free survival and disease-specific survival rates did not differ significantly between pregnancy- and lactation-associated cases.

CONCLUSION: In this cohort, breast malignancies diagnosed during pregnancy and during lactation demonstrated broadly similar stage distribution, tumor biology, treatment patterns, and survival outcomes. However, the higher frequency of family history in lactation-associated cases and the greater rate of multifocal or multicentric disease in pregnancy-associated cases suggest that these two clinical settings may not be entirely identical. Larger studies are warranted to determine whether timing of diagnosis reflects distinct underlying biology or variation within the spectrum of pregnancy-associated breast cancer.

Keywords: breast cancer, ki-67, lactation, pregnancy

SS-009

HPV-16 vs HPV-18: Which better predicts CIN2+ lesions? The added value of colposcopic assessment

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OBJECTIVES: To compare the clinical and histopathological outcomes associated with HPV-16 and HPV-18 infections and to identify independent predictors of high-grade cervical intraepithelial neoplasia (CIN) or worse lesions, with a particular focus on the added value of colposcopic assessment.

METHODS: This retrospective study analyzed 67 women with HPV-16 or HPV-18 positivity screened for cervical cancer at the İskenderun Early Diagnosis, Screening, and Education Center (KETEM) and referred to İskenderun State Hospital Gynecologic Oncology outpatient clinic from May 2025 to February 2026. Demographic and clinical variables, including age, parity, smoking status, comorbidities, menopausal status, contraceptive use, symptoms, and vaccination status, were recorded. Colposcopic evaluations, transformation zone types, cervical biopsy results, and endocervical curettage (ECC) findings were analyzed. Continuous variables were expressed as mean ± standard deviation and compared using the independent samples t-test. Categorical variables were analyzed using Pearson's chi-square or Fisher's exact test, as appropriate. To determine factors associated with CIN2+ lesions, univariate logistic regression analysis was initially performed, followed by multivariate logistic regression including variables with statistical or clinical relevance. Statistical significance was defined as $p<0.05$.

RESULTS: Colposcopy and biopsies were performed in all patients.The study population consisted predominantly of HPV-16–positive patients (82.1%, n=55), with a smaller proportion of HPV-18–positive cases (17.9%, n=12). The two groups were comparable in terms of demographic and clinical characteristics, with no statistically significant differences in age, parity, type of delivery, delivery time,smoking status, comorbidities, menopausal status, contraceptive method,vaccination status or presence of symptom (all $p>0.05$). Similarly, abnormal colposcopic findings were observed at comparable rates in both groups (58.2% vs. 58.3%, p=1.000).Histopathological evaluation of cervical biopsies revealed that CIN2 (30.9%) and CIN3 (21.8%) lesions were more frequent in the HPV-16 group, whereas CIN1 was the predominant finding in the HPV-18 group (50.0%). Invasive lesions, including squamous cell carcinoma (n=2) and adenocarcinoma in situ (n=1), were observed only in HPV-16–positive patients. However, the overall distribution of cervical pathology did not differ significantly between groups (p=0.353). ECC findings were also similar (p=0.631).In univariate logistic regression analysis, HPV-16 positivity (OR: 3.875; 95% CI: 0.945–15.890; p=0.060) and transformation zone type (OR: 0.538; 95% CI: 0.274–1.056; p=0.072) remained at the threshold of statistical significance; however, positive colposcopic findings were found to be significantly associated with CIN2+ pathology (OR: 0.148; 95% CI: 0.050–0.442; p=0.001).In multivariate analysis, abnormal colposcopy emerged as a strong independent predictor of CIN2+ lesions (OR: 6.623; 95% CI: 2.028–21.662; p=0.002). Interestingly, HPV-16 positivity was identified as an independent protective factor (OR: 0.138; 95% CI: 0.025–0.754; p=0.022). Transformation zone type was not independently associated with CIN2+ (p=0.167).

CONCLUSION: In this study, HPV-16 and HPV-18 infections did not differ significantly in predicting CIN2+ lesions. Colposcopic findings were the strongest independent predictor of high-grade cervical pathology, underscoring their critical role in clinical decision-making. The unexpected reversal in the effect of HPV-16 between univariate and multivariate analyses highlights the potential impact of confounding factors and limited sample size. These findings suggest that HPV genotyping alone may be insufficient for risk stratification and should be interpreted in conjunction with colposcopic and clinical evaluation.

Keywords: human papillomavirus, cervical intraepithelial neoplasia, colposcopy

SS-010

Impact of Letrozole Co-Treatment on Hormonal Profile and Ovarian Response in Poor Responder Patients Undergoing Controlled Ovarian Stimulation

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INTRODUCTION: This study aimed to evaluate the effect of letrozole co-treatment on hormonal profile and ovarian response in poor responder patients, defined according to POSEIDON groups 3 and 4, undergoing controlled ovarian stimulation (COS).

MATERIALS-METHODS: This retrospective study was conducted at a tertiary care in vitro fertilization (IVF) center. A total of 100 poor responder women, classified according to POSEIDON groups 3 and 4, were included and divided into two groups: letrozole-treated (n=50) and non-letrozole (n=50). Baseline characteristics, hormonal parameters, and cycle outcomes were compared. Additionally, a multivariate linear regression analysis was performed to identify independent predictors of oocyte yield.

RESULTS: The groups were comparable in terms of age (28.64 ± 3.29 vs 29.12 ± 3.51 years, p=0.521), basal FSH levels (9.56 ± 2.31 vs 9.78 ± 2.45 IU/L, p=0.733), AMH (0.65 ± 0.31 vs 0.69 ± 0.34 ng/mL, p=0.281), basal estradiol levels (54.46 ± 14.33 vs 57.12 ± 15.08 pg/mL, p=0.206), and prolactin (14.06 ± 6.62 vs 15.21 ± 7.03 ng/mL, p=0.264). Total oocyte yield (5.50 ± 2.48 vs 5.71 ± 2.63, p=0.813) and the number of MII oocytes (4.24 ± 2.25 vs 4.67 ± 2.41, p=0.197) were also similar between the groups.

However, body mass index (BMI) was significantly lower in the letrozole group (18.66 ± 0.68 vs 22.94 ± 2.11 kg/m², p<0.001). Luteinizing hormone (LH) levels were also significantly different (6.53 ± 2.32 vs 8.11 ± 2.87 IU/L, p=0.002). Trigger day estradiol levels were markedly reduced in the letrozole group (243.52 ± 50.23 vs 412.76 ± 85.34 pg/mL, p<0.001).

In multivariate regression analysis, AMH emerged as the only significant independent predictor of oocyte yield (β = 5.12, 95% CI: 3.62–6.62, p<0.001). Letrozole use (β = 0.22, p=0.681), age (β = −0.03, p=0.739), BMI (β = −0.19, p=0.325), and other hormonal parameters were not independently associated with oocyte yield.

DISCUSSION: Although letrozole significantly alters the hormonal milieu, particularly by reducing estradiol levels, it does not independently improve ovarian response in POSEIDON group 3–4 poor responder patients. AMH remains the strongest predictor of oocyte yield in this population. These findings suggest that the clinical benefit of letrozole in COS protocols may be limited to endocrine modulation rather than improvement in oocyte outcomes. Further prospective studies in well-defined low-prognosis populations are warranted.

Keywords: Letrozole,Poor ovarian response,Controlled ovarian stimulation,IVF

TABLE 1

Table 1. Baseline Characteristics and Cycle Outcomes

Parameter	Letrozole (+)	Letrozole (-)	p-value
Age	28.64 ± 3.29	28.71 ± 2.17	0.521
BMI	18.66 ± 0.68	20.27 ± 1.35	<0.001
FSH	9.56 ± 2.31	9.36 ± 0.99	0.733
LH	6.53 ± 2.32	5.24 ± 1.12	0.002
Basal Estradiol	54.46 ± 14.33	58.11 ± 13.36	0.206
AMH	0.65 ± 0.31	0.70 ± 0.23	0.281
Prolactin	14.06 ± 6.62	15.20 ± 3.09	0.264
Total Oocytes	5.50 ± 2.48	5.34 ± 2.38	0.813
MII Oocytes	4.24 ± 2.25	4.90 ± 2.53	0.197
Trigger Day Estradiol	243.52 ± 50.23	59.54 ± 17.06	<0.001

TABLE 2

Table 2. Multivariate Linear Regression Analysis of Factors Associated with Oocyte Yield in POSEIDON Group 3–4 Poor Responder Patients

Variable	β coefficient	95% CI	p-value
Letrozole use	0.216	-0.825 – 1.257	0.681
Age	-0.025	-0.172 – 0.123	0.739
BMI	-0.189	-0.567 – 0.190	0.325
AMH	5.118	3.616 – 6.620	<0.001
FSH	-0.103	-0.334 – 0.128	0.379
LH	-0.064	-0.290 – 0.163	0.577
Basal Estradiol (E2)	-0.003	-0.033 – 0.026	0.819

SS-011

Obstetrics and gynecology services in a field hospital Setting: a three-month clinical experience

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INTRODUCTION: In times of disaster and humanitarian crisis, field hospitals are vital to the provision of important healthcare services. Obstetric and gynecological care is especially crucial for women's health in such environments. Among the most prevalent clinical illnesses in field hospitals are pelvic floor disorders, vaginal infections, infertility, and pregnancy follow-up. The purpose of this study was to assess how obstetric and gynecological services were distributed in a field hospital over the course of three months, as well as the surgical results.

MATERIALS-METHODS: Medical records of patients who visited a field hospital's obstetrics and gynecology outpatient clinic during a three-month period were examined for this retrospective descriptive study. Surgical methods and obstetric and gynecological diagnosis were examined. Patients who had surgery had their early postoperative complications assessed.

RESULTS: A total of 1,015 pregnant patients were monitored over the study period. Infertility (420 patients), menorrhagia (241 patients), uterine prolapse (195 patients), vaginitis (187 patients), and cystitis (140 patients) were the most frequently diagnosed conditions among gynecological outpatient visits.There were 44 surgical procedures carried out. Vaginal hysterectomy with anterior and posterior colporrhaphy was the most often performed surgical technique (21 patients). Twelve patients underwent total abdominal hysterectomy ± bilateral salpingo-oophorectomy, one underwent unilateral salpingo-oophorectomy, two underwent myomectomy, two underwent sacrocolpopexy, two underwent Le Fort colpocleisis, two underwent surgery for ectopic pregnancy, and two underwent uterine evacuation and curettage.Two patients needed blood transfusions, one patient experienced postoperative fever, and one patient experienced surgical site infection as short-term postoperative sequelae. There were no instances of pneumonia, thromboembolism, bladder damage, postoperative bleeding, urinary retention, reoperation, or death

CONCLUSION: In addition to provide emergency obstetric care, field hospitals are crucial for the diagnosis and surgical treatment of gynecological disorders. Our results show that even in settings with low resources, comprehensive and sustainable obstetrics and gynecology treatments may be provided. Additionally, the low incidence of immediate surgical complications implies that both vaginal and abdominal surgical procedures can be carried out safely in environments with limited resources. Therefore, organized obstetric and gynecological services are crucial for post-disaster healthcare planning.

Keywords: disaster medicine,field hospital, gynecological surgery, obstetrics and gynecology,

SS-012

A Rare Placental Site Nodule Accompanied by a Paravertebral Müllerian Cyst: A Case Report

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INTRODUCTION: Placental site nodule is a rare benign lesion originating from intermediate trophoblastic cells that persist at the site of placental implantation from a previous pregnancy. It is most commonly detected incidentally in endometrial biopsy or curettage specimens obtained for gynecologic complaints such as abnormal uterine bleeding. The reported incidence is approximately 0.1–0.2%. Although it is generally asymptomatic and clinically insignificant, accurate recognition is important because it may histopathologically mimic other trophoblastic proliferations.

CASE: A 43-year-old woman with a history of four pregnancies and four cesarean deliveries, the most recent performed 23 months earlier, presented to an external gynecology clinic with complaints of abdominal distension, vaginal spotting, and foul-smelling discharge. Transvaginal ultrasonography revealed intrauterine fluid and hyperechogenic clot-like material, as well as a cystic structure measuring approximately 4 mm at the cesarean section scar site (isthmocele?). Endometrial biopsy performed at the outside center was reported as follows: "Trophoblastic cell clusters positive for GATA-3 are observed within well-circumscribed hyalinized stroma among proliferative endometrial fragments. No mitotic activity or necrosis is identified in these two small nodules. The findings are suggestive of a placental site nodule; however, reevaluation in a specialized center is recommended for definitive diagnosis." The patient subsequently presented to our institution and was evaluated in a multidisciplinary gynecologic oncology council including pathology, radiology, and medical oncology. Computed tomography performed for metastatic evaluation showed no suspicious thoracic or abdominal metastatic lesions; however, thoracic CT revealed a low-density paravertebral lesion considered to represent a cyst or a neurogenic tumor. Following evaluation by the thoracic council, spinal MRI demonstrated a purely cystic lesion located in the right paravertebral region. The patient underwent right single-port video-assisted thoracoscopic surgery (VATS) exploration and mediastinal cyst excision performed by the thoracic surgery team. Histopathological examination of the cyst was reported as a Müllerian cyst (positive for WT1, PAX8, and ER; negative for calretinin, p40, TTF1, and CDX2).

DISCUSSION: To our knowledge, the coexistence of a placental site nodule and a paravertebral Müllerian cyst in the same patient has not been previously reported in the literature. Therefore, it is difficult to draw a definitive conclusion regarding the pathogenesis of this association. Nevertheless, the hormone-responsive epithelial and stromal characteristics observed in both lesions may provide a theoretical basis for reconsidering potential developmental and molecular similarities between trophoblastic and Müllerian tissues.

CONCLUSION: The coexistence of a placental site nodule and a paravertebral Müllerian cyst in the same patient is extremely rare and has not been previously described in the literature. Although this association is most likely incidental, further studies are needed to better understand the potential developmental relationships between trophoblastic and Müllerian tissues. This case may contribute to the literature by demonstrating the simultaneous presence of these two rare benign lesions.

Keywords: Placental site nodule, Müllerian cyst, paravertebral cyst, trophoblastic lesion

Figure 1: Right paravertebral cyst observed on axial thoracic CT imaging.

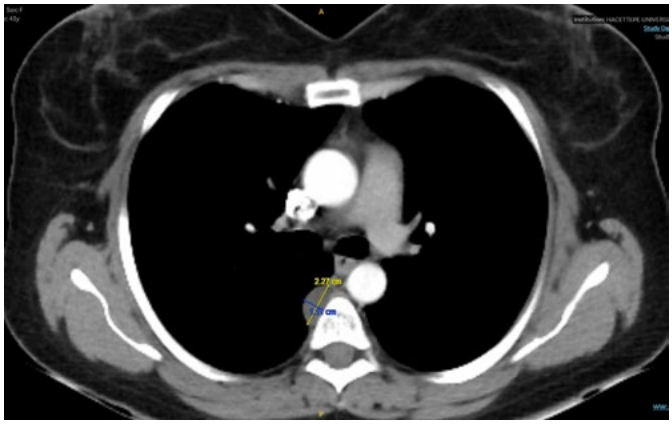
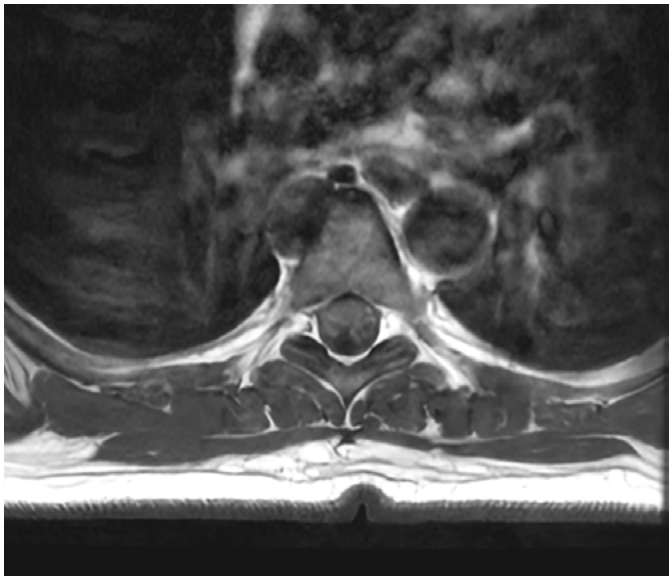


Figure 2: Right paravertebral cyst observed on sagittal spinal MRI imaging.



Figure 3: Right paravertebral cyst observed on axial spinal MRI imaging.



SS-013

Changes in Medical Specialty Examination (TUS) Preference Trends in Turkey Between 2007-2025: An Analysis Focused on Obstetrics and Gynecology with International Comparisons

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AIM: This study aims to analyze the trends in preferences for the Medical Specialty Examination (TUS) in Turkey between 2007 and 2025, with a particular focus on Obstetrics and Gynecology (OBGYN). Objectives include comparing the top and bottom 10 specialties by scores in 2007 and 2025, examining changes in OBGYN base scores, assessing the impact of malpractice risk, burnout, financially uncompensated long working hours, and patient-physician communication on OBGYN's popularity, evaluating the effects of the 2010 Full-Time Law and 2022 Malpractice Regulation, comparing Turkey's trends with specialty preferences in the USA, Brazil, Argentina, India, Canada, Australia, and Germany, and analyzing the long-term effects of declining surgical specialty popularity to prevent specialist shortages and address public health issues.

METHODS: TUS data from 2007-2025 were sourced from OSYM, TUSDATA, and Tus- time; burnout and working conditions from Turkish Medical Association (TTB) 2023 reports and Ministry of Health 2024 data; malpractice data from TTB and the Ministry of Justice. International comparisons were compiled from PubMed, World Health Organization (WHO), American Medical Association (AMA), and Canadian Medical Association (CMA) sources. Data were analyzed using SPSS 26.0 with time-series analysis and t-tests; reasons for popularity changes were explored qualitatively.

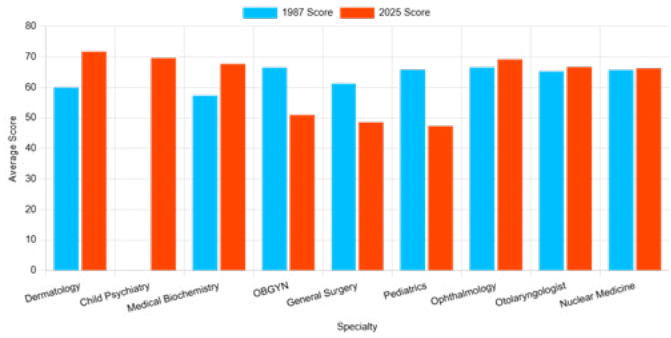
FINDINGS: In 2007, OBGYN and surgical specialties (e.g., General Surgery, Neurosurgery) were popular due to prestige and private practice income, whereas in 2025, less risky specialties like dermatology and physical medicine gained prominence. OBGYN base scores fell from 67.68 in 2007 to 51.43 in 2025. This is linked to 64% burnout among doctors, being financially uncompensated, 60-80 hours of workweeks and high malpractice risk. The 2010 Full-Time Law reduced income by closing private practices; the 2022 Malpractice Regulation mitigated risks but did not significantly boost scores. Australia and Canada's incentive models enhance OBGYN appeal, while Turkey faces significant rural OBGYN specialist shortages.

CONCLUSION: The declining popularity of surgical specialties increases the risk of specialist shortages by 2045. Recommendations include increasing malpractice

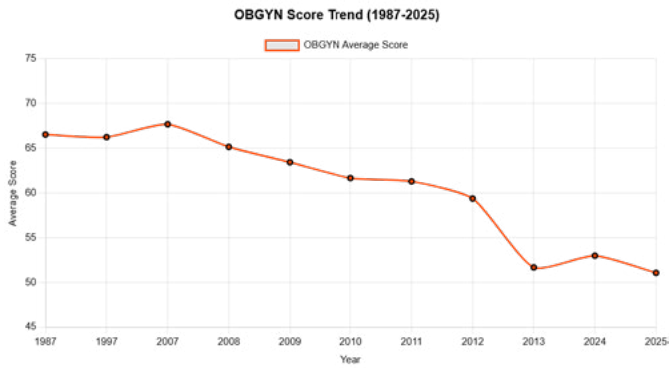
insurance premiums and coverage amounts, maintaining state subsidies, providing financial improvements for risky specialties, implementing burnout prevention programs, investing in technology, offering patient-physician communication training and providing incentives for rural areas. Turkey can adapt Australia and Canada's models to enhance the appeal of OBGYN and surgical specialties.

Keywords: Medical Specialty Examination (TUS), Obstetrics and Gynecology (OBGYN), malpractice, burnout, surgical specialties, specialty preferences.

1987-2025 Specialty Comparison



OBGYN Score Trend (1987-2025)



SS-014

A Rare 'Never Event' in Obstetrics: Fluoroscopy-Guided Retrieval of a Retained Needle During Episiotomy Repair

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INTRODUCTION: Episiotomy is a frequently performed obstetric procedure involving a controlled incision of the perineum during vaginal delivery. Although its selective use is recommended to minimize maternal morbidity, procedure-related complications may still occur. Early complications include bleeding, hematoma, and infection, while late complications may involve scar sensitivity and dyspareunia. Retained surgical material is classified as a "never event" in contemporary surgical practice. However, intraoperative fracture and retention of a suture needle during episiotomy repair is exceedingly rare and only sporadically reported in the obstetric literature, raising significant concerns regarding patient safety and medicolegal responsibility.

CASE PRESENTATION: A 27-year-old primiparous woman at term underwent spontaneous vaginal delivery with mediolateral episiotomy. During perineal repair, the suture needle fractured approximately 5 cm distal to the hymenal ring, and the distal fragment became embedded within the vaginal soft tissues. Careful visual inspection and digital palpation failed to identify the retained fragment. Subsequent portable pelvic radiography demonstrated a small metallic foreign body within the vaginal region. The patient was transferred to the operating room and positioned in lithotomy under spinal anesthesia. Intraoperative fluoroscopic guidance enabled precise localization of the retained needle fragment, which was successfully retrieved with minimal soft tissue dissection. The procedure was completed without complications, and the postoperative course was uneventful.

DISCUSSION: Needle fracture and retention during episiotomy repair represents an exceptionally uncommon complication. Potential contributing factors include excessive mechanical stress on the needle, inappropriate needle angulation, increased tissue resistance, unsuitable suture material, or manufacturing defects. Early intraoperative recognition is critical to prevent fragment migration, tissue injury, or delayed complications. Blind surgical exploration may increase morbidity, whereas imaging modalities such as radiography and fluoroscopy allow accurate localization and facilitate safe retrieval of retained metallic fragments.

CONCLUSION: Retained needle fragments during

episiotomy repair constitute a rare but preventable obstetric "never event." Prompt recognition of the complication, radiographic confirmation, and fluoroscopy-guided extraction under controlled operative conditions represent an effective and minimally invasive management strategy. This case underscores the importance of surgical vigilance and highlights the role of imaging-guided techniques in the management of unexpected intraoperative complications in obstetric practice.

Keywords: Episiotomy, Fluoroscopy-guided extraction,Patient safety, Radiographic confirmation, Retained surgical material, Vaginal foreign body

Radiographic images



Radiographic and fluoroscopic images demonstrating the localization of a broken suture needle retained within the vaginal tissue during episiotomy repair. Image showing the fractured suture needle fragment.

SS-015

Life-threatening uterine hemorrhage due to gestational choriocarcinoma initially misdiagnosed as uterine myoma

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OBJECTIVE: Gestational trophoblastic neoplasia (GTN) is a rare group of tumors arising from abnormal proliferation of trophoblastic tissue associated with pregnancy. Choriocarcinoma is one of the most aggressive forms of GTN and is characterized by rapid growth and early hematogenous metastasis, most commonly to the lungs, liver, and brain. Although GTN is highly sensitive to chemotherapy, delayed diagnosis may lead to life-threatening complications such as massive hemorrhage or widespread metastatic disease. In some cases, choriocarcinoma may present as a uterine mass and mimic uterine leiomyoma, which may result in diagnostic delay. The aim of this report is to present a case of gestational choriocarcinoma initially misdiagnosed as uterine myoma and requiring emergency surgical intervention due to severe uterine bleeding.

METHODS: We present the clinical course, diagnostic process, and management of a patient who was initially evaluated with a diagnosis of uterine myoma but was later diagnosed with gestational trophoblastic tumor. Clinical findings, imaging results, laboratory parameters, and treatment approach were reviewed.

RESULTS: A 49-year-old multiparous woman presented to an external medical center with abdominal and gastric pain in March 2025. Pelvic computed tomography revealed heterogeneous uterine masses with peripheral calcifications, the largest measuring approximately 6 cm, and the lesion was interpreted as uterine leiomyoma. Subsequent pelvic magnetic resonance imaging demonstrated increased uterine size, endometrial thickening (41 mm), and two uterine masses with cystic degeneration measuring approximately 70×48 mm and 65×50 mm. In mid-May 2025, the patient developed vaginal bleeding. Serum β-human chorionic gonadotropin (β-hCG) was markedly elevated at 250000 mIU/mL, and dilatation and curettage was performed. However, the initial pathology did not reveal malignancy. Because β-hCG levels remained persistently elevated and vaginal bleeding continued, a second endometrial biopsy was performed in July 2025 and reported as gestational trophoblastic tumor. When the patient presented to our tertiary center, severe vaginal bleeding and a highly vascular uterine mass approximately 8 cm in size were detected on transvaginal ultrasonography. Emergency uterine evacuation resulted in uncontrollable massive

bleeding, and the patient became hemodynamically unstable with a hemoglobin level of 4.8 g/dL. Emergency exploratory laparotomy followed by total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed. Postoperative pathology confirmed choriocarcinoma measuring 9.5 cm with myometrial and lymphovascular invasion. Positron emission tomography–computed tomography revealed bilateral pulmonary metastases, and the patient was subsequently started on multi-agent EMA-CO chemotherapy.

CONCLUSION: Gestational choriocarcinoma may mimic uterine leiomyoma and may also present with false-negative biopsy results, which can delay diagnosis. In patients with unexplained vaginal bleeding and markedly elevated β-hCG levels, gestational trophoblastic neoplasia should be considered in the differential diagnosis of atypical uterine masses. Early recognition is essential, as delayed diagnosis may lead to life-threatening hemorrhage requiring emergency surgical intervention. This case highlights the importance of considering GTN even in perimenopausal patients presenting with atypical uterine masses.

Keywords: Choriocarcinoma, Gestational trophoblastic neoplasia, Hemorrhage, Misdiagnosis

SS-016

Temporal Trends in Neonatal Vaccine Refusal and Associated Maternal and Obstetric Characteristics: A Single-Center Experience

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OBJECTIVE: This study aimed to evaluate temporal trends in neonatal vaccine refusal rates and to investigate the maternal demographic and obstetric characteristics associated with vaccine refusal.

METHODS: In this retrospective study, all mothers who refused neonatal vaccination between 2018 and 2025 at Duzce Atatürk State Hospital were included. Annual vaccine refusal rates were calculated based on the total number of deliveries per year. The study population was stratified into two periods: pre-pandemic (2018–2021) and post-pandemic (2022–2025). Maternal demographic characteristics, antenatal follow-up data, and obstetric outcomes were compared between the two periods. Continuous variables were expressed as median and compared using the Mann–Whitney U test, while categorical variables were analyzed using the chi-square test. A p-value <0.05 was considered statistically significant.

RESULTS: A total of 76 cases of neonatal vaccine refusal were identified. The vaccine refusal rate increased significantly from 0.36% in the pre-pandemic period to 1.15% in the post-pandemic period, representing more than a threefold increase ($p<0.01$). Trend analysis demonstrated a statistically significant upward trajectory in vaccine refusal rates over time (p for trend = 0.03), with a particularly marked rise observed in 2024 and 2025.

No statistically significant differences were found between the two periods in terms of maternal age, gravida, parity, number of living children, antenatal screening tests, or detailed ultrasound evaluation ($p>0.05$). Similarly, obstetric outcomes—including gestational age at delivery, mode of delivery, birth weight, and Apgar scores—were comparable between groups ($p>0.05$).

CONCLUSION: Neonatal vaccine refusal rates have increased significantly in the post-pandemic period, independent of maternal demographic and obstetric characteristics. These findings suggest that the observed rise in vaccine refusal is likely driven by behavioral and societal factors rather than clinical determinants. Notably, increased public discourse regarding potential side effects of COVID-19 vaccines since 2023 may have contributed

to declining vaccine confidence, thereby influencing parental decisions regarding neonatal vaccination. This underscores the urgent need to address vaccine hesitancy in the post-pandemic era.

Keywords: vaccine,covıd19,birth

SS-017

The Role of Maternal Serum Calponin-2 Levels in Predicting the Transition to Active Labor in Term Pregnancies

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OBJECTIVE: Early and reliable prediction of active labor may optimize labor ward management and help prevent unnecessary hospital admissions and obstetric interventions. Therefore, the identification of objective biomarkers that can support clinical assessment remains an important goal in obstetric practice. The assessment of labor progression is currently based largely on subjective methods such as vaginal examination and Bishop score evaluation. Calponin-2 (CNN2), a cytoskeletal protein involved in the regulation of smooth muscle contraction, may serve as a potential biomarker reflecting myometrial contractile activity. This study aimed to compare serum CNN2 levels between the latent and active phases of labor and to assess its predictive role in identifying the transition to active labor in term pregnancies.

MATERIALS-METHODS: In this prospective cross-sectional study, 40 singleton term pregnant women with cephalic presentation who were admitted with spontaneous labor were included. Demographic characteristics, Bishop scores, cervical length measurements, and obstetric data were recorded. Maternal venous blood samples were obtained both in latent and active phase, and serum CNN2 levels were measured using enzyme-linked immunosorbent assay. Comparative statistical analyses were used to compare CNN2 levels between the latent and active phase groups. The predictive performance of CNN2 levels in the transition to active labor was evaluated using receiver operating characteristic (ROC) curve analysis.

RESULTS: The demographic and laboratory characteristics of the study population are presented in Table 1. The median CNN2 level was significantly lower in latent phase as compared to active phase (3.2 ng/mL (1.01–14.12) and 5.2 ng/mL (1.85–26.88), p=0.001). Spearman correlation analysis revealed a moderate positive correlation between CNN2 and CRP levels (r=0.483, p=0.002). A strong negative correlation was observed between CNN2 and cervical length (r=–0.695, p<0.001). There was no statistically significant correlation between CNN2 and admission Bishop score (p=0.579), age (p=0.051), parity (p=0.119), or BMI (p=0.069) (Table 2). In ROC analysis, the area under the curve (AUC) was 0.733 (95% CI: 0.622-0.825) and a CNN2 cut-off value of 3.92 ng/mL yielded a sensitivity of

72.5% and a specificity of 70% for predicting transition to the active phase.

CONCLUSION: Maternal serum CNN2 levels may represent a novel biomarker reflecting uterine contractile activation in term pregnancies and may support decision-making processes in labor management. These findings suggest that maternal serum CNN2 demonstrates clinically meaningful discriminative ability in identifying patients transitioning to active labor. This potential role of CNN2 may contribute to a more objective and biochemically supported assessment of labor progression.

Keywords: Active labor, calponin-2, labor progression, term pregnancy

Figure. Receiver operating characteristic (ROC) curve analysis evaluating the predictive performance of CNN2 levels in the transition to active labor

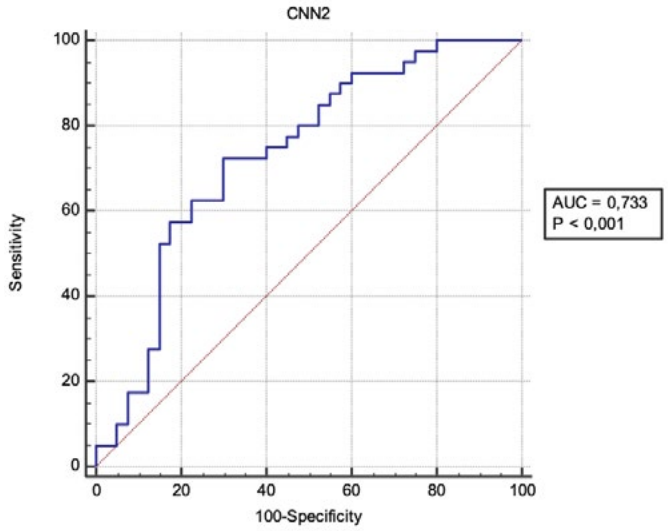


Table 1. Demographic and Laboratory Characteristics of Term Pregnancies in Latent and Active Phases of Labor

Variable	
Age (years)	24 (18-42)
Gravida (n)	1 (1–7)
Parity (n)	0 (0–4)
Abortus (n)	0 (0–4)
Fetal weight (g)	3214.8 ± 398.4
BMI (kg/m²)	28.3 (21.5-46.2)
Cervical length (mm)	19.3 ± 2.9
Admission Bishop score	4 (2–5)
Hemoglobin (g/dL)	12 (8–13)
WBC (×10³/mm³)	10 (5–22)
Platelet (×10³/mm³)	245 ± 68.9
BUN (mg/dL)	7.2 ± 2.2
Alanine aminotransferase (U/L)	10.6 ± 3.8
Aspartate aminotransferase (U/L)	18 (11–40)
Creatinine (mg/dL)	0.4 (0.3–0.9)
CRP (mg/dL)	4 (2–11)
CNN2 at latent phase (ng/mL)	3.2 (1.01–14.12)
CNN2 at active phase (ng/mL)	5.2 (1.85-26.88)

Table 2. Spearman correlation analysis evaluating the relationship between CNN2 at latent phase and clinical parameters

Variable	Spearman r	p value
Age	-0.311	0.051
Parity	-0.250	0.119
BMI	-0.291	0.069
Bishop score	0.090	0.579
CRP	0.483	0.002
Cervical length	-0.695	<0.001

SS-018

Pregnancy with the 'Golden Blood' Phenotype (Rh-null): A Rare Case Report First reported case in Türkiye

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The Rh-null phenotype, also known as "golden blood," is an extremely rare blood group characterized by the complete absence of Rh antigens on the surface of erythrocytes. Its estimated prevalence is approximately 1 in 6 million individuals worldwide. We present a rare case of pregnancy complicated by Rh-null phenotype diagnosed during evaluation for transfusion incompatibility.

INTRODUCTION: The Rh blood group system is one of the most clinically significant blood group systems in transfusion medicine. The Rh-null phenotype is characterized by the absence of all Rh antigens on erythrocytes and may occur through two main mechanisms: the regulator type caused by mutations in the RHAG(rh-associated glycoprotein) gene, and the amorph type resulting from deletions or mutations in the RHD and RHCE genes. Because compatible donor blood is extremely rare, pregnancy management requires careful planning and coordination with transfusion services.

CASE PRESENTATION, METHODS AND FINDINGS: A 30yearold pregnant woman (G3P2A0Y2) with a history of two previous cesarean sections was referred to our tertiary care center during the second trimester due to anemia and incompatibility detected during crossmatching prior to a planned blood transfusion. Initial tests revealed the patient's blood type was A Rh negative, while his spouse's was B Rh positive. The patient reported a previous history of erythrocyte suspension transfusion during an earlier pregnancy without any adverse reactions. Her children were healthy, and there was no known family history of similar hematological conditions.

Further immunohematological investigations were performed because of persistent crossmatch incompatibility. Rh subgroup analysis revealed absence of all Rh antigens. The indirect coombs test was positive while the direct coombs test was negative. Antibody screening demonstrated panreactivity. Peripheral blood smear evaluation showed stomatocytes, suggesting erythrocyte membrane instability associated with Rh-null phenotype.

The patient was managed as a highrisk pregnancy with close collaboration between obstetrics, hematology, and the blood bank. Weekly fetal surveillance was performed using middle cerebral artery peak systolic velocity (MCAPSV) Doppler measurements to monitor possible fetal anemia and hydrops fetalis. International registries of rare blood donors were contacted to provide emergency transfusion support if needed.

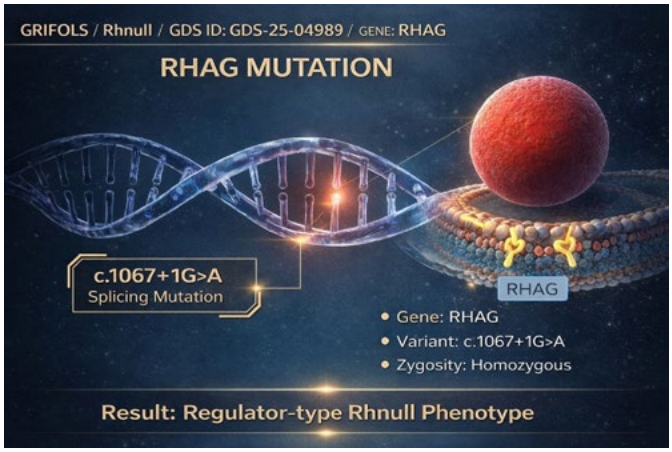
Delivery was planned after multidisciplinary consultation and completion of preoperative preparations. A cesarean section was performed, and the neonate was delivered in good condition. The newborn's blood type was determined as A Rh positive. Following a pediatric consultation, RhoGAM (Rh 0 (D) immunoglobulin) was not administered. Postpartum maternal hemoglobin levels decreased and two units of erythrocyte suspension were administered. Both maternal and neonatal followup periods were uneventful.

DISCUSSION AND CONCLUSION: Rh-null phenotype represents one of the rarest blood group conditions in transfusion medicine. Diagnosis often requires advanced serological testing and molecular genetic analysis, which remains the gold standard for confirmation. Peripheral blood smear findings such as stomatocytosis may provide important diagnostic clues. Pregnancy in individuals with this phenotype requires careful monitoring, multidisciplinary management, and coordination with rare blood donor registries to ensure availability of compatible blood products.

Early recognition and coordinated obstetric and hematological care are crucial to achieve favorable maternal and neonatal outcomes in these extremely rare cases.

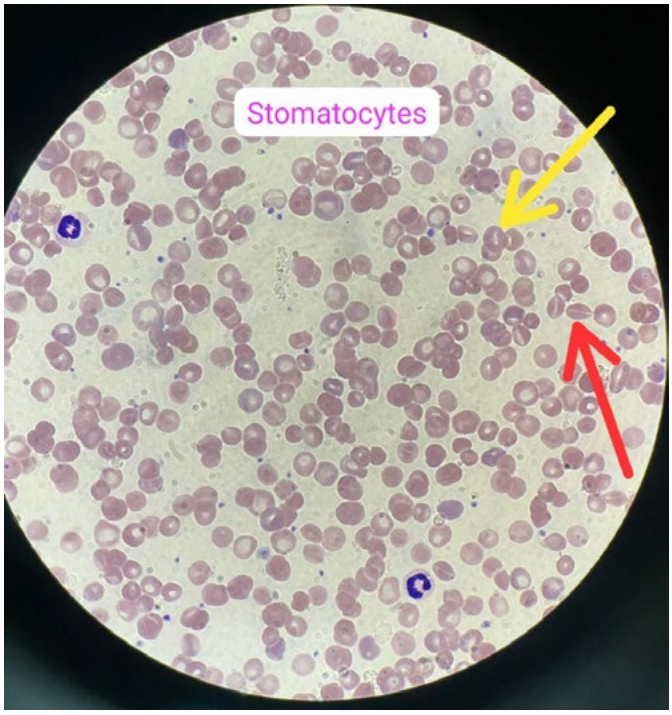
Keywords: Golden blood, Pregnancy, Rh-null phenotype, Transfusion management

Molecular genetic diagnosis



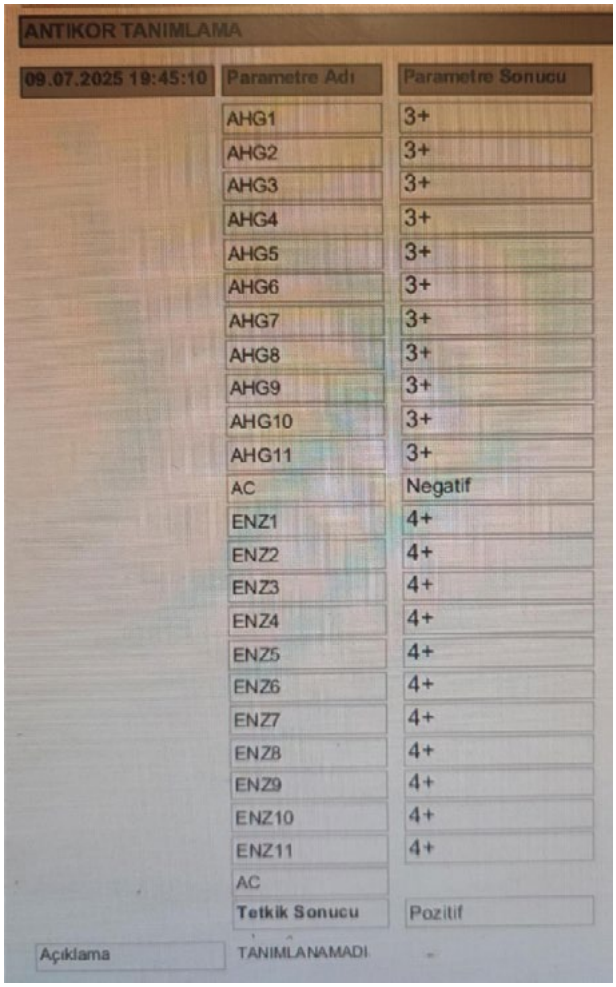
Molecular genetic diagnosis is the gold standard method for diagnosing Rh nullity.

Peripheral smear



Stomatocytes in peripheral blood smears are a visible result of erythrocyte membrane instability and impaired cell hydration that develops in Rh null individuals.

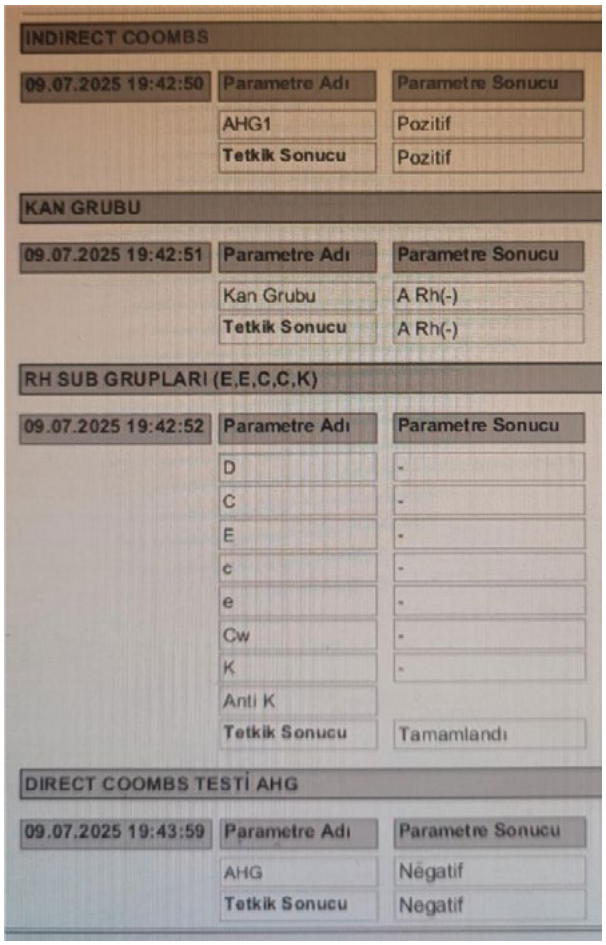
Serological examination



ANTIKOR TANIMLAMA

09.07.2025 19:45:10	Parametre Adı	Parametre Sonucu
	AHG1	3+
	AHG2	3+
	AHG3	3+
	AHG4	3+
	AHG5	3+
	AHG6	3+
	AHG7	3+
	AHG8	3+
	AHG9	3+
	AHG10	3+
	AHG11	3+
	AC	Negatif
	ENZ1	4+
	ENZ2	4+
	ENZ3	4+
	ENZ4	4+
	ENZ5	4+
	ENZ6	4+
	ENZ7	4+
	ENZ8	4+
	ENZ9	4+
	ENZ10	4+
	ENZ11	4+
	AC	
	Tetkik Sonucu	Pozitif
Açıklama	TANIMLANAMADI	

Rh system subgroups



INDIRECT COOMBS

09.07.2025 19:42:50	Parametre Adı	Parametre Sonucu
	AHG1	Pozitif
	Tetkik Sonucu	Pozitif

KAN GRUBU

09.07.2025 19:42:51	Parametre Adı	Parametre Sonucu
	Kan Grubu	A Rh(-)
	Tetkik Sonucu	A Rh(-)

RH SUB GRUPLARI (E,E,C,C,K)

09.07.2025 19:42:52	Parametre Adı	Parametre Sonucu
	D	-
	C	-
	E	-
	c	-
	e	-
	Cw	-
	K	-
	Anti K	
	Tetkik Sonucu	Tamamlandı

DIRECT COOMBS TESTİ AHG

09.07.2025 19:43:59	Parametre Adı	Parametre Sonucu
	AHG	Negatif
	Tetkik Sonucu	Negatif

SS-020

Maternal, neonatal and hematologic outcomes in high-risk pregnancies with and without low-dose aspirin

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OBJECTIVE: To assess maternal, neonatal, and blood-related outcomes in pregnant women taking low-dose aspirin (LDA) versus non-users, with a focus on inflammatory and blood-related markers like the lymphocyte-to-monocyte ratio (LMR), hemoglobin-to-platelet ratio (HPR), and hematocrit-to-platelet ratio (HCT/PLT).

METHODS: This retrospective study included 368 pregnant women who attended a high-risk pregnancy clinic at a tertiary center between December 2023 and January 2025. Participants were divided into two groups based on LDA use. Data on demographics, obstetric history, perinatal outcomes, and laboratory findings were collected from hospital records. The analysis was limited to hemogram parameters, as consistent coagulation and biochemical data were not available for all participants.

RESULTS: Of the total, 208 women used LDA and 160 did not. The LDA group had higher rates of advanced maternal age, obesity, IVF pregnancies, and pregestational conditions ($p<0.05$). Preterm delivery (<37 weeks) and NICU admission were more frequent among LDA users ($p<0.001$). No significant differences were found in prenatal or postpartum bleeding. Hematologically, the LDA group showed lower monocyte counts and higher LMR ($p<0.05$), while HPR and HCT/PLT ratios did not differ significantly. Postpartum venous thromboembolism was more common in the LDA group.

CONCLUSION: Low-dose aspirin appears hematologically safe and does not increase bleeding complications. However, the increased adverse perinatal outcomes may reflect the higher baseline risk in the aspirin group. Prospective studies are necessary to better understand these findings.

Keywords: HPR, hematologic markers, LMR, low-dose aspirin, pregnancy, preterm birth

SS-021

Association between uterine contraction frequency in the last hour of labor and neonatal outcomes in vaginal deliveries: the effect of oxytocin use

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AIM: To investigate the relationship between uterine contraction frequency recorded on cardiotocography (CTG) during the last 60 minutes before delivery and neonatal outcomes, and to evaluate the effect of oxytocin use on this relationship in term vaginal deliveries.

METHODS: This retrospective cohort study included 60 singleton term pregnancies delivered vaginally at Ankara Etlik City Hospital between December 2025 and March 2026. Patients were divided into two groups according to oxytocin use during labor: Group A (oxytocin+, n=30) and Group B (oxytocin−, n=30). CTG recordings were reviewed in six consecutive 10-minute windows and contraction frequency was calculated across each window. Uterine tachysystole was operationally defined as more than five contractions in any 10-minute window. Umbilical arterial pH, base excess (BE), and 1- and 5-minute Apgar scores were recorded as neonatal outcome measures. Multiple pregnancies, fetal anomalies, and incomplete CTG recordings were excluded. Mann-Whitney U, Fisher's exact, and Spearman correlation analyses were used.

RESULTS: Demographic characteristics were comparable between groups ($p>0.05$ for all). Contraction frequency and uterine tachysystole rate were significantly higher in Group A compared to Group B (median 5.00 vs 3.67 per 10 minutes, $p<0.001$; 97% vs 63%, $p=0.004$). No significant differences were observed between groups regarding umbilical arterial pH (median 7.285 vs 7.285, $p=0.836$), BE (−3.5 vs −2.5 mmol/L, $p=0.553$), umbilical arterial acidosis (pH<7.20; 33% vs 23%, $p=0.568$), 1-minute Apgar (8 vs 8, $p=0.246$), or 5-minute Apgar score (9 vs 10, $p=0.274$). Across the entire cohort, increasing contraction frequency was associated with lower umbilical arterial pH ($r=-0.507$, $p<0.001$), lower 1-minute Apgar ($r=-0.443$, $p<0.001$), and lower 5-minute Apgar scores ($r=-0.355$, $p=0.005$). The association between contraction frequency and BE did not reach statistical significance ($r=-0.246$, $p=0.058$).

CONCLUSION: Uterine contraction frequency during the last hour of labor demonstrates significant negative correlations with umbilical arterial pH and Apgar scores in term vaginal deliveries. Although oxytocin use increased contraction frequency and tachysystole rate, no significant between-group difference in neonatal outcomes was detected. These findings suggest that

intrapartum CTG interpretation should systematically incorporate contraction frequency assessment in addition to fetal heart rate patterns.

Keywords: Cardiotocography, Uterine tachysystole, Neonatal outcomes, Oxytocin,Umbilical cord blood gas

SS-022

Pregnancy-associated breast cancer successfully managed with surgery and adjuvant chemotherapy during pregnancy resulting in a healthy term delivery

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OBJECTIVE: Breast cancer diagnosed during pregnancy is a rare condition that poses significant challenges in balancing optimal maternal treatment with fetal safety. The timing and safety of chemotherapy during pregnancy require careful multidisciplinary management. We present a case of breast cancer diagnosed during the first trimester that was successfully managed with surgery and adjuvant chemotherapy during pregnancy, resulting in a favorable maternal and neonatal outcome.

METHODS: A 36-year-old woman (gravida 1, parity 0) presented in December 2024 with a complaint of a palpable mass in the left breast. Her last menstrual period was January 9, 2025. At 12 weeks of gestation, breast ultrasonography revealed a BI-RADS 4B lesion in the left breast, and a biopsy was recommended. Tru-cut biopsy confirmed grade 1 invasive breast carcinoma. At 17 weeks of gestation, the patient underwent left mastectomy with sentinel lymph node dissection on May 15, 2025. Pathological evaluation revealed pT2N1 disease with estrogen receptor positivity of 60%, HER2 negativity, and a Ki-67 proliferation index of 20%. Postoperatively, adjuvant chemotherapy consisting of Adriamycin and cyclophosphamide (AC) every 21 days was initiated. The first cycle was administered on June 24, 2025, and a total of four cycles were completed during pregnancy. Throughout this period, the patient continued regular antenatal follow-up in the perinatology clinic.

RESULTS: During pregnancy follow-up, detailed obstetric ultrasonographic examinations revealed no fetal structural abnormalities. The final cycle of adjuvant chemotherapy was administered on August 27, 2025. At 37 weeks of gestation, on October 8, 2025, the patient presented with active labor, with cervical dilation of 5–6 cm and 70% effacement. A spontaneous vaginal delivery with episiotomy was performed. After 24 hours of postpartum observation, both mother and newborn were discharged in good condition. Postpartum PET-CT imaging performed in October 2025 revealed no evidence of recurrence or metastasis. Adjuvant paclitaxel therapy

was subsequently planned by the medical oncology team. Follow-up examinations showed normal growth and development of the newborn without any abnormalities.

CONCLUSION: Breast cancer diagnosed during pregnancy can be safely managed with an appropriate multidisciplinary approach. Surgical treatment and selected chemotherapy regimens administered after the first trimester may allow effective maternal treatment while maintaining favorable fetal outcomes. This case highlights the feasibility of continuing pregnancy during cancer treatment and underscores the importance of coordinated care among oncology, obstetrics, and perinatology teams.

Keywords: Pregnancy-associated breast cancer, chemotherapy during pregnancy, adjuvant chemotherapy, multidisciplinary management, maternal and fetal outcomes

SS-023

Seven-day delayed interval delivery in a cerclage-treated dichorionic diamniotic twin pregnancy at the periviable gestational age: a case report

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INTRODUCTION: Delayed interval delivery is an uncommon obstetric management strategy in multiple pregnancies in which the delivery of the remaining fetus is intentionally delayed after the birth of the first fetus. The main goal of this approach is to prolong the intrauterine survival of the remaining fetus and improve neonatal outcomes. This strategy is particularly considered in dichorionic pregnancies when the first fetus is delivered prematurely and the second fetus remains viable. However, delayed interval delivery remains controversial because of the potential risks of maternal infection, hemorrhage, and other obstetric complications. Management becomes even more challenging in the periviable period, generally defined as 22–24 weeks of gestation. Here, we present a case of a seven-day delayed interval delivery in a cerclage-treated dichorionic diamniotic twin pregnancy at 23 weeks of gestation.

CASE REPORT: A 35-year-old pregnant woman with a dichorionic diamniotic twin pregnancy at 23 weeks of gestation was admitted to our clinic with threatened preterm labor. The patient had a previously placed cervical cerclage and her medical and surgical history was otherwise unremarkable. Ultrasonographic examination demonstrated two viable fetuses with estimated fetal weights of 478 g and 515 g, respectively. Due to progressive cervical dilation and increasing uterine contractions, the patient was hospitalized and managed with tocolytic therapy, magnesium sulfate, antenatal corticosteroids, and broad-spectrum antibiotics. During follow-up, the first fetus was delivered vaginally on September 16, 2025 at 23 weeks of gestation with a birth weight of 540 g. Following delivery, tocolytic therapy was continued to suppress uterine contractions and antibiotic therapy was maintained for infection prophylaxis. Maternal vital signs and inflammatory markers were closely monitored. With this management strategy, the intrauterine duration of the second fetus was prolonged. The second fetus was delivered vaginally seven days after the first delivery, on September 23, 2025, with a birth weight of 530 g. Postpartum placental retention occurred and manual removal of the placenta followed by uterine curettage was performed. Unfortunately, both

neonates died during the neonatal period.

DISCUSSION: Delayed interval delivery is a rare but potentially beneficial management strategy in selected cases of multiple pregnancies. Previous studies have shown that prolongation of the inter-delivery interval may improve neonatal survival and reduce complications associated with extreme prematurity. The success of delayed interval delivery depends on several factors including chorionicity, absence of intrauterine infection, and close maternal monitoring. Dichorionic pregnancies are generally considered more suitable candidates for this approach because the placentas are separate, which may reduce the risk of infection affecting the remaining fetus. Reported inter-delivery intervals in the literature vary widely, ranging from several days to several weeks. Even a short prolongation of pregnancy may provide clinically meaningful benefits for fetal maturation. However, the risk of maternal complications such as chorioamnionitis, sepsis, and postpartum hemorrhage necessitates careful patient selection and close surveillance.

Keywords: delayed interval delivery, twin pregnancy, periviable period, cervical cerclage, preterm birth

SS-024

Prenatal genotype–phenotype correlation in Harel–Yoon syndrome due to homozygous ATAD3A deletion: a recurrent familial case

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BACKGROUND: Mutations in the ATAD3A gene are associated with severe mitochondrial dysfunction and lethal neurometabolic syndromes, including Harel–Yoon syndrome. Prenatal recognition is rare, and most reported cases are diagnosed postnatally. Early molecular confirmation is critical for pregnancy management and recurrence risk counseling.

CASE PRESENTATION: A 29-year-old pregnant woman (gravida 4, para 1, abortus 2) with no history of consanguinity was referred for prenatal evaluation. In her previous pregnancy, delivery was performed at 32 weeks due to decreased fetal movements and suspected fetal distress. The neonate developed hypotonia and respiratory distress shortly after birth. Postnatal whole exome sequencing revealed a homozygous deletion in the ATAD3A gene.

In the current pregnancy, early genetic counseling was provided because of the known familial mutation and the 25% recurrence risk consistent with autosomal recessive inheritance. Amniocentesis was performed at 16 weeks of gestation for targeted molecular analysis. Detailed ultrasonographic evaluation at 20 weeks demonstrated increased nuchal fold thickness (8 mm), enlarged cisterna magna (11 mm), scalp edema, decreased fetal movements, bilateral clenched hands, hyperextension of the extremities, lower limb rigidity, bilateral pes equinovarus, and mild cardiomegaly. Genetic confirmation of a homozygous deletion involving exons 2–3 of the ATAD3A gene was obtained at 24 weeks of gestation. The variant was classified as pathogenic according to American College of Medical Genetics and Genomics criteria and was consistent with Harel–Yoon syndrome. A strong genotype–phenotype correlation was observed between prenatal imaging findings and molecular results.

Following molecular confirmation at 24 weeks and multidisciplinary counseling regarding the poor prognosis, pregnancy termination was performed. The family was informed about parental carrier testing and future reproductive options, including preimplantation genetic testing.

CONCLUSION: This recurrent familial case illustrates the importance of early invasive testing in pregnancies

at risk for Harel–Yoon syndrome. Characteristic prenatal findings such as fetal hypomotility, rigidity, edema, clenched hands, and cardiomegaly may raise suspicion in high-risk families. Timely molecular diagnosis enables informed decision-making, appropriate pregnancy management, and structured genetic counseling for future pregnancies.

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Keywords: ATAD3A gene deletion, Harel–Yoon syndrome, Prenatal diagnosis, Fetal hypomotility

SS-025

Inflammatory Hematological Indices in Early Partial Molar Pregnancy: A Retrospective Case–Control Study

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BACKGROUND: The contribution of systemic inflammatory response to the early diagnosis of molar pregnancy remains unclear. We aimed to compare inflammatory hematological indices derived from routine complete blood counts among patients with partial molar pregnancy, missed abortion, and uncomplicated early pregnancy, and to assess whether these parameters provide clinically meaningful discrimination for early identification of partial molar pregnancy.

METHODS: Electronic medical records of patients presenting between 01 January 2020 and 31 December 2025 to a university hospital were reviewed retrospectively. Cases with histologically confirmed partial molar pregnancy (n = 32) were compared to missed abortion (n = 35) and uncomplicated early pregnancy (n = 40). Neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), monocyte-to-lymphocyte ratio (MLR), systemic immune-inflammation index (SII), and systemic inflammatory response index (SIRI) were calculated from pre-evacuation complete blood counts.

RESULTS: No significant differences were observed among groups for NLR, PLR, MLR, SII, or SIRI (all $p > .05$). Gestational age at presentation differed between groups but showed no correlation with any inflammatory index examined.

CONCLUSION: Inflammatory hematological indices obtained from routine complete blood counts do not appear to serve as reliable standalone diagnostic biomarkers for differentiating partial molar pregnancy in early gestation. Studies with larger sample sizes and prospective designs are needed to clarify the role of systemic inflammation in this clinical context.

Keywords: first trimester, gestational trophoblastic disease, hydatidiform mole, inflammation, lymphocytes, neutrophils

Demographic Characteristics and Inflammatory Hematological Indices of Patients

Variable	Uncomplicated early pregnancy (n = 40)	Missed abortion (n = 35)	Partial hydatidiform mole (n = 32)	*p* value
Age (years)	29.9 ± 4.5	30.0 ± 5.5	29.3 ± 5.9	.86
Gestational age (weeks)	12 (6–13)[a]	10 (7–13)[b]	8.5 (5–13)[c]	**< .001**
NLR	2.92 (1.2–7.1)	3.01 (0.7–6.1)	2.65 (1.76–8.09)	.74
PLR	130.6 (63.1–210.9)	118.4 (66.4–266.4)	133.45 (67–272.7)	.29
MLR	0.24 (0.14–0.41)	0.22 (0.11–0.49)	0.26 (0.17–0.81)	.11
SII	746.93 (262.8–1672.5)	803.83 (153.3–1740.9)	790.07 (314.9–2427.3)	.85
SIRI	1.493 (0.6–3.8)	1.53 (0.4–4.6)	1.53 (0.9–7.3)	.68

Data are presented as mean ± SD or median (range). NLR = neutrophil-to-lymphocyte ratio; PLR = platelet-to-lymphocyte ratio; MLR = monocyte-to-lymphocyte ratio; SII = systemic immune-inflammation index; SIRI = systemic inflammatory response index. [a],[b],[c] Superscripts indicate significant pairwise differences (Bonferroni-corrected Mann–Whitney U test, p <.05).

SS-026

Diffuse Hepatic Infarction Complicating HELLP Syndrome: A Case Report

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INTRODUCTION: HELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelet count) is a severe complication of preeclampsia and an important cause of maternal morbidity and mortality. Although hepatic involvement is relatively common in HELLP syndrome, severe complications such as subcapsular hematoma, hepatic rupture, and hepatic infarction are rare but potentially life-threatening. Diffuse hepatic infarction, in particular, is an extremely uncommon manifestation and may progress to acute liver failure requiring liver transplantation. The underlying pathophysiology is thought to involve microvascular thrombosis, endothelial injury, and impaired hepatic perfusion. Due to the rarity of this condition, the number of reported cases in the literature remains limited, and clinical outcomes are often associated with severe multiorgan dysfunction. Herein, we present a rare case of diffuse hepatic infarction associated with HELLP syndrome that was successfully managed with intensive supportive therapy without the need for liver transplantation.

CASE PRESENTATION: A 31-year-old woman, gravida 3 para 2, at 31 weeks of gestation, initially presented to an external center with hand swelling and was admitted with a preliminary diagnosis of preeclampsia. During follow-up, vaginal bleeding developed, raising suspicion for placental abruption. Due to breech presentation, an emergency cesarean section was performed, resulting in the delivery of a stillborn female infant weighing 1105 g. In the postoperative period, the patient developed hypotension and anuria, prompting an emergency laparotomy for suspected intra-abdominal bleeding; however, no active bleeding source was identified. The patient was subsequently referred to our tertiary care center with suspected HELLP syndrome requiring advanced management.

On admission, the patient was conscious and hemodynamically stable with a blood pressure of 155/104 mmHg. Laboratory investigations revealed severe hepatocellular injury (AST 4917 U/L, ALT 3220 U/L), thrombocytopenia (56×10^9/L), hemolytic anemia, and acute kidney injury (creatinine 4.51 mg/dL). Contrast-enhanced abdominal computed tomography demonstrated extensive hypodense areas involving approximately 50% of the hepatic parenchyma, consistent with diffuse hepatic infarction secondary to HELLP syndrome. During intensive care follow-up, the patient required hemodialysis for acute

renal failure. Broad-spectrum antibiotic therapy was initiated following the development of bacteremia, and supportive management included transfusion of blood products. A total of 15 units of erythrocyte suspension were administered during hospitalization, along with one session of apheresis. Although the patient was evaluated for liver transplantation due to the extent of hepatic injury, transplantation was not performed as hepatic encephalopathy did not develop and clinical stability was maintained. With intensive supportive care, the patient's clinical condition gradually improved, and she was discharged in stable condition after approximately six weeks of follow-up.

CONCLUSION: Diffuse hepatic infarction is a rare but life-threatening complication of HELLP syndrome. Early recognition, prompt imaging evaluation, and multidisciplinary intensive care management are crucial for improving maternal outcomes. This case highlights that even extensive hepatic infarction associated with HELLP syndrome may be successfully managed with aggressive supportive treatment without the need for liver transplantation.

Keywords: HELLP syndrome, hepatic infarction, acute kidney injury, intensive care, hemodialysis

hepatic infarction



hepatic infarction ct

SS-027

Acute stage IV rectal prolapse in the immediate postpartum period: a case report

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OBJECTIVE: Rectal prolapse is uncommon in women of reproductive age and is rarely reported as an acute complication immediately after vaginal delivery. We present a case of acute stage IV rectal prolapse occurring in the immediate postpartum period and emphasize the importance of early recognition and multidisciplinary management.

METHODS: A 36-year-old multiparous woman (gravida 5, para 5) who delivered at term was evaluated in the immediate postpartum period. Clinical presentation, physical examination findings, initial management, surgical approach, and short-term outcome were documented as a case report.

RESULTS: The patient delivered a healthy neonate via spontaneous vaginal delivery without instrumental assistance. The second stage of labor was not prolonged. Shortly after delivery, she reported severe perineal discomfort and a protruding mass from the anal region. Examination revealed an edematous, circumferential, full-thickness rectal prolapse protruding through the anal canal, consistent with stage IV rectal prolapse. There were no signs of ischemia or necrosis. Manual reduction was attempted but was unsuccessful. Urgent consultation with the general surgery team was obtained, and surgical management was planned due to the advanced, irreducible prolapse. A perineal proctosigmoidectomy (Altemeier procedure) was performed in the postpartum period. The postoperative course was uneventful, and the patient was discharged in stable condition.

CONCLUSION: Acute stage IV rectal prolapse immediately after vaginal delivery is a rare but serious postpartum complication. Even in the absence of a prolonged second stage, multiparity-related pelvic floor weakness may predispose patients to this condition. Prompt diagnosis and timely multidisciplinary management, including appropriate surgical intervention when reduction fails, are essential to prevent complications and optimize maternal outcomes.

Keywords: Rectal prolapse, Vaginal delivery, Postpartum complication, Multiparity,

Acute stage IV rectal prolapse



Acute stage IV rectal prolapse observed in the immediate postpartum period following spontaneous vaginal delivery, demonstrating circumferential full-thickness protrusion of the rectal wall through the anal canal.

SS-028

Covid-19 vaccination in pregnancy: a large cohort study reveals no increase in adverse maternal and fetal outcomes

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OBJECTIVE: To investigate the association between COVID-19 vaccination status and vaccine type with maternal and fetal complications in a large cohort of pregnant women.

METHODS: This retrospective cohort study included 1,196 pregnant women who delivered at a tertiary care center. Participants were categorized as unvaccinated (n=291) or vaccinated (n=905). The vaccinated group was further stratified into BioNTech (n=728), Sinovac (n=123), and mixed vaccination (n=54). Pregnancy outcomes analyzed included fetal growth restriction (FGR), preeclampsia, gestational diabetes mellitus (GDM), macrosomia, placenta previa, placenta accreta spectrum (PAS), low birth weight (LBW), very low birth weight (VLBW), gestational hypertension (GHT), fetal distress, oligohydramnios, polyhydramnios, intrauterine fetal death (IUFD), cholestasis, post-term pregnancy, premature rupture of membranes (PROM), and preterm PROM (PPROM). Categorical variables were compared using chi-square analysis, with $p<0.05$ considered statistically significant.

RESULTS: Among all evaluated outcomes, only GDM showed a statistically significant difference between vaccinated and unvaccinated groups, with higher rates observed in vaccinated women (4.31% vs 1.37%, p=0.017). No significant differences were identified for other maternal or fetal complications ($p>0.05$). Notably, lower rates of placenta previa, LBW, and fetal distress were observed in vaccinated women, suggesting a potential protective trend, although these did not reach statistical significance.

Subgroup analysis by vaccine type demonstrated differences in FGR (p=0.005), GDM (p=0.036), and preeclampsia (p=0.047). Higher FGR rates were observed in the Sinovac group, while GDM was more frequent in BioNTech and mixed vaccination groups. Preeclampsia rates were highest in the mixed vaccination group. However, these findings should be interpreted cautiously

due to limited sample sizes in certain subgroups.

CONCLUSION: In this large cohort, COVID-19 vaccination was not associated with an increased risk of adverse pregnancy outcomes and supports maternal–fetal safety while addressing vaccine hesitancy. Despite a higher rate of GDM among vaccinated women, no consistent detrimental effect was observed across major maternal and fetal complications. Importantly, the absence of increased rates of severe outcomes such as FGR, IUFD, or preeclampsia supports the safety of COVID-19 vaccination during pregnancy.

These findings provide clinically relevant evidence reinforcing the safety profile of COVID-19 vaccines in pregnancy and may help reduce vaccine hesitancy among expectant mothers.

Keywords: Covid-19 vaccine, maternal-fetal outcome, preeclampsia

SS-029

Late antenatal diagnosis of fetal goiter: A case report related to prenatal diagnosis and delivery management

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INTRODUCTION: Fetal goiter is a rare condition characterized by diffuse enlargement of the fetal thyroid gland and is reported in approximately 1 in 30,000–50,000 live births. It represents a clinical manifestation of fetal thyroid dysfunction and may be associated with hypothyroidism, hyperthyroidism, or euthyroidism. Fetal goiter may lead to serious complications such as polyhydramnios due to esophageal and tracheal compression, neck hyperextension, delivery dystocia, and neurodevelopmental sequelae if left untreated. Therefore, early antenatal diagnosis and appropriate management are of critical importance.

CASE PRESENTATION: A pregnant woman presented at 33 weeks and 4 days of gestation. Ultrasonographic examination revealed a well-circumscribed, hyperechogenic mass measuring approximately 3.5 × 3.3 cm in the cervical region of the fetus, surrounding the trachea. The lesion had bilobulated contours. Color Doppler examination demonstrated prominent peripheral vascularization with minimal internal vascularity, findings that were interpreted as suggestive of fetal goiter. Fetal magnetic resonance imaging supported the diagnosis by demonstrating a smooth-contoured soft tissue mass located in the thyroid bed, encircling the trachea anteriorly and laterally, with a maximal thickness of 18 mm.

Maternal history revealed that the patient had been diagnosed with hyperthyroidism during pregnancy and had been treated with propylthiouracil; however, the treatment had been discontinued at the 24th week of gestation. Delivery was performed by cesarean section at 36 weeks of gestation. Postnatally, levothyroxine therapy was initiated in the neonate, and no respiratory distress was observed. In the postpartum period, the mother developed marked hyperthyroidism, and methimazole therapy was initiated. Further investigations were performed with a preliminary diagnosis of Graves' disease.

DISCUSSION: Although the most common cause of fetal goiter is fetal hypothyroidism, maternal thyroid disorders and the use of antithyroid medications are among the important etiological factors. In maternal Graves' disease, thyroid-stimulating hormone (TSH) receptor antibodies that cross the placenta may affect fetal thyroid function. In addition, the transplacental passage

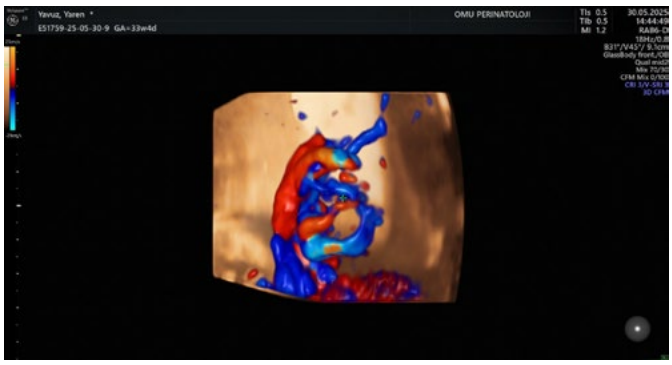
of antithyroid drugs may lead to fetal hypothyroidism. In the present case, both the possible presence of maternal thyroid-blocking antibodies and the use of antithyroid medication were considered potential contributors to the fetal condition.

On antenatal ultrasonography, a symmetric, homogeneous, bilobulated mass located in the anterior fetal neck is a key diagnostic feature. Doppler evaluation showing predominant peripheral vascularization is more commonly associated with hypothyroidism, whereas central vascularization may suggest hyperthyroidism. Although cordocentesis with assessment of fetal thyroid function is recommended for definitive diagnosis, it is not performed in every case due to its invasive nature. Therefore, the combined evaluation of maternal thyroid history, ultrasonographic findings, and Doppler characteristics plays an important role in the clinical decision-making process. In the present case, maternal hyperthyroidism and the use of antithyroid therapy were considered possible etiological factors contributing to the development of fetal goiter.

CONCLUSION: The antenatal recognition of fetal goiter is crucial for evaluating possible fetal thyroid dysfunction and planning appropriate perinatal management. Careful monitoring of maternal thyroid diseases and a multidisciplinary approach may contribute to improved perinatal outcomes in such cases.

Keywords: Fetal goiter, prenatal diagnosis, fetal thyroid dysfunction, maternal hyperthyroidism, prenatal ultrasonography

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SS-030

Association Between Maternal Body Mass Index at the Beginning of Pregnancy and Postterm Pregnancy

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OBJECTIVE: Postterm pregnancy (≥42 weeks) is an important obstetric condition associated with increased perinatal morbidity and mortality. The impact of maternal obesity on the timing of delivery has gained increasing attention in recent years. This study aimed to evaluate the association between maternal body mass index (BMI) at the beginning of pregnancy and the risk of postterm pregnancy.

MATERIALS AND METHODS: In this retrospective cohort study, a total of 180 singleton pregnancies with regular antenatal follow-up, who delivered at our hospital between January 2023 -2025, were included. Patients with BMI records obtained during the first trimester or at the first antenatal visit and with gestational age confirmed by first-trimester ultrasonography were enrolled. Multiple pregnancies, major fetal anomalies, and cases with incomplete data were excluded. Maternal BMI was categorized according to the World Health Organization (WHO) classification as normal (18.5–24.9 kg/m²), overweight (25.0–29.9 kg/m²), and obese (≥30 kg/m²). Patients were grouped according to gestational age at delivery as term (37+0–40+6 weeks), late-term (41+0–41+6 weeks), and postterm (≥42+0 weeks). The primary outcome was postterm pregnancy, and the secondary outcome was late-term pregnancy. Categorical variables were compared using the chi-square test. Independent risk factors for postterm pregnancy were evaluated using multivariable logistic regression analysis. Results were reported as odds ratios (OR) with 95% confidence intervals (CI).

RESULTS: The mean age of the 180 patients was 29.8 ± 5.4 years. The BMI distribution was 51.1% normal, 28.9% overweight, and 20.0% obese. Regarding pregnancy outcomes, 74.4% delivered at term, 17.2% at late-term, and 8.3% postterm. The rate of postterm pregnancy was 4.3% in the normal BMI group, 9.6% in the overweight group, and 16.7% in the obese group. The postterm pregnancy rate was significantly higher in the obese group ($p = 0.02$). In multivariable logistic regression analysis, obesity was identified as an independent risk factor for postterm pregnancy (OR: 2.8, 95% CI: 1.1–7.2, $p = 0.03$). Additionally, each 1 kg/m² increase in BMI was associated with an increased risk of postterm pregnancy (OR: 1.12, 95% CI: 1.02–1.24, $p = 0.01$).

CONCLUSION: A higher maternal BMI at the beginning of pregnancy is associated with an increased risk of postterm pregnancy and can be considered an independent risk factor. Therefore, closer monitoring and appropriate obstetric management strategies should be planned in obese pregnant women.

Keywords: Maternal BMI, postterm pregnancy, late-term pregnancy, obesity

SS-031

Evaluation of Agreement Between Spot Urine Protein-to-Creatinine Ratio and 24-Hour Urinary Protein Excretion in Pregnant Women Using Bland–Altman Analysis

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OBJECTIVE: Hypertensive disorders of pregnancy are major causes of maternal and fetal morbidity and mortality, and proteinuria is a key diagnostic criterion for preeclampsia. Although 24-hour urinary protein excretion is the standard method, it is time-consuming and limited by patient compliance. The spot urine protein-to-creatinine ratio (sPCR) has been proposed as a rapid and practical alternative; however, its agreement with 24-hour proteinuria remains controversial. This study aimed to evaluate the relationship and agreement between sPCR and 24-hour urinary protein excretion in pregnant women with suspected hypertensive disorders using Spearman correlation and Bland–Altman analysis.

METHODS: This cross-sectional observational study was conducted between April and June 2025 at Bursa City Hospital. A total of 100 third-trimester pregnant women with suspected preeclampsia or gestational hypertension were included. Spot urine samples and 24-hour urine collections were obtained simultaneously at admission. sPCR (mg/mg) and total protein excretion (mg/day) were measured. The relationship between methods was assessed using Spearman correlation (r_s), and agreement was evaluated with Bland–Altman analysis. Statistical analyses were performed using IBM SPSS Statistics 28, with $p < 0.05$ considered significant. Patients with chronic kidney disease, urinary tract infection, diabetic nephropathy, or other causes of proteinuria were excluded.

RESULTS: The mean maternal age was 30.8 ± 5.1 years, and the mean gestational age was 33.2 ± 2.4 weeks. The median sPCR was 0.47 mg/mg (IQR: 0.32–0.68), and the median 24-hour urinary protein excretion was 512 mg/day (IQR: 390–720). A strong positive correlation was observed between sPCR and 24-hour proteinuria ($r_s = 0.81$, $p < 0.001$). Bland–Altman analysis showed a mean difference (bias) of –486.2 mg, with 95% limits of agreement ranging from –690.3 to –282.1 mg. Although most values were within these limits, the relatively large differences indicate limited clinical agreement between the methods.

CONCLUSION: sPCR demonstrates a strong

correlation with 24-hour urinary protein excretion but shows significant bias and wide limits of agreement. Therefore, it cannot be considered fully interchangeable with the standard method, particularly near diagnostic thresholds. However, due to its practicality and rapid availability, sPCR may be useful as a first-line screening tool. It should be used as a complementary method, while 24-hour urine collection remains the preferred approach for definitive diagnosis.

Keywords: Preeclampsia, Proteinuria, Spot urine protein-to-creatinine ratio, Bland–Altman analysis

Figure 1: Bland–Altman Analizi

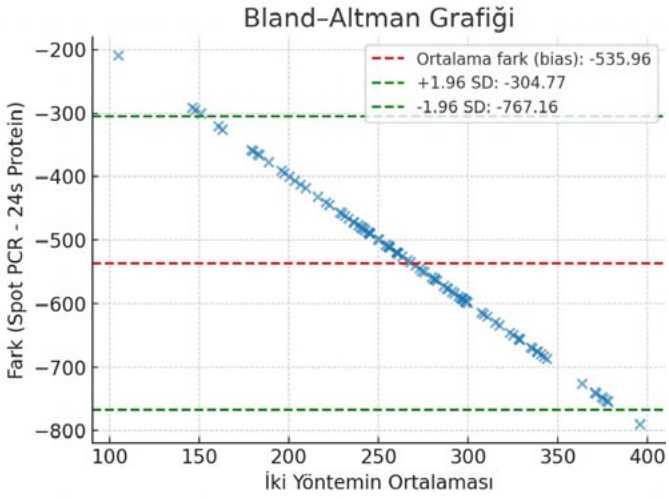


Table 1. Demographic and Laboratory Data

Variable	Value
Age (years)	30.8 ± 5.1
Gestational age (weeks)	33.2 ± 2.4
Spot urine protein-to-creatinine ratio (mg/mg)	0.47 (0.32–0.68)
24-hour urinary protein excretion (mg/day)	512 (390–720)
Spearman correlation coefficient (r_s)	0.81
p-value	< 0.001

Note: Continuous variables with normal distribution are presented as mean ± standard deviation, while non-normally distributed variables are presented as median (interquartile range, IQR). A statistically significant and strong positive correlation was observed between the spot urine protein-to-creatinine ratio and 24-hour urinary protein excretion (r_s = 0.81, $p < 0.001$).

SS-033

Endometriosis knowledge and awareness among young physicians

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OBJECTIVE: The aim of this study was to assess the awareness and experiences of young doctors regarding endometriosis, focusing particularly on available classification systems, imaging techniques, and the need for specific educational opportunities to improve clinical competence in the diagnostic process and intervention for endometriosis. Senior physicians were also invited to participate to gather experiential insights that may not yet be accessible to junior doctors.

DESIGN: This descriptive, observational study was carried out via an online survey delivered globally to young gynecologists between November 2024 and May 2025. The questionnaire consisted of 21 questions addressing the diagnosis, classification, and management of endometriosis. Multiple-answer questions were included. Associations between knowledge level, professional status, and continent of practice were evaluated.

RESULTS: A total of 186 participants from Europe, Asia, Africa, and the Americas were included. Most respondents were residents (39.7%) and young specialists within five years after residency (38.6%). It is important to note that awareness of core symptomatology, such as pelvic pain and fertility issues, was notably high, whereas recognition of urinary and systemic manifestations was substantially lower. Specific theoretical training in endometriosis during residency was reported by 27.3% (n = 50) of participants; however, only 8.1% (n = 15) had this training formally documented in their curriculum vitae. Attendance at a fellowship program dedicated to endometriosis was reported by only one participant (0.5%). The predominant rationale for seeking consultation with an endometriosis specialist arises from concerns about fertility or family planning (64.8%, n = 103). Two-thirds

of respondents (66.7%, n = 120) reported actively using at least one classification system, most commonly the rASRM. Knowledge levels, defined by recognition of ≥3 out of 4 core symptoms, differed significantly by continent of training (χ^2 test, p = 0.0044).

CONCLUSION: This study highlights persistent gaps in structured endometriosis education among young physicians worldwide. Despite reasonable awareness of common symptoms, deficiencies remain in comprehensive clinical knowledge and access to formal training pathways. Structured, evidence-based educational initiatives and the expansion of dedicated endometriosis units are essential to improve diagnostic accuracy, management strategies, and patient outcomes.

Keywords: Awareness, Endometriosis, Knowledge, Residency, Training

SS-034

Laparoscopic Low Anterior Resection and Natural Orifice Specimen Extraction (NOSE) Surgery in Deep Pelvic Endometriosis

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Laparoscopic Low Anterior Resection and Natural Orifice Specimen Extraction (NOSE) Surgery in Deep Pelvic Endometriosis

AIM: Deep pelvic endometriosis (DPE) is one of the most severe forms of endometriosis and is characterized by the infiltration of endometrial-like tissue more than 5 mm beneath the peritoneal surface. In cases involving the rectosigmoid colon, patients may present with symptoms such as pelvic pain, dyschezia, and bowel dysfunction. Surgical treatment becomes necessary when medical therapy is insufficient. In advanced cases with bowel involvement, segmental resection may be required. With the development of minimally invasive surgical techniques, the Natural Orifice Specimen Extraction (NOSE) method has emerged as an approach that eliminates the need for an abdominal specimen retrieval incision. This study aims to present a case of deep pelvic endometriosis with rectosigmoid involvement treated with laparoscopic low anterior resection combined with the Natural Orifice Specimen Extraction (NOSE) technique.

METHODS: A 38-year-old patient presenting with pelvic pain and bowel-related symptoms was evaluated and diagnosed with a left ovarian endometrioma and deep pelvic endometriosis. Preoperative assessment included pelvic magnetic resonance imaging (MRI) and transvaginal ultrasonography. MRI demonstrated a normal bladder wall thickness and lumen. The uterus was retroflexed, with cesarean scar changes and an isthmocele noted at the anterior corpus. Retention cysts were observed in the cervix, and thickening of the posterior myometrium was present. A 32 × 18 mm endometrioma was identified in the left ovary. Additionally, a plaque-like soft tissue density was observed between the left ovary, uterus, and rectum. Deep pelvic endometriosis infiltration was detected along the anterior rectal wall, extending approximately 35 mm in length, beginning about 10 cm proximal to the anal verge, with a maximum thickness of 6.5 mm. Diffusion-weighted imaging demonstrated diffusion restriction within the left ovarian endometrioma. Based on these findings, the patient was evaluated by a multidisciplinary team and surgical treatment was planned.

RESULTS: During laparoscopic exploration, a

cystic lesion consistent with an approximately 3 cm endometrioma was identified in the left ovary. Deep pelvic endometriosis infiltration involving the anterior rectal wall and extending approximately 3–4 cm with full-thickness bowel wall involvement was observed. The rectal mesentery was opened medially and mesorectal dissection was performed, allowing the rectum to be mobilized down to the pelvic floor. The resected specimen was extracted transanally using the Natural Orifice Specimen Extraction (NOSE) technique. Subsequently, a colorectal anastomosis was created by performing an end-to-end anastomosis between the proximal colon and distal rectum.

CONCLUSION: Laparoscopic low anterior resection is an effective surgical treatment option for deep pelvic endometriosis with rectosigmoid involvement. The Natural Orifice Specimen Extraction (NOSE) technique may reduce postoperative pain, wound-related complications, and the risk of incisional hernia by eliminating the need for an abdominal extraction incision. With appropriate patient selection and a multidisciplinary surgical approach, this technique appears to be a safe and feasible option.

Keywords: endometriosis, nose, low anterior resection

SS-035

Association Between Laparoscopic rASRM Stage and Irritable Bowel Syndrome in Women with Endometriosis: A Cross-Sectional Study

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BACKGROUND: Endometriosis and Irritable Bowel Syndrome (IBS) frequently coexist and share overlapping gastrointestinal and pain-related symptoms. While IBS is a functional disorder characterized by visceral hypersensitivity and dysregulation of the gut–brain axis, endometriosis is an inflammatory, estrogen-dependent condition associated with structural pelvic pathology. The relationship between anatomical disease severity, as defined by the Revised American Society for Reproductive Medicine (rASRM) classification, and IBS remains unclear. To evaluate the association between laparoscopically confirmed endometriosis severity (rASRM stage and score) and the presence and severity of IBS diagnosed according to Rome IV criteria.

METHODS: This cross-sectional study included reproductive-age women undergoing laparoscopy for suspected endometriosis. Endometriosis was confirmed intraoperatively and staged using the rASRM classification. Patients were further stratified into two groups: Stage I–II (minimal/mild) and Stage III–IV (moderate/severe). IBS diagnosis was established according to Rome IV criteria, and symptom severity was assessed using the IBS Severity Scoring System (IBS-SSS). Patients with known organic gastrointestinal diseases, including Crohn disease and Ulcerative colitis, were excluded. Statistical analyses included chi-square tests, Spearman's correlation, and multivariable logistic regression.

RESULTS: A total of 63 patients with laparoscopically confirmed endometriosis were included. IBS was diagnosed in 36.5 % of patients overall. When stratified by disease stage, IBS was present in 35% of patients with Stage I–II disease and 39 % of those with Stage III–IV disease, with no statistically significant difference between the groups ($p=0.68$). Furthermore, no significant correlation was observed between total rASRM score and IBS-SSS ($r=0.12$, $p=0.18$). In multivariable analysis, rASRM stage was not an independent predictor of IBS (adjusted OR 1.05, 95% CI 0.78–1.42). In contrast, higher pelvic pain scores and the presence of dyschezia were independently associated with IBS diagnosis ($p<0.05$).

CONCLUSION: IBS is highly prevalent among women with endometriosis; however, its presence and severity do

not correlate with laparoscopic disease stage as defined by rASRM. The absence of a stage-dependent relationship suggests that IBS symptoms in this population may be driven predominantly by functional and neuroimmune mechanisms rather than anatomical disease burden.

Keywords: ENDOMETRIOSIS, IRRITABLE BOWEL SYNDROME, PELVİC PAİN, rASRM CLASSIFICATION

SS-037

Non-palpable Nexplanon implant: successful localization with multimodal imaging after ultrasound failure

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OBJECTIVE: Subdermal contraceptive implants are among the most effective long-acting reversible contraceptive methods. In rare cases, the implant may become non-palpable due to deep insertion or migration, making localization difficult prior to removal. Accurate imaging is essential to prevent complications during extraction. Ultrasonography (USG) is usually the first-line imaging modality; however, in some cases the implant cannot be detected with USG. This report aims to present the localization and removal of an ultrasound-occult subdermal contraceptive implant (Nexplanon®, Organon) using multimodal imaging including radiography, magnetic resonance imaging (MRI), and fluoroscopy.

METHODS: A 36-year-old woman (gravida 1, parity 1, abortus 0) presented to the gynecology outpatient clinic with a complaint of spotting for nine months. She had a history of subdermal Nexplanon® (etonogestrel 68 mg implant; Organon) insertion in the left upper arm. Physical examination revealed that the implant was non-palpable at the expected insertion site. Serum beta-human chorionic gonadotropin (β-hCG) testing was negative. High-frequency superficial soft-tissue USG performed by the radiology department failed to visualize the implant. Plain radiography of the left upper arm was subsequently performed and demonstrated the implant due to the radiopaque barium sulfate contained in Nexplanon®. To further determine implant depth and its relationship to surrounding structures, non-contrast MRI of the left upper arm was obtained, demonstrating the implant located approximately 2 cm below the skin surface. Intraoperative fluoroscopy was used to confirm localization and guide removal.

3Plain radiography successfully visualized the Nexplanon® implant within the arm. MRI provided detailed information about the implant's anatomical location and its relationship to adjacent soft tissues and neurovascular structures. Based on imaging findings, the localization area was marked on the skin. The implant was successfully removed under local anesthesia through a small incision. Intraoperative fluoroscopy confirmed the implant position and assisted the procedure. The implant was retrieved intact without complications.

CONCLUSION: Non-palpable subdermal contraceptive implants require accurate localization prior to removal. Although USG is the first-line imaging modality, it may occasionally fail to identify the implant. In such cases, the radiopaque properties of Nexplanon® due to its barium sulfate content make plain radiography a useful diagnostic method. MRI can further delineate implant depth and its relationship to surrounding structures. A multimodal imaging approach including radiography, magnetic resonance imaging, and fluoroscopy can therefore represent an effective strategy for managing ultrasound-occult Nexplanon®

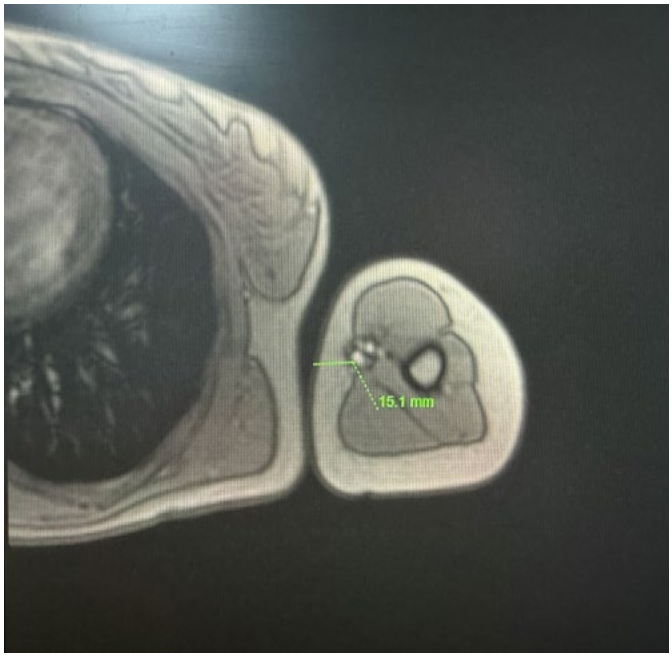
Keywords: Nexplanon, non-palpable implant, subdermal contraceptive implant, implant localization, magnetic resonance imaging, fluoroscopy

Figure 1.



Plain radiography of the left upper arm demonstrating the radiopaque Nexplanon® implant within the soft tissue.

Figure 2.



MRI (implant depth ~2 cm)

Figure 3.



Sequential intraoperative images demonstrating the surgical removal of the non-palpable Nexplanon® implant through a small incision.

SS-038

When Implantation Is Enough: Subcutaneous Endometriosis After Cesarean Section Without Prior Disease

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OBJECTIVE: Cesarean scar endometriosis is a rare form of extraperitoneal endometriosis located along a surgical incision in the abdominal wall and is usually associated with prior obstetric surgery. However, isolated scar lesions occurring in patients without a previous history of pelvic endometriosis or endometrioma have been discussed only to a limited extent in the literature. The aim of this case report is to present an isolated cesarean scar endometriosis in a patient with no known history of endometriosis and to evaluate whether implantation may represent a sufficient pathogenic mechanism in selected phenotypes.

CASE: A 32-year-old woman, gravida 2 para 1, had no surgical history other than a previous cesarean section. She had no known history of pelvic endometriosis or endometrioma. At the beginning of her pregnancy, she reported recurrent swelling and pain at the right lateral corner of her previous cesarean incision during each menstrual period. On physical examination, a firm, poorly mobile nodular lesion measuring approximately 3–4 cm was palpated at the right corner of the scar. During pregnancy, partial regression in the size of the mass and a decrease in pain intensity were observed. At 38 weeks of gestation, an elective cesarean section was performed, and a 3020-gram live male infant in cephalic presentation was delivered. Intraoperatively, a nodular mass was identified in the subcutaneous tissue adjacent to the fascial edge of the previous incision. The lesion was completely excised by careful dissection from the fascia without creating a fascial defect. (Figure 1, Figure 2). Histopathological evaluation confirmed endometriosis. No recurrence or symptom relapse was observed during one year of follow-up.

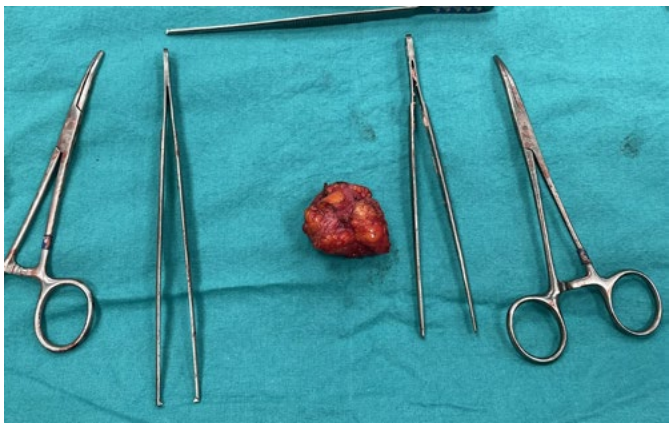
CONCLUSION: This case provides important clinical insight into the pathogenesis of cesarean scar endometriosis. Although endometriosis is generally considered a multifactorial disease, not all phenotypes can be explained by a single mechanism. While retrograde menstruation is often proposed for pelvic disease, the presence of a lesion strictly confined to a surgical scar strongly supports the implantation mechanism.The isolated subcutaneous location and confinement of the lesion to the fascial edge of the surgical incision make systemic dissemination or metaplasia less likely and favor local cellular transfer. The implantation of viable endometrial cells into the abdominal wall during surgery, followed by their survival, proliferation, and hormonal responsiveness within a suitable microenvironment, appears sufficient to explain this phenotype. The regression in lesion size and symptom relief during pregnancy further suggest that the ectopic tissue remained hormonally responsive and functionally active. These findings indicate that the implanted cells were not passive remnants but biologically active tissue capable of adapting to hormonal changes. Cesarean scar endometriosis should be considered in the differential diagnosis of cyclic painful masses at surgical scar sites. Complete surgical excision is both diagnostic and generally curative. In conclusion, this case suggests that implantation may not merely contribute to disease development but may, in selected extraperitoneal phenotypes, represent a sufficient pathogenic pathway on its own. Cesarean scar endometriosis serves as a clinical model underscoring the need to consider implantation as an independent initiating event in specific phenotypes.

Keywords: Cesarean scar, Endometriosis, Pathogenesis, Subcutaneous endometriosis, Surgical implantation

Figure 1



Figure 2



SS-039

Preoperative inflammatory indices, CA-125 levels and cyst size in endometrioma patients: A cross-sectional analysis

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OBJECTIVE: Endometriosis is a chronic inflammatory disease affecting reproductive-aged women and represents one of the leading causes of infertility and pelvic pain. While CA-125 remains the most widely used biomarker in the evaluation of endometrioma, hematological indices reflecting systemic inflammation have recently gained attention as potential indicators of disease pathogenesis. In particular, the neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), systemic immune-inflammation index (SII), systemic inflammation response index (SIRI), and pan-immune-inflammation value (PIV) have emerged as readily accessible markers of systemic inflammation. This study aimed to evaluate the relationship between preoperative inflammatory parameters, CA-125 levels, and cyst size in patients who underwent surgery for endometrioma.

METHODS: This cross-sectional study included 68 patients who underwent surgical intervention for endometrioma. Patients were categorized into two groups based on endometriotic cyst diameter: Group 1 (<5 cm, n=29) and Group 2 (>5 cm, n=39). Preoperative complete blood count parameters were used to calculate NLR, PLR, SII, SIRI, and PIV. CA-125 levels and cyst dimensions were recorded from preoperative assessments. Normality of distribution was assessed using the Shapiro-Wilk test. Group comparisons were performed using the Mann-Whitney U test. Statistical significance was accepted as $p<0.05$.

RESULTS: The median age was significantly higher in the <5 cm group compared to the >5 cm group (35.0 vs. 31.0 years; p=0.001). Gravidity and parity were also significantly greater in the smaller cyst group (p=0.004 and p=0.007, respectively). CA-125 levels were significantly elevated in patients with cysts >5 cm compared to those with cysts <5 cm (median 71.0 vs. 51.0 U/mL; p=0.018). In contrast, none of the composite inflammatory indices (NLR, PLR, SII, SIRI, PIV) demonstrated a statistically significant difference between the two groups (all p>0.05).

CONCLUSION: Although CA-125 levels were significantly associated with endometrioma size, preoperative hematological inflammatory indices including NLR, PLR, SII, SIRI, and PIV did not significantly differ according to cyst diameter. These findings suggest that systemic inflammatory burden, as reflected by routine hematological parameters, may not be a reliable predictor of endometrioma size. Further studies with larger cohorts and longitudinal designs are warranted to clarify the role of inflammatory indices in the clinical assessment of endometrioma.

Keywords: endometrioma, systemic immune-inflammation index (SII), systemic inflammation response index (SIRI), ca 125

Table 1. Comparison of clinical and laboratory parameters according to endometrioma size

Variable	Cyst <5 cm (n=29) Median (IQR)	Cyst >5 cm (n=39) Median (IQR)	p value
Age (years)	35.0 (29.0–43.0)	31.0 (26.0–36.0)	0.001
Gravidity	1.0 (0.0–2.0)	0.0 (0.0–1.0)	0.004
Parity	1.0 (0.0–2.0)	0.0 (0.0–1.0)	0.007
CA-125 (U/mL)	51.0 (20.0–66.0)	71.0 (39.5–122.5)	0.018
NLR	2.30 (1.83–2.85)	2.15 (1.66–2.70)	0.375
PLR	148.95 (121.74–182.19)	155.26 (133.51–180.28)	0.715
SII	673.86 (476.73–831.48)	723.98 (482.57–942.29)	0.417
SIRI	1.03 (0.91–1.52)	1.03 (0.72–1.69)	0.523
PIV	322.89 (228.83–450.34)	318.55 (199.92–627.09)	0.651

SS-042

Primary amenorrhea and dyspareunia in a patient with Mayer–Rokitansky–Küster–Hauser syndrome: a case report

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INTRODUCTION: Mayer–Rokitansky–Küster–Hauser (MRKH) syndrome is a rare congenital anomaly characterized by agenesis or severe hypoplasia of the uterus and the upper two-thirds of the vagina in individuals with normal secondary sexual characteristics and a normal 46,XX karyotype. It is the second most common cause of primary amenorrhea after gonadal dysgenesis and occurs in approximately 1 in 4,500–5,000 female births. Patients usually present during adolescence with primary amenorrhea despite normal pubertal development. Imaging plays a crucial role in confirming the diagnosis and identifying associated anomalies. We present a case of MRKH syndrome diagnosed in a patient presenting with primary amenorrhea and dyspareunia.

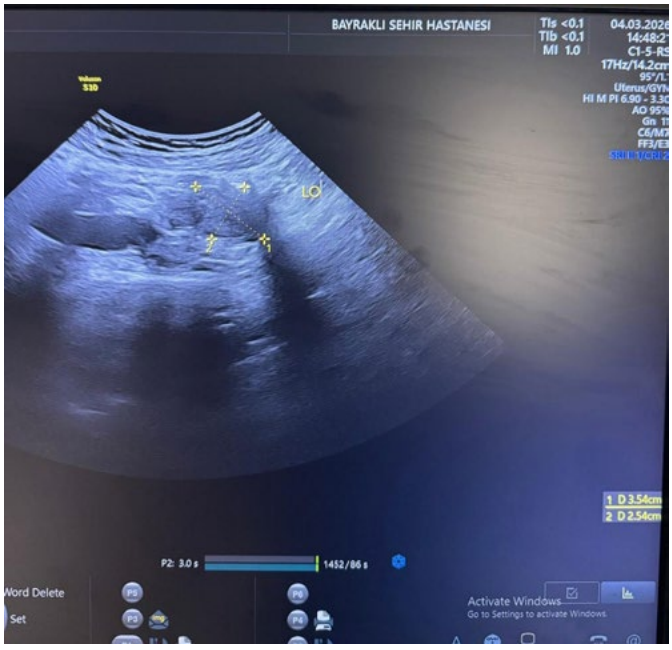
CASE: A 19-year-old woman presented to the gynecology clinic with primary amenorrhea and dyspareunia. Her medical history was unremarkable except for familial consanguinity. Genetic evaluation demonstrated a normal 46,XX karyotype with normal Fragile X analysis. Physical examination revealed normal secondary sexual characteristics and normally developed external genitalia. The vaginal canal was short and ended in a blind pouch with an estimated length of approximately 6 cm. Transabdominal ultrasonography did not visualize the uterus. Both ovaries appeared normal in morphology; the right ovary measured 37 × 24 mm and the left ovary 35 × 25 mm, each containing multiple follicles. Representative ultrasound images of the ovaries are shown in Figures 1 and 2. Hormonal evaluation showed FSH 5.73 IU/L, LH 6.47 IU/L, estradiol 52.8 pg/mL, AMH 1.92 ng/mL, and prolactin 25 ng/mL. Pelvic magnetic resonance imaging confirmed complete uterine agenesis and absence of the vaginal canal. Coronal and sagittal MRI sections are presented in Figures 3 and 4. Both ovaries were normal in size and signal intensity.

DISCUSSION: MRKH syndrome should be considered in adolescents presenting with primary amenorrhea despite normal secondary sexual development and normal hormonal profiles. Diagnosis is established through clinical examination and imaging studies, particularly ultrasonography and MRI, which confirm uterine agenesis and evaluate pelvic structures.

CONCLUSION: Early recognition of MRKH syndrome is important for appropriate counseling regarding sexual function, reproductive options, and psychological support. A multidisciplinary approach involving gynecologists, radiologists, and mental health professionals is essential for optimal management.

Keywords: congenital Müllerian anomaly, dyspareunia, Mayer–Rokitansky–Küster–Hauser syndrome, primary amenorrhea, uterine agenesis

Figure 1



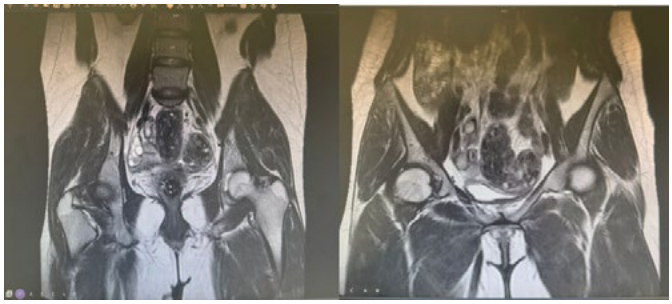
Transabdominal ultrasound image of the left ovary showing normal morphology with multiple follicles.

Figure 2



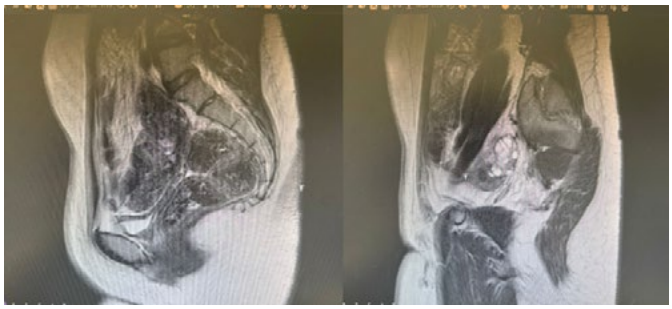
Transabdominal ultrasound image of the right ovary showing normal morphology with multiple follicles.

Figure 3



Coronal pelvic magnetic resonance imaging (MRI) demonstrating uterine agenesis.

Figure 4



Sagittal pelvic MRI confirming absence of the uterus and upper vaginal canal.

SS-044

Parity as an independent predictor of pregnancy intention: Evidence for a decline in intended pregnancy after the second birth

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BACKGROUND: Unintended pregnancy remains a significant public health concern worldwide and is associated with adverse maternal, neonatal, and psychosocial outcomes. Although contraceptive access and education have improved in many settings, reproductive history and family size dynamics may play a crucial role in shaping pregnancy intention. Identifying clinical and demographic predictors of unintended pregnancy is essential for developing targeted preventive strategies. This study aimed to evaluate factors associated with pregnancy intention and to determine the parity threshold at which the likelihood of intended pregnancy decreases.

METHODS: This cross-sectional analytical study included 240 non-pregnant women who were assessed regarding sociodemographic characteristics, reproductive history, contraceptive practices, and pregnancy intention status. Pregnancy intention was classified as intended or unintended based on self-reported responses. Continuous variables were analyzed for normality and presented as mean ± standard deviation, while categorical variables were expressed as frequencies and percentages. Comparisons between intended and unintended pregnancy groups were performed using Chi-square tests and independent samples t-tests or Mann–Whitney U tests as appropriate. Variables that were clinically relevant or statistically significant in univariate analyses were entered into a multivariate binary logistic regression model to identify independent predictors of pregnancy intention. Additionally, receiver operating characteristic (ROC) curve analysis was conducted to determine the parity threshold associated with reduced likelihood of intended pregnancy.

RESULTS: The mean maternal age of participants was 29.08 ± 5.33 years. Intended pregnancies accounted for 77.5% of cases, while 22.5% were reported as unintended. Women with unintended pregnancy were significantly older than those with intended pregnancy (30.76 ± 5.73 vs. 28.59 ± 5.12 years, $p = 0.008$). Reproductive history indicators were also higher among women with unintended pregnancy, with significantly greater gravida (2.81 ± 1.47 vs. 2.17 ± 1.30, $p = 0.002$) and parity (1.57 ± 1.16 vs. 0.88 ± 0.92, $p < 0.001$). In multivariate analysis, multiparity emerged as an independent predictor of pregnancy intention status. Multiparous women had significantly lower odds of reporting their pregnancy as

intended compared with nulliparous women (OR = 0.389, 95% CI: 0.170–0.890, p = 0.025), whereas maternal age showed a non-significant trend. The type of contraceptive method used prior to pregnancy was not independently associated with pregnancy intention. ROC curve analysis demonstrated moderate discriminatory ability of parity for predicting intended pregnancy (AUC = 0.678). The optimal cut-off value was identified as parity ≥2, yielding a sensitivity of 48.1% and a specificity of 79.0%.

CONCLUSION: These findings suggest that increasing parity is associated with a reduced likelihood of intended pregnancy, with the probability of intended conception declining notably after the second birth. Reproductive experience appears to be a stronger determinant of pregnancy intention than contraceptive behavior in this population. Identifying women with higher parity as a priority group for targeted contraceptive counseling and family planning interventions may help reduce unintended pregnancy rates. Future studies should explore psychosocial, cultural, and health system factors influencing pregnancy intention to inform more effective reproductive health strategies.

Keywords: Unintended pregnancy, parity, reproductive history, family planning, contraceptive use

Comparisons between intended and unintended pregnancy groups

Variable	Intended pregnancy (n=186)	Unintended pregnancy (n=54)	p-value
Age	28,59±5,118	30,76±5,733	0,008
Gravida	2,17±1,304	2,81±1,468	0,002
Parity	0,88±0,922	1,57±1,159	<0,001

The mean age of women with unintended pregnancy was significantly higher compared to those with intended pregnancy (30.76 ± 5.73 vs. 28.59 ± 5.12 years, p = 0.008). Similarly, gravida and parity were significantly greater in the unintended pregnancy group (gravida: 2.81 ± 1.47 vs. 2.17 ± 1.30, p = 0.002; parity: 1.57 ± 1.16 vs. 0.88 ± 0.92, p < 0.001).

SS-045

Multidisciplinary Surgical Approach for Comprehensive Endometriosis Management

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OBJECTIVE: To demonstrate a comprehensive laparoscopic surgical approach for the management of deep infiltrating endometriosis involving the ovary and rectosigmoid colon. The video highlights a multidisciplinary strategy addressing complex pelvic disease through multiple procedures performed for a single therapeutic objective. Special emphasis is placed on ovarian endometrioma management using ablation rather than cystectomy in order to preserve ovarian reserve while achieving effective disease control.

SETTING: The procedure was performed in a tertiary referral center specializing in advanced minimally invasive gynecologic surgery and endometriosis management. The surgery was conducted in a fully equipped laparoscopic operating room with a multidisciplinary surgical team including gynecologic and colorectal surgical expertise.

PARTICIPANTS: The participant is a reproductive-age woman diagnosed with advanced deep infiltrating endometriosis presenting with severe pelvic adhesions, ovarian endometrioma, and rectosigmoid colon involvement. Preoperative imaging and clinical findings suggested bowel infiltration and dense adhesions between pelvic organs, necessitating a combined gynecologic and colorectal surgical approach.

INTERVENTIONS: The video demonstrates step-by-step laparoscopic management of advanced endometriosis. Surgical steps include retroperitoneal dissection and ureterolysis to safely identify and protect the ureter, adhesiolysis with separation of bowel adhesions from the uterus, and management of ovarian endometrioma using ablative techniques rather than cystectomy to minimize ovarian tissue damage. In addition, endometriotic involvement of the rectosigmoid colon required a laparoscopic low anterior resection followed by colorectal anastomosis. The procedure illustrates the integration of multiple surgical techniques—including pelvic dissection, ovarian endometrioma ablation, bowel resection, and restoration of intestinal continuity—within a single minimally invasive operation.

CONCLUSION: Advanced laparoscopic surgery allows effective treatment of deep infiltrating endometriosis involving both pelvic organs and the bowel. A

multidisciplinary approach enables safe performance of complex procedures such as ureterolysis, ovarian endometrioma ablation, and colorectal resection within the same operation. Ovarian endometrioma ablation may represent a fertility-preserving alternative to cystectomy in selected patients. This video highlights how multiple coordinated surgical steps can achieve comprehensive disease management while maintaining minimally invasive principles and preserving reproductive potential when possible.

Keywords: Deep infiltrating endometriosis (DIE),,Endometrioma, Fertility, Minimally invasive surgery, Colorectal endometriosis

SS-046

Multidisciplinary laparoscopic management of deep infiltrating endometriosis with rectosigmoid involvement

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OBJECTIVE: We aim to present the surgical steps and clinical feasibility of laparoscopic full-thickness discoid resection for rectosigmoid endometriosis, emphasizing a fertility-sparing approach in a patient with recurrent IVF failures and complex deep infiltrating endometriosis.

SETTING: This surgical video was recorded at a tertiary referral center specializing in minimally invasive gynecologic surgery and advanced endometriosis management.

PARTICIPANTS: A 34-year-old patient with chronic pelvic pain and a history of six failed IVF cycles was diagnosed with severe DIE. Laparoscopy revealed a frozen pelvis with a large endometriotic nodule infiltrating the rectosigmoid and the posterior vaginal wall, causing complete obliteration of the Pouch of Douglas.

INTERVENTIONS: Diagnostic laparoscopy revealed a 'frozen pelvis' with extensive adhesions and a large bowel-associated conglomerate mass obliterating the Pouch of Douglas. Following bilateral retroperitoneal dissection and detailed ureterolysis to ensure surgical safety, a left salpingectomy was performed due to the presence of hydrosalpinx, aiming to optimize the environment for future IVF success. Subsequently, the rectum was meticulously mobilized from the posterior uterine wall. A posterior fornix resection and bilateral sacrouterine ligament excision were performed to achieve complete macroscopic excision of all deep infiltrating lesions. For the rectal involvement, a full-thickness discoid resection of the 1-cm nodule was executed. The rectal defect was repaired using an intracorporeal manual with two layer suturing technique. The integrity of the repair was confirmed with negative air-leak test. Finally, right-sided tubal patency was successfully confirmed via chromopertubation.

CONCLUSION: This case demonstrates that laparoscopic discoid resection is an effective, fertility-sparing alternative to segmental resection for localized bowel endometriosis. Complete excision of DIE nodules, even in complex cases with a frozen pelvis, can be

safely performed to improve both quality of life and future reproductive outcomes when meticulous surgical techniques are employed.

Keywords: Deep infiltrating endometriosis, discoid resection, laparoscopy, rectosigmoid endometriosis, recurrent IVF failure

SS-047

A comparison of two minimally invasive techniques for complete pelvic lymphadenectomy: vNOTES versus conventional laparoscopy—insights from a single-surgeon experience

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AIM: To compare and assess the outcomes of bilateral complete pelvic lymph node dissection performed via multiport conventional laparoscopy (MCL) versus Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) for surgical staging in endometrial cancer patients with failed sentinel lymph node (SLN) mapping.

METHOD: This retrospective cohort study analyzed 42 patients diagnosed with grade I or II endometrioid endometrial cancer who underwent hysterectomy with bilateral salpingo-oophorectomy, followed by comprehensive retroperitoneal pelvic lymphadenectomy after failed bilateral SLN mapping via vNOTES (n=21) or MCL (n=21). Demographic characteristics, operative times, perioperative and postoperative complications, pain scores, and Quality of Recovery-15 (QoR-15) scores were recorded and compared between the groups.

RESULTS: Both groups showed similar demographic and clinical characteristics, with no statistically significant differences identified. The vNOTES group had a significantly longer operative time (53.8 ± 7.4 minutes) compared to the MCL group (46.9 ± 9.2 minutes; P=0.01). However, no significant differences were found in blood loss (17.7 ± 5.6 mL vs. 18.8 ± 5.0 mL; P=0.50) or the number of retrieved lymph nodes (32.1 ± 6.6 vs. 35.0 ± 8.1; P=0.21). Postoperative VAS scores were consistently lower for vNOTES at 6 hours (4.3 ± 1.1 vs. 5.5 ± 1.0; P=0.01), 12 hours (3.5 ± 0.8 vs. 4.8 ± 1.1; P <0.001), and 24 hours (2.1 ± 0.6 vs. 3.1 ± 0.9; P<0.001). FPS-R scores corroborated these findings, showing significantly reduced pain for vNOTES at 6 hours (P=0.002), 12 hours (P<0.001), and 24 hours (P=0.04). Additionally, the vNOTES group showed higher QoR-15 scores 48 hours post-surgery (109.33 ± 4.7 vs. 104.90 ± 4.1; P=0.002).

CONCLUSION: vNOTES complete lymphadenectomy provides a clinically significant blend of minimized postoperative pain, scar-free surgery, and improved recovery quality, all while ensuring oncologic effectiveness comparable to MCL.

Keywords: Vaginal Natural Orifice Transluminal Endoscopic Surgery, multiport conventional laparoscopy, complete pelvic lymph node dissection

SS-048

Total Vaginal Natural Orifice Transendoscopic Hysterectomy versus Single-Incision Laparoscopic Hysterectomy in Patients with a Narrow Pubic Arch

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BACKGROUND: Total vaginal natural orifice transendoscopic hysterectomy (TVNH) is a procedure conducted entirely through an endoscopic approach via the vagina, where every surgical step, including the colpotomy, is performed endoscopically. This technique is particularly suitable for patients who have not undergone vaginal childbirth, have a long and narrow vagina, lack uterine prolapse, or have a history of cervical conization, conditions in which exposure of the cervix through open vaginal surgery may be technically challenging.

AIM: To compare the intraoperative and postoperative outcomes of TVNH and single-incision laparoscopic hysterectomy (SILH) in patients with a narrow pubic arch.

METHOD: This observational retrospective study was conducted between January 2023 and September 2025. Patients with a narrow pubic arch (subpubic arch angle ≤ 100°) who were nulliparous or multiparous without a history of vaginal delivery, had limited vaginal space, absence of uterine descent, a uterine volume < 150 cm^3, and who underwent TVNH or SILH were included in the study.Demographic characteristics, operative times, peripost operative complications, pain scores, and Quality of Recovery-15 (QoR-15) were recorded and compared between the groups.

RESULTS: Among patients scheduled for hysterectomy with a narrow pubic arch, 30 patients (65.2%) underwent the SILH procedure, while 16 patients (34.8%) underwent the TVNH procedure. Hysterectomy combined with oophorectomy was performed in 25 patients (83.3%) in the SILH group and in 13 patients (81.3%) in the TVNH group. The operative duration was significantly longer in the TVNH group compared to the SILH group (83.1 ± 13.7 vs. 74.5 ± 12.3 minutes; P = 0.036). No major intraoperative complications were observed in either group. The mean VAS score at the 6th postoperative hour was significantly lower in the TVNH group than in the SILH group (5.0 ± 1.0 vs. 5.9 ± 1.5; P = 0.044). Similarly, at the 24th postoperative hour, the VAS score remained significantly lower in the TVNH group compared with

the SILH group (1.5 ± 0.7 vs. 2.1 ± 0.7; P = 0.020). FPS-R scores were also significantly lower in the TVNH group. At 48 hours postoperatively, the QoR-15 score was higher in the TVNH group.

CONCLUSION: Despite a relatively longer operative time in patients with a narrow pubic arch, TVNH provides several advantages, including reduced postoperative pain, improved cosmetic outcomes, enhanced quality of recovery, and no increase in complication rates.

Keywords: Hysterectomy, single-incision laparoscopic surgery, vaginal natural orifice transendoscopic surgery, narrow pubic arch.

SS-050

A rare mimic of pelvic organ prolapse: paraurethral cyst in a postmenopausal woman

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A rare mimic of pelvic organ prolapse: paraurethral cyst in a postmenopausal woman

OBJECTIVE: Paraurethral cysts are rare benign periurethral lesions and are often asymptomatic. When symptomatic, they may present with vaginal fullness, dyspareunia, or lower urinary tract symptoms. In postmenopausal women, these lesions may clinically mimic pelvic organ prolapse and may lead to misdiagnosis and unnecessary surgical interventions. In this study, we aimed to present a case that was initially suspected as pelvic organ prolapse but was subsequently diagnosed as a paraurethral cyst following detailed evaluation, emphasizing the importance of differential diagnosis.

METHODS: A 61-year-old postmenopausal, multiparous woman presented with complaints of a palpable vaginal mass and dyspareunia. Based on the initial clinical evaluation, uterine descent, cystocele, or rectocele were considered as preliminary diagnoses. However, detailed pelvic examination revealed no evidence of pelvic organ prolapse. Instead, a well-circumscribed, fluctuant cystic lesion approximately 2 cm in diameter was identified inferior to the urethra. Transvaginal ultrasonography showed no pathology in the uterus or adnexa. Ultrasonographic evaluation of the perineal region demonstrated a well-defined, anechoic cystic lesion measuring 20 × 18 mm located beneath the urethra on the anterior vaginal wall. No communication with the urethral lumen was observed.

The patient had no history of postvoid dribbling, urinary incontinence, or recurrent urinary tract infections. Due to the absence of urethral communication on imaging and lack of clinical findings suggestive of urethral diverticulum, diverticulum was not considered the leading diagnosis, and further imaging was not planned. The lesion was completely excised under local anesthesia and sent for histopathological examination.

RESULTS: The surgical procedure was completed without intraoperative or postoperative complications. Intraoperatively, absence of communication between the lesion and the urethra was confirmed. No postoperative urinary retention, infection, or incontinence occurred. The patient's dyspareunia and palpable vaginal mass resolved completely during follow-up.

Histopathological examination revealed a cystic lesion

predominantly lined by columnar epithelium with focal squamous metaplasia and a fibromuscular wall. These findings confirmed the diagnosis of a paraurethral cyst.

CONCLUSION: Paraurethral cysts may clinically mimic pelvic organ prolapse in postmenopausal women. Although they are usually solitary, small, and asymptomatic, enlargement may lead to vaginal fullness, dyspareunia, and lower urinary tract symptoms. These lesions can resemble other pelvic pathologies and may be misdiagnosed as cystocele.

Careful evaluation of clinical symptoms and demonstration of the absence of urethral communication on ultrasonography are crucial in the differential diagnosis. Urethral diverticulum is the most common cause of periurethral masses, whereas paraurethral cysts are less frequent. This case highlights that a vaginal bulging sensation in postmenopausal women does not always indicate pelvic organ prolapse. In appropriately selected patients, complete surgical excision without the need for advanced imaging can be both diagnostic and curative.

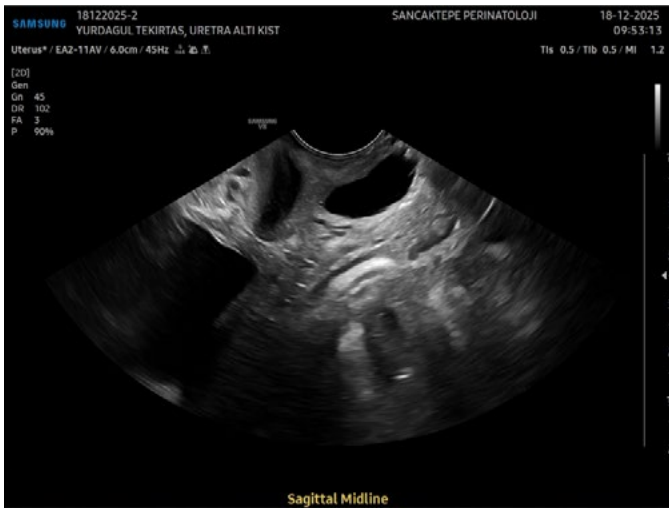
Keywords: Differential diagnosis, Paraurethral cyst, Pelvic organ prolapse, Periurethral mass, Urethral diverticulum

Preoperative view of paraurethral cyst located on the anterior vaginal wall



Preoperative appearance of the paraurethral cyst

Transvaginal ultrasonographic image of paraurethral cyst



Sagittal transvaginal ultrasonographic view showing a well-defined, anechoic cystic lesion measuring 20 × 18 mm located inferior to the urethra on the anterior vaginal wall, without communication with the urethral lumen.

SS-051

Comparison of the Effectiveness of Periurethral Ligament Plication and Tension-free Obturator Tape Method in Stress Urinary Incontinence

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BACKGROUND/ AIM: Stress urinary incontinence (SUI) is a common pelvic floor disorder characterized by involuntary urine leakage during activities that increase intra-abdominal pressure such as coughing, sneezing, or physical exertion. It significantly impairs quality of life and leads to social and psychological distress. Midurethral sling procedures, particularly the tension-free obturator tape (TOT) method, are currently considered the gold standard surgical treatment for SUI.. The aim of this study was to compare the effectiveness, complication rates, and patient satisfaction of periurethral ligament plication and the TOT method in the surgical treatment of stress urinary incontinence.

METHODS: This study included patients diagnosed with stress urinary incontinence who underwent surgical treatment. The patients were divided into two groups: PUL and TOT. Operative time, length of hospital stay, and perioperative complications were recorded. The mean follow-up period was 3,6 months.

RESULTS: In intergroup analysis, FSFI scores were found to be significantly higher in the PUL group at 3 and 6 months postoperatively. At six months, an increase of approximately 31% in sexual function scores was observed in the PUL group, while this increase remained at approximately 6% in the TOT group. This indicates that the PUL method is more advantageous in terms of sexual function. When evaluated in terms of urinary incontinence severity, the TOT group had higher ICIQ-SF scores and greater symptom severity in the preoperative period. However, a significant improvement of approximately 78–83% was achieved in both groups in the postoperative period, and no significant difference was observed between the groups at 3 and 6 months postoperatively. These findings demonstrate that both surgical methods are similarly effective in the treatment of incontinence.

DISCUSSION: This findings suggest that the TOT procedure provides higher objective and subjective success rates in the treatment of stress urinary incontinence. However, potential mesh-related complications must be considered.

CONCLUSION: In conclusion, surgical approaches to treating stress urinary incontinence should not be uniform. It is crucial to create an individualized treatment plan considering patient age, comorbidities, anatomical features, previous surgical history, risk of complications, and patient expectations. Correct patient selection and appropriate surgical technique choice are fundamental factors in increasing treatment success. Future studies with larger sample sizes and long-term results will more clearly reveal the efficacy and safety profiles of different surgical methods.

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Keywords: Stress urinary incontinence,Tension-free obturator tape,Periurethral ligament plication, Midurethral sling

SS-052

When Insufflation Is Not an Option: Redefining Pelvic Access Through a Natural Orifice Endoscopic Approach

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INTRODUCTION: Minimally invasive pelvic surgery has been largely built upon pneumoperitoneum. However, increased intra-abdominal pressure may represent a cardiopulmonary limitation in selected patients. In such circumstances, the question arises whether pelvic access can be achieved through alternative strategies. This case presents a pelvic surgical procedure performed without abdominal insufflation, utilizing a natural orifice approach in a patient for whom pneumoperitoneum was contraindicated.

CASE: A 36-year-old woman, G2P2, presented requesting definitive surgical contraception. She had previously used combined oral contraceptives and an intrauterine device but discontinued both due to adverse effects. For the past year, she had relied on injectable contraception, again reporting significant systemic side effects.

Her medical history was notable for a thoracic gunshot injury 13 years earlier, requiring cardiovascular surgery. A previously planned laparoscopic procedure had been canceled because pneumoperitoneum was considered potentially harmful. Therefore, techniques involving increased intra-abdominal pressure were avoided. The patient was operated in the lithotomy position. Posterior colpotomy was performed to enter the peritoneal cavity. The uterus was brought into anteversion using a uterine manipulator. Without establishing pneumoperitoneum, a 5-mm optic and slender endoscopic instruments were introduced through the posterior colpotomy. Trendelenburg positioning allowed bowel loops to shift cranially, and uterine anteversion facilitated direct visualization of the ovaries and fallopian tubes.

Both tubes were identified, and the procedure was completed through the posterior colpotomy incision by transection and secure ligation. Total operative time was 20 minutes. No intraoperative bleeding occurred. Postoperatively, the patient reported no pain and required minimal analgesia. She was discharged uneventfully at the 8th postoperative hour. Follow-up at day 10 and at one month was unremarkable.

CONCLUSION: This case demonstrates that pelvic surgery does not inevitably require pneumoperitoneum or abdominal wall access. Posterior colpotomy provided direct natural orifice entry to the pelvis, allowing adequate visualization and a stable operative field. The working space was achieved through patient positioning, uterine manipulation, and anatomical orientation rather than artificial insufflation, maintaining physiological stability throughout the procedure. Natural orifice surgery has largely been promoted as a scarless alternative to conventional laparoscopy. However, most natural orifice techniques continue to rely on pneumoperitoneum to create operative space. In this case, we demonstrate that even this foundational assumption may be reconsidered. By eliminating not only abdominal incisions but also intra-abdominal pressurization, the degree of invasiveness may be further reduced.

This physiology-conscious approach may be particularly valuable in patients with cardiopulmonary compromise, prior thoracic surgery, or formal contraindications to insufflation—patients who might otherwise be directed toward laparotomy. Moreover, natural orifice access without pneumoperitoneum may open new avenues for selected therapeutic and diagnostic pelvic procedures in high-risk or complex cases.

With appropriate patient selection and surgical expertise, insufflation-free natural orifice endoscopic access has the potential to extend the boundaries of minimally invasive pelvic surgery. Rather than being defined solely by incision size or cosmetic outcome, minimal invasiveness may also be redefined by physiological respect and reduced systemic burden. This case suggests that the next evolution of natural orifice surgery may not only be scarless—but also pressureless.

Keywords: insufflation-free surgery, minimally invasive, natural orifice surgery

SS-053

Comparison of preoperative elastography and postoperative histochemical markers in patients who underwent surgery for vulvodynia and a control group: A prospective designed case control study

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INTRODUCTION: Vulvodynia is a subgroup of dyspareunia, encompassing many different disorders that cause pain during sexual intercourse. The aim of this study is to find diagnostic methods that will easily differentiate vulvodynia, a condition subjectively and difficult to diagnose, from other sexual pain disorders with similar clinical presentations.

METHOD: This prospective case-control study included 63 premenopausal patients (32 in the study group and 31 in the control group) who underwent perineoplasty surgery in Giresun University Obstetrics and Pediatrics Education and Research Hospital between June 2018 and June 2021. This study was approved by the Giresun University Clinical Research Ethics Committee (18.10.2017/KAEK-55). The study group consisted of sexually active patients over 18 years of age with the diagnosis of `Localized Vulvodynia', resistant to medical treatment and indicated for perineoplasty operation. The control group consisted of patients with indications such as rectocele, enterocele, and/or perineal weakness who were scheduled for perineoplasty surgery but did not have symptoms of vulvodynia. Pregnant women, sexually inactive women, adolescents, postmenopausal women, and patients without indications for perineoplasty were excluded from the study. The preoperative elastosonography was performed at the 3, 5, 6, 7, and 9 o'clock positions of the vulva to determine the stiffness ratio of the soft tissue according to the surrounding soft fatty tissue. Postoperative pathology specimens were obtained from the posterior vulvovaginal wall, which we routinely removed as required by the operation. Immmnohistochemical markers were checked blindly by two different pathologists. Immunohistochemical markers CD34 showed immune activation and vascular proliferation, PGP 9.5 showed neuronal activation, and Masson Trickrome showed fibrosis. The uptake/absence of Masson Trichrome in each field at 200x magnification under a light microscope, the density of CD34 according to the number of cells in each field and the thickness (mm) of PGP 9.5 were evaluated. SPSS 17.0 was used for statistical analysis. The Mann Whitney U test was used to compare study groups with control groups and to compare elastography results with immunohistochemical results. The Fisher exact test was used for categorical data. P value <0.05 was considered significant.

RESULTS: There was no statistically significant difference between the study and control groups in terms of age, gravida and parity (p>0.05). Vulva elastography measurements revealed significantly higher tissue stiffness levels in the group diagnosed with vulvodynia. Immunohistochemically, the panneuronal marker PGP 9.5 was statistically significantly higher in the vulvodynia group (p < 0.001). The vascularization marker CD34 was significantly lower in this group (p < 0.001).

CONCLUSION: The use of strain elastosonography is a noninvasive and acceptable method for early diagnosis of vulvodynia with neuronal involvement.

Keywords: Dyspareunia, elastography, sexual dysfunction, vulvodynia

Table 1: Demographic data, elastography and immunohistochemical data in the groups with and without vulvodynia.

			p value
Age	41.78 ± 9.5	41.29 ± 7.0	0.5
Gravida	2.50 ± 0.8	2.29 ± 0.8	0.4
Parity	2.19 ± 0.6	2.06 ± 0.6	0.4
Elastography			
Clockwise 3	1.62 ± 0.3	1.25 ± 0.2	<0.001
Clockwise 5	1.62 ± 0.4	1.31 ± 0.2	0.003
Clockwise 6	1.72 ± 0.3	1.36 ± 0.2	<0.001
Clockwise 7	1.59 ± 0.4	1.25 ± 0.2	<0.001
Clockwise 9	1.59 ± 0.4	1.13 ± 0.1	<0.001
Immunohistochemistry			
PGP 9.5 (Panneuronal marker)	6.08 ± 3.4	2.31 ± 2.0	<0.001
CD 34	1.47 ± 0.5	1.94 ± 0.3	<0.001

**Mann-Whitney U Testi*

SS-055

Retrospective Analysis of Indications, Complications, and Histopathology Results of Patients Undergoing Hysteroscopy at Uşak Training and Research Hospital in the Last Year

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OBJECTIVE: To evaluate the indications and outcomes of hysteroscopic operations performed in our hospital, to examine preoperative blood parameters, and to assess the compatibility of these data with the current literature.

METHODS: A total of 94 patients who underwent hysteroscopy at Uşak Training and Research Hospital between January 1, 2025, and January 1, 2026, were included in the study. The diagnostic correlation between preoperative hysteroscopic findings and postoperative histopathological diagnoses, the incidence of specific pathologies, complication rates, and the descriptive effects of demographic data (age, parity) on these outcomes were evaluated. Data were analyzed using SPSS version 26.0. The distribution of data was assessed with the Kolmogorov-Smirnov test; non-normally distributed data were presented as median (minimum-maximum).

RESULTS: The median age of the 94 patients was 42 (17–70) years. Regarding hysteroscopy indications, the most frequent was a preliminary diagnosis of polyps at 56.4% (n=53), followed by abnormal uterine bleeding (AUB) at 11.7% (n=11). Other indications included myoma (8.5%, n=8), increased endometrial thickness (7.4%, n=7), postmenopausal bleeding (6.4%, n=6), lost intrauterine device (4.3%, n=4), and retained products of conception (3.2%, n=3). Less common indications were isthmocele (1.1%, n=1) and pre-IVF evaluation (1.1%, n=1). Histopathological results revealed that the most common diagnosis was endometrial polyp at 34.0% (n=32), followed by proliferative endometrium (22.3%, n=21) and secretory endometrium (16.0%, n=15). Insufficient or inconclusive material was reported in 13.8% (n=13) of cases, while myoma (7.4%, n=7), hyperplasia (4.3%, n=4), and decidua (2.1%, n=2) were also observed. No gynecological surgical complications occurred; however, 4 patients experienced spinal anesthesia-related headaches. Preoperative laboratory parameters showed a median WBC of 6.57 (4.52–15.69) ×10³/µL, Hmg of 12.40 (7.60–15.10) g/dL, and Htc of 38.10% (25.90–39.6). The median platelet count was 283 (169–462) ×10³/µL and albumin level was 46 (35–54) g/L.

CONCLUSION: Hysteroscopy is an effective and safe method for evaluating common gynecological conditions, particularly endometrial polyps and abnormal uterine bleeding. Our findings reaffirm the diagnostic and therapeutic value of hysteroscopy. The lower rate of pre-fertility treatment hysteroscopy compared to the literature clearly highlights the presence of regional differences in clinical practice.

Keywords: Hysteroscopy, endometrial polyp, abnormal uterine bleeding, histopathology, minimally invasive surgery

Demographic and Baseline Characteristics of Patients (N=94)

Variable	Median (min-max)
Age (years)	42,00 (17,00 - 70,00)
Gravida	2,00 (0,00 - 5,00)
Parity	2,00 (0,00 - 4,00)
Abortus	0,00 (0,00 - 3,00)
Preop WBC (10^3 µl)	6,57 (4,52 - 15,69)
Preop Hmg (g/dL)	12,40 (7,60 - 15,10)
Preop Htc (%)	38,10 (25,90 – 39,6)
Preop Plt (10^3 µl)	283 (169 - 462)
Preop Alb (g/L)	46,00 (35,00 - 54,00)
Preop Neu (10^3 µl)	3,98 (2,10 - 13,45)
Preop Lym (10^3 µl)	2,09 (0,56 - 4,31)
Preop PDW	15,90 (11,10 - 17,00)

Data distribution was evaluated using the Kolmogorov-Smirnov test, and numerical parameters that did not conform to a normal distribution were expressed with median (minimum - maximum) values. Categorical data (indication, pathology result, complication) are expressed as number (n) and percentage (%).

Indications for Hysteroscopy

Indications	(n)	%
Polyp	53	56,4
Automated Uterine Bleeding (AUB)	11	11,7
Myoma uteri	8	8,5
Endometrial Thickening	7	7,4
Postmenopausal Bleeding (PMB)	6	6,4
Missing IUD	4	4,3
Rest Placenta	3	3,2
Istmocele	1	1,1
Pre-IVF Evaluation	1	1,1

Pathology Results

	(n)	%
Polyp	32	34
Proliferative Endometrium	21	22,3
Secretory Endometrium	15	16,0
Myoma	7	7,4
Hyperplasia	4	4,3
Retained products of conception	2	2,1
Insufficient Material	13	13,8

SS-056

A 28-year-old married woman presenting with acute abdominal symptoms, presenting with a spontaneously developed malignant neoplasm of the right ovary with a single-turn torsion appearance

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Ovarian cancer is a common gynecological malignancy ranking third in incidence after cervical and endometrial cancers, but represents the leading cause of death among gynecological malignancies. Over 70 % of patients with ovarian cancer were diagnosed at an advanced stage, as International Federation of Gynecology and Obstetrics (FIGO) stage III or IV, due to its insidious onset and the lack of early detection methods. Nowadays, Carbohydrate Antigen 125 (CA125) and Human epididymis protein 4 (HE4) are the only approved serum biomarkers for use in ovarian cancer, however not sufficient for early detection. Multivariate index (MVI) assays have been developed to mitigate the limitations of single serum biomarkers in the diagnosis of ovarian cancer. The Risk of malignancy algorithm (ROMA) integrates menopausal status, CA125 and HE4 concentrations to diagnose women with a pelvic mass, showing higher sensitivity and specificity. Lymphatic spread and peritoneal dissemination constitute the main metastatic routes in ovarian cancer. Three primary lymphatic metastasis have been described: (1) along infundibulopelvic ligament to paraaortic and paracava lymph nodes, (2) via subovarian plexus to the obturator and pelvic iliac lymph nodes, and (3) through the bilateral round ligament to the external iliac and deep inguinal lymph nodes, which finally drained towards the superficial inguinal lymph nodes (SILNs).

High-grade serous ovarian cancer (HGSOC) is the most common type of epithelial ovarian cancer (EOC) that accounts for nearly 70% of all ovarian cancer. HGSOC is a fast-growing and rapidly spreading cancer that was recently believed to originate from the epithelial cells of the fallopian tubes rather than the ovary. Like other ovarian cancers, HGSOC is often diagnosed at a late

stage when it has already metastasized to other parts of the body. Similar to other types of cancer, ovarian cancer metastasis can occur through various routes including direct extension, peritoneal seeding, lymphatic spread, and hematogenous spread. The most common routes for ovarian cancer metastasis are through direct extension to nearby pelvic organs and peritoneal seeding. This report discusses a case of stage 1c high-grade ovarian carcinoma in a 28-year-old woman who presented to the acute abdomen clinic and the gynaecology outpatient clinic, where intraoperative laparoscopic findings consistent with a ruptured tubo-ovarian abscess were observed.

Keywords: Acute abdomen, ovarian torsion, tubo-ovarian abscess, high grade stage 1c ovarian serous carcinoma

SS-057

The Importance of Allowing Adequate Time for Reperfusion and Ovarian Fixation in Adnexal Torsion: A Case Report

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INTRODUCTION: Adnexal torsion is a gynecological emergency characterized by the rotation of the ovary, often together with the fallopian tube, around its vascular pedicle. Although rare, it is a fertility-threatening condition that occurs most frequently in women of reproductive age but may be seen in all age groups. It typically presents with acute-onset lower abdominal pain, and diagnosis is usually based on a combination of clinical findings and imaging modalities. One of the most important predisposing factors for adnexal torsion is the presence of ovarian or tubal masses, particularly benign cystic lesions. Tubal cysts are usually asymptomatic and incidentally detected benign adnexal lesions; however, when they reach larger sizes, they may predispose to torsion. The mainstay of treatment is surgical detorsion with preservation of ovarian tissue whenever possible. In recent years, fertility-preserving approaches have gained importance, and ovarian fixation has been suggested in selected cases to prevent recurrence.

CASE: A 24-year-old nulliparous, sexually inactive patient initially presented to an external emergency department with groin pain. Computed tomography revealed an approximately 11 cm thin-walled cyst located superior to the bladder, along with millimetric cysts in the adnexal regions, and was interpreted as possibly consistent with cyst rupture. The patient left the emergency department but later presented to our institution due to worsening symptoms. Magnetic resonance imaging demonstrated left ovarian torsion, with an enlarged ovary measuring 87×30 mm, absence of contrast enhancement suggestive of necrosis, a 9 cm cyst likely contributing to torsion, and pelvic free fluid. Due to clinical findings, including guarding, the patient was taken for emergency surgery.

Intraoperatively, a ~13 cm cystic lesion originating from the left tube was identified. The left adnexa had undergone two complete rotations, with compromised perfusion and necrotic appearance. Detorsion was performed, and after a 10-minute observation period, gradual improvement in ovarian color was noted; therefore, salpingo-oophorectomy was avoided. The tubal cyst was drained from the antimesenteric side, and the ovary was fixed to the pelvic sidewall using three separate 2-0 vicryl sutures. A drain was placed, and the procedure was completed without complications. At the postoperative second-week follow-up, pelvic ultrasonography demonstrated

a normal-sized left ovary with preserved Doppler blood flow.

DISCUSSION: Current management of adnexal torsion favors conservative surgery with preservation of ovarian tissue, even in cases with a necrotic appearance. Following detorsion, many ovaries that initially appear ischemic or necrotic may regain perfusion over time. Therefore, allowing sufficient intraoperative time for reassessment after detorsion is crucial to prevent unnecessary oophorectomy. Additionally, oophoropexy may be considered in selected cases, such as recurrent torsion, torsion of a normal ovary (with higher recurrence risk), pediatric/adolescent patients, in the presence of a single functional ovary, as it may reduce the risk of recurrence by improving anatomical stability.

CONCLUSION: In adnexal torsion, especially in young patients, conservative surgical management should be prioritized to preserve fertility. Allowing adequate time for reperfusion assessment following detorsion is critical in preventing unnecessary oophorectomy. Oophoropexy may serve as an effective surgical option to reduce the risk of recurrent torsion in selected cases.

Keywords: Adnexal torsion, tubal cyst, detorsion, oophoropexy, fertility preservation

Figure 1: Sagittal MRI image of a 13 cm torsioned tubal cystic lesion

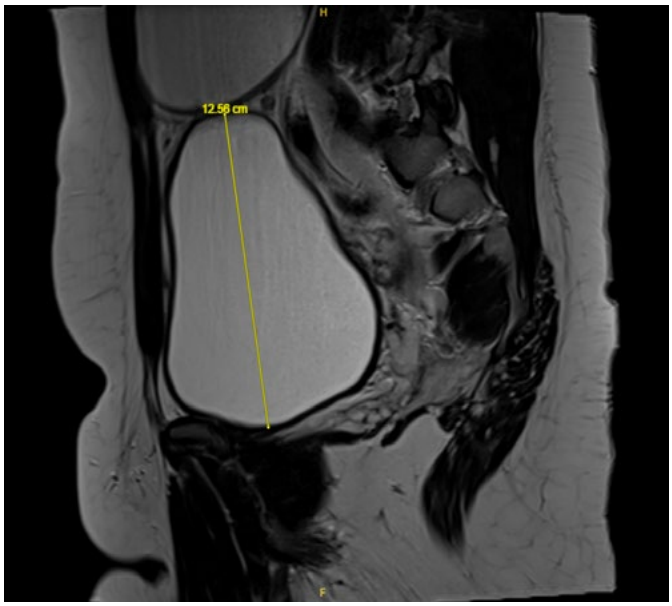
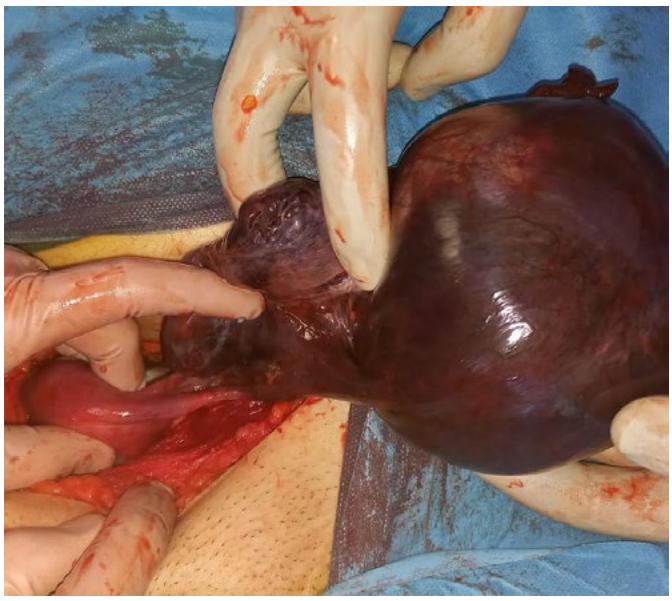


Figure 2: Intraoperative view of the left tube and ovary with two complete torsions and necrotic appearance, along with a well-defined 13 cm cyst in the left tube



SS-058

Pelvic Mass Mimicking Gynecologic Sarcoma: High-Grade Lymphoma with Cardiac Atrial Involvement:A Rare Case Report

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INTRODUCTION: Adnexal masses are frequently encountered in gynecologic practice and are most commonly associated with ovarian or uterine pathology. However, in rare cases non-gynecologic malignancies such as lymphoma may present as pelvic masses and mimic gynecologic tumors, posing diagnostic challenges.

CASE PRESENTATION: We present a case of a 52-year-old woman who was admitted with complaints of progressive abdominal distension and dizziness. Her medical history included mitral insufficiency, arrhythmia, and hypertension. The patient had three previous vaginal deliveries. Imaging studies revealed a large pelvic mass measuring approximately 15 cm. Tumor markers demonstrated elevated levels of CA-125 (145 U/mL) and CA 15-3 (145 U/mL), while AFP was within normal range (7.2 ng/mL). Based on these findings, a gynecologic malignancy, particularly sarcoma or ovarian cancer, was initially suspected.

Furtherradiologicevaluationdemonstratedanapproximately 10 cm nodular lesion surrounding the kidneys, suggesting retroperitoneal involvement. Laboratory investigations revealed elevated creatinine (1.6 mg/dL) and urea (62 mg/dL), indicating possible renal involvement or compression. A radiologically guided biopsy of the pelvic mass was performed, after which a rapid regression of the lesion was observed, raising suspicion for a hematologic malignancy.

During the diagnostic process, the patient developed cardiac tamponade. Cardiac magnetic resonance imaging revealed a 5 cm atrial mass. The patient underwent cardiovascular surgery, and the atrial mass was surgically excised. Histopathological examination confirmed the diagnosis of high-grade lymphoma.

CONCLUSION: Lymphoma may rarely present as a pelvic mass mimicking gynecologic malignancy. Elevated tumor markers and imaging findings may lead to an initial suspicion of ovarian cancer or Sarcoma. Awareness of this possibility is important for gynecologists, as early recognition and multidisciplinary management are essential in atypical presentations of pelvic masses.

Keywords: Pelvic mass,Lymphoma,Cardiac involvement,Cardiac tamponade,gynaecology malıgnancy mimic

SS-059

Management of a very large uterine fibroid observed in the postmenopausal period: a case report

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Uterine leiomyomas are the most common tumors of the female genital system originating from smooth muscle. The incidence of uterine fibroid increases during the reproductive period and decreases after menopause. Leiomyoma is detected in approximately half of the women over 35 years of age. Myomas can be microscopic in size or reach giant sizes. Uterine fibroids can cause the following complaints, depending on their size and number; abnormal uterine bleeding, abdominal distension, dyspepsia, chronic pelvic pain, constipation, pollakiuria, urinary retention. Patients with large myomas may present to the hospital with a wide variety of clinical findings briefly. Sometimes they can reach giant sizes, completely filling the abdominal cavity. Especially, giant myomas are very rare in developed countries. Myomas rarely spread excessively to the lungs and other surrounding organs and if they apply pressure, they can lead to dangerous consequences. If appropriate surgical treatment and careful perioperative care can be provided, postoperative good results can be achieved in myomas.

We aimed to present the clinical and surgical management of a 59-year-old patient with a very large myoma that extends approximately 5 cm above the umbilicus level.

Keywords: Large uterine myoma, wide variety of clinical findings, surgical treatment, dyspepsia

Figure 1: Image of the large uterus with myoma before total abdominal hysterectomy and bilateral salpingo-oophorectomy was performed

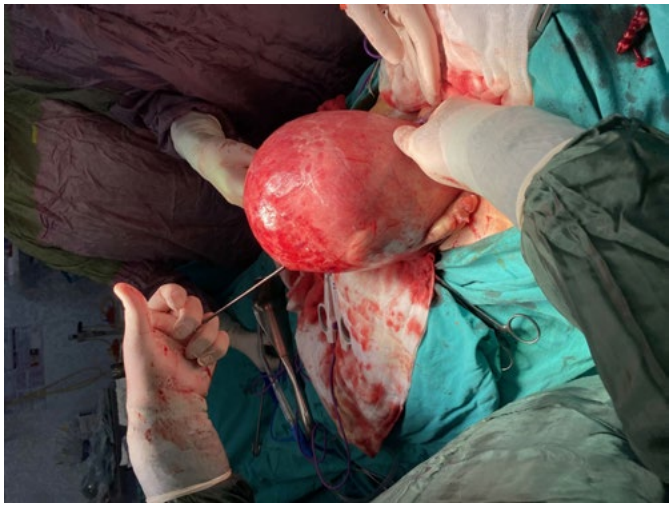


Figure 1: Image of the large uterus with myoma before total abdominal hysterectomy and bilateral salpingo-oophorectomy was performed

Figure 2: Total abdominal hysterectomy and bilateral salpingo-oophorectomy material was arranged side by side on the operating theatre scales



Figure 2: Total abdominal hysterectomy and bilateral salpingo-oophorectomy material was arranged side by side on the operating theatre scales

SS-060

Successful Spontaneous Pregnancy Following Vaginal Septum Resection in a Patient with Uterus Didelphys and Double Cervix: A Case Report

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BACKGROUND: Uterus didelphys is a rare congenital Müllerian duct anomaly characterized by complete failure of fusion of the paired Müllerian ducts, resulting in two separate uterine cavities and typically two cervices. It may also be associated with a longitudinal or, more rarely, a transverse vaginal septum. Although fertility can be preserved in many patients, these anomalies are generally associated with increased risks of miscarriage, preterm birth, malpresentation, etc. We present a case of uterus didelphys with a double cervix discovered after vaginal septum resection, followed by a successful spontaneous pregnancy and a favorable obstetric outcome.

CASE PRESENTATION: A 25-year-old nulligravid woman initially presented in 2022 to another center with dyspareunia and was found to have a longitudinal vaginal septum on gynecologic examination. Vaginal septum resection was performed, and two distinct cervical ostia were identified, raising suspicion for a Müllerian duct anomaly. Further imaging (including hysterosalpingography and magnetic resonance imaging) confirmed the diagnosis of uterus didelphys with double cervix.

Three years after surgery, the patient conceived spontaneously without assisted reproductive techniques and was referred to our clinic for antenatal follow-up. Due to the known obstetric risks associated with uterine anomalies, her pregnancy was closely monitored. The antenatal period remained uneventful, with no significant maternal or fetal complications.

At 37 weeks of gestation, a planned cesarean section was performed, resulting in the delivery of a healthy neonate. Both maternal and neonatal outcomes were favorable. Intraoperative findings confirmed uterus didelphys, and no intraoperative complications occurred.

CONCLUSION: Although uterus didelphys has a complex anatomical structure, positive reproductive and obstetric results are achievable. This case demonstrates that fertility can be preserved in women with Müllerian anomalies, and spontaneous conception along with uncomplicated pregnancies are possible. Identifying related vaginal anomalies and providing suitable surgical treatment when necessary can improve reproductive outcomes. Careful antenatal surveillance is essential for these patients due to potential obstetric complications.

Keywords: didelphys uterus, vaginal septum, double cervix

Didelphys uterus picture from C-section 1



Didelphys uterus picture from C-section 2



Double cervix, spc examination



SS-061

Fetal Megacystis Detected in Early Gestation: A Case Report

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OBJECTIVE: Posterior urethral valve (PUV) is a rare but serious congenital anomaly that causes lower urinary tract obstruction in male fetuses. When obstruction develops early in pregnancy, it may lead to severe complications including bladder dilatation, progressive renal damage, and pulmonary hypoplasia. This study aimed to present the prenatal findings and clinical course of a fetus with marked bladder dilatation detected in the second trimester who underwent fetal vesicoamniotic shunt placement with a preliminary diagnosis of posterior urethral valve.

METHODS: A 32-year-old gravida 4, para 2 patient presented to our hospital at 14 weeks of gestation for routine prenatal follow-up. Fetal ultrasonographic examinations were performed using a Voluson S10 ultrasound system.

RESULTS: Fetal biometric measurements were consistent with 14 weeks of gestation. Detailed ultrasonographic evaluation demonstrated that the fetal bladder was markedly enlarged, filling the abdominal cavity and extending to the level of the diaphragm. Bladder dimensions were measured as 37 × 26 × 16 mm, and a keyhole sign was observed. Both kidneys were located in their normal renal fossae and demonstrated normal size and morphology. These findings were considered suggestive of PUV (Figures 1–2). Following informed parental consent, invasive prenatal genetic testing via chorionic villus sampling (CVS) was performed, and a fetal vesicoamniotic shunt was placed during the same procedure. Post-procedural ultrasonographic assessment demonstrated a significant reduction in bladder size and confirmed correct positioning of the shunt. Cytogenetic and microarray analyses of the fetus were normal. In subsequent follow-up examinations during later gestational weeks, bilateral multicystic changes of the fetal kidneys, fetal ascites, increased echogenicity of both lung parenchymas, and mesocardia were observed. Based on these findings, the case was considered suggestive of congenital high airway obstruction syndrome (CHAOS). The case was evaluated by the perinatology council, and due to the poor prognosis, termination of pregnancy was recommended. The family opted for termination, and the pregnancy was terminated using a misoprostol protocol.

CONCLUSION: PUV is an important cause of lower urinary tract obstruction associated with significant renal

and pulmonary morbidity in the prenatal period. Marked fetal bladder dilatation detected in early gestation and accompanying ultrasonographic findings are critical in predicting prognosis. Although vesicoamniotic shunting may provide urinary decompression in selected cases, progressive renal damage and pulmonary developmental impairment may still occur. This case highlights the importance of multidisciplinary management and close prenatal follow-up in fetuses diagnosed with megacystis in early gestation.

Keywords: Posterior urethral valve, fetal megacystis, prenatal ultrasonography, lower urinary tract obstruction

Figure 1: Prenatal ultrasound image showing marked bladder dilatation consistent with fetal megacystis and bladder measurement at 14 weeks of gestation

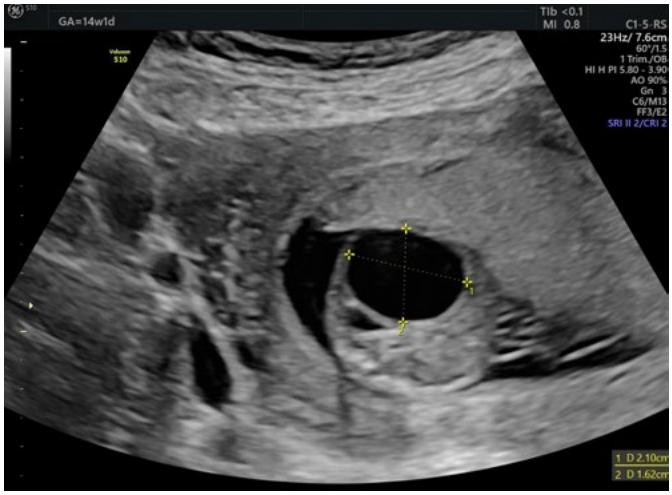


Figure 1: Prenatal ultrasound image showing marked bladder dilatation consistent with fetal megacystis and bladder measurement at 14 weeks of gestation

Figure 2: Prenatal ultrasound image demonstrating fetal megacystis with the keyhole sign at 14 weeks of gestation.Figure 2: Prenatal ultrasound image demonstrating fetal megacystis with the keyhole sign at 14 weeks of gestation.

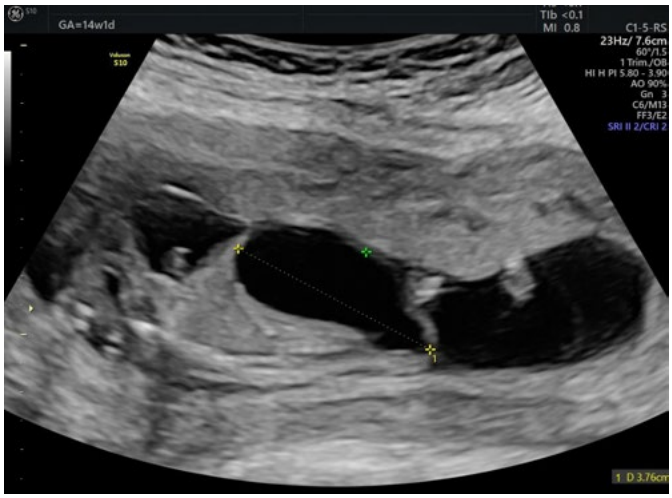


Figure 2: Prenatal ultrasound image demonstrating fetal megacystis with the keyhole sign at 14 weeks of gestation.

SS-062

Prenatally Diagnosed Teratoma in an Undescended Fetal Testis: A Rare Case Report

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Fetal intraabdominal masses detected during pregnancy are rare and require careful differential diagnosis. Prenatal ultrasonography plays a crucial role in the early detection and characterization of these lesions. We present a rare case of a prenatally diagnosed teratoma arising from an undescended fetal testis.

A 29-year-old pregnant woman was referred to our center at 29 weeks and 2 days of gestation due to a suspected fetal abdominal cyst detected at an outside institution. Previous aneuploidy screening tests were low risk and earlier detailed ultrasonography had shown no abnormalities. On detailed ultrasound examination at our center, a 28 × 26 mm cystic lesion with an anechoic component and internal solid areas was identified on the left side adjacent to the bladder. No direct relationship with the kidney or bladder was observed. The left testis was not visualized within the scrotum, raising suspicion for a cystic teratoma arising from an undescended testis. To further characterize the lesion, fetal magnetic resonance imaging (MRI) was performed and the findings were interpreted as compatible with a teratoma. No complications related to the mass developed during antenatal follow-up.

Delivery was performed at 39 weeks of gestation due to diet-controlled gestational diabetes mellitus and suspected small-for-gestational-age fetus. A 3125 g male neonate was delivered with Apgar scores of 9 and 10 at 1 and 5 minutes, respectively. Postnatal ultrasonography demonstrated an intraabdominal mass suggestive of teratoma, and the left testis remained non-palpable within the scrotum, consistent with an undescended testis. Serum alpha-fetoprotein (AFP) levels were elevated initially but showed a decreasing trend during follow-up. Considering the benign appearance of the lesion and declining AFP levels, immediate surgical intervention was deferred and close follow-up was planned.

Teratoma arising from an undescended fetal testis is an extremely rare condition. This case highlights the importance of prenatal ultrasonography and fetal MRI in the diagnosis and postnatal management planning of fetal intraabdominal masses.

Keywords: prenatal diagnosis, teratoma, undescended testis

Figure 1. Prenatal ultrasound demonstrating a cystic lesion measuring approximately 28 × 26 mm with an internal solid component located in the left lower abdomen adjacent to the fetal bladder.



SS-064

Sudden Onset Fetal Ascites at Early 3rd Trimester Pregnancy: Spontaneous Bowel Perforation due to Ileal Atresia

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INTRODUCTION: Isolated fetal ascites is a diagnostically challenging prenatal finding, often requiring a broad differential that spans structural, infectious, hematologic, and gastrointestinal causes. Among the latter, ileal atresia is a rare etiology, especially when complicated by intrauterine perforation.

CASE PRESENTATION: A 33-year-old woman at 30+5 weeks of gestation was referred for isolated fetal ascites. Multimodal evaluation including detailed ultrasound, genetic testing, and simultaneous amniocentesis and fetal peritoneal paracentesis was performed. Comparative biochemical analysis revealed elevated bilirubin and alkaline phosphatase levels in the peritoneal fluid, raising suspicion for gastrointestinal perforation. At 33+3 weeks, a male neonate was delivered via cesarean section due to progressive abdominal distention. Postnatal laparotomy revealed Type IIIa ileal atresia with proximal bowel perforation. Primary anastomosis was performed, and postoperative recovery was uneventful.

CONCLUSION: This case highlights the critical role of fetal peritoneal fluid analysis in detecting intraabdominal pathology when conventional imaging is inconclusive. Recognizing distinct biochemical profiles between fetal compartments can enhance prenatal diagnostic accuracy and inform surgical planning in rare gastrointestinal anomalies.

Keywords: fetal peritoneal fluid analysis, ileal atresia, isolated fetal ascites, prenatal diagnosis

Figure 1



Initial prenatal ultrasound showing isolated fetal ascites and bilateral hydrocele.

Figure 2



Ultrasound after diagnostic peritoneal paracentesis showing partial resolution

Figure 3



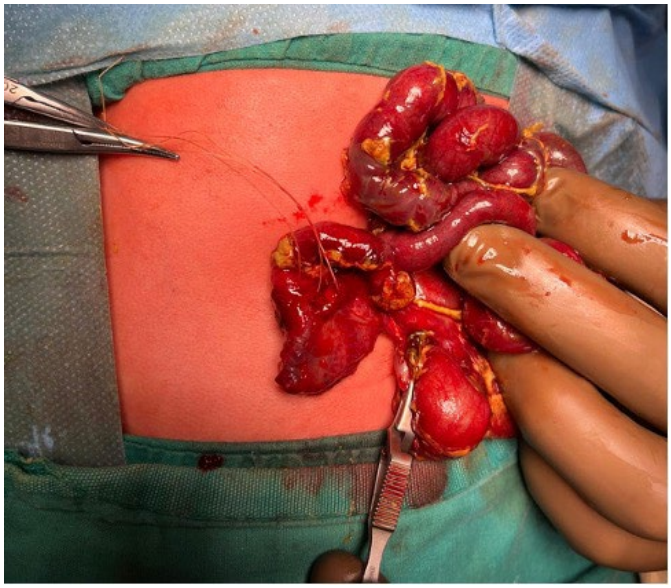
Follow-up ultrasound showing persistent ascites with increased bowel echogenicity.

Figure 4



Final prenatal ultrasound before delivery indicating worsening ascites and dilated loops.

Figure 5



Intraoperative image showing matted small bowel loops with meconium residue and perforation site.

SS-065

Prenatal Diagnosis of TRPV4 Mutation by Ultrasound and Genetic Analysis: A Rare Case of Skeletal Dysplasia

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OBJECTIVE: TRPV4 gene mutation is a rare autosomal dominant inherited genetic disorder associated with neuropathies and skeletal dysplasias. In this report, we aimed to present a rare case of skeletal dysplasia due to a TRPV4 gene mutation diagnosed in the prenatal period.

METHODS: A 26-year-old, gravida 1, para 0 woman was referred to our clinic at the 20th week of gestation with a preliminary diagnosis of multiple fetal anomalies. Fetal ultrasonographic examinations were performed using a Voluson E8 device.

RESULTS: Fetal ultrasonography revealed rudimentary appearance of the radius and ulna in both upper extremities (<1st percentile), oligo-syndactyly in both hands, curvature of the femur in the left lower extremity, hyperechogenic bowel, and hypospadias (Figures 1–3). Genetic testing and counseling were recommended. Fetal genetic analysis demonstrated a heterozygous variant in the TRPV4 gene. Parental analysis confirmed the same heterozygous variant in the father. The case was evaluated at the perinatology council, and termination of pregnancy was recommended due to poor prognosis. With parental consent, the pregnancy was terminated using a misoprostol protocol (Figures 4 and 5).

CONCLUSION: TRPV4 gene mutations, although rare, may lead to severe limb anomalies. Therefore, in the prenatal period, when upper and lower limb defects are identified, TRPV4 mutations should be considered in the differential diagnosis, as this is crucial for early diagnosis and appropriate genetic counseling. Keywords: TRPV4 gene mutation, skeletal dysplasia, prenatal diagnosis

Keywords: TRPV4 gene mutation, skeletal dysplasia, prenatal diagnosis

Figure 1: Oligo-syndactyly



Figure 1: Oligo-syndactyly

Figure 2: Femoral curvature



Figure 2: Femoral curvature

Figure 3: Hypospadias



Figure 3: Hypospadias

Figure 4: Post mortem abortion material



Figure 4: Post mortem abortion material

Figure 5: Radiological image of postmortem abortion material



Figure 5: Radiological image of postmortem abortion material

SS-066

Perineal Ultrasonographic Evaluation and Management of a Fourth-Degree Perineal Laceration Following Vaginal Delivery

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AIM: Fourth-degree perineal lacerations following vaginal delivery are rare but serious obstetric complications associated with significant maternal morbidity. Obstetric anal sphincter injuries (OASIS) occur in approximately 1–11% of vaginal deliveries, whereas fourth-degree lacerations are less common, with an incidence of about 0.25–0.5%.These injuries may lead to long-term complications such as anal incontinence and pelvic floor dysfunction. Early diagnosis and appropriate surgical repair are therefore essential to preserve anal sphincter function. Perineal ultrasonography has recently emerged as a useful imaging modality for evaluating the anal sphincter complex. This case report aims to demonstrate the role of perineal ultrasonography in the diagnosis and management of a patient who developed a fourth-degree perineal laceration following vaginal delivery.

METHODS: A patient whose labor was followed at the Department of Obstetrics and Gynecology, Bursa Uludağ University, was found to have a perineal laceration during postpartum evaluation. After placental separation, further examination revealed extension of the laceration to the anal mucosa. According to the Sultan classification, the injury was diagnosed as a fourth-degree perineal laceration. Perineal ultrasonography was performed to evaluate the anal sphincter complex, confirming the defect and documenting the injury. The patient was then transferred to the operating room for surgical repair.

RESULTS: A 22-year-old primigravid patient at 39+1 weeks of gestation, with a diagnosis of maternal obesity (BMI: 41), was admitted for planned delivery. She had no known systemic disease, and her antenatal follow-up had been uneventful. Cervical ripening was initiated with 50 µg misoprostol at 08:30. At 14:45, spontaneous rupture of membranes occurred when the cervix was 7 cm dilated and 70% effaced. Due to absent effective contractions, oxytocin augmentation was started. At 16:15, she delivered a female infant weighing 3290 g with Apgar scores of 10 and 10.

During the fourth stage of labor, a fourth-degree perineal laceration was identified on physical examination and confirmed by perineal ultrasonography(fig1-2). Surgical repair was performed under general anesthesia. The anal mucosal laceration extending approximately 1.5

cm above the dentate line was repaired with continuous 3-0 Vicryl sutures. The internal anal sphincter was repaired using an end-to-end U-suture technique, and the external anal sphincter using the overlap technique with 3-0 Vicryl. The vaginal laceration was then closed with continuous 1-0 Vicryl sutures.

Postoperative perineal ultrasonography demonstrated overlapping of the external anal sphincter, continuity of the internal anal sphincter, and restoration of anal mucosal integrity with mild tissue edema(fig3-4). At the first postoperative week, the patient reported voluntary control of flatus and stool.Examination confirmed preserved anal tone, and ultrasonography demonstrated intact external and internal anal sphincters and anal mucosa(fig5-6).

CONCLUSION: Fourth-degree perineal lacerations are serious obstetric injuries associated with maternal morbidity.Early diagnosis and appropriate surgical repair are crucial for preserving anal sphincter function. While careful postpartum perineal examination remains the cornerstone of diagnosis, perineal ultrasonography may serve as a valuable adjunct for evaluating the anal sphincter complex and confirming the success of surgical repair. This case highlights the utility of perineal ultrasonography in both the diagnosis and postoperative assessment of obstetric anal sphincter injuries.

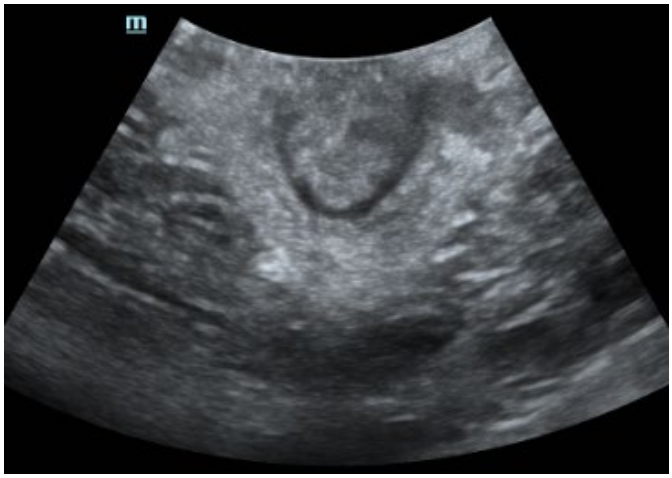
Keywords: Fourth-degree perineal laceration,Obstetric anal sphincter injury (OASIS),Perineal ultrasonography,Surgical repair.Vaginal delivery

Figure 1



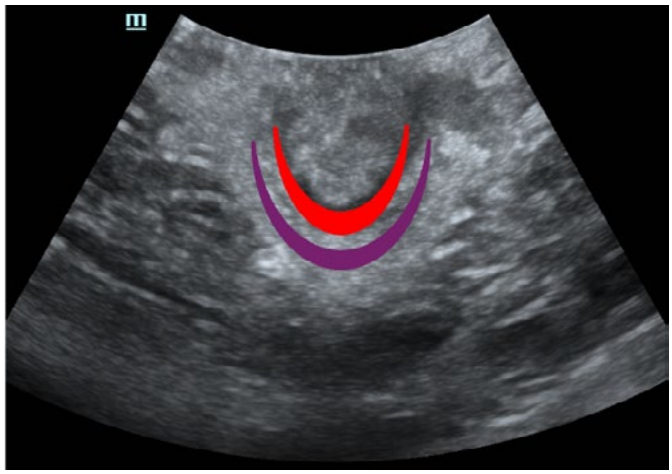
Postpartum laceration on pelvic examination

Figure 2a



Perineal ultrasonography shows anal mucosa, internal and external anal sphincters that have lost their integrity.

Figure 2b



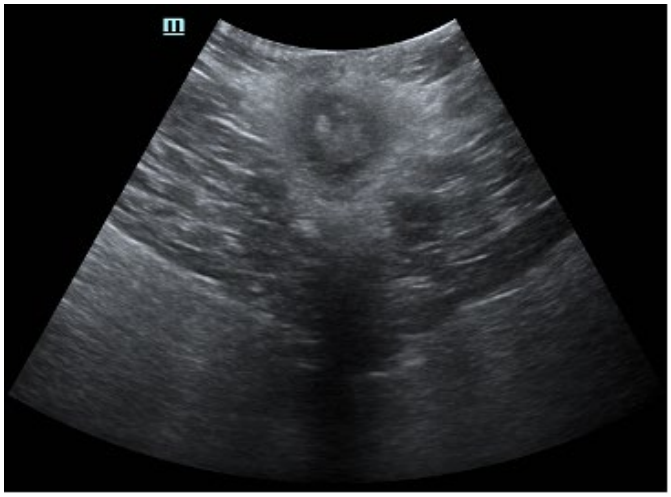
The area schematically represented in red shows the internal anal sphincter; the area schematically represented in purple shows the external anal sphincter.

Figure 3



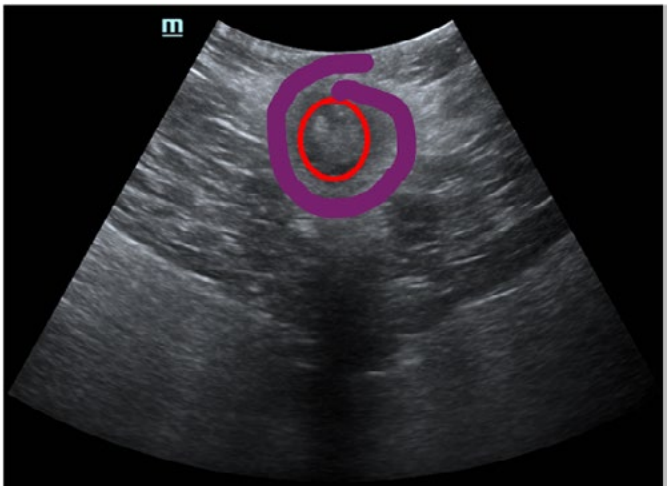
Postoperative perineum after repair

Figure 4a



The perineal ultrasonography image taken on the first postoperative day shows that the external anal sphincter is overlapping, the continuity of the internal anal sphincter and the integrity of the anal mucosa are maintained, and the tissues are edematous.

Figure 4b



The area schematically represented in red shows the internal anal sphincter; the area schematically represented in purple shows the external anal sphincter.

Figure 5



Perineal image at 1 week postoperatively after perineal repair.

Figure 6



Perineal ultrasonography performed one week postoperatively after perineal repair also showed that the integrity of the external anal sphincter, internal anal sphincter, and anal mucosa was preserved.

SS-067

Clinical Course of Prenatally Diagnosed Fetal Cardiac Rhabdomyomas: A Two-Case Report

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BACKGROUND: Fetal cardiac rhabdomyoma is the most common primary cardiac tumor detected during the prenatal period. Although fetal cardiac tumors are rare, with an incidence reported between 0.08% and 0.2% of pregnancies, rhabdomyomas constitute approximately 60–85% of these lesions. They are typically detected during routine obstetric ultrasonography or fetal echocardiography as homogeneous hyperechogenic intracardiac masses, most commonly located within the ventricular myocardium or interventricular septum.

Although many rhabdomyomas regress spontaneously after birth, their size and location may lead to clinically significant complications including arrhythmias, inflow or outflow tract obstruction, valvular dysfunction, or cardiac failure. The most important clinical aspect of fetal rhabdomyoma is its strong association with tuberous sclerosis complex (TSC), particularly when multiple tumors are present. Therefore, prenatal detection requires careful evaluation and postnatal follow-up.

CASE 1: A 16-year-old primiparous patient at 37 weeks of gestation was referred to our tertiary center after multiple intracardiac masses were detected during second-trimester ultrasonography. First-trimester laboratory findings and second-trimester screening tests were normal.

Fetal echocardiography performed at 28 weeks and 6 days demonstrated multiple intracardiac masses measuring up to 15 mm. Invasive prenatal genetic testing was offered but declined by the patient. Subsequent ultrasonography revealed fetal growth restriction, bilateral intracardiac masses measuring up to 26 mm, and mild pericardial effusion (3.8 mm). No fetal arrhythmia was detected.

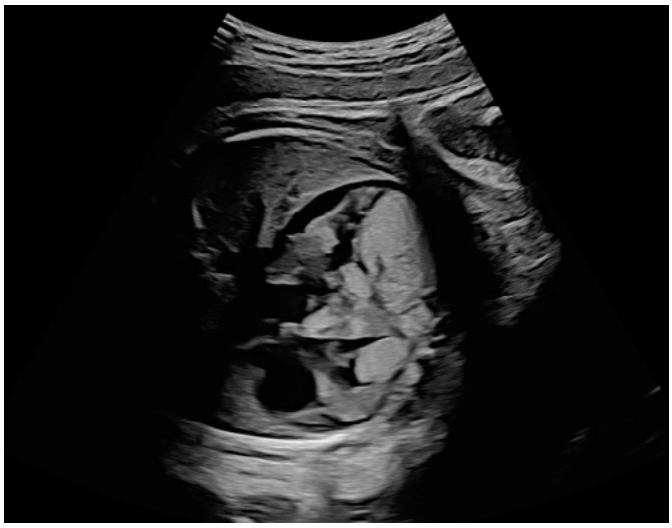
An elective cesarean section was performed at 37 weeks. A female neonate weighting 2240 g was delivered with Apgar scores of 8 and 10 at the first and fifth minutes. The newborn was admitted to the neonatal intensive care unit for monitoring. Postnatal echocardiography revealed no arrhythmia or significant cardiac dysfunction, and respiratory support was not required. Cranial MRI was planned for further evaluation.

CASE 2: A 22-year-old primiparous patient at 37 weeks of gestation was referred to our center because of fetal growth restriction, oligohydramnios, and suspected intracardiac masses. The patient had been diagnosed with tuberous sclerosis complex in 2017 and had a history of epileptic seizures.First-trimester laboratory tests and second-trimester screening results were normal. However, the patient did not attend routine antenatal follow-up visits after the second trimester and presented again with uterine contractions shortly before referral.Ultrasonographic examination demonstrated fetal growth restriction, oligohydramnios, bilateral intracardiac masses, and minimal pericardial effusion. An elective cesarean section was performed at 37 weeks. A female neonate weighting 2490 g was delivered with Apgar scores of 8 and 9 at the first and fifth minutes. The newborn was admitted to the neonatal intensive care unit for cardiac monitoring. Postnatal echocardiography did not demonstrate arrhythmia or hemodynamic compromise.

CONCLUSION: Fetal cardiac rhabdomyomas are frequently multiple and strongly associated with tuberous sclerosis complex. Despite potential prenatal complications, many lesions regress spontaneously after birth and the overall prognosis is favorable with appropriate monitoring. Early prenatal recognition remains essential for counseling, surveillance, and multidisciplinary perinatal management.

Keywords: Fetal Cardiac Tumors, Fetal Rhadomyoma, Prenatal diagnosis, Arrythmia, Tuberous Sclerosis Complex

Figure1



Ultrasonography of Fetal Heart in case 1

Figure2



Ultrasonography of Fetal Heart in case 2

SS-068

Posthemorrhagic Hydrocephalus Associated with Severe Cerebral Parenchymal Destruction: Prenatal Diagnosis and Postnatal Confirmation

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Ondokuz Mayıs Üniversitesi

INTRODUCTION: Posthemorrhagic hydrocephalus (PHH) is a severe neurological condition resulting from intracranial hemorrhage and subsequent disruption of cerebrospinal fluid circulation. Extensive hemorrhagic injury during fetal life may lead to progressive ventricular enlargement and significant destruction of cerebral parenchyma. Prenatal imaging plays a critical role in the early identification of such abnormalities and in guiding parental counseling and perinatal management. Here, we present a case of severe posthemorrhagic hydrocephalus with extensive cerebral parenchymal destruction that was suspected prenatally and confirmed after birth.

CASE PRESENTATION: A 37-year-old pregnant woman (G2P1) was referred to the perinatology clinic following abnormal findings on routine fetal ultrasonography. The patient had no history of consanguinity, teratogenic exposure, or radiation exposure during pregnancy. Her medical history was significant only for depression. Detailed fetal neurosonographic evaluation demonstrated marked abnormalities of the fetal brain. The supratentorial cranial cavity appeared to be largely filled with fluid, with only minimal residual cerebral tissue detected in the occipital region. Doppler examination demonstrated the presence of the circle of Willis (Figure 1A), indicating preserved major intracranial vascular structures. Further ultrasonographic evaluation revealed abnormal morphology of the posterior fossa (Figure 1B). In addition, a mobile echogenic intracranial area compatible with hemorrhagic debris was identified in the anterior cerebral region (Figure 1C). Visualization of the falx cerebri in the posterior region supported the preservation of midline structures (Figure 1D). Fetal magnetic resonance imaging (MRI) was subsequently performed and confirmed severe supratentorial cerebral parenchymal destruction. Genetic investigations including microarray analysis and CMV PCR testing were initiated. Cordocentesis was performed and chromosomal microarray analysis showed that the fetal platelet count was within normal limits. Due to the extremely poor neurological prognosis, the case was discussed in a multidisciplinary fetomaternal council. Pregnancy termination was recommended; however, after detailed counseling regarding possible outcomes, the family chose to continue the pregnancy. The pregnancy was followed with serial obstetric ultrasonography. At 37 weeks and

3 days of gestation, a male infant weighing 2850 g was delivered via cesarean section due to suspected fetal intracranial hemorrhage. Following delivery, the neonate was admitted to the neonatal intensive care unit with a diagnosis of congenital hydrocephalus.

DISCUSSION: Posthemorrhagic hydrocephalus represents one of the most severe complications of fetal intracranial hemorrhage. Massive hemorrhagic injury may lead to widespread cerebral tissue destruction and disruption of cerebrospinal fluid pathways. Prenatal ultrasonography and fetal MRI are essential imaging modalities for detecting these abnormalities and differentiating them from other severe cerebral malformations such as hydranencephaly or alobar holoprosencephaly. Early prenatal diagnosis allows accurate parental counseling and multidisciplinary perinatal management

CONCLUSION: Severe posthemorrhagic hydrocephalus associated with extensive cerebral parenchymal destruction is a rare but devastating condition. Prenatal neurosonography and fetal MRI play key roles in early diagnosis and counseling, while postnatal imaging confirms the diagnosis and determines the extent of brain injury

Keywords: Cerebral parenchymal destruction, Cordocentesis, Fetal MRI, Posthemorrhagic hydrocephalus, Prenatal diagnosis

figure 1

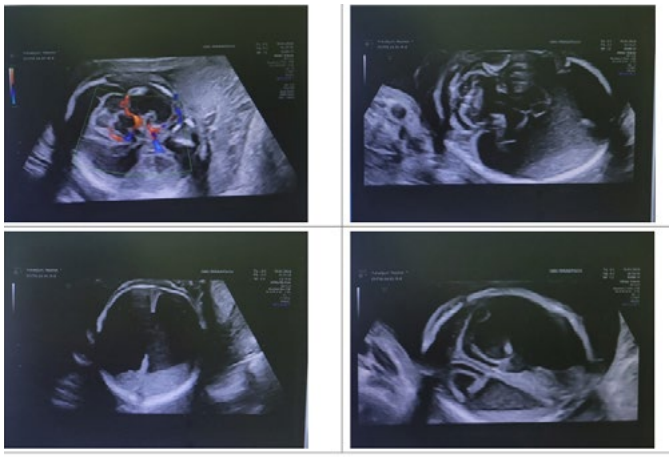
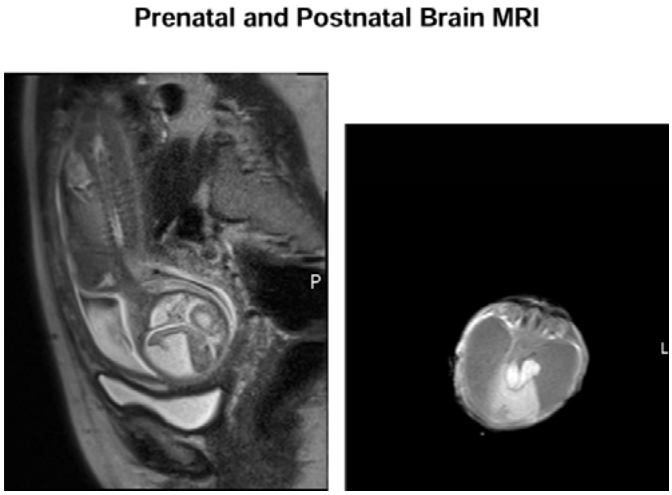


Figure 1. Prenatal neurosonographic findings in posthemorrhagic hydrocephalus.
(A) Doppler ultrasound demonstrating the circle of Willis. (B) Ultrasound image showing abnormal posterior fossa morphology. (C) Mobile echogenic intracranial area suggestive of intracranial hemorrhage in the anterior region. (D) Visualization of the falx cerebri indicating preserved midline structures.

figure 2



SS-069

Prenatal diagnosis of vein of Galen aneurysmal malformation: two cases with different clinical outcomes

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Galen vein aneurysm (GVA) is a rare congenital vascular malformation associated with high mortality. Prenatal diagnosis is essential for prognosis and perinatal management. We present two fetuses diagnosed with ventriculomegaly and Galen vein aneurysm during detailed ultrasonography at 20 weeks of gestation. Both cases were evaluated prenatally, families received counseling, and postnatal management was planned using a multidisciplinary approach. These cases highlight the importance of early prenatal diagnosis and coordinated perinatal care.

AIM: Vein of Galen aneurysmal malformation (VGAM) is a rare congenital cerebrovascular anomaly characterized by high-flow arteriovenous shunting and associated with severe neonatal morbidity and mortality. It represents approximately 1% of fetal intracranial vascular malformations and results from persistence of the embryonic median prosencephalic vein during early fetal development (1–3).

The abnormal shunting may cause hydrocephalus, cerebral injury, and high-output cardiac failure (4,5). Advances in prenatal imaging, particularly ultrasonography and fetal magnetic resonance imaging (MRI), enable earlier diagnosis and improved perinatal management (6,7).

This study presents two prenatally diagnosed cases of VGAM and emphasizes the importance of prenatal diagnosis and multidisciplinary care.

METHODS: Two fetuses diagnosed with VGAM during prenatal evaluation at our tertiary referral center were retrospectively reviewed. Detailed ultrasonography and color Doppler imaging were used for the initial diagnosis, and fetal MRI confirmed the diagnosis and assessed cerebral abnormalities. Families received prenatal counseling regarding prognosis and treatment options. Both cases were managed using a multidisciplinary approach including perinatology, neonatology, pediatric cardiology, neurosurgery, and interventional neuroradiology specialists.

RESULTS: The first case involved a 25-year-old primigravida referred at 20 weeks of gestation after ventriculomegaly was detected during routine ultrasonography. Imaging showed bilateral lateral ventricular dilatation (20–21 mm) and a cystic structure compatible with VGAM with turbulent Doppler flow. Fetal MRI confirmed aneurysmal dilation of the vein of Galen with cerebral abnormalities including porencephalic cysts and decreased white matter volume. Delivery occurred by cesarean section at 33+6 weeks of gestation. Postnatal imaging confirmed severe hydrocephalus and cerebral atrophy, and endovascular treatment was not considered appropriate.The second case was referred at 36 weeks of gestation due to fetal cardiomegaly. Prenatal imaging revealed VGAM with ventriculomegaly and cardiovascular anomalies including aortic coarctation and severe cardiomegaly. The neonate was delivered at 36+5 weeks and underwent endovascular embolization on the fifth day of life. Progressive hydrocephalus required ventriculoperitoneal shunt placement; however, the infant died on the 79th postnatal day.

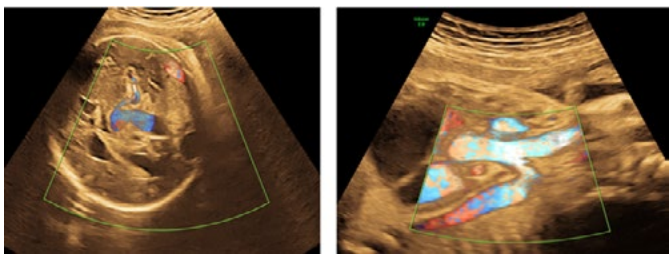
CONCLUSION: VGAM is a rare but severe vascular malformation with variable outcomes. Prenatal diagnosis using ultrasonography and fetal MRI allows early detection of complications and enables appropriate counseling and perinatal planning. Prognosis depends on the degree of arteriovenous shunting, cardiac failure, and cerebral injury (8). Early recognition and multidisciplinary management are essential for improving neonatal outcomes.

Keywords: fetal ultrasound, prenatal diagnosis, vein of Galen aneurysmal malformation, ventriculomegaly

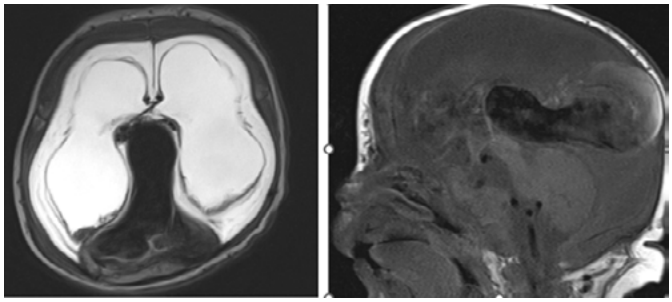
endovascular embolization



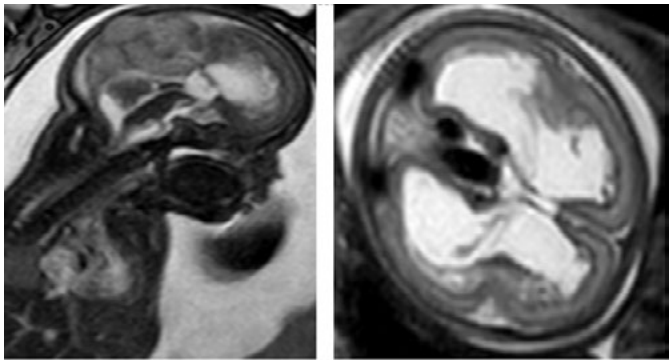
vein of Galen aneurysmal malformation



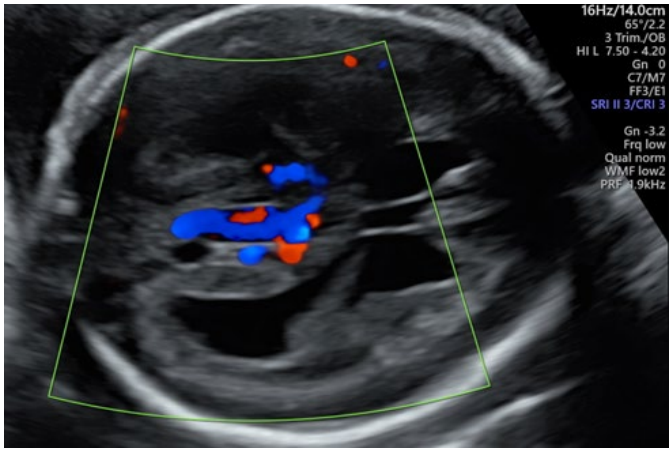
Vein of Galen MRI image



Vein of Galen MRI image



Vein of Galen MRI image



SS-070

Case report: fetal blood transfusion in a pregnancy complicated by placental chorioangioma

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OBJECTIVE: This report aims to describe the prenatal management of a case diagnosed with a giant placental chorioangioma, focusing on the monitoring of maternal-fetal complications and the application of intrauterine blood transfusion to correct fetal anemia.

METHODS: We evaluated a case referred to the Perinatology Clinic of Izmir City Hospital due to polyhydramnios.

RESULTS: A 29-year-old pregnant woman (G2P1Y1) at 29 weeks and 5 days of gestation presented with a total amniotic fluid index (AFI) of 280 mm. Ultrasonography revealed fetal biometry consistent with the gestational age.Ultrasonography revealed a well-circumscribed, vascular mass measuring 71x57x45 mm located at the fundal extension of the anterior placenta, consistent with placental chorioangioma. While the systemic fetal examination was otherwise unremarkable, the Middle Cerebral Artery Peak Systolic Velocity (MCA-PSV) was calculated at 1.9 MoM, indicating fetal anemia. No signs of hydrops fetalis were detected. Following the administration of a betamethasone course and informed consent for invasive intervention, cordocentesis was performed for hemoglobin measurement, followed by a single intrauterine fetal erythrocyte transfusion. Subsequent monitoring showed no progression to fetal hydrops. At 31 weeks, following the onset of preterm labor, a 1850-gram female infant was delivered via Cesarean section with a 1-minute APGAR score of 8. The neonate, who had a postnatal hemoglobin level of 9.9 g/dL, received a transfusion in the neonatal intensive care unit. No further complications occurred during follow-up.

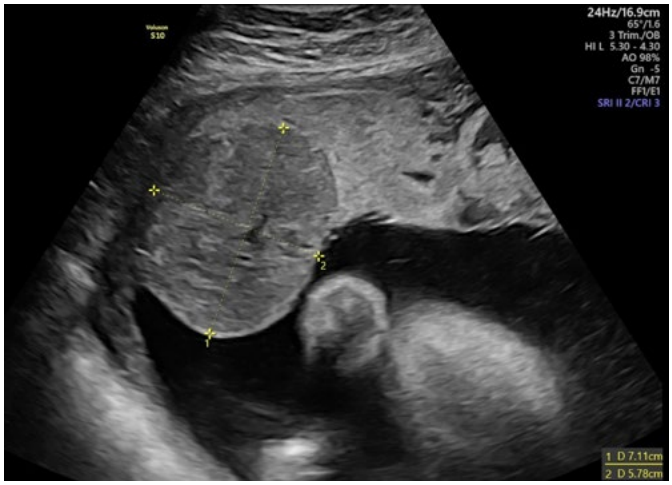
CONCLUSION: Placental chorioangiomas are benign, non-trophoblastic vascular tumors of the placenta. While small lesions are typically asymptomatic, “giant” chorioangiomas (≥4 cm) are associated with adverse fetal outcomes such as anemia, heart failure, hydrops, polyhydramnios, and high perinatal mortality, as well as maternal complications like postpartum hemorrhage and Mirror syndrome. Fetal anemia may result from blood sequestration within the tumor, microangiopathic hemolysis, or the “steal phenomenon” caused by arteriovenous shunting.

Ultrasonography is critical for diagnosis and monitoring, with MCA-PSV >1.5 MoM serving as the primary

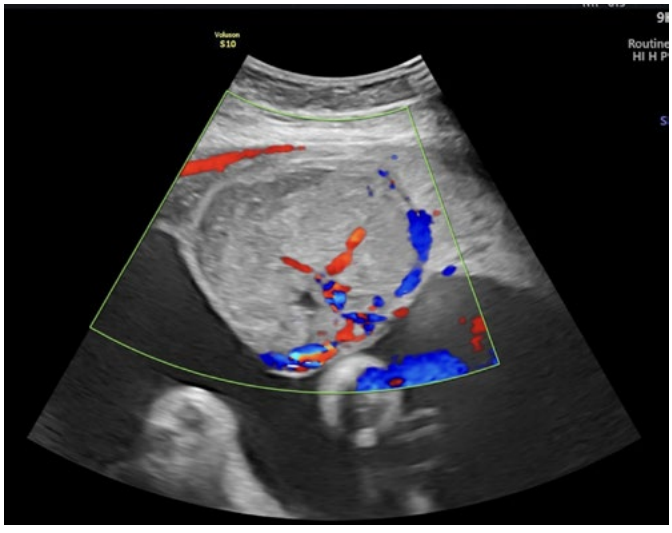
screening tool for fetal anemia. Early diagnosis, vigilant prenatal surveillance, and timely intervention are essential to minimize morbidity and mortality. This case demonstrates that fetal blood transfusion can be life-saving in managing anemia secondary to giant chorioangiomas, particularly when performed before the onset of hydrops.

Keywords: fetal anemia, intrauterine blood transfusion, placental chorioangioma, placental mass

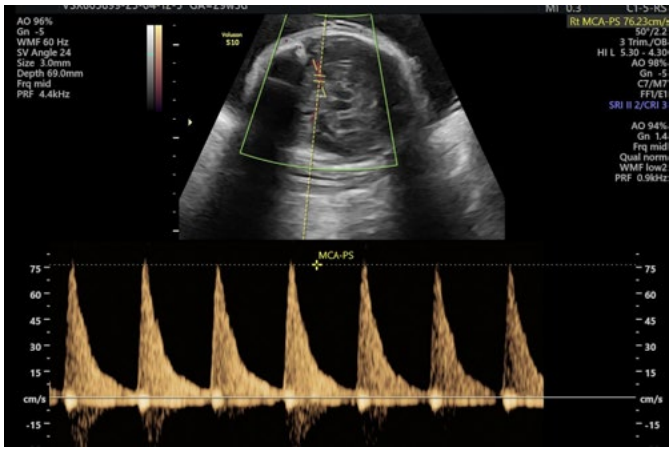
Picture 1: Gray scale ultrasound image of placental chorioangioma.



Picture 2: Doppler ultrasound vascularization image of placental chorioangioma.



Picture 3: MCA-PSV measurement in fetal Doppler ultrasound



Picture 4: Macroscopic view of placental chorioangioma



SS-074

Serum presepsin, tumor necrosis factor-α, interleukin-6, and interleukin-1 beta levels in women with unexplained infertility: A case control study

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AIM: The aim of this case-control study was to evaluate serum levels of presepsin, tumor necrosis factor-alpha (TNF-α), interleukin-6 (IL-6), and interleukin-1 beta (IL-1β) in women with unexplained infertility, and to investigate their potential role as biomarkers of systemic inflammation associated with infertility.

METHODS: This study was approved by the Institutional review board and written consent form was obtained from all patients. Thirty-five female patients diagnosed with unexplained primary infertility (normal semen analysis, normal basal hormonal profile, normal ovulatory function detected by transvaginal ultrasound or midluteal phase progesterone value, normal uterine cavity and tubal pattern detected by the hysterosalpingography) aged 20-40 years were included in the study. Thirty-six fertile patients had at least a vaginal live birth, had regular menstrual cycle, normal physical and pelvic examinations and did not use hormonal contraception were included in the control group. Participants with sexual transmitted diseases, additional illness such as hypertension, diabetes, obese (BMI of 30 kg/m2 or more) were excluded. Also, women who have used medication in the last month that could affect study results were excluded.

Following night fasting, a 5 mL of blood samples were collected in the follicular phase of the cycle (on day 3 of the menstrual cycle) between 09:00 and 10:30 am. The serum was separated by centrifuge at 3000 rpm for 5 min and stored at a temperature of -20 °C until analysis. In serum samples, routine hematological and biochemical parameters, hormone profile, presepsin, TNF-α, IL-6, and IL-1β levels were analyzed. The data were recorded in SPSS 13.0 program and independent T test was used for statistical analyses. A Pearson correlation analysis was performed to detect the relationship between demographic-clinical data and serum parameters. The P value less than 0.05 was considered statistically significant.

RESULTS: A total of 71 women were included in the study, consisting of 35 women with unexplained infertility and 36 fertile controls. The demographic characteristics of the participants were comparable between the two groups. The comparison of hormonal and routine biochemical parameters revealed no significant differences between the two groups. Except for lymphocyte count, hematological parameters were similar between the groups. Lymphocyte count was lower in patients with unexplained infertility compared with the fertile group. Among the systemic inflammatory indices, the NLR, PLR, and SII were significantly higher in the unexplained infertility group compared to fertile group. (Tables 1 and 2). Regarding inflammatory markers, TNF-α levels were significantly higher in women with unexplained infertility compared with the fertile group. In contrast, IL-1β, IL-6, and CRP levels did not differ significantly between the two groups. Notably, presepsin levels were markedly elevated in the unexplained infertility group compared with fertile controls (Table 3). In Pearson's correlation analysis, positive correlation was found between serum presepsin levels with the TNF-α ($r=0.538$, $p<0.001$), NLR ($r=0.317$, $p=0.007$), and hemoglobin ($r=0.254$, $p=0.033$) (Figures 1-3).

CONCLUSION: Increased presepsin and TNF-α levels in women with unexplained infertility indicate a possible role of inflammatory mechanisms in the pathophysiology of unexplained infertility.

Keywords: İnfertility, inflammation, presepsin, serum

Figure 1. Correlation between serum presepsin and TNF-α (tumor necrosis factor-alpha) levels.

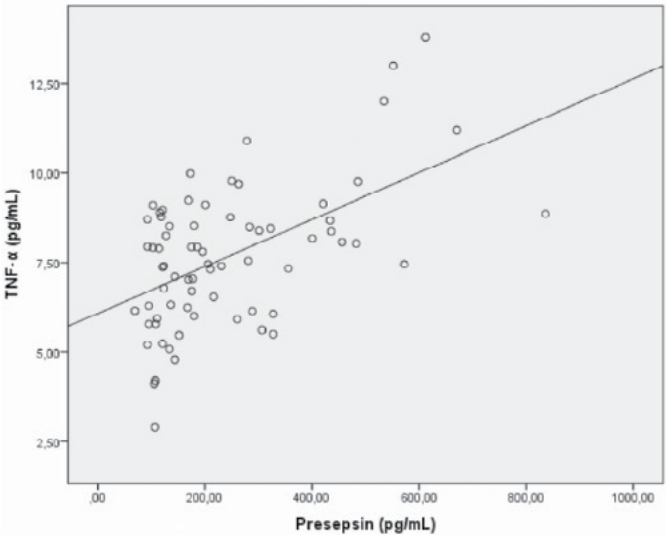


Figure 2. Association of serum presepsin levels with NLR (neutrophil-to-lymphocyte ratio).

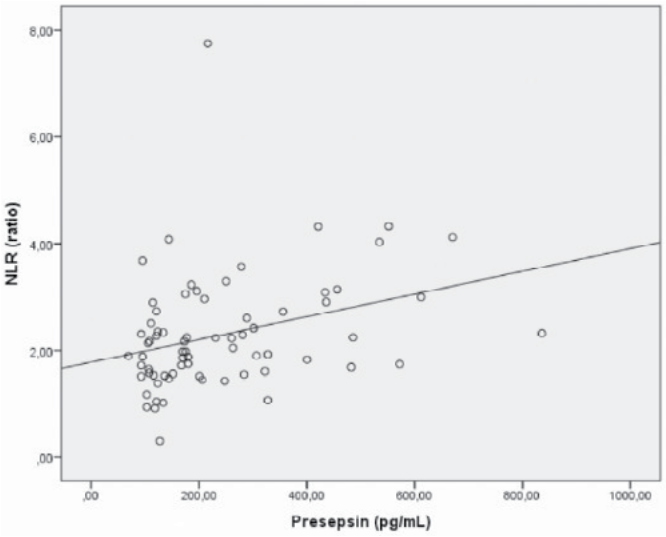


Figure 3. Association between serum presepsin and Hemoglobin levels.

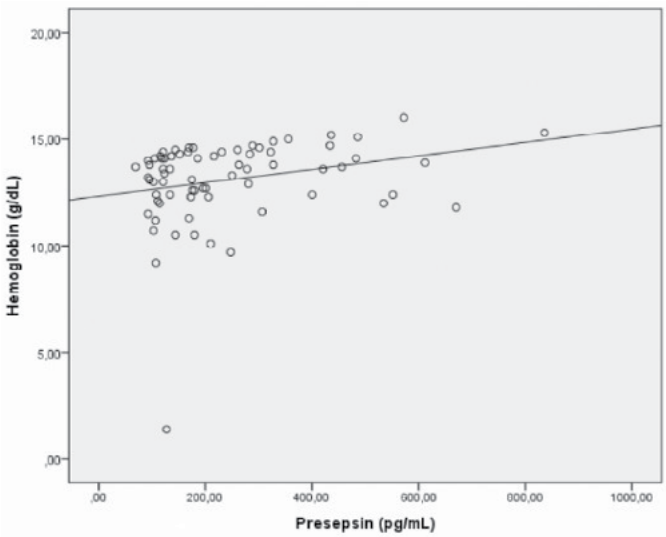


Table 1. Comparison of the groups in terms of demographic and hormonal parameters.

	Unexplained infertility group (n=35)	Fertile group (n=36)	P value
Age (years)	29.51 ± 3.54	30.81 ± 2.93	0.097
BMI (kg/m2)	24.65±1.29	24.19±1.11	0.146
Gravidity (n)	-	2.56 ± 0.88	_
Parity (n)	-	2.36 ± 0.68	_
Basal FSH (mIU/mL)	29.51 ± 3.54 24.65±1.29 5.91 ± 1.35	6.04 ± 1.80	0.731
Basal LH (mIU/mL)	4.87 ± 2.08	4.78 ± 2.78	0.880
Basal E2 (pg/mL)	38.68 ± 9.83	37.75 ± 6.77	0.645
Basal progesterone (ng/mL)	0.48 ± 0.10	0.45 ± 0.14	0.315
Prolactin (ng/mL)	12.24 ± 4.37	11.30 ± 4.52	0.375
TSH (µIU/mL	2.30 ± 1.29	1.77 ± 1.23	0.083
FT4 (pg/mL)	1.20 ± 0.14	1.13 ± 0.16	0.056
AMH (ng/mL)	2.50 ± 1.17	2.64 ± 1.43	0.648

*BMI, body mass index; FSH, follicle-stimulating hormone; LH, luteinizing hormone; E2, estradiol; TSH, thyroid-stimulating hormone; FT4, free thyroxine; AMH, anti-Müllerian hormone. Data are presented as mean ± standard deviation (SD). *: p<0.05. A p value < 0.05 was considered statistically significant.*

Table 2. Comparison of inflammatory markers, and laboratory findings between groups.

	Unexplained infertility group (n=35)	Fertile group (n=36)	P value
Hemoglobin (g/dL)	13.54 ± 1.42	12.66 ± 2.37	0.062
WBC (10^3/µL)	7.71 ± 2.19	7.58 ± 1.74	0.778
Platelet (10^3/µL)	306.91 ± 83.85	304.22 ± 70.23	0.884
Neutrophil (10^3/µL)	4.64 ± 1.66	5.00 ± 1.70	0.360
Lymphocyte (10^3/µL)	2.03 ± 0.55	2.53 ± 0.85	0.005*
Monocyte (10^3/µL)	0.49 ± 0.15	0.73 ± 1.33	0.284
PLR (ratio)	2.64 ± 1.24	1.94 ± 0.76	0.005*
PLR (ratio)	159.22 ± 52.96	131.83 ± 53.60	0.034*
MLR (ratio)	0.20 ± 0.06	0.37 ± 0.61	0.125
SII (index)	802.42 ± 396.95	614.33 ± 356.31	0.039*
Glucose (mg/dL)	85.57 ± 11.90	85.85 ± 10.37	0.917
Urea (mg/dL)	10.65 ± 3.36	11.20 ± 3.22	0.485
Creatinine (mg/dL)	0.68 ± 0.09	0.68 ± 0.11	0.944
	43.83 ± 1.98	42.10 ± 6.94	0.158
AST (U/L)	20.51 ± 6.93	16.92 ± 7.94	0.046*
ALT (U/L)	23.20 ± 7.86	23.35 ± 13.61	0.955

*WBC, white blood cell; NLR, neutrophil-to-lymphocyte ratio; PLR, platelet-to-lymphocyte ratio; MLR, monocyte-to-lymphocyte ratio; SII, systemic immune-inflammation index, AST, aspartate aminotransferase; ALT, alanine aminotransferase. Data are presented as mean ± standard deviation (SD). *: p<0.05. A p value < 0.05 was considered statistically significant.*

Table 3. Comparison of serum IL1β, IL6, TNFα, CRP, and Presepsin levels between groups.

	Unexplained infertility group (n=35)	Fertile group (n=36)	P value
IL1β (pg/mL)	4.03 ± 23.83	7.49 ± 34.26	0.622
IL6 (pg/mL)	2.33 ± 4.02	2.38 ± 4.57	0.959
TNFα (pg/mL)	8.43 ± 1.95	6.91 ± 1.69	0.001*
CRP (mg/L)	4.33 ± 1.57	4.75 ± 3.11	0.479
Presepsin (pg/mL)	337.57 ± 170.25	149.92 ± 77.93	0.000*

*CRP, C-reactive protein; IL-1β, interleukin-1 beta; IL-6, interleukin-6; TNF-α, tumor necrosis factor-alpha; HDL, high-density lipoprotein. Data are presented as mean ± standard deviation (SD). *: p<0.05. A p value < 0.05 was considered statistically significant.*

SS-077

A silent postoperative catastrophe: acute vaginal cuff dehiscence and organized hematoma following vaginal hysterectomy: a case report

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BACKGROUND: The coexistence of vaginal cuff dehiscence and organized pelvic hematoma following vaginal hysterectomy is a rare but clinically significant postoperative complication associated with substantial morbidity and requiring meticulous clinical evaluation. In this case report, we aimed to present acute vaginal cuff dehiscence accompanied by an organized pelvic hematoma after vaginal hysterectomy, and to discuss its clinical course, diagnostic approach, and surgical management in light of the current literature.

CASE PRESENTATION: A 64-year-old woman, gravida 4 para 4, presented with the complaint of a vaginal mass. The patient was postmenopausal and had a medical history notable only for hypertension. Pelvic examination revealed grade 3 cystocele and marked uterine descent.

After preoperative evaluation, vaginal hysterectomy with anterior and posterior colporrhaphy and perineoplasty was planned. The procedure was performed under general anesthesia without complications. The vaginal cuff was closed with continuous no. 1 polyglactin-910 sutures, and anterior–posterior repair was completed. Hemostasis was confirmed, and the operation was concluded. The patient had an uneventful postoperative course and was discharged on postoperative day 3.

At the postoperative day 11 outpatient visit, the patient's general condition and vital signs were stable. Vaginal examination revealed an intact suture line with dark brown spotting. Transvaginal ultrasonography (TVUS) demonstrated a 37 × 35 mm mass in the Douglas pouch (figure 1). Magnetic resonance imaging (MRI) confirmed a 45 × 40 × 22 mm organized hematoma. Laboratory parameters, including hemoglobin, WBC, and CRP, remained stable.

The patient was admitted with the provisional diagnosis of postoperative pelvic hematoma, and ceftriaxone plus metronidazole therapy was initiated. Her clinical and laboratory findings remained stable during the first three days. On day 4 of hospitalization, examination revealed disruption of the vaginal cuff with visible separation and scattered dark brown hematoma debris. TVUS showed a 20 × 18 mm irregular pelvic collection between the cuff and the Douglas pouch (figure 2). A diagnosis of vaginal cuff dehiscence was made, and surgical repair was planned.

Under general anesthesia, the hematoma was evacuated vaginally, clots were removed, and refreshed cuff edges were reapproximated with absorbable sutures. The postoperative course was stable, and the patient was discharged on the third postoperative day. Histopathological evaluation revealed normal uterine, cervical, and endometrial tissues.

Throughout the process, the patient experienced anxiety and uncertainty related to her advanced prolapse and subsequent surgical complications. The discovery of the pelvic hematoma and cuff dehiscence further heightened her distress. Successful postoperative recovery after reoperation led to improved reassurance and emotional well-being. This case underscores the psychological implications of postoperative complications on patient recovery.

CONCLUSION: Persistent vaginal spotting and pelvic collections after vaginal hysterectomy warrant comprehensive evaluation, including the possibility of vaginal cuff dehiscence in addition to hematoma or infection. Although rare, cuff dehiscence may lead to significant morbidity if not promptly recognized. Careful postoperative surveillance, appropriate imaging, and timely surgical intervention are essential to ensure favorable outcomes. Preventive strategies, including meticulous surgical technique and adequate hemostasis, remain crucial in reducing complication rates and optimizing recovery following vaginal hysterectomy.

Keywords: Vaginal hysterectomy, cuff dehiscence, hematoma, pelvic organ prolapse, complication.

Figure 1. Transvaginal ultrasonography image of a vaginal hematoma obtained at the initial postoperative presentation following vaginal hysterectomy.



Figure 2. Transvaginal ultrasonography image obtained in the postoperative period following vaginal hysterectomy, demonstrating vaginal cuff dehiscence accompanied by an organized pelvic hematoma.



SS-078

Association Between the Degree of Ovarian Torsion and Systemic Inflammatory Markers: A Single-Center Experience

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OBJECTIVE: Ovarian torsion is a gynecological emergency characterized by the rotation of adnexal structures around their vascular pedicle, requiring prompt diagnosis and surgical intervention. Delayed management may lead to impaired venous and arterial flow, resulting in ischemia, necrosis, and potential loss of ovarian function. The degree of torsion (number of rotations) is thought to be associated with the severity of ischemic injury and the subsequent systemic inflammatory response. However, data regarding the relationship between torsion degree and inflammatory markers are limited. This study aimed to evaluate the association between laparoscopically determined torsion degree and preoperative systemic inflammatory markers.

MATERIALS AND METHODS: This retrospective cross-sectional study included 122 patients who underwent surgery for ovarian torsion between January 2020 and December 2025. The diagnosis was confirmed intraoperatively in all cases. Surgical records were reviewed to determine the degree of torsion, and patients were categorized into three groups: ≤360° (Group 1), 360°–720° (Group 2), and ≥720° (Group 3). Preoperative laboratory parameters were recorded, including white blood cell count (WBC), neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), and C-reactive protein (CRP). Demographic data such as age and body mass index were also analyzed. Statistical analyses were performed using SPSS software. Continuous variables were compared using ANOVA or the Kruskal–Wallis test, depending on distribution. Post-hoc analyses were conducted with Bonferroni correction. Spearman correlation analysis was used to evaluate the relationship between torsion degree and inflammatory markers. A p-value <0.05 was considered statistically significant.

RESULTS: The mean age of the 122 patients was 28.6 ± 7.4 years. No significant differences were observed among the groups in terms of age or body mass index ($p>0.05$). WBC, NLR, and CRP levels increased significantly with higher degrees of torsion (all $p<0.001$), with the highest values observed in the ≥720° group. In contrast, PLR did not differ significantly among the groups ($p=0.09$). Spearman correlation analysis demonstrated a moderate positive correlation between torsion degree and NLR ($r=0.46$, $p<0.001$), and a strong positive correlation with CRP ($r=0.58$, $p<0.001$). WBC also showed a significant

but weaker correlation. These findings indicate that the systemic inflammatory response increases proportionally with the degree of torsion.

CONCLUSION: This study demonstrates a significant association between the degree of ovarian torsion and systemic inflammatory response. NLR and CRP, in particular, appear to be practical and accessible biomarkers for predicting the severity of torsion. These markers may provide additional value in the preoperative assessment of disease severity alongside clinical and imaging findings. However, since the degree of torsion is estimated intraoperatively and inflammatory responses may be influenced by factors such as symptom duration, further prospective studies are needed to validate these findings.

Keywords: Gynecological emergency, Ovarian Torsion, Systemic Inflammatory Markers

SS-079

Fournier's gangrene in a diabetic postmenopausal patient: early gynecological surgical intervention and multidisciplinary management

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OBJECTIVE: Fournier's gangrene is a rapidly progressive necrotizing soft tissue infection of the perineal and genital regions associated with high morbidity and mortality. In the presence of diabetes mellitus, microvascular circulatory impairment, immune insufficiency, and metabolic imbalance contribute to a more aggressive disease course and increased risk of sepsis. Concomitant renal dysfunction and hypoalbuminemia further increase mortality risk in diabetic patients. In vulvar-localized cases, early surgical intervention is critical for limiting tissue loss and preserving anatomical integrity. The aim of this study was to present the course of Fournier's gangrene in a diabetic postmenopausal patient, emphasizing early surgical debridement and the impact of multidisciplinary management on clinical outcomes.

METHODS: A 72-year-old postmenopausal woman presented with pain, warmth, and erythema localized to the left labium majus. Her medical history included insulin-dependent diabetes mellitus, hypertension, and psoriasis. On admission, vital signs were as follows: body temperature 39°C, pulse rate 105/min, arterial blood pressure 140/80 mmHg, and fasting blood glucose 256 mg/dL. Laboratory investigations revealed hemoglobin 9.9 g/dL, white blood cell count 19.1×10³/µL, platelet count 111×10³/µL, C-reactive protein 279.66 mg/L, procalcitonin 2.21 ng/mL, fibrinogen 729 mg/dL, creatinine 2.43 mg/dL, urea 86 mg/dL, sodium 133 mmol/L, and albumin 30 g/L. The Laboratory Risk Indicator for Necrotizing Fasciitis (LRINEC) score was calculated as 12 and interpreted as high risk for necrotizing infection. Pelvic computed tomography demonstrated no intra-abdominal extension, and internal genital organs appeared normal for age. Based on clinical and laboratory findings, emergency surgical debridement was performed by the gynecologic surgical team on the day of admission.

RESULTS: After obtaining blood and urine cultures, dose-adjusted meropenem and vancomycin therapy were initiated according to glomerular filtration rate. Necrotic tissues were surgically debrided in the early period. Larval therapy was incorporated into wound care for biodebridement. On the ninth day, inflammatory

parameters regressed, with C-reactive protein decreasing from 279.66 to 86 mg/L and procalcitonin from 2.21 to 0.16 ng/mL. Serum creatinine levels improved from 2.43 to 1.67 mg/dL. During follow-up, a trunk-predominant maculopapular rash developed and was considered consistent with morbilliform drug eruption. Antibiotic therapy was modified to piperacillin-tazobactam and daptomycin; however, due to fluctuations in acute phase reactants, treatment was revised to tigecycline and ciprofloxacin. The clinical course was complicated by acute kidney injury requiring hemodialysis. The wound site was reopened and re-debrided, larval therapy was continued, and local wound care with Peru balsam dressings was maintained. Approximation sutures were placed during healing. Histopathological examination demonstrated ulceration, dense polymorphonuclear leukocyte infiltration, abscess formation, bacterial colonization, and granulation tissue development. Long-term follow-up showed regression of infection findings and clinical recovery.

CONCLUSION: Fournier's gangrene carries a high mortality risk in diabetic patients. In this case, the high LRINEC score calculated at presentation supported early surgical decision-making, and aggressive debridement performed on the day of admission was decisive in infection control. Multidisciplinary management under gynecologic surgical leadership, combined with dynamic antibiotic therapy and advanced wound care strategies, prevented mortality and resulted in successful clinical recovery. Early surgical intervention remains the principal determinant of prognosis in vulvar-localized Fournier's gangrene.

Keywords: Fournier's gangrene,Vulvar necrotizing infection,Gynecological surgical debridement, Diabetes mellitus,LRINEC score

excised necrotic tissue



Excised necrotic tissue specimen obtained during surgical debridement of vulvar Fournier gangrene

fournier gangrène



intraoperative view during surgical debridement of vulvar Fournier gangrene

larval debridement



Postoperative wound appearance following larval debridement therapy after surgical treatment of vulvar Fournier gangrene

postoeprative woud healing



SS-080

Isolated Massive Vulvar Edema Due to Mechanical Lymphatic Compression in a Diabetic Pregnancy: A Case Report

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OBJECTIVE: Massive vulvar edema during pregnancy is a rare yet clinically significant finding that may herald an underlying systemic pathology. While the existing literature has largely attributed this condition to preeclampsia-associated capillary leak mechanisms, we present a case of isolated massive vulvar edema developing in the complete absence of preeclampsia in a primigravid patient with pre-existing Type 2 diabetes mellitus (T2DM), proposing cumulative pelvic mechanical compression from fetal macrosomia and polyhydramnios (PHA) as the underlying pathogenetic mechanism.

METHODS: A G1P0 patient with T2DM presented at 34 weeks and 1 day of gestation with severe vulvar edema and complete inability to ambulate. She was hospitalized and monitored under inpatient conditions for 15 days. Positional management was applied to minimize further impairment of lymphatic return secondary to immobilization. Serial blood pressure measurements, spot and 24-hour urinary protein quantification, complete blood count, hepatic and renal function panels, and serum albumin levels were obtained. Dermatology, internal medicine, and infectious disease consultations were requested to systematically exclude infectious, metabolic, and inflammatory etiologies. Ultrasonographic assessment included fetal biometry and amniotic fluid index (AFI) measurement. Needle fenestration of the labia minora was performed twice, five days apart, with aspiration of 50 cc of serous exudate per session.

RESULTS: Blood pressure remained consistently within normal limits throughout admission; no proteinuria was detected, and hepatic enzymes and platelet counts stayed within physiological ranges, confirming that no clinical or laboratory criteria for preeclampsia were satisfied. Ultrasonography revealed fetal biometry consistent with 37 weeks of gestation alongside significant PHA. Physical examination demonstrated markedly edematous labia minora with complete obliteration of anatomical boundaries and a prolapsed appearance. A characteristic "peau d'orange" texture was observed over the inguinal region and infraumbilical abdominal wall, representing the classic dermal manifestation of lymphatic insufficiency. Multidisciplinary consultations excluded an infectious etiology. Following two needle fenestration sessions, substantial symptomatic relief and partial recovery of ambulatory capacity were achieved. Pregnancy was terminated at 37 weeks via cesarean section. Upon simultaneous removal of a macrosomic fetus weighing 3,985 grams, a bulky placenta, and excess amniotic fluid, acute pelvic decompression was achieved; strikingly, vulvar edema resolved dramatically within minutes.

CONCLUSION: This case demonstrates that massive vulvar edema may arise through mechanisms entirely independent of preeclampsia. In the setting of T2DM, cumulative pelvic mechanical compression from fetal macrosomia and PHA appears sufficient to obstruct lymphatic drainage and precipitate isolated vulvar lymphedema of non-capillary origin. Experimental evidence linking chronic hyperglycemia to lymphatic endothelial dysfunction via suppression of the VEGF-C/VEGFR3 signaling axis supports the intrinsic lymphatic vulnerability present in this patient. Furthermore, immobilization secondary to edema likely perpetuated lymphatic stasis in a self-sustaining cycle. The rapid resolution of edema following cesarean-induced pelvic decompression constitutes the most compelling clinical evidence for the proposed hypothesis. Needle fenestration represents an effective, safe, and minimally invasive bridging intervention in such cases.

Keywords: Diabetes mellitus type 2, Fetal macrosomia, Lymphatic obstruction, Pregnancy complications, Needle fenestration, Vulvar edema

Figure 1. Clinical photographs demonstrating the progression and resolution of massive vulvar edema.

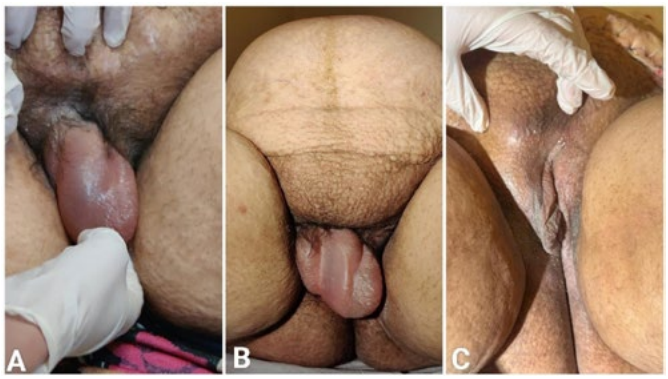


Figure 1. (A) Needle fenestration of prolapsed, massively edematous labia minora. (B) Peak vulvar edema with characteristic "peau d'orange" appearance reflecting lymphatic insufficiency. (C) Near-complete resolution within minutes of cesarean-induced pelvic decompression.

SS-081

Association Between Serum Vitamin Levels and Cervical Intraepithelial Neoplasia in HPV-Positive Women: A Prospective Cross-Sectional Study

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BACKGROUND: Persistent infection with high-risk human papillomavirus (HPV) is the principal cause of cervical intraepithelial neoplasia (CIN) and cervical cancer. Micronutrient deficiencies may modulate immune responses and HPV persistence, but evidence remains inconclusive.

METHODS: In this prospective cross-sectional study, 101 HPV-DNA positive women aged 23–62 years undergoing colposcopy at a tertiary center were consecutively enrolled between September 2021 and September 2022 at Bursa Uludağ University. All participants had cervical cytology, colposcopy-directed biopsy, and fasting blood sampling. Serum concentrations of 25-hydroxyvitamin D [25(OH)D], vitamin B12, folate, and antioxidant vitamins A, C, and E were measured using standardized automated assays.

HPV persistence was defined as the detection of the same high-risk HPV genotype on two consecutive HPV-DNA tests performed at least 12 months apart. Histopathology was classified as normal, LSIL/CIN1, or HSIL/CIN3 (CIN2 was not observed). Group comparisons and univariate logistic regression were performed, followed by multivariate logistic regression to identify independent predictors of CIN.

Exclusion criteria included pregnancy, prior hysterectomy, history of cervical surgery or malignancy, immunosuppressive diseases, immunomodulatory medications, and current use of oral contraceptives, all of which may influence hormonal or immune responses.

RESULTS: A total of 101 HPV–positive women were analyzed. The median age was 41 years, and the median BMI was 30 kg/m². Smoking was reported by 44.6% of participants; systemic diseases were present in 37.6%; multiple partners were reported by 40.6%; mean age at first coitus was 25 years. HPV persistence was detected in 37.6%. Contraceptive methods included withdrawal (23.8%) and condom (40.6%). 35.6% reported no contraception.

HPV-16 was the most frequently identified genotype (46.5%), followed by other high-risk types (37.6%), HPV-18 (8.9%), HPV-31 (4.0%), HPV-51 (2.0%), and HPV-33 (1.0%).

Cervical cytology was normal in 51.5% of cases, while abnormal findings included LSIL (24.8%), ASC-US (17.8%), HSIL (4.0%), and ASC-H (2.0%). intraepithelial lesion (HSIL) in 4 (4.0%), and atypical squamous cells—cannot exclude HSIL (ASC-H) in 2 cases (2.0%).

Histopathological examination demonstrated normal findings in 49.5% of women, LSIL/CIN1 in 29.7%, and HSIL/CIN3 in 20.8%.

Serum 25(OH)D levels were significantly lower in women with CIN compared with those with normal histology (12.2 vs 20.1 ng/mL; p = 0.01). No significant associations were observed between CIN and serum levels of vitamin B12, folate, or antioxidant vitamins A, C, and E. In multivariable logistic regression analysis, BMI (OR 1.34), smoking (OR 8.21), multiple sexual partners (OR 5.33), age at first intercourse (OR 1.21), and HPV persistence (OR 18.52) were identified as independent predictors of CIN. Serum vitamin levels were not independently associated with CIN. However, subgroup analysis revealed a significant association between vitamin D deficiency and CIN among smokers (p = 0.008).

CONCLUSIONS: Among HPV-positive women, low vitamin D levels are associated with CIN in unadjusted analyses, particularly among smokers, but do not independently predict CIN after accounting for behavioral and viral risk factors. Vitamin D may represent a modifiable cofactor within a multifactorial risk profile rather than a primary determinant of cervical neoplasia.

Keywords: Cervical intraepithelial neoplasia, HPV, micronutrients

SS-082

Comparison of Clinical and Imaging Findings Between Type 0 Submucosal Myoma and Endometrial Polyps

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OBJECTIVE: Endometrial polyps and type 0 submucosal myomas are among the most common intrauterine cavity lesions associated with abnormal uterine bleeding and infertility. These two entities may present with similar clinical symptoms and overlapping imaging features, making preoperative differentiation challenging. However, accurate diagnosis is crucial for appropriate treatment planning and surgical management. This study aimed to compare the clinical, ultrasonographic, and hysteroscopic characteristics of type 0 submucosal myomas and endometrial polyps and to identify parameters that may aid in their preoperative differentiation.

MATERIALS AND METHODS: This retrospective study included a total of 148 patients who underwent hysteroscopy at our center between 2020 and 2025 and were histopathologically diagnosed with either type 0 submucosal myoma or endometrial polyp. Patients were divided into two groups: type 0 submucosal myoma (n=62) and endometrial polyp (n=86). Demographic characteristics, presenting symptoms, transvaginal ultrasonography findings, Doppler vascular patterns, and hysteroscopic features were evaluated and compared between the groups. Ultrasonographic parameters included lesion size, morphology (pedunculated vs broad-based), vascularity pattern (single feeding vessel vs diffuse/peripheral vascularity), and the presence of acoustic shadowing. Hysteroscopic findings such as lesion consistency, surface characteristics, and resection difficulty were also recorded.

RESULTS: The mean age was 35.8 ± 6.9 years in the myoma group and 34.2 ± 7.3 years in the polyp group, with no significant difference between the groups (p=0.18). Lesion size was significantly larger in the myoma group (22.4 ± 8.6 mm vs 13.1 ± 5.2 mm, p<0.001). In terms of clinical presentation, menorrhagia was more frequent in patients with myoma (61.3% vs 32.5%, p=0.001), whereas intermenstrual bleeding was more commonly observed in the polyp group (48.8% vs 24.2%, p=0.003); infertility rates were comparable between the two groups (27.4% vs 31.4%, p=0.59). Ultrasonographic evaluation demonstrated that broad-based morphology was significantly more common in myomas (72.6% vs 29.1%, p<0.001), while pedunculated lesions were more frequently observed in polyps (64.0% vs 19.3%, p<0.001). A single feeding vessel pattern was more prevalent in polyps (58.1% vs 21.0%, p<0.001), whereas diffuse or peripheral vascularity was more frequently detected in myomas (66.1% vs 27.9%, p<0.001). Additionally, acoustic shadowing was significantly more common in the myoma group (41.9% vs 9.3%, p<0.001). Hysteroscopically, myomas were more often firm with regular contours (74.2% vs 28.0%, p<0.001), whereas polyps were typically soft and mobile (69.8% vs 22.6%, p<0.001). Finally, operative time was significantly longer in the myoma group compared to the polyp group (18.6 ± 6.2 minutes vs 11.2 ± 4.8 minutes, p<0.001).

CONCLUSION: Significant differences exist between type 0 submucosal myomas and endometrial polyps in terms of clinical presentation, ultrasonographic features, and hysteroscopic findings. Lesion size, vascularity pattern, and lesion base morphology appear to be key parameters in preoperative differentiation. A combined evaluation of these features may improve diagnostic accuracy and guide appropriate surgical planning.

Keywords: Endometrial polyp, Type 0 myoma, Hysteroscopy

SS-083

Transrectal Ultrasound Diagnosis and Medical Management of Ectopic Pregnancy Revealing a Complex Müllerian Anomaly: Blind Vagina with Double Cervix

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Transrectal Ultrasound Diagnosis and Medical Management of Ectopic Pregnancy Revealing a Complex Müllerian Anomaly: Blind Vagina with Double Cervix

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OBJECTIVE: Ectopic pregnancy in the setting of congenital müllerian duct anomalies is rare and may present with atypical anatomical and diagnostic challenges. The coexistence of a blind vagina and double cervix represents an exceptionally uncommon müllerian anomaly. This case report describes the diagnosis and successful medical management of ectopic pregnancy in a patient with a blind vagina and double cervix, utilizing transrectal ultrasonography (TRUS) and magnetic resonance imaging (MRI).

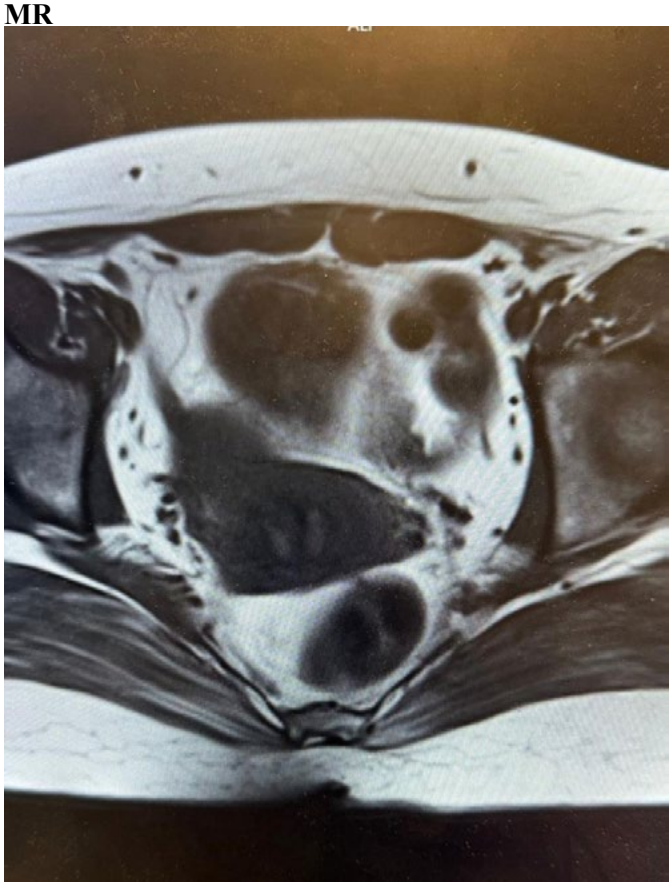
CASE PRESENTATION: A 29-year-old nulliparous woman (G1P0), married for one month, presented to the gynecology outpatient clinic with pelvic pain and amenorrhea. Gynecological examination revealed a blind vaginal pouch that precluded conventional transvaginal ultrasonography. Transrectal ultrasonography (TRUS) was therefore performed as an alternative imaging modality. Imaging findings were suspicious for ectopic pregnancy, and serum beta-human chorionic gonadotropin (β-hCG) was markedly elevated. Magnetic resonance imaging (MRI) was subsequently obtained to further delineate pelvic anatomy and characterize the suspected müllerian duct anomaly.

RESULTS: Transrectal ultrasonography demonstrated findings consistent with ectopic pregnancy and revealed an underlying müllerian anomaly. Magnetic resonance imaging confirmed a complex müllerian duct anomaly characterized by a blind vagina and double cervix. The patient received a single-dose intramuscular methotrexate (MTX) of 92.5 mg (50 mg/m²) on day 0. Serial serum β-hCG measurements demonstrated a progressive and favorable decline: the initial level was 2,658 mIU/mL, which decreased to 451 mIU/mL on day 4 and 178 mIU/mL on day 7, confirming successful medical treatment.

CONCLUSION: The coexistence of ectopic pregnancy with a blind vagina and double cervix represents an exceptionally rare clinical scenario. In patients with obstructive genital tract anomalies in whom transvaginal ultrasonography is not feasible, transrectal ultrasonography may serve as an effective and safe alternative imaging modality, while MRI provides comprehensive anatomical characterization of complex müllerian anomalies. This case underscores the diagnostic value of TRUS and highlights that single-dose methotrexate therapy can achieve successful resolution of ectopic pregnancy even in the presence of rare congenital genital tract anomalies.

Keywords: blind vagina,double cervix,ectopic pregnancy,methotrexate,müllerian anomaly, transrectal ultrasonography

MR



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MR2



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SS-084

Ovarian Torsion with Missed Preoperative Radiological Diagnosis Complicated by Ventricular Tachycardia Following Anesthesia: A Case Report

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INTRODUCTION: Ovarian torsion is a rare gynecological emergency that may result in irreversible ovarian damage if the diagnosis is delayed. It predominantly affects women of reproductive age and is frequently associated with benign cystic or neoplastic ovarian lesions. This case report highlights the challenges in radiological diagnosis and a rare anesthesia-related complication.

CASE PRESENTATION: This report presents the case of a 33-year-old woman (G1P1, previous cesarean section) who presented with abdominal pain persisting for five days. Initial contrast-enhanced computed tomography described the left ovary as edematous and measuring approximately 10 cm, but no cyst was identified (Figure-1). Subsequent transvaginal ultrasonography revealed a 10×8 cm septated cystic lesion with sonographic signs of torsion, leading to an urgent surgery. During induction of anesthesia with propofol, the patient developed unstable ventricular tachycardia, which was successfully managed with cardioversion. Exploration via laparotomy revealed that left ovary was twisted three times around its pedicle with an approximately 10 cm mucinous cyst and any signs of necrosis was not visualized (Figure-2). Despite patient's symptoms had continued during 5 days, detorsion was performed and perfusion of ovary observed (Figure-3). Cyst excision was performed after the detorsion. Histopathological evaluation confirmed mucinous cystadenoma. During the early postoperative period, the tachycardia was persisted (120–135 bpm), which was diagnosed as sinus tachycardia with left bundle branch block, with no structural cardiac pathology on echocardiography. She was discharged in stable condition.

CONCLUSION: This case is notable for the initial radiological omission of the ovarian cyst, emphasizing the importance of multidisciplinary evaluation, and the rare occurrence of anesthesia-related ventricular tachycardia during management. As ovarian torsion may be overlooked on computed tomography imaging, obstetricians and gynecologists should place particular reliance on their own ultrasonographic assessment. It highlights the need for attention regarding potential anesthesia-related complications and the timing of diagnosis and surgical management to preserve ovarian function.

Keywords: Ovarian torsion, Mucinous cystadenoma, Ventricular tachycardia

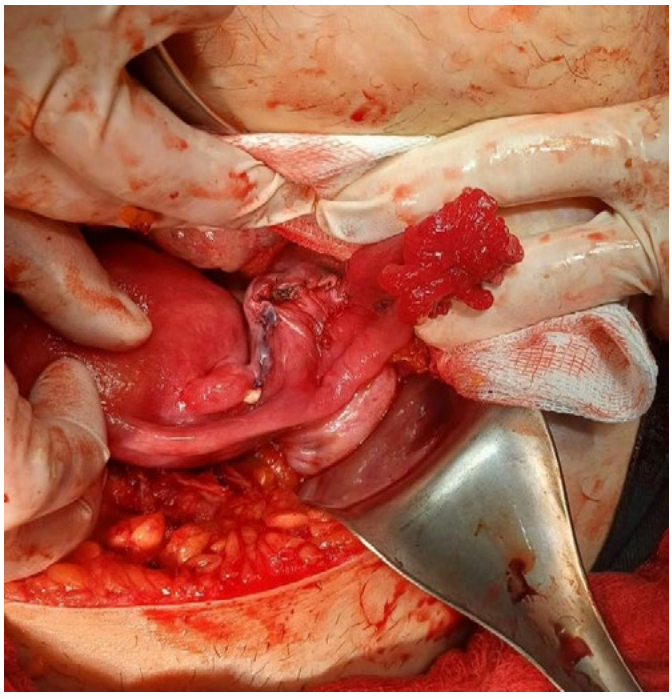
Figure-1



Figure-2



Figure-3



SS-086

Giant peritoneal inclusion cyst mimicking an ovarian neoplasm after multiple pelvic surgeries: A case report

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AIM: Peritoneal inclusion cysts (PICs) are benign multiloculated fluid collections arising from reactive mesothelial proliferation adjacent to peritoneal surfaces. They are frequently associated with previous pelvic surgery and develop when ovarian fluid becomes trapped within peritoneal adhesions formed after surgical trauma or inflammation [1,2]. Although PICs are benign lesions, their radiological appearance may mimic ovarian neoplasms, particularly when they reach large sizes or demonstrate multiloculated morphology. The aim of this report is to present the clinical presentation, radiological findings, surgical management, and histopathological confirmation of a giant peritoneal inclusion cyst occurring in a patient with a history of multiple pelvic surgeries.

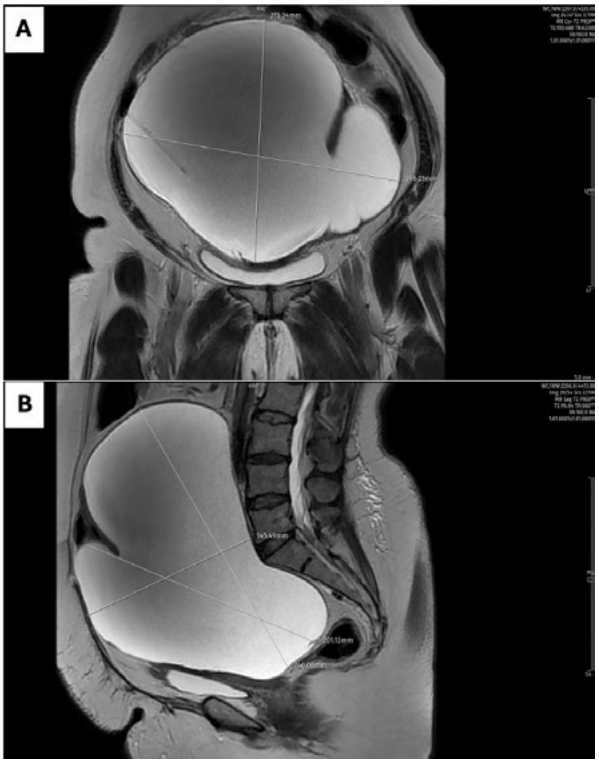
METHODS: A 49-year-old woman presented with abdominal pain lasting three months and progressive abdominal distension for one month. Her surgical history included multiple pelvic procedures, including two cesarean sections, myomectomy, and total abdominal hysterectomy. Physical examination revealed marked abdominal distension. Laboratory investigations, including tumor markers, were within normal limits. Imaging studies were performed using transvaginal ultrasonography and magnetic resonance imaging (MRI) to evaluate the pelvic mass. Due to the large size of the lesion and the inability to exclude ovarian malignancy, surgical exploration was planned. Intraoperative findings and histopathological examination were used to establish the final diagnosis.

RESULTS: Transvaginal ultrasonography demonstrated a large cystic pelvic mass measuring approximately 11 cm. MRI revealed a multiloculated cystic lesion measuring 246 × 145 × 105 mm, occupying the pelvis and extending toward the lower abdomen. The lesion showed internal septations without contrast-enhancing solid components or diffusion restriction. It appeared hypointense on T1-weighted images and hyperintense on T2-weighted images and caused extrinsic compression of the urinary bladder and displacement of adjacent pelvic structures (Figure 1A,1B). Although imaging findings suggested a benign cystic lesion, ovarian cystic neoplasms could not be excluded. Exploratory laparotomy revealed a giant multiloculated cystic mass filling the pelvis with dense adhesions to the sigmoid colon and surrounding bowel loops (Figure 2A,2B). Following careful adhesiolysis, the cyst was completely excised and approximately 2500 mL of serous fluid was drained. Both ovaries were identified intraoperatively and appeared normal. The operative time was approximately 90 minutes, and estimated blood loss was 150 mL. The postoperative course was uneventful. Histopathological examination demonstrated a cyst wall lined by mesothelial cells without evidence of malignancy, confirming the diagnosis of a benign peritoneal inclusion cyst.

CONCLUSION: Peritoneal inclusion cysts are reactive lesions typically occurring in women with a history of pelvic surgery due to the accumulation of ovarian fluid trapped between peritoneal adhesions [2,4]. Large multiloculated lesions may mimic ovarian malignancies and create diagnostic challenges during preoperative evaluation [1,5]. Therefore, PICs should be considered in the differential diagnosis of large septated pelvic masses, especially in patients with previous pelvic surgery. Imaging modalities, particularly MRI, play a critical role in the evaluation of these lesions, while surgical excision provides both definitive diagnosis and effective treatment in giant symptomatic cases [3,5,6].

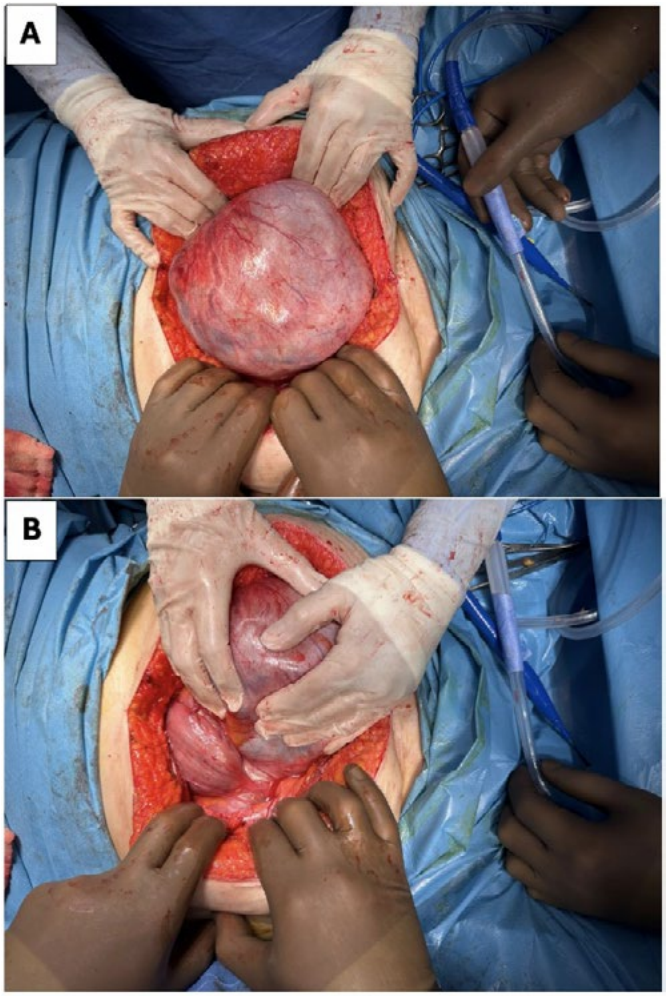
Keywords: Peritoneal Inclusion Cyst, Pelvic Cystic Mass, Pelvic Adhesions, Magnetic Resonance Imaging, Myomectomy

Figure 1. Magnetic resonance imaging (MRI) of the pelvic lesion.



(A) Coronal T2-weighted MRI demonstrating a giant multiloculated cystic lesion occupying the pelvis, measuring approximately 246 × 145 × 105 mm. (B) Sagittal T2-weighted MRI showing the large cystic lesion filling the pelvis and causing extrinsic compression of the urinary bladder.

Figure 2. Intraoperative views of the giant peritoneal inclusion cyst.



(A) Giant peritoneal inclusion cyst occupying the pelvis after laparotomy. (B) Dense adhesions between the cyst wall and the sigmoid colon observed during surgical exploration.

SS-087

Evaluation of the Relationship Between HPV 16 Viral Load Detected by Droplet Digital PCR (ddPCR), Age, and Number of Sexual Partners

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INTRODUCTION AND OBJECTIVE: Among the high-risk Human Papillomavirus (HPV) types, which are the most critical factors in cervical carcinogenesis, the role of HPV 16 viral load levels in disease progression and persistence is increasingly being investigated. In recent years, Droplet Digital PCR (ddPCR) technology, which provides high sensitivity and absolute quantification in viral load measurement, has come to the forefront. The aim of this study is to investigate the relationship between the HPV 16 viral load detected by the ddPCR method, patients' age groups, and the number of sexual partners.

MATERIALS AND METHODS: The ddPCR results obtained from cervical swab samples of patients who tested positive for HPV 16 in our clinic were analyzed prospectively. Patients were categorized according to their age (<45 years and ≥45 years) and the number of sexual partners (single partner and multiple partners). Differences in HPV 16 viral load (copies/µL) between the groups were analyzed statistically.

RESULTS: In the evaluation of the patients included in the study according to age groups; the mean HPV 16 viral load in the under-45 age group was measured as 21,920 ± 13,841 copies/µL, whereas it was 36,980 ± 29,858 copies/µL in the 45 years and older age group. Although a numerical increase was observed in the older age group, this difference was not statistically significant (p=0.672).

In the analysis based on the number of partners; the mean viral load in patients with a single partner was 18,143 ± 12,689 copies/µL, while it was 41,941 ± 32,347 copies/µL in patients with multiple partners. Although the viral load was numerically more than double in the multiple-partner group, the difference did not reach statistical significance due to the high standard deviations (p=0.500). Furthermore, no independent effect of age, smoking, or the co-infection of HPV 16 with other types was observed in the prediction of High-Grade Squamous Intraepithelial Lesion (HSIL).

DISCUSSION AND CONCLUSION: The absence of a significant effect of classical risk factors, such as age and number of sexual partners, on viral load levels suggests that the viral load is primarily determined by the biological dynamics of the infection. Our findings confirm that ddPCR is a robust method offering high analytical sensitivity for the quantification of HPV viral load in cervical swab samples. However, the lack of correlation between single-time point viral load measurements and SIL severity indicates that viral load alone is insufficient to serve as an independent clinical biomarker.

To clearly establish the diagnostic and prognostic value of viral load, longitudinal studies based on serial measurements are required, along with the evaluation of these data alongside additional parameters such as immune response, oncoprotein expression, and cervicovaginal microbiota. Based on current data, there is no independent sociodemographic risk factor for HSIL prediction, nor is there a defined pre-colposcopy triage factor for patients identified as HPV 16 positive. Therefore, referring all HPV 16 positive patients to colposcopy remains the most appropriate and reliable approach in clinical practice.

Keywords: HPV 16, Viral Load, Droplet Digital PCR, Cervical Cancer, Colposcopy, HSIL.

SS-089

46,XY Gonadal Dysgenesis (Swyer Syndrome) in a Phenotypic Female Presenting with Primary Amenorrhea: A Case Report

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OBJECTIVE: 46,XY gonadal dysgenesis (Swyer syndrome) is a rare disorder of sex development that typically presents with primary amenorrhea in individuals with a phenotypically female appearance. This case report aims to present the diagnostic process and clinical management of a patient evaluated for primary amenorrhea in whom a 46,XY karyotype was detected during genetic investigation.

METHODS: A 22-year-old female patient was evaluated due to primary amenorrhea. Her medical history revealed type 1 diabetes mellitus and bipolar disorder. The patient was receiving insulin, fluoxetine, carbamazepine, risperidone, and hormonal therapy. She also had a history of leukemia treated during childhood. On physical examination, her height was 155 cm and weight was 40 kg. Evaluation of secondary sexual characteristics showed absence of breast development and lack of axillary and pubic hair. The patient reported experiencing withdrawal bleeding only with cyclic hormone therapy (Cyclo-Progynova) since the age of 15. Transvaginal ultrasonography revealed a small uterus measuring 22 × 20 × 17 mm, and the ovaries could not be clearly visualized. Pelvic magnetic resonance imaging reported a uterus smaller than expected for age and absence of normal ovarian morphology. Genetic investigation performed to determine the etiology demonstrated a karyotype of 46,XY.

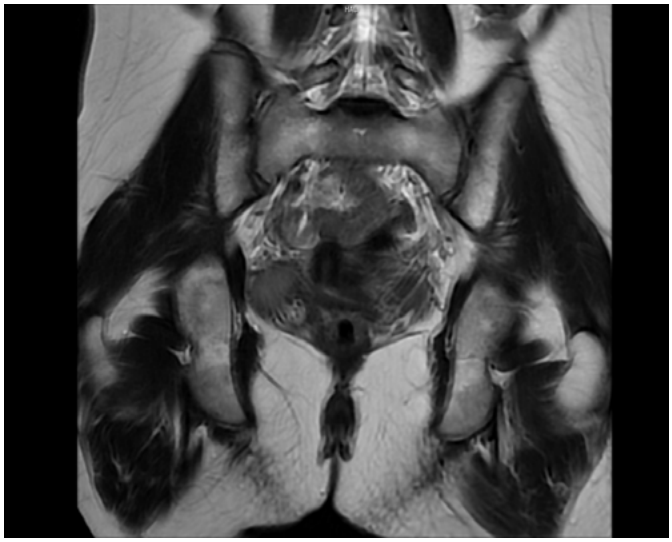
RESULTS: Laboratory investigations showed follicle-stimulating hormone (FSH) level of 52.3 IU/L, luteinizing hormone (LH) level of 28 IU/L, and estradiol level of 5.1 pg/mL. The markedly elevated gonadotropin levels together with low estradiol levels were consistent with hypergonadotropic hypogonadism. In this phenotypically female patient presenting with primary amenorrhea, absence of secondary sexual characteristics, a small uterus, and failure to identify normal ovarian tissue on imaging led to further investigation. Detection of a 46,XY karyotype resulted in the diagnosis of 46,XY gonadal dysgenesis (Swyer syndrome). Due to the high risk of gonadoblastoma development in streak gonads, prophylactic gonadectomy was planned.

CONCLUSION: 46,XY gonadal dysgenesis should be considered, although rare, in patients presenting

with primary amenorrhea and absent secondary sexual characteristics. Detailed physical examination, hormonal evaluation, imaging methods, and genetic testing play a crucial role in the diagnostic process. Because of the significant risk of gonadoblastoma, early prophylactic gonadectomy is recommended once the diagnosis is established.

Keywords: primary amenorrhea, gonadal dysgenesis, Swyer syndrome, gonadoblastoma risk

MRG



MRG2



SS-090

Bilateral ovarian torsion detected during surgery for acute abdomen: a case report

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OBJECTIVE: Ovarian torsion is one of the most important gynecologic emergencies. Early diagnosis and prompt surgical intervention are essential for preserving ovarian function, particularly in young and nulliparous women. Bilateral ovarian torsion is extremely rare but may have serious consequences for future fertility. In this report, we present a case of bilateral ovarian torsion detected during surgery for acute abdomen.

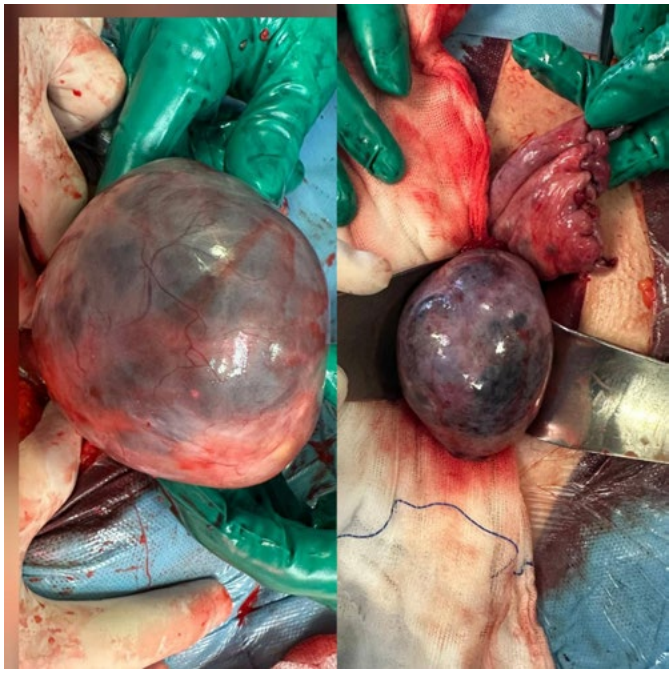
METHOD: A 28-year-old nulliparous woman was admitted to our gynecology clinic with severe lower abdominal pain. She had a history of laparoscopic surgery for ovarian torsion 9 years earlier. The patient had been using 2 mg dienogest for an ovarian cyst suspected to be an endometrioma. Physical examination revealed findings consistent with an acute abdomen. Ultrasonographic evaluation demonstrated an approximately 5 cm cyst in the right adnexal region and a 6.5 × 10 cm cystic mass compatible with cystic teratoma. The left ovary could not be clearly evaluated due to the large cystic mass.

RESULTS: Due to the presence of acute abdomen findings, laparotomy was performed to diagnose and treat possible ovarian torsion. During surgical exploration, the uterus appeared normal; however, both ovaries were found to be torsioned. Bilateral detorsion and cystectomy were performed. Following revascularization, the color of the left ovary returned to normal, whereas the right ovary remained unchanged. Considering the patient's previous torsion history, bilateral shortening of the ovarium proprium ligament was performed using figure-of-eight sutures in order to prevent recurrence. Pathological examination revealed mucinous cystadenoma in the right ovary and mature cystic teratoma in the left ovary. The anti-Müllerian hormone level was 2.66 ng/mL on the first postoperative day and 3.76 ng/mL six months after surgery.

CONCLUSION: Ovarian torsion should be considered in women presenting with lower abdominal pain and acute abdomen findings. Early diagnosis and prompt surgical intervention are crucial for preserving ovarian function and fertility. Preventive surgical procedures may be considered in patients with a history of recurrent ovarian torsion.

Keywords: Torsion, bilateral, ovary, fertility

torsion of the bilateral ovaries



torsion of the bilateral ovaries, left and right,

SS-091

A Rare Cause of Persistent Postpartum Hemorrhage: Acquired Hemophilia A

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OBJECTIVE: Acquired hemophilia A (AHA) is a rare but potentially life-threatening bleeding disorder caused by autoantibodies against factor VIII. Its incidence in the general population is approximately 1–1.5 per million per year, and a small proportion of cases occur during the postpartum period. Postpartum AHA usually develops within the first few months after delivery and may present with unexplained bleeding. In obstetric patients, postpartum hemorrhage is most often attributed to uterine atony, retained placental tissue, or surgical complications, which may delay the recognition of underlying coagulation disorders. Delayed diagnosis has been associated with repeated surgical interventions and unnecessary hysterectomies. This study aims to present a rare case of acquired hemophilia A diagnosed after secondary postpartum hemorrhage and multiple surgical procedures.

METHODS: The clinical findings, laboratory results, surgical interventions, and hematological treatment course of a 31-year-old patient (gravida 3, para 2, abortus 1) were retrospectively reviewed. Obstetric history, postpartum bleeding episodes, performed surgical procedures, coagulation parameters, and hematological treatments were evaluated.

RESULTS: The patient presented with secondary postpartum hemorrhage 10 days after vaginal delivery. Initial evaluation suggested an obstetric cause of bleeding. Uterine curettage was performed for suspected retained placental tissue; however, no placental tissue was identified. Due to persistent bleeding, a Bakri balloon was placed for uterine tamponade, but bleeding could not be controlled and the patient was referred to a tertiary care center. At admission, hemoglobin was 9.4 g/dL and rapidly decreased to 6.8 g/dL. Despite medical management, revision curettage, and uterotonic therapy, bleeding persisted and total abdominal hysterectomy was performed for presumed uterine atony. The patient initially remained stable but presented again with vaginal bleeding on postoperative day six. Laboratory evaluation revealed markedly prolonged activated partial thromboplastin time (aPTT) (65 seconds) with normal prothrombin time. Due to recurrent bleeding, additional surgical procedures including vaginal cuff repair and bilateral hypogastric artery ligation were performed. During the clinical course, the patient required multiple surgical interventions and transfusion of 20 units of

packed red blood cells, 16 units of fresh frozen plasma, and 8 units of cryoprecipitate. Further hematological evaluation revealed factor VIII activity of 1.5% and a factor VIII inhibitor level of 312 Bethesda units (BU/mL), confirming the diagnosis of acquired hemophilia A. Hemostasis was achieved using bypassing agents (FEIBA and recombinant factor VIIa), and inhibitor eradication therapy included high-dose corticosteroids, cyclophosphamide, and rituximab. Bleeding was eventually controlled with a multidisciplinary approach.

CONCLUSION: Although rare, acquired hemophilia A should be considered in cases of postpartum hemorrhage that cannot be controlled with standard obstetric management. Unexplained bleeding accompanied by isolated prolongation of aPTT is an important diagnostic clue. Early recognition may prevent unnecessary surgical interventions and allow timely initiation of appropriate hematological treatment.

Keywords: Acquired hemophilia A, Factor VIII inhibitor, Postpartum hemorrhage, Postpartum hysterectomy

SS-092

Silent uterine rupture in a pregnancy with a history of recurrent cesarean sections that reached term

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AIM: Uterine rupture is a rare but potentially life-threatening obstetric complication for both the mother and the fetus. It may occur as complete rupture, involving separation of all uterine layers including the serosa, or as incomplete rupture where the serosa remains intact. Most cases present with acute maternal or fetal distress; however, in rare situations uterine rupture may occur with minimal or no symptoms. The aim of this report is to present a case of silent complete uterine rupture that was incidentally detected during a planned cesarean section in a hemodynamically stable term pregnancy with a history of multiple previous cesarean deliveries.

METHODS: A 33-year-old pregnant woman (gravida 4, parity 3) at 39 weeks of gestation was admitted to the obstetrics department for a planned cesarean delivery due to a history of three previous cesarean sections. The patient reported only mild lower abdominal pain and denied uterine contractions. Her general condition was good and vital signs were stable.

Non-stress test (NST, non-stress test) monitoring was reactive, with a baseline fetal heart rate of approximately 120 beats per minute, and no uterine contractions were detected. Ultrasonographic examination revealed no evidence of hemoperitoneum or free intraperitoneal fluid.

As the patient was scheduled for elective delivery, she was prepared for surgery and a cesarean section was performed under spinal anesthesia.

RESULTS: Following a Pfannenstiel incision and entry into the abdominal cavity, a complete uterine rupture measuring approximately 4 × 5 cm was unexpectedly observed in the lower uterine segment. The amniotic sac remained intact despite the rupture. After opening the membranes, clear amniotic fluid was observed. A live female neonate weighing 3180 g, measuring 50 cm in length, and with a head circumference of 33 cm was delivered by cephalic extraction. The placenta was removed completely and the uterus was repaired using a locked continuous polyglactin suture. Intraoperative inspection revealed normal ovaries and no additional pelvic pathology. No hemoperitoneum or significant intra-abdominal bleeding was observed. The postoperative course was uneventful, and the patient was discharged on postoperative day two in stable condition.

CONCLUSION: Uterine rupture may occur with

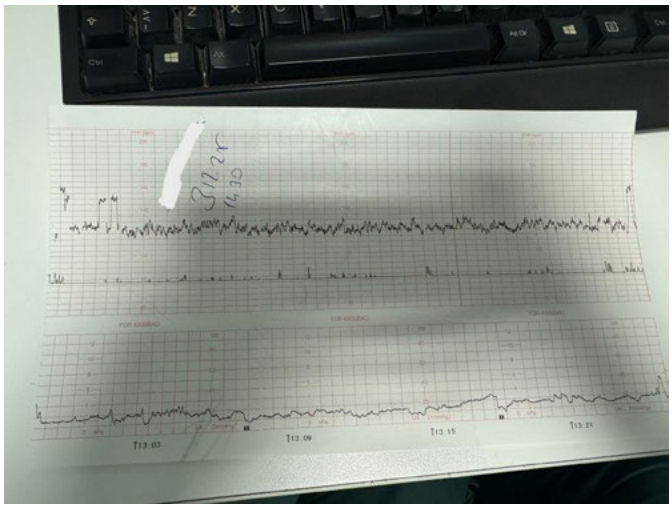
minimal or atypical clinical findings, particularly in patients with a history of multiple cesarean deliveries. Even minimally abdominal pain or subtle abnormalities in fetal monitoring may represent early signs of this serious condition. Clinicians should maintain a high level of suspicion in high-risk pregnancies, as early recognition and timely surgical management are essential to prevent severe maternal and fetal morbidity and mortality.

Keywords: Elective cesarean delivery, Obstetric complication, previous cesarean section, silent uterine rupture, uterine rupture,

3. Ay Kontrol Usg



NST



uterine rupture



SS-093

Comparison of maternal, obstetric, and neonatal outcomes between singleton and twin pregnancies with preterm prelabor rupture of membranes at 24+0–33+6 weeks' gestation

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AIM: To compare maternal, obstetric, and neonatal outcomes between singleton and twin pregnancies complicated by preterm prelabor rupture of membranes (PPROM) at 24+0–33+6 weeks' gestation. In particular, we aimed to assess whether the interval from PPROM diagnosis to delivery (latent period), hospitalization characteristics, and the need for neonatal intensive care differ according to pregnancy plurality.

METHODS: This retrospective cohort study was conducted at Necmettin Erbakan University Faculty of Medicine between January 2020 and June 2025. A total of 270 pregnancies diagnosed with PPROM between 24+0 and 33+6 weeks' gestation were included. Cases were categorized as singleton (n=208) or twin (n=62) pregnancies. Pregnancies complicated by major fetal anomalies, intrauterine fetal demise, or insufficient core clinical data were excluded. Maternal and obstetric outcomes were analysed at the pregnancy level, whereas neonatal outcomes were evaluated at the infant level. Continuous variables were presented as median [IQR] and categorical variables as n (%). Pregnancy-level comparisons were performed using the Mann–Whitney U test and the chi-square or Fisher's exact test, as appropriate. Because co-neonates from the same twin pregnancy were not statistically independent, neonatal analyses were performed using clustered generalized estimating equation models accounting for within-pregnancy correlation. Ethical approval was obtained from the Necmettin Erbakan University Ethics Committee (Decision No: 2026/6374).

RESULTS: Maternal age and gravidity were similar between the groups (p>0.05). However, parity was lower in twin pregnancies (0 [0–1] vs 1 [0–2], p=0.013). Although PPROM was diagnosed at a later gestational age in twin pregnancies (31 [28–32] weeks vs 29 [26–32] weeks, p=0.003), the latent period was significantly shorter (3 [1–8] days vs 8 [4–31.25] days, p<0.001). Likewise, total maternal hospital stay related to PPROM was shorter in twin pregnancies (3 [1–5.75] days vs 5 [4–10] days, p<0.001). Home follow-up was less frequent in twin pregnancies (9.7% vs 31.2%, p<0.001). A history of threatened abortion in the index pregnancy was more common in twin pregnancies (25.8% vs 12.0%, p=0.008). Cesarean delivery was more frequent in twin pregnancies, although the difference was not statistically significant (95.2% vs 86.5%, p=0.062). Major maternal morbidities, including chorioamnionitis, placental abruption, postpartum endometritis, and maternal sepsis, were comparable between the groups (all p>0.05). Neonatal outcomes were less favorable in twin pregnancies. Neonatal intensive care unit admission was more frequent in twin pregnancies (72.6% vs 53.4%, p=0.003), and birth weight was lower (1680 [1315–1937.5] g vs 1760 [1300–2302.5] g, p=0.008). Apgar scores, duration of neonatal intensive care stay, and neonatal mortality did not differ significantly between the groups (all p>0.05).

CONCLUSION: Among pregnancies complicated by PPROM at 24+0–33+6 weeks' gestation, twin pregnancies were associated with a shorter latent period, less frequent home follow-up, and a greater need for neonatal intensive care compared with singleton pregnancies. Although major maternal infectious morbidity was similar between the groups, neonatal burden appeared to be higher in twin pregnancies. These findings suggest that antenatal surveillance and neonatal preparedness should be planned more carefully in twin pregnancies complicated by PPROM.

Keywords: latent period, neonatal outcomes, preterm prelabor rupture of membranes, twin pregnancy

SS-094

Factor VII Deficiency and Management in Pregnancy and Childbirth

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Factor VII deficiency is a rare (1/500,000) autosomal recessive disorder characterized by low plasma levels of the FVII protein, which plays a role in the exogenous pathway of the coagulation cascade. The severity of bleeding episodes in patients is not proportional to factor levels. It can cause placental-retroplacental bleeding. Life-threatening bleeding may occur from the episiotomy site and during cesarean section. Bleeding episodes due to factor VII deficiency are treated with prothrombin complex concentrates (PCC, aPCC) and fresh frozen plasma (FFP). The aim of this study is to discuss, in light of the literature, the pre- and post-natal management strategies of a pregnant woman with factor VII deficiency diagnosed with isolated PT prolongation and severe anemia during the follow-up period until delivery. The study included a 26-year-old female patient from the Obstetrics and Gynecology Clinic of Fethi Sekin City Hospital. In this presentation, we aim to present the pregnancy and delivery management of a patient with F7 deficiency who had previously experienced two abortions and underwent cesarean section at 38 weeks of gestation due to fetal distress. The patient's blood values were measured and monitored in the laboratory throughout her pregnancy. A coagulation abnormality was detected during routine prenatal checkups.

In obstetric practice, isolated PT prolongation should be considered a "red flag," and FVII deficiency should be ruled out in the differential diagnosis.

Modern Management and Use of rFVIIa: Although fresh frozen plasma (FFP) is used in conventional treatment, the volume overload and transfusion-associated lung injury (TRALI) risks created by FFP can increase mortality in pregnant women. The literature shows that this increase is variable in patients with hereditary FVII deficiency and generally remains below the safe hemostatic threshold (20-30%). The 2.7 INR and 30.4-second PT detected in our case demonstrated that the patient was at risk of serious bleeding despite her pregnancy physiology.

Keywords: Factor VII deficiency, coagulation abnormalities in pregnancy, bleeding time disorders.

SS-095

Maternal and Neonatal Outcomes of Vacuum-Assisted Versus Non-Vacuum Vaginal Deliveries A Retrospective Cohort Study

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OBJECTIVE: Vacuum-assisted vaginal delivery is commonly used to shorten the second stage of labor, particularly in cases of fetal distress or prolonged labor. However, concerns remain regarding its potential impact on maternal and neonatal outcomes. This study aimed to compare maternal and neonatal outcomes between vacuum-assisted and non-vacuum vaginal deliveries in a tertiary care setting.

METHODS: This retrospective cohort study was conducted at a tertiary referral center between January 2024 and January 2025. Medical records of women who delivered vaginally were reviewed. Singleton pregnancies with cephalic presentation at ≥37 weeks of gestation were included. Preterm deliveries, multiple pregnancies, intrauterine fetal demise, and major fetal anomalies were excluded. A total of 82 patients were included and divided into two groups: Vacuum-assisted vaginal delivery group Spontaneous (non-vacuum) vaginal delivery group Maternal variables included age, parity, gestational age, episiotomy rate, severe perineal lacerations (grade 3–4), and need for blood transfusion. Neonatal outcomes included birth weight, Apgar scores at 1 and 5 minutes, umbilical cord pH, neonatal complications, and neonatal intensive care unit (NICU) admission. Statistical analyses were performed using appropriate parametric and non-parametric tests, with $p<0.05$ considered statistically significant.

RESULTS: A total of 228 patients were analyzed. Maternal demographic characteristics were similar between the two groups. Nulliparity was more frequent in the vacuum-assisted delivery group. Episiotomy rates were higher in the vacuum group compared to spontaneous vaginal delivery. There were no statistically significant differences between groups regarding severe perineal lacerations or blood transfusion requirements ($p>0.05$). In terms of neonatal outcomes, Apgar scores at both 1st and 5th minutes were lower in the vacuum-assisted delivery group. However, birth weight, umbilical cord pH, and base excess values were comparable between groups. NICU admission rates were higher in the vacuum group, although this difference did not reach statistical significance. Regarding neonatal complications, cephalohematoma and caput succedaneum were more frequently observed in the vacuum-assisted group, while spontaneous vaginal delivery was associated with

fewer trauma-related findings. No cases of intracranial hemorrhage or permanent neurological injury were detected in either group.

CONCLUSION: Vacuum-assisted vaginal delivery is a safe and effective intervention when used with appropriate indications. Although it is associated with relatively lower Apgar scores and increased minor neonatal trauma, these findings are likely related to underlying obstetric indications such as fetal distress rather than the procedure itself. Importantly, vacuum-assisted delivery does not increase severe maternal or neonatal morbidity compared to spontaneous vaginal delivery. These findings support the judicious use of vacuum extraction as a valuable tool to avoid unnecessary cesarean sections. Appropriate patient selection and operator experience remain critical factors in optimizing outcomes.

Keywords: Vacuum-assisted delivery, spontaneous vaginal delivery, neonatal outcomes, maternal outcomes, operative vaginal delivery

SS-096

Spontaneous pregnancy in the presence of extremely low anti-Müllerian hormone level (0.04 ng/mL): A case report

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Anti-Müllerian hormone (AMH) is widely used as a proxy for ovarian reserve. However, extremely low levels are often misinterpreted as an absolute barrier to natural conception. This case report aims to demonstrate that AMH reflects the quantity of the ovarian follicular pool but does not necessarily predict oocyte quality or the absolute potential for spontaneous pregnancy. We present the clinical course and laboratory findings of a 32-year-old female patient, gravida 2, para 1, who was diagnosed with premature ovarian insufficiency (POI) and subsequently achieved a spontaneous pregnancy. The diagnosis of POI was based on an AMH level of 0.04 ng/mL and follicle-stimulating hormone (FSH) levels exceeding 40 mIU/mL, with menses occurring only under hormone replacement therapy.

In February 2026, the patient presented with suspected pregnancy. Her medical records from January 2025 revealed an AMH level of 0.04 ng/mL and an FSH level of 50.28 mIU/mL. Despite the diagnosis of POI and without any assisted reproductive technology (ART) intervention, spontaneous conception occurred. Laboratory analysis showed a beta-hCG level of 30,493 IU/L. Transvaginal ultrasonography (USG) confirmed a single intrauterine live pregnancy at 6 weeks and 6 days of gestation with positive fetal cardiac activity. A 50x46 mm corpus luteum cyst was also noted on the left ovary.

This case proves that spontaneous conception remains possible even with an AMH level as low as 0.04 ng/mL and a diagnosis of POI. AMH is a quantitative marker and does not account for the functional capacity of remaining follicles or oocyte quality, which may be preserved in younger patients. Clinicians should exercise caution and avoid absolute prognostic statements that exclude the possibility of natural conception based solely on AMH values. Individualized counseling is essential for patients with severely diminished ovarian reserve.

Keywords: anti-Müllerian hormone, ovarian reserve, diminished ovarian reserve, premature ovarian insufficiency, spontaneous conception, natural pregnancy

Basic Hormonal and Biochemical Laboratory Values of the Patient

Tablo 1. Hastanın Temel Hormonal ve Biyokimyasal Laboratuvar Değerleri

Parametre	Oca 2025	Mar 2025	Şub 2026	Referans Aralığı
FSH (mIU/mL)	50,28	46,38	—	Folik. faz: 3,50–12,5
LH (mIU/mL)	33,25	31,39	—	Folik. faz: 2,40–12,6
Östradiol / E2 (pg/mL)	20,10	46,55	—	Folik. faz: 12,4–233
AMH (ng/mL)	0,04*	—	—	<0,1: ciddi DOR
Progesteron (ng/mL)	—	0,120	14,01 µg/L**	Folik. faz: 0,2–1,5
TSH (mIU/L)	—	1,365	—	0,38–5,33
Serbest T4 (ng/dL)	—	0,68	—	0,58–1,38
Serbest T3 (pg/mL)	—	3,17	—	2,13–4,5
Prolaktin (ng/mL)	7,65	5,25	—	4,79–23,3
Beta-hCG (IU/L)	0,303	—	30.493	Hamile değil: <1
HGB (g/dL)	—	—	13,9	12,2–16,2
PLT (×10³/µL)	—	—	261	140–400

SS-097

Pregnancy Complicated by Mechanical Mitral Valve Thrombosis in the First Trimester Treated with Systemic Alteplase and Resulting in Term Delivery: A Rare Case Report

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OBJECTIVE: The management of anticoagulation in pregnant women with mechanical heart valves is of critical importance in minimizing both maternal and fetal complications. Inadequate anticoagulation in this population may lead to life-threatening conditions such as prosthetic valve thrombosis. This report aims to present a rare clinical course in a patient with a history of mitral valve replacement who developed valve thrombosis during the first trimester of pregnancy and was successfully treated with systemic alteplase, resulting in a term delivery.

CASE PRESENTATION: A 28-year-old, G1P0 woman with a history of mechanical mitral valve replacement performed two years earlier due to rheumatic mitral stenosis conceived unintentionally while on therapeutic warfarin therapy. Warfarin was discontinued at 6 weeks of gestation, and anticoagulation was maintained with low-molecular-weight heparin (LMWH, enoxaparin). At 11 weeks of gestation, the patient presented to the cardiology outpatient clinic for routine follow-up. Transthoracic and transesophageal echocardiography (TTE/TEE) revealed pathological formations consistent with mobile thrombi on the leaflets of the mechanical mitral prosthetic valve.

Following a multidisciplinary team decision involving cardiology, perinatology, cardiovascular surgery, and anesthesiology, systemic thrombolytic therapy was initiated using a low-dose, slow-infusion protocol. Alteplase was administered in low-dose, sequential courses at a daily dose of 25 mg over four consecutive days, reaching a cumulative dose of 100 mg. Echocardiographic assessments were performed after each course to closely monitor thrombus burden and valve function. At the end of treatment, a marked improvement in hemodynamic parameters was observed, and follow-up TEE demonstrated complete resolution of the thrombus. After thrombolytic therapy, considering the history of mechanical valve thrombosis and the increased thrombotic risk, oral warfarin therapy was resumed. During follow-up, the patient was closely

monitored with clinical and laboratory parameters, and fetal growth as well as uteroplacental Doppler findings remained within normal limits. To minimize bleeding risk prior to delivery, warfarin was discontinued at 36 weeks of gestation and anticoagulation was switched back to LMWH. At 37 weeks, a healthy male infant weighing 2900 g with Apgar scores of 9 and 10 was delivered via elective cesarean section. Oral warfarin therapy was restarted on postpartum day 5. Low-dose systemic alteplase therapy resulted in complete thrombus resolution, and the pregnancy progressed without maternal or fetal complications, culminating in a healthy term delivery. No complications such as recurrent thrombosis, bleeding, preeclampsia, or fetal growth restriction were observed during follow-up.

CONCLUSION: Mechanical mitral valve thrombosis during pregnancy is a rare but serious condition. In cases where surgical intervention carries a high risk or is not feasible, systemic thrombolytic therapy may be considered as an alternative. This case demonstrates that systemic alteplase therapy, when implemented within a multidisciplinary framework and accompanied by careful patient selection and close monitoring, can be a safe and effective treatment option for both maternal and fetal outcomes.

Keywords: Pregnancy, mechanical mitral valve, prosthetic valve thrombosis, thrombolytic therapy, anticoagulation,

SS-098

Multidisciplinary Perinatal Management of an IVF Pregnancy Complicated by Massive Intracranial Hemorrhage: A Case Report

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OBJECTIVE: Intracranial hemorrhage during pregnancy is a rare but serious clinical condition associated with high maternal and perinatal morbidity and mortality. In severe maternal neurological conditions developing particularly in the early weeks of pregnancy, achieving a balance between maternal stabilization and continuation of the pregnancy poses significant clinical challenges. In this report, we aimed to present the clinical course and multidisciplinary perinatal management of an in vitro fertilization (IVF) pregnancy diagnosed with intracranial hemorrhage in the second trimester.

METHODS: A 38-year-old primigravid woman with an IVF pregnancy and no known comorbidities, whose antenatal follow-up had been conducted at an outside center, presented at 16 weeks of gestation with sudden-onset headache, vomiting, and generalized tonic-clonic seizure. Neuroimaging performed at the outside center revealed massive intracerebral hemorrhage involving the cerebral and cerebellar regions, accompanied by cerebral herniation. The patient underwent neurosurgical intervention and was admitted to the intensive care unit for postoperative follow-up. While being monitored in the ICU in the postoperative period with impaired consciousness and a low Glasgow Coma Scale score, she was referred to our hospital, a tertiary referral center, for perinatology follow-up. At the time of admission to our clinic, she was at 27 weeks of gestation. Due to the severe maternal neurological condition, tracheostomy, and presence of a ventriculoperitoneal shunt, the patient was managed in a multidisciplinary manner through close collaboration among the obstetrics, neurosurgery, and intensive care teams.

RESULTS: During follow-up, maternal vital signs and infection parameters were closely monitored. Serial fetal assessments demonstrated an abdominal circumference below the 3rd percentile, consistent with fetal growth restriction (FGR); however, no abnormal findings were detected on fetal Doppler examinations. Because of the onset of preterm labor during follow-up, delivery was performed by cesarean section at 31 weeks of gestation. The neonate, delivered in breech presentation, had Apgar scores of 7 and 8 at the 1st and 5th minutes, respectively, and a birth weight of 1,160 g. In the postpartum period,

the mother remained hemodynamically stable; however, due to severe neurological sequelae, she continues to be followed in the palliative care unit. She remains tracheostomized, is supported with home ventilation, and is receiving enteral nutrition via a nasogastric tube.

CONCLUSION: Intracranial hemorrhage during pregnancy is a rare but life-threatening condition that requires a multidisciplinary approach for the management of both maternal and fetal prognosis. In this case, despite severe maternal neurological impairment, close perinatology follow-up allowed prolongation of the pregnancy to improve fetal viability. In such cases, maternal stabilization should always remain the primary goal, while the timing of delivery should be individualized according to maternal condition and fetal prognosis.

Keywords: Intracranial hemorrhage, in vitro fertilization, multidisciplinary approach

SS-099

A case report of placental abruption with subserosal hematoma

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OBJECTIVE: Placental abruption is a serious obstetric emergency that may endanger the lives of both mother and baby due to the separation of the placenta from the uterine wall before delivery. Subserosal hematoma is a condition characterized by the accumulation of blood beneath the uterine serosa, usually following gynecological and obstetric surgeries or trauma. In this case report, we describe a case of placental abruption complicated by subserosal hematoma.

CASE PRESENTATION: A 34-year-old pregnant woman, at 37 weeks and 4 days pregnancy, who had previously had a cesarean section, presented to us with abdominal pain and vaginal bleeding. Ultrasonography revealed fetal bradycardia, decreased amniotic fluid and an anteriorly located placenta. The patient underwent emergency cesarean delivery with preliminary diagnoses of fetal distress, placental abruption and uterine rupture. A 4 cm subserosal hematoma, thought to be due to a possible small rupture area, was observed on the left side of the previous uterine incision (Figure 1). Upon entering the uterine cavity, placental abruption and a large amount of blood clots were observed (Figures 2-3). A live female infant, weighing 2290 grams with an Apgar score of 2-6 was rapidly delivered. After bleeding control, the operation was completed without any complications. The patient's hemoglobin level dropped from 11.3 g/dL to 7.1 g/dL after surgery, requiring a blood transfusion. The placenta was sent to pathology. Pathology results revealed acute chorioamnionitis and funiculitis.

DISCUSSION: The incidence of placental abruption which usually occurs in the third trimester is approximately 3 to 10 per 1000 births. While the exact cause is unknown, the main risk factors include grand multiparity, multiple pregnancies, advanced maternal age, preeclampsia, thrombophilia, polyhydramnios, and trauma. Clinically, patients may present with occult or overt bleeding, uterine tenderness, and contractions. Ultrasonography is important for differential diagnosis and especially for evaluating placenta previa in late pregnancy bleedings. Retroplacental, preplacental, or subchorionic hematomas may be observed on ultrasonography. However, nearly half of placental abruption cases, especially those with active vaginal bleeding, may have no specific findings on ultrasonography, because there will be no accumulation of blood or clots in the uterus. A normal ultrasound

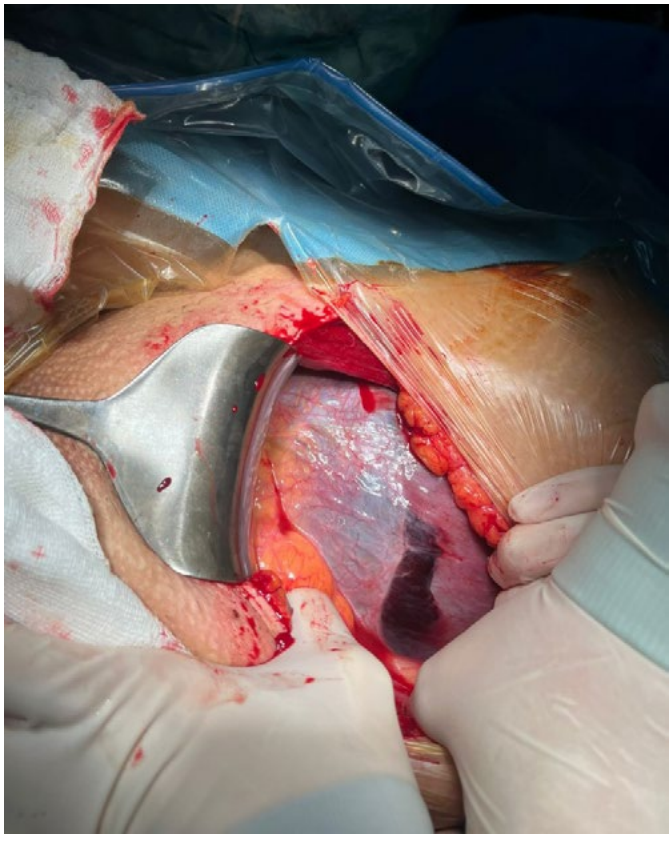
examination doesn't rule out the possibility of placental abruption.

Bleeding that begins with placental separation, can leak through a small rupture area in the myometrium and accumulate under the serosa, causing a subserosal hematoma, as in our patient. Severe cases of placental abruption can lead to a bluish-purplish Couvelaire uterus, due to blood extravasation from the myometrium to the serosa, and bleeding may even spread into the peritoneal cavity. Hemorrhagic shock, the need for blood transfusions, acute renal failure, and disseminated intravascular coagulation are the most common maternal complications of placental abruption. Common perinatal issues include prematurity, fetal hypoxia, and fetal death.

CONCLUSION: Placental abruption still remains a significant cause of maternal and perinatal morbidity and mortality today. Pregnant women presenting with pain and bleeding should be rapidly evaluated for placental abruption to minimize complications. Early diagnosis and treatment will be life-saving for both mother and baby.

Keywords: Cesarean section, placental abruption, subserosal hematoma

Figure 1



Subserosal hematoma

Figure 2



Intraoperative image

Figure 3



Intraoperative image

SS-100

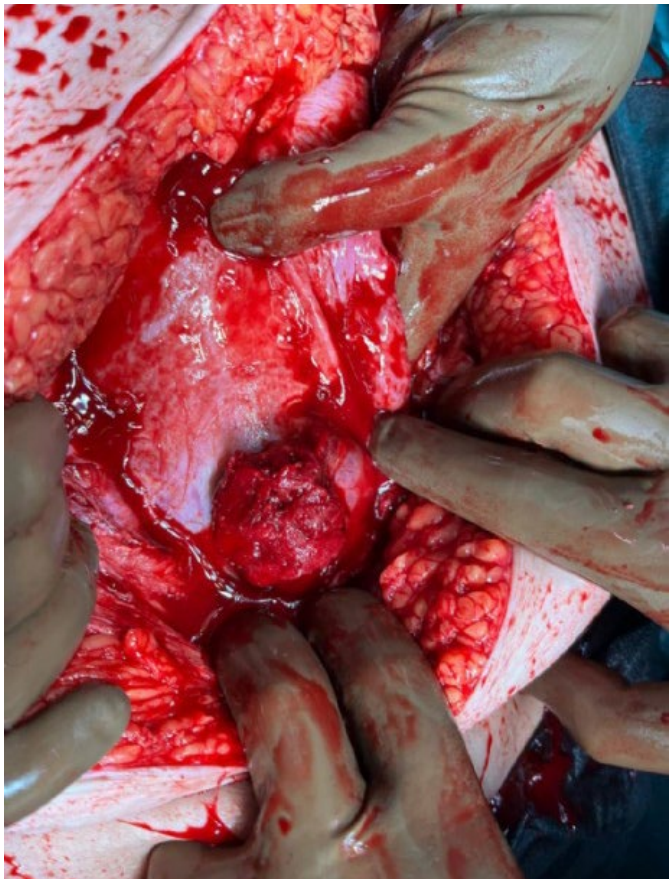
Uterine Rupture Due to Placenta Accreta Spectrum in Early Gestation: A Case Report of Emergency Management

Atilla Mutlu, Ilayda Gercik, Yasam Kemal Akpak, Atalay Ekin
IZMIR SEHIR HASTANESI KADIN HASTALIKLARI VE DOGUM

Placenta accreta spectrum can lead to uterine rupture and severe intraperitoneal hemorrhage even in early gestational weeks. In patients with a history of previous cesarean section, a high index of clinical suspicion for placental invasion is essential. This case demonstrates that early diagnosis, serial hemogram monitoring, and prompt surgical intervention are critical in reducing maternal morbidity and mortality in PAS cases

Keywords: Placenta accreta spectrum, uterine rupture, obstetric emergencies

Figür 1



Intraoperative appearance of uterine rupture caused by placenta accreta spectrum. Loss of myometrial integrity at the site of placental invasion and active bleeding foci along the rupture line are observed.

SS-101

Management of a complete uterine septum incidentally detected during an emergency cesarean section

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OBJECTIVE: Septate uterus is a congenital Müllerian anomaly that can be associated with adverse outcomes such as infertility, recurrent pregnancy loss, or premature birth. Uterine septum, which can be diagnosed with ultrasonography, hysterosalpingography, and magnetic resonance imaging, is treated with hysteroscopic resection as the standard procedure. We aim to discuss the management of a complete uterine septum encountered in a premature birth case undergoing emergency cesarean section.

CASE PRESENTATION: A 22-year-old, primiparous woman, married for one year and 34 weeks and 4 days pregnant, presented to the emergency room with labor pains. Vaginal examination revealed 2 cm cervical dilation, 50% effacement, and breech presentation. Due to the regular contractions and development of fetal bradycardia, she underwent emergency cesarean section. A live fetus weighing 2300 grams with two cord turns around the fetal neck was delivered with an Apgar score of 8-8. The patient stated that she had undergone surgery for a vaginal longitudinal septum one year prior. After the fetus and placenta were delivered, examination of the uterine cavity revealed a complete uterine septum extending from the isthmus to the fundus(Figures 1-2). The fetus and placenta were located in the right cavity. The complete septum structure was resected with Ligasure and sent to pathology, and the endometrial cavity was restored to its normal anatomical structure(Figure 3). The cervical septum was left untouched. The operation was completed without any complications. No additional problems were detected during postpartum follow-up. The pathology results showed hemorrhagic decidualized tissue and congested fibromuscular tissues. Postoperatively, a hysterosalpingogram performed one year prior revealed a complete uterine and vaginal septum(Figures 4-5).

DISCUSSION: Uterine septum is the most frequently diagnosed congenital Müllerian anomaly and the one most associated with obstetric complications, accounting for approximately half of this group. Although its prevalence in reproductive women is estimated at 1.5%, it is difficult to state the true incidence due to varying diagnostic criteria and the fact that most patients are asymptomatic. It can be partial or complete. A complete uterine septum can be seen with a septate or duplicated cervix and a longitudinal vaginal septum.

Isolated uterine septum cases are usually asymptomatic and are detected incidentally during imaging or cesarean delivery. The most common adverse outcomes are infertility, recurrent first-trimester miscarriages, and premature birth. It can also be detected with fetal malpresentation, intrauterine growth restriction, and placental abruption cases. Sometimes, pregnancy can proceed without complications and result in a normal delivery.

Hysteroscopic septum resection has been shown to increase clinical pregnancy rates in infertile couples and improve subsequent pregnancy outcomes in patients who have previously experienced first-trimester pregnancy loss or premature birth.

CONCLUSION: Uterine septum can lead to obstetric complications such as preterm labor and delivery, and malpresentation, as in our patient. Resection of the uterine septum, which is known or incidentally detected during cesarean section will provide an advantage in preventing the development of complications such as preterm labor, malpresentation, and pregnancy loss that may be encountered in subsequent pregnancies without the need for another surgery.

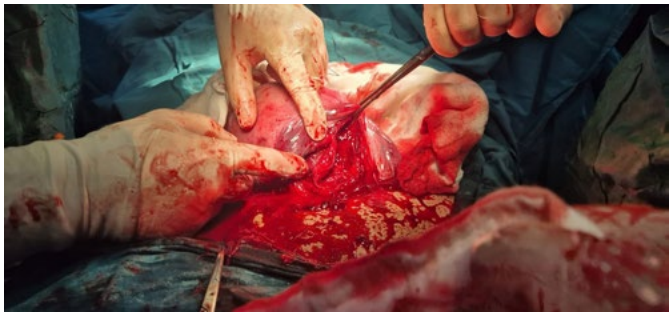
Keywords: cesarean section, Müllerian anomaly, uterine septum resection

Figure 1



Intraoperative image

Figure 2



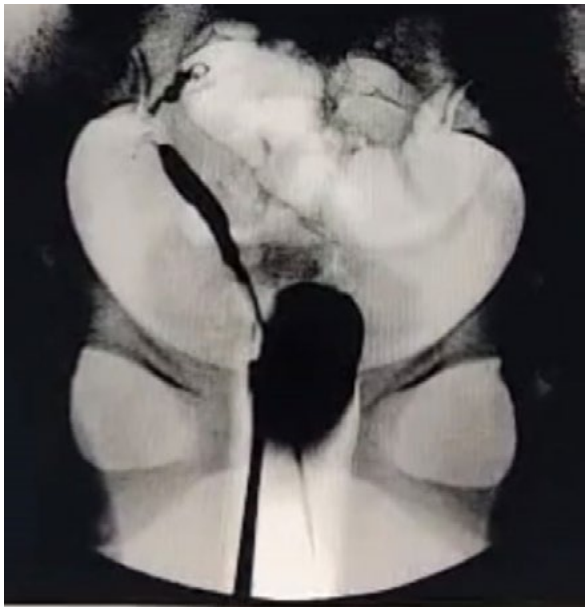
Intraoperative image

Figure 3



Intraoperative image

Figure 4



Hysterosalpingography

Figure 5



Hysterosalpingography

SS-103

HELLP Syndrome Associated with Isolated Oligohydramnios and Intrauterine Growth Restriction: A Case Report

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BACKGROUND: HELLP syndrome is a severe variant of preeclampsia that may manifest through vascular insufficiency and uteroplacental dysfunction. While it classically manifests through a triad of hemolysis, elevated liver enzymes, and low platelet count after the second trimester, its clinical presentation can be remarkably heterogeneous. Reduced amniotic fluid volume is is considered an early ultrasonographic marker of uteroplacental insufficiency. In rare instances, HELLP syndrome follows an atypical, "clinically silent" course where the absence of hypertension or overt warning signs challenges traditional diagnostic timelines. Through this case, we aimed to highlight the necessity of vigilant maternal-fetal surveillance when early ultrasonographic markers of placental insufficiency emerge, even in the absence of overt clinical symptoms.

METHODS: A 35-year-old multiparous pregnant patient (G2P1A0) with an unremarkable medical history was followed up in our clinic. Initial prenatal screening indicated an intermediate risk in the first-trimester combined test, while subsequent non-invasive prenatal testing (NIPT) yielded a low-risk result. Following the detection of early-onset oligohydramnios and hyperechogenic bowel, the clinical management protocol included a detailed fetal ultrasonographic survey. At 22 weeks of gestation, diagnostic amniocentesis for genetic evaluation (karyotype and chromosomal microarray) was performed. To maintain pregnancy and improve fetal outcomes, therapeutic amnioinfusion was conducted concurrently with amniocentesis and repeated at 28 weeks. Maternal-fetal surveillance was maintained through serial fetal biometry, amniotic fluid index (AFI) quantification, umbilical artery Doppler velocimetry, and Non-Stress Tests (NST), alongside regular maternal biochemical and hematological screening.

RESULTS: Genetic analysis revealed a normal fetal karyotype and microarray results. Following the initial and repeat amnioinfusion, the AFI was successfully maintained within physiological limits (Figure 1). However, at 33 weeks, fetal growth restriction (IUGR) was diagnosed with an abdominal circumference below the 1st percentile. Despite persistent IUGR, fetal Doppler and NST parameters remained reassuring. At 37 weeks, a cesarean section was scheduled due to breech presentation and IUGR. On the day of the planned delivery, the patient developed acute epigastric pain. Laboratory evaluation confirmed HELLP syndrome with elevated liver enzymes (AST: 550 U/L, ALT: 336 U/L), LDH (870 U/L), and a progressive declining platelet count (155×10^9/L). An emergent cesarean section was performed, resulting in the delivery of a 2135 g infant with Apgar scores of 7 and 9 at 1 and 5 minutes, respectively.

CONCLUSION: This case underscores that HELLP syndrome may present atypically, remaining clinically and biochemically silent despite severe fetal manifestations such as IUGR and oligohydramnios. The presence of hyperechogenic bowel and early-onset oligohydramnios should raise a high index of suspicion for underlying uteroplacental insufficiency. Therefore, even in the absence of overt maternal symptoms, vigilant and continuous maternal–fetal surveillance is essential to enable timely intervention for potential late-onset complications.

Keywords: HELLP syndrome, IUGR, Oligohydramnios

Figür 1



Figure 1. The first ultrasound image at 22 weeks (pre-amnioinfusion) showed a single deepest pocket of 2.5 cm and AFI of 4 cm; following repeated amnioinfusion, the second ultrasound image at 37 weeks shows a single deepest pocket of 3.7 cm.

SS-105

Pelvic organ prolapse during pregnancy

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OBJECTIVE: Pelvic organ prolapse (POP) is a rare condition during pregnancy but may lead to clinically significant maternal and fetal complications. This study aimed to present a case of pelvic organ prolapse complicating pregnancy and to discuss its management in light of current literature.

CASE PRESENTATION: A pregnant patient diagnosed with pelvic organ prolapse during the antenatal period presented with complaints of vaginal bulging and discomfort. On physical examination, prolapse was confirmed and evaluated using standard classification systems. As no significant obstetric complications were identified, a conservative management approach was adopted. The pregnancy was followed with close antenatal monitoring, symptomatic supportive treatment, and pessary application. The patient was regularly evaluated for potential complications, including infection, preterm labor, and urinary dysfunction. The mode of delivery was individualized based on the severity of prolapse and obstetric conditions. The case was successfully managed without major maternal or fetal complications, and postpartum reassessment was performed.

RESULTS: No significant progression of prolapse was observed throughout pregnancy, and symptoms were effectively controlled with conservative management. The patient completed pregnancy without adverse maternal or fetal outcomes. Postpartum evaluation demonstrated regression of prolapse findings.

CONCLUSION: Although pelvic organ prolapse during pregnancy is rare, it requires careful monitoring and appropriate management. Conservative treatment is effective in most cases, and the mode of delivery should be determined based on obstetric indications rather than prolapse alone. Reporting such cases contributes to the existing literature and may help improve clinical management strategies.

Keywords: Pelvic organ prolapse, obstetric management, pessary use, conservative treatment

şekil-1



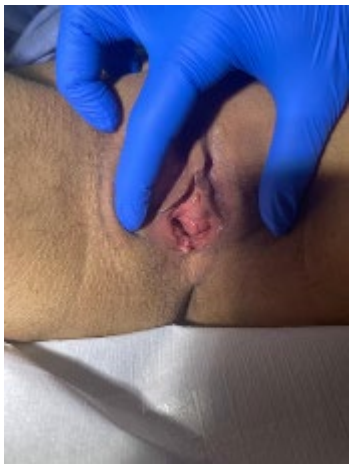
Gebelikte prolapsus hali

şekil-2



Hastanın doğum sonrası hali

şekil-3



6.hafta kontrolü

SS-106

Uterine atony following tocolytic and magnesium sulfate therapy in a patient with muscular dystrophy: successful surgical management with compression sutures

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OBJECTIVE: Pregnancies complicated by muscular dystrophy may be particularly vulnerable to impaired uterine contractility due to both underlying myopathic pathology and pharmacologic interventions. The concomitant use of tocolytic agents and magnesium sulfate may further exacerbate this risk, predisposing patients to postpartum uterine atony. We aimed to present a case of severe uterine atony in a pregnant patient with muscular dystrophy receiving combined tocolytic and magnesium sulfate therapy, and to discuss the potential synergistic effects of these factors on uterine contractility.

METHODS: We retrospectively evaluated the clinical course of a 27-year-old pregnant woman (G2A1P0) at 31+2 weeks of gestation with a known diagnosis of muscular dystrophy. The patient initially presented to an external center with regular uterine contractions and a cervical dilation of 2 cm. She received oral nifedipine for tocolysis, magnesium sulfate for fetal neuroprotection, and a single course of betamethasone for fetal lung maturation. Due to persistent contractions and the anticipated need for neonatal intensive care, she was referred to our tertiary care center.

RESULTS: Upon admission, cervical dilation had progressed to 6 cm. Ultrasonographic evaluation demonstrated a fetus appropriate for gestational age, accompanied by polyhydramnios and transverse lie. An emergency cesarean delivery was therefore performed. Preoperative hemoglobin level was 14.4 g/dL.

A live neonate weighing 1375 g was delivered under spinal anesthesia, with Apgar scores of 0/1/1/2/7. Intraoperatively, the uterus appeared disproportionately enlarged relative to gestational age. Following difficult placental separation, massive hemorrhage ensued secondary to uterine atony.

Standard postpartum hemorrhage management was promptly initiated, including intravenous oxytocin infusion, intramuscular methylergonovine, rectal misoprostol and uterine massage. Despite these measures, adequate uterine contraction could not be achieved. Consequently, a uterine compression suture using the B-Lynch technique was performed, resulting in immediate restoration of uterine tone and effective hemostasis.

Intraoperative hemoglobin declined to 8.3 g/dL. The patient received 1 unit of packed red blood cells and 2 units of fresh frozen plasma intraoperatively. Postoperatively, she was monitored in the intensive care unit and received an additional 2 units of packed red blood cells due to further hemoglobin decline. No ongoing vaginal bleeding or abnormal drain output was observed. The patient remained hemodynamically stable and was discharged in good clinical condition on postoperative day 3.

CONCLUSION: The combined administration of tocolytic agents and magnesium sulfate in patients with muscular dystrophy may result in profound suppression of uterine contractility, significantly increasing the risk of uterine atony. The presence of additional contributing factors such as polyhydramnios, leading to uterine overdistension, may further potentiate this risk.

Heightened clinical vigilance, early recognition, and rapid intervention are essential in this high-risk population. In cases refractory to medical management, uterine compression sutures represent an effective, fertility-preserving, and potentially life-saving surgical strategy.

Keywords: Uterine atony, muscular dystrophy, preterm labor, postpartum hemorrhage, tocolysis, magnesium sulfate

SS-107

First-Trimester Uterine Rupture with an Intact Intrauterine Pregnancy: A Diagnostic Pitfall

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BACKGROUND: Uterine rupture in the first trimester is an exceptionally rare but life-threatening emergency. Diagnosis is challenging, as ultrasonography may demonstrate an intact intrauterine pregnancy despite rupture. A high index of suspicion is essential, particularly in patients with a history of uterine surgery presenting with acute abdominal pain and hemoperitoneum.

METHODS: A 35-year-old multiparous patient (G2P1) at 14 weeks of gestation presented with an acute onset of severe abdominal pain. Her history included a primary cesarean section six years prior. Physical examination revealed abdominal guarding and rebound tenderness. While initial ultrasonography demonstrated a viable singleton intrauterine pregnancy, significant fluid accumulation consistent with hemoperitoneum was visualized in the right abdominal quadrants. During surveillance, serial hemoglobin measurements showed a rapid decline from 11.5 g/dL to 9.0 g/dL. Given the deteriorating hemodynamic status and high suspicion of uterine rupture, an emergency laparotomy was performed.

RESULTS: An emergency Pfannenstiel laparotomy revealed extensive intraperitoneal coagulum and active hemorrhage. The fetus and placenta were identified entirely outside the uterine cavity following a total rupture along the previous scar line (Figure 1). After extraction, the site was meticulously repaired using a continuous suture technique with Vicryl. Hemostasis was successfully achieved. Perioperatively, the patient received two units of packed red blood cells and two units of fresh frozen plasma. Following the intervention, the patient demonstrated rapid recovery with stabilized hemodynamic parameters. Hemoglobin levels increased postoperatively to 11 g/dL. The recovery remained unremarkable, and she was discharged in stable condition.

CONCLUSION: First-trimester uterine rupture carries a significant risk of catastrophic hemorrhage. Clinicians must maintain a high index of suspicion in patients presenting with acute abdomen and hemoperitoneum, even when an intrauterine pregnancy is visualized. Prompt surgical intervention is essential for maternal survival.

Keywords: First trimester, Hemoperitoneum, Uterine Rupture

Figure 1



Figure 1. Intraoperative view demonstrating complete uterine rupture along the previous cesarean scar, with the fetus and placenta located outside the uterine cavity and extensive hemoperitoneum.

SS-108

Agggressıve Angıomyxoma Case Report

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Aggressive Angiomyxoma of the Vagina: A Rare Case Report

OBJECTIVE: Aggressive angiomyxoma is a rare mesenchymal tumor of myofibroblastic origin that predominantly affects women and typically arises from the deep soft tissues of the pelvis, perineum, and vulvovaginal region. Due to its rarity and nonspecific clinical presentation, it is frequently misdiagnosed preoperatively. Here, we present a case of vaginal aggressive angiomyxoma managed surgically in our clinic.

CASE PRESENTATION: A 43-year-old woman (G3P2, three living children) presented to our clinic with the complaint of vaginal bleeding. Her medical history was unremarkable except for a previous cesarean section performed via a Pfannenstiel incision. On gynecological examination, a firm and fixed lesion approximately 5 cm in diameter was palpated posterior to the multiparous cervical os. No active bleeding or leukorrhea was observed.

Contrast-enhanced pelvic magnetic resonance imaging (MRI) revealed a lobulated, multiseptated complex cystic mass measuring approximately 40 × 25 mm located in the uterine cervix, showing contrast enhancement after intravenous contrast administration. Histopathological evaluation was recommended due to the suspicion of malignancy. Additionally, Nabothian cysts were noted in the cervix and small follicular cysts were detected in both ovaries.

The patient subsequently underwent surgery, including Manchester-Fothergill operation, polypectomy, endocervical curettage (ECC), and intraoperative frozen section examination. Frozen section analysis indicated a benign soft tissue tumor with low suspicion for malignancy. The procedure was terminated with the plan for complementary surgery after final pathology evaluation.

Final histopathological examination revealed a polypoid, highly vascular myxoid mesenchymal tumor extending to the surgical margin. Immunohistochemical analysis demonstrated diffuse strong positivity for estrogen receptors (ER) and positivity for desmin and smooth muscle actin (SMA) in myoid cells. Morphological and immunohistochemical findings were consistent with fibroblastic–myofibroblastic tumors of the genital tract, particularly aggressive angiomyxoma. Re-excision and close follow-up were recommended due to the involvement of the surgical margin.

Tumor markers were within normal limits. The patient underwent a second-stage operation consisting of total abdominal hysterectomy (TAH), bilateral salpingo-oophorectomy (BSO), and ureterolysis. Intraoperatively, a cystic structure extending from the uterine isthmus to the cervical level and another cystic lesion approximately 1 cm in diameter on the muscle layer were observed.

CONCLUSION: Aggressive angiomyxoma is a rare tumor with a high rate of preoperative misdiagnosis due to its similarity to benign vulvovaginal lesions such as Bartholin cysts, vaginal cysts, polyps, and Gartner duct cysts. The diagnosis is primarily established through histopathological and immunohistochemical examination. Estrogen and progesterone receptor positivity, frequently observed in these tumors, supports the role of hormonal factors in tumor development and may guide adjuvant treatment strategies such as GnRH agonist therapy. Wide local excision remains the mainstay of treatment, while long-term clinical follow-up is essential due to the reported local recurrence rate of 10–30%

Keywords: aggressive angiomyxoma, vagina, recurrence

SS-109

Determinants of Embryo Development in Polycystic Ovary Syndrome: Impact of Hormonal and Stimulation Parameters on Blastocyst, Cleavage, and Empty Zona Counts

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BACKGROUND: Polycystic ovary syndrome (PCOS) is characterized by altered folliculogenesis and oocyte competence, which may influence embryo development during assisted reproductive technology cycles. While ovarian reserve markers and stimulation parameters are widely used in clinical practice, their independent effects on embryo yield and quality remain incompletely understood. This study aimed to evaluate the impact of clinical, hormonal, and stimulation-related parameters on blastocyst, cleavage-stage embryo, and empty zona (EZ) counts in women with PCOS.

METHODS: This retrospective cohort study included PCOS patients undergoing controlled ovarian stimulation. The effects of age, body mass index (BMI), anti-Müllerian hormone (AMH), basal follicle-stimulating hormone (FSH), basal luteinizing hormone (LH), trigger day estradiol (E2), total FSH dose, LH dose, and stimulation duration on embryo outcomes were analyzed. Correlation analyses were performed using Spearman's test. Multivariate linear regression models were constructed separately for blastocyst count, cleavage-stage embryo count, and empty zona count.

RESULTS: The mean age of the cohort was 26.7 ± 3.7 years, with a mean BMI of 26.2 ± 3.7 kg/m². Mean AMH level was 6.53 ± 3.67 ng/mL, while basal FSH and LH levels were 6.67 ± 1.74 IU/L and 7.24 ± 4.78 IU/L, respectively. The mean trigger day estradiol level was 3709.6 ± 2255.8 pg/mL, and the mean total FSH dose was 2027.7 ± 686.0 IU. The average stimulation duration was 10.34 ± 1.35 days.

The mean number of blastocysts was 4.51 ± 4.17, cleavage-stage embryos was 9.49 ± 5.51, and empty zona count was 4.43 ± 3.69.

In correlation analysis, AMH showed a positive correlation with blastocyst (r=0.30) and cleavage embryo counts (r=0.36). Trigger day E2 demonstrated a moderate positive correlation with cleavage-stage embryos (r=0.45). Total LH dose showed a strong negative correlation with blastocyst (r=−0.70) and cleavage embryo counts (r=−0.74), while it was positively correlated with empty zona count (r=0.63). BMI was positively correlated with blastocyst count (r=0.83, p=0.040).

In multivariate regression analysis, trigger day E2 was an independent positive predictor of both blastocyst (B=0.001, p=0.007) and cleavage-stage embryo counts (B=0.001, p=0.004). Stimulation duration was negatively associated with cleavage-stage embryo count (B=−1.033, p=0.046). No independent predictors were identified for empty zona count; however, basal FSH showed a borderline negative association (B=−0.517, p=0.078).

CONCLUSION: Trigger day estradiol is a significant independent determinant of embryo development in PCOS patients, positively influencing both blastocyst and cleavage-stage embryo yield. Increased gonadotropin exposure, particularly LH, may adversely affect embryo quality by reducing embryo yield and increasing empty zona formation. These findings highlight the importance of individualized stimulation strategies in optimizing embryo development in PCOS.

Keywords: polycystic ovary syndrome, blastocyst, cleavage embryo, empty zona, estradiol, ovarian stimulation

TABLOLAR

Table 1. Baseline and stimulation characteristics

Variable	n	Mean	SD
Age	65	26.71	3.69
BMI	65	26.25	3.70
AMH	65	6.53	3.67
Basal FSH	65	6.67	1.74
Basal LH	64	7.24	4.78
Trigger day E2	64	3709.58	2255.75
Total FSH dose	65	2027.69	685.95
Total LH dose	6	2350.00	634.03
Stimulation duration	64	10.34	1.35
Blast count	65	4.51	4.17
Cleavage count	65	9.49	5.51
Empty zona count	65	4.43	3.69

Table 2. Spearman correlation analysis between clinical, hormonal, and stimulation parameters and embryo outcomes

Variable	Blast count (r, p)	Cleavage count (r, p)	Empty zona count (r, p)
Age	r=-0.09; p=0.494	r=-0.18; p=0.159	r=0.06; p=0.644
BMI	r=-0.10; p=0.427	r=-0.21; p=0.101	r=-0.15; p=0.246
AMH	r=0.30; p=0.014	r=0.36; p=0.003	r=0.21; p=0.093
Basal FSH	r=0.02; p=0.903	r=-0.12; p=0.359	r=-0.28; p=0.026
Basal LH	r=0.13; p=0.300	r=0.18; p=0.154	r=0.11; p=0.391
Trigger day E2	r=0.26; p=0.040	r=0.45; p=0.000	r=0.05; p=0.706
Total FSH dose	r=-0.15; p=0.248	r=-0.15; p=0.221	r=-0.08; p=0.532
Total LH dose	r=-0.70; p=0.120	r=-0.74; p=0.096	r=0.63; p=0.183
Stimulation duration	r=-0.05; p=0.675	r=-0.18; p=0.163	r=-0.03; p=0.813

Table 3. Multivariate linear regression analysis for predictors of embryo outcomes

Variable	Blast B	95% CI	p	Cleavage B	95% CI	p	Empty zona B	95% CI	p
Age	-0.058	-0.370 to 0.253	0.708	-0.047	-0.424 to 0.330	0.803	0.179	-0.105 to 0.463	0.212
BMI	0.024	-0.273 to 0.321	0.871	-0.105	-0.464 to 0.255	0.562	-0.047	-0.318 to 0.224	0.731
AMH	-0.101	-0.570 to 0.368	0.668	0.112	-0.455 to 0.680	0.693	0.335	-0.093 to 0.763	0.122
Basal FSH	-0.218	-0.850 to 0.413	0.491	-0.309	-1.073 to 0.455	0.421	-0.517	-1.094 to 0.059	0.078
Basal LH	0.138	-0.183 to 0.458	0.393	0.132	-0.255 to 0.520	0.496	0.035	-0.258 to 0.328	0.811
Trigger day E2	0.001	0.000 to 0.002	0.007	0.001	0.000 to 0.002	0.004	-0.000	-0.001 to 0.000	0.229
Total FSH dose	-0.001	-0.002 to 0.001	0.437	0.000	-0.002 to 0.002	0.767	-0.000	-0.002 to 0.002	0.923
Stimulation duration	-0.274	-1.111 to 0.563	0.515	-1.033	-2.046 to -0.021	0.046	0.266	-0.498 to 1.030	0.488

Model performance: Blast count R^2=0.210, model p=0.106; Cleavage count R^2=0.320, model p=0.006; Empty zona count R^2=0.168, model p=0.246.

tablo

SS-110

Gynecologic Involvement of Chronic Lymphocytic Leukemia: Cervical and Vaginal Cuff Infiltration in Two Cases

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BACKGROUND: Chronic lymphocytic leukemia (CLL) is the most common leukemia in adults and is characterized by the clonal proliferation of mature B lymphocytes (1,2). The disease typically involves the peripheral blood, bone marrow, and lymph nodes and follows an indolent clinical course (1). Although extranodal involvement may occur during disease progression, it remains relatively uncommon (3). Among extranodal sites, involvement of the female genital tract is particularly rare. While ovarian and uterine infiltration have been reported more frequently, cervical involvement is less common and vaginal involvement is exceedingly rare (4,5). These atypical presentations may clinically mimic primary gynecologic malignancies, posing significant diagnostic challenges and potentially leading to unnecessary invasive procedures (4,5,7).

CASE PRESENTATION: We report two cases of postmenopausal women with known CLL who presented with abnormal gynecologic screening findings. The first case involved a 61-year-old woman with persistent high-risk human papillomavirus (HPV type 31) positivity and negative cytology. Due to persistent HPV infection, colposcopic evaluation revealed acetowhite changes, and a loop electrosurgical excision procedure (LEEP) was performed. Histopathological examination demonstrated subepithelial infiltration by small, monotonous lymphoid cells. Immunohistochemical analysis revealed CD20, CD5, and CD23 positivity with Cyclin D1 negativity and a low Ki-67 proliferation index, consistent with CLL/small lymphocytic lymphoma (SLL) infiltration of the cervix (6).

The second case involved a 65-year-old woman with a history of total abdominal hysterectomy and bilateral salpingo-oophorectomy who presented with atypical squamous cells—cannot exclude high-grade lesion (ASC-H) on cytology. Colposcopic evaluation of the vaginal cuff revealed multiple Lugol-negative areas and a protruding lesion. Histopathological analysis demonstrated submucosal infiltration by small lymphoid cells with an immunophenotype consistent with CLL/SLL (CD20+, CD5+, CD23+, p16 negative, with accompanying CD3-positive T lymphocytes) (6,7). No epithelial dysplasia or intraepithelial neoplasia was identified in either case.

Both patients were asymptomatic at the time of diagnosis and did not exhibit constitutional symptoms, cytopenias, or organ dysfunction. Hematological evaluation confirmed that neither patient met the iwCLL criteria for treatment initiation, and both were managed with a watch-and-wait approach in accordance with current guidelines (1,2).

CONCLUSION: These cases highlight that CLL can rarely involve the cervix and vaginal cuff and may be incidentally detected during routine gynecological evaluation. Such involvement may mimic primary gynecologic malignancies, underscoring the importance of histopathological and immunohistochemical confirmation (6). Awareness of this rare presentation is essential to avoid misdiagnosis and unnecessary interventions. Management should be guided by systemic disease activity rather than local extranodal involvement, and asymptomatic patients can be safely followed with active surveillance (1,2,3).

Keywords: cervix, Chronic Lymphocytic Leukemia, vagina

SS-111

Transurethral Extrusion of the Umbilical Cord: A Rare Presentation of Uterine and Bladder Rupture During Second Trimester Termination

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INTRODUCTION: Second trimester pregnancy termination is associated with an increased risk of uterine rupture, particularly in patients with a history of previous cesarean sections. Although rare, uterine rupture represents a serious obstetric emergency that may lead to significant maternal morbidity. In exceptionally rare cases, the rupture may extend into adjacent organs such as the bladder, resulting in unusual and atypical clinical presentations. Here, we report a rare and striking case of uterine rupture complicated by bladder involvement and transurethral extrusion of the umbilical cord following medical termination of pregnancy.

CASE PRESENTATION: A 30-year-old gravida 5 para 3 abortion 2 (G5P3A2) woman with a history of three previous cesarean sections presented at 20 weeks of gestation with complaints of vaginal fluid leakage. Vaginal examination confirmed active amniotic fluid leakage. Ultrasonographic evaluation revealed anhydramnios with positive fetal cardiac activity. The placenta was located on the anterior uterine wall. Laboratory findings showed a white blood cell count of 12,000/mm³, and fetal biometry was consistent with 241 grams.

Following counseling, termination of pregnancy was planned in accordance with current guidelines, and informed consent was obtained. An intracervical Foley catheter was inserted and inflated with 20 cc saline. Twelve hours later, the catheter was spontaneously expelled. Subsequently, medical termination was continued using misoprostol according to the FIGO 2023 protocol. Approximately nine hours later, due to increasing uterine contractions, the patient underwent repeat vaginal examination. Unexpectedly, the umbilical cord was observed protruding through the urethra.

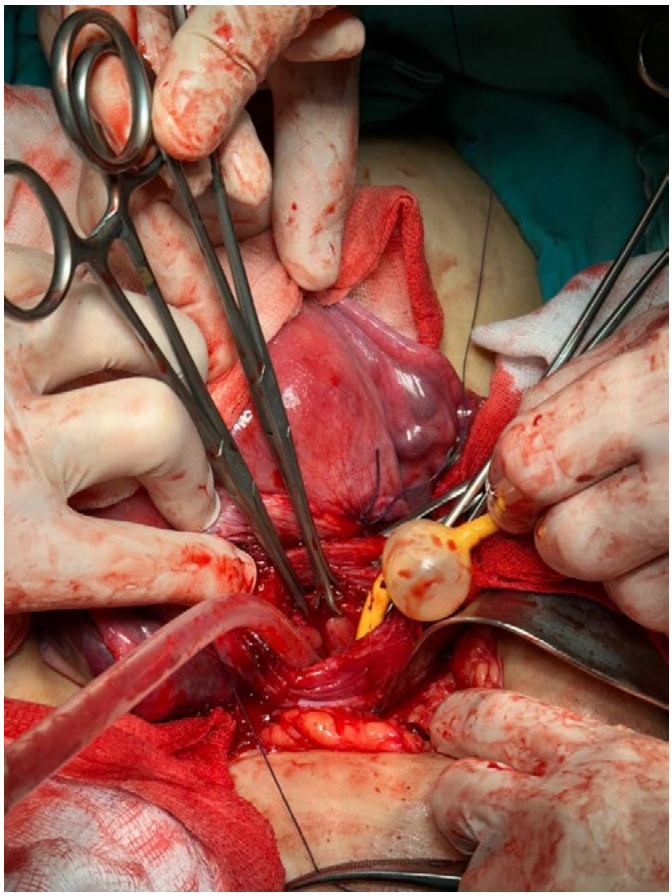
The patient was immediately taken for emergency laparotomy. Through a Pfannenstiel incision, the abdominal cavity was entered. Intraoperative evaluation revealed uterine rupture at the previous cesarean scar site, extending into the posterior wall of the bladder. The umbilical cord had traversed into the bladder and exited through the urethra. The fetus and placenta were carefully removed. The bladder was repaired in two layers using no:2/0 Vicryl sutures, followed by repair of the uterine rupture with no:1 Vicryl sutures after uterine cavity clearance.

Postoperatively, a Foley catheter was maintained for 21 days in accordance with urology recommendations. The patient was discharged on postoperative day 2 with antibiotic therapy. At three-week follow-up, cystography demonstrated no evidence of leakage, and the catheter was removed after confirmation of a sterile urine culture.

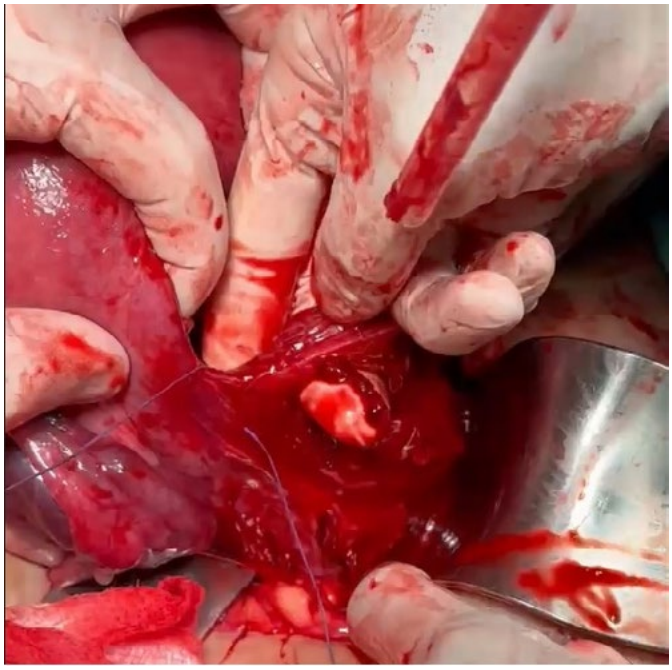
CONCLUSION: Uterine rupture during second trimester pregnancy termination, especially in patients with a history of cesarean section, can lead to rare but severe complications. Bladder involvement and transurethral extrusion of the umbilical cord represent an extremely uncommon and remarkable clinical presentation. Early recognition of such atypical findings and prompt surgical management are essential to minimize maternal morbidity and ensure favorable outcomes.

Keywords: Uterine rupture, second trimester termination, Foley catheter, bladder injury, cesarean section

Intraoperative view



Intraoperative view of bladder and uterine rupture



Umbilical cord protruding from the urethra



SS-112

Unexpectedly indolent course of vulvar squamous cell carcinoma after a six-year delay in treatment: a case report

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OBJECTIVE: Vulvar squamous cell carcinoma (VSCC) is a relatively rare gynecologic malignancy, predominantly affecting postmenopausal women. Lymph node involvement is the most important prognostic factor, and disease progression or recurrence is most commonly observed within the first two years following primary treatment. We present an unusual case of VSCC demonstrating minimal progression despite a six-year delay in treatment.

METHODS: A 64-year-old postmenopausal woman presented in 2019 with vulvar pruritus. A vulvar biopsy revealed well-differentiated squamous cell carcinoma with a depth of invasion of 3 mm, and the invasive focus was reported to be less than 1 mm from the surgical margin. The patient did not return for further evaluation or treatment. Six years later, in 2025, she presented again with persistent vulvar itching. A repeat biopsy was performed and staging was evaluated with positron emission tomography–computed tomography (PET-CT). Subsequently, anterior modified radical vulvectomy with bilateral inguinofemoral lymphadenectomy was performed.

RESULTS: The second biopsy demonstrated a well-differentiated squamous cell carcinoma measuring 1 cm with a depth of invasion of 4 mm. Lymphovascular space invasion was not detected and surgical margins were negative. PET-CT showed no pathological fluorodeoxyglucose uptake. Final histopathological examination of the surgical specimen revealed vulvar intraepithelial neoplasia grade 3 (VIN3). All inguinofemoral lymph nodes were negative for metastasis. Surgical margins were negative and lymphovascular invasion was not identified. No adjuvant therapy was planned and the patient was placed under follow-up.

CONCLUSION: Most recurrences in vulvar cancer occur within the first two years after primary treatment, and groin recurrences are associated with particularly poor prognosis. In contrast, our patient showed minimal tumor progression and no nodal metastasis despite a six-year delay between initial diagnosis and definitive surgical treatment. This case highlights the possibility that some well-differentiated VSCCs may exhibit a relatively indolent biological behavior, although early diagnosis and appropriate surgical management remain essential in the treatment of vulvar cancer.

Keywords: Delayed treatment, Indolent progression, Vulvar squamous cell carcinoma

SS-113

Virilizing Ovarian Thecoma in a Postmenopausal Woman: A Video Case Report of Diagnostic Workup and Laparoscopic Management

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BACKGROUND: Ovarian thecoma is a rare sex cord–stromal tumor that may present with virilization due to androgen excess, particularly in postmenopausal women. Pure thecomas are benign, malignant behavior is rare and typically confined to one ovary. This video demonstrates the diagnostic workup and laparoscopic management of an ovarian thecoma presenting with virilization in a postmenopausal patient.

METHODS: A 69-year-old woman presented with progressive hirsutism, voice deepening, and clitoromegaly (Figure 1). Laboratory tests revealed elevated serum testosterone with normal adrenal and pituitary profiles. The patient had a prior hysterectomy due to uterine leiomyoma. Transvaginal ultrasound demonstrated a unilateral, solid, hypoechoic ovarian mass measuring approximately 3 cm with moderate internal vascularization on Doppler imaging (Figure 2). Pelvic CT confirmed a well-circumscribed solid lesion suggestive of a sex cord–stromal tumor. After multidisciplinary discussion, laparoscopic bilateral salpingo-oophorectomy was performed.

RESULTS: Intraoperatively, a 3 cm solid, yellowish ovarian mass with smooth surface and no peritoneal implants was identified. The specimen was retrieved in an endoscopic bag without intraperitoneal rupture. Histopathology confirmed benign thecoma with negative margins. Postoperatively, serum androgen levels normalized within weeks, with progressive regression of virilization signs.

CONCLUSIONS: This case highlights the importance of targeted hormonal assessment and high-resolution imaging in the evaluation of androgen-secreting tumors. In women desiring fertility, unilateral oophorectomy may be sufficient. In postmenopausal and perimenopausal women, total hysterectomy with bilateral salpingo-oophorectomy is generally recommended, providing definitive diagnosis, symptom resolution, and favorable clinical outcomes.

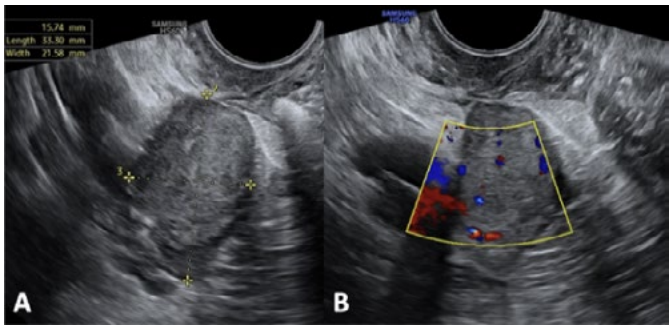
Keywords: Ovarian thecoma, sex cord–stromal tumor, virilization

Figure 1



Clinical features of virilization: male-pattern alopecia (A, B) and clitoromegaly (C).

Figure 2



Transvaginal ultrasound demonstrating a unilateral, solid, hypoechoic ovarian mass (A), with color Doppler imaging showing moderate intralesional vascular flow (B).

SS-114

Posterior uterine rupture diagnosed intraoperatively in a pregnancy with a history of multiple endometriosis surgeries: a case report

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OBJECTIVE: Uterine rupture is an uncommon but serious obstetric emergency associated with significant maternal and fetal morbidity and mortality. Although it most commonly occurs in women with previous cesarean section scars, it may also develop following other uterine surgeries. Posterior uterine rupture is particularly rare and may be difficult to diagnose preoperatively due to nonspecific clinical findings (1,2). We aimed to present a rare case of posterior uterine rupture in a patient with a history of multiple endometriosis surgeries.

CASE PRESENTATION: A 37-year-old gravida 1 para 0 woman presented at 32 weeks and 6 days of gestation with abdominal pain. Her medical history included two previous surgeries for endometriosis and laparoscopic adenomyomectomy. On admission, vital signs were stable. Non-stress testing showed no uterine contractions. Ultrasonography demonstrated absence of fetal cardiac activity. The patient was taken to the operating room for emergency cesarean section.

RESULTS: Following a Pfannenstiel incision, no free fluid was observed in the abdominal cavity. Dense posterior pelvic adhesions related to previous surgeries were noted. A 2300 g male fetus was delivered without signs of life. Intraoperative exploration revealed a full-thickness uterine rupture measuring approximately 6 cm extending from the posterior uterine fundus toward the isthmus (Figure 1). Dense adhesions involving the Douglas pouch, lateral peritoneum, and rectosigmoid colon were carefully dissected. The uterine defect was repaired with absorbable sutures. Due to medically refractory uterine atony, bilateral uterine artery ligation was performed, resulting in restoration of uterine tone. The patient received one unit of erythrocyte suspension and one unit of fresh frozen plasma intraoperatively. Broad-spectrum triple antibiotic therapy (ceftriaxone, metronidazole, doxycycline) was initiated. Uterine preservation was achieved without hysterectomy.

DISCUSSION: Posterior uterine rupture is an extremely rare obstetric complication, with limited cases reported in the literature (1,2). It is often associated with atypical risk factors and may present with nonspecific clinical findings, leading to delayed or intraoperative diagnosis. Deep infiltrating endometriosis and repeated pelvic surgeries are known to cause extensive fibrosis, altered pelvic anatomy, and weakened uterine integrity (3,4). In addition, surgical procedures such as adenomyomectomy may further compromise myometrial strength.

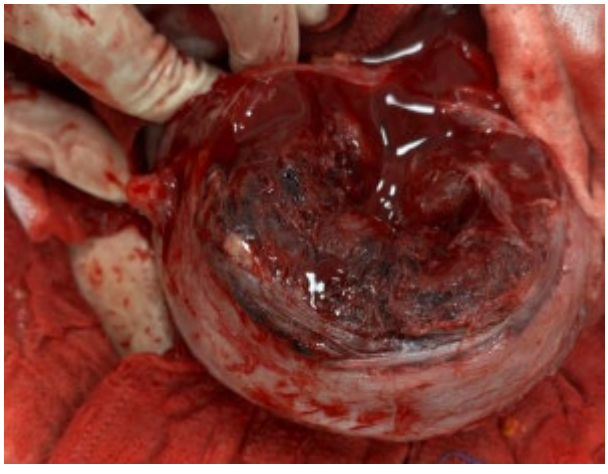
In our case, the presence of multiple endometriosis surgeries and laparoscopic adenomyomectomy likely contributed to the development of a posterior uterine rupture. Dense adhesions involving the rectosigmoid colon and posterior uterine wall further support the role of previous deep infiltrating endometriosis surgery in altering pelvic anatomy.

Despite the complexity of the case, including a large full-thickness rupture and extensive adhesions, successful conservative surgical management was achieved. Meticulous repair of the uterine defect combined with bilateral uterine artery ligation enabled effective hemorrhage control and preservation of the uterus.

CONCLUSION: Posterior uterine rupture is a rare but potentially life-threatening obstetric emergency. A history of deep infiltrating endometriosis surgery and adenomyomectomy may increase the risk of rupture in atypical locations. Clinicians should maintain a high index of suspicion in pregnant patients presenting with abdominal pain and a history of complex pelvic surgery. Early surgical intervention may allow successful uterine preservation and reduction of maternal morbidity.

Keywords: adenomyomectomy, deep infiltrating endometriosis, endometriosis surgery, obstetric emergency, posterior uterine rupture,

Figure 1



SS-115

Unicornuate uterus with ipsilateral adnexal and renal agenesis in a multiparous woman: a rare incidental finding

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AIM: Unicornuate uterus is a rare congenital Müllerian duct anomaly that may be associated with urinary tract malformations due to their common embryological origin. This report aims to present a rare case of unicornuate uterus associated with ipsilateral adnexal and renal agenesis that was incidentally diagnosed in a multiparous woman.

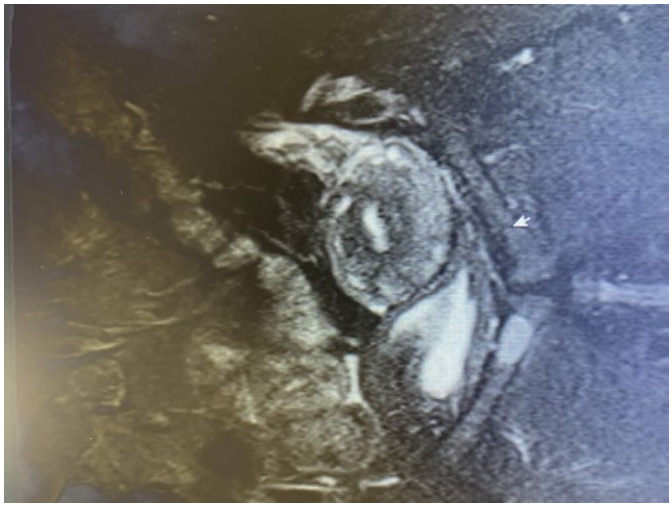
METHODS: A 44-year-old multiparous woman (gravida 3, para 2) was admitted to our clinic for planned hysterectomy and bilateral salpingectomy due to atypical squamous cells of undetermined significance (ASC-US) and persistent high-risk human papillomavirus positivity. As part of the preoperative evaluation, pelvic magnetic resonance imaging (MRI) was performed.

RESULTS: Pelvic magnetic resonance imaging demonstrated the absence of the right hemi-uterus, right ovary, right fallopian tube, and right kidney, while the left uterine horn and left adnexa appeared normal (Figure 1). Based on these findings, unicornuate uterus associated with ipsilateral adnexal and renal agenesis was suspected. During surgery, a left-sided hemi-uterus with normal left adnexa was identified, and no uterine horn, fallopian tube, or ovary was observed on the right side, confirming the diagnosis (Figure 2). Macroscopic examination of the hysterectomy specimen demonstrated a left hemi-uterus with left adnexa, while the right uterine horn and right adnexa were absent (Figure 3). The patient had no history of infertility or obstetric complications and had two previous uncomplicated term vaginal deliveries.

CONCLUSION: This case highlights a rare coexistence of unicornuate uterus with ipsilateral renal and adnexal agenesis in a multiparous woman with a normal reproductive history. The anomaly was incidentally diagnosed during preoperative imaging. Recognition of such congenital anomalies is important for accurate diagnosis, surgical planning, and evaluation of associated urinary tract abnormalities.

Keywords: Unicornuate uterus, Müllerian duct anomalies, renal agenesis, adnexal agenesis, multiparity

Figure 1



Pelvic magnetic resonance imaging demonstrating a left-sided hemi-uterus consistent with a unicornuate uterus. The right uterine horn, right ovary, and right fallopian tube are absent. Additionally, ipsilateral right renal agenesis is observed. The left adnexa appear normal. These findings are consistent with unicornuate uterus associated with ipsilateral adnexal and renal agenesis.

Figure 2



Intraoperative image showing the presence of a left hemi-uterus with normal left adnexa. No uterine horn, fallopian tube, or ovary was identified on the right side, confirming the diagnosis of unicornuate uterus associated with ipsilateral adnexal agenesis.

Figure 3



Macroscopic view of the hysterectomy specimen demonstrating a left-sided hemi-uterus with the left ovary and fallopian tube. The right uterine horn and right adnexa are absent, consistent with unicornuate uterus associated with ipsilateral adnexal agenesis

SS-117

Ruptured interstitial ectopic pregnancy at eleven weeks of gestation: A fertility-preserving surgical management

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OBJECTIVE: Interstitial pregnancy (IP), often used interchangeably with cornual pregnancy in clinical practice, involves implantation within the intramural segment of the fallopian tube. This specific location allows the gestational sac to expand significantly—sometimes up to 16 weeks—due to the distensibility of the surrounding myometrium. However, this proximity to the uterine artery leads to a higher risk of catastrophic hemorrhage upon rupture. This report presents the emergency management of a ruptured 11-week IP using a fertility-preserving technique.

METHODS: A 32-year-old woman presented with acute abdominal pain, vaginal bleeding, and signs of hemodynamic compromise. Transvaginal ultrasonography (TVUS) showed an empty uterine cavity with an eccentric gestational sac at the left horn, demonstrating the "interstitial line sign" (an echogenic line extending from the endometrial cavity to the sac). The overlying myometrial thickness was measured at less than 5 mm. Given the diagnosis of ruptured IP and presence of significant hemoperitoneum, an emergency laparotomy was initiated.

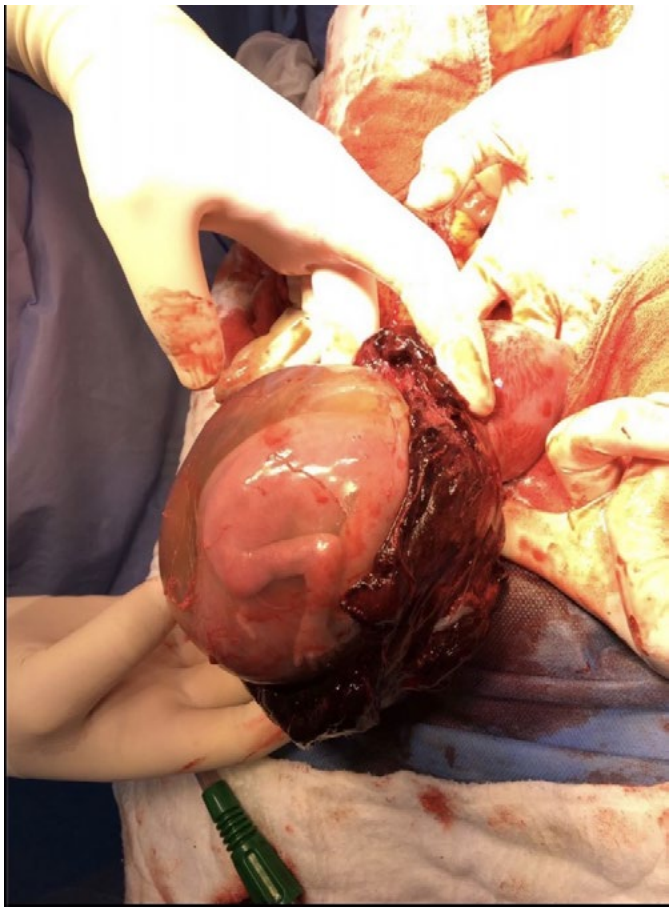
FINDINGS: Surgery revealed 1800 ml of hemoperitoneum. The left cornual region was ruptured, and an 11-week fetus was identified within an intact amniotic sac, expelled into the abdominal cavity. To avoid the long-term obstetric risks associated with radical cornual wedge resection, such as uterine rupture in future pregnancies, a conservative cornuostomy was performed. A purse-string suture was placed at the base of the cornual bulge to achieve transient vascular control. After the removal of the conceptus, the cornual defect was reconstructed using a double-layer imbricated suture technique to ensure robust myometrial reapproximation and hemostasis. The patient received appropriate blood product replacement and had an unremarkable recovery.

CONCLUSION: Managing an advanced 11-week IP requires balancing life-saving measures with future reproductive goals. While cornual wedge resection is a traditional approach, this case confirms that conservative techniques like cornuostomy and purse-string hemostasis are safe and effective, even in ruptured cases. Adherence to sonographic criteria and prompt surgical intervention are vital to reducing the maternal mortality rate associated

with this rare ectopic subtype.

Keywords: Cornual pregnancy, Interstitial pregnancy, Ectopic pregnancy rupture, Cornuostomy, Fertility-sparing surgery

Figure 1



Intraoperative view of a ruptured left interstitial pregnancy at 11 weeks of gestation. The image demonstrates a fetus entirely encased within an intact amniotic sac, having been expelled through a transmural myometrial defect. Significant local hemorrhage and a hypervascular cornual region are visible at the rupture site.

SS-118

Postoperative Diagnosis of Leiomyosarcoma Following an Initial Ectopic Pregnancy Assessment: A Case Highlighting Diagnostic Challenges

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INTRODUCTION: Uterine leiomyosarcoma (LMS) is a rare but highly aggressive malignancy arising from the smooth muscle of the uterine wall and is associated with higher recurrence and mortality rates compared to other uterine cancers.[1] Because clinical and radiological findings are often nonspecific, preoperative diagnosis is difficult, and the definitive diagnosis is frequently made after pathological examination following surgery performed with a preliminary diagnosis of leiomyoma.[2,3] The reported incidence of LMS in surgeries for presumed leiomyoma is approximately 1/350–1/500.[4] Therefore, careful treatment planning is essential. Retrospective studies have shown that patients diagnosed with LMS after morcellation have an increased risk of sarcomatosis and poorer survival outcomes.[6–7]

Treatment depends on stage. In early-stage disease (Stage I–II), surgery followed by observation is generally sufficient, and total hysterectomy is recommended for disease confined to the uterus. A National Cancer Database analysis reported no survival difference between premenopausal patients who underwent bilateral salpingo-oophorectomy and those who did not.[8] In advanced stages (Stage III–IV), adjuvant chemotherapy is recommended after surgery. Prognosis remains poor regardless of stage, with reported five-year overall survival rates of 76%, 60%, 45%, and 29% for stages I–IV, respectively.[9,10]

CASE REPORT: A 38-year-old patient, gravida 4, para 3 (all cesarean section), abortus 1, was admitted to our clinic after revision curettage was recommended due to suspected retained material following dilation and curettage performed 15 days earlier for nonviable pregnancy. The patient presented with abnormal uterine bleeding and abdominal pain. Ultrasound revealed a 9 cm mass filling the uterine cavity compatible with myoma and a 7 cm cystic anechoic lesion in the left adnexa. Laboratory evaluation showed a β-hCG level of 71 IU/L.

Tranexamic acid and blood transfusion were administered due to persistent bleeding. Within 24 hours, β-hCG decreased to 23 IU/L, but symptoms persisted, and at 48 hours the β-hCG level increased to 87 IU/L. Magnetic resonance imaging demonstrated a uterine mass suggestive of degenerating myoma, a 7 cm left adnexal cyst, and pelvic free fluid. Surgery was planned

with preliminary diagnoses of ectopic pregnancy and degenerated myoma.

Intraoperatively, the left adnexa was edematous with serohemorrhagic intra-abdominal fluid. Total abdominal hysterectomy, left salpingo-oophorectomy, right salpingectomy, and partial omentectomy were performed. The patient was discharged on postoperative day three in stable condition. Histopathological examination revealed an 8 cm spindle-cell leiomyosarcoma with high mitotic activity and extensive necrosis. Tumor implantation was detected in the left adnexa, and staging according to FIGO was T2aNxMx. No histological evidence of ectopic pregnancy was found.

CONCLUSION: Uterine leiomyosarcoma may mimic benign uterine conditions or pregnancy-related disorders because of nonspecific clinical and radiological findings. In this case, elevated β-hCG and adnexal mass suggested ectopic pregnancy, while the uterine mass was considered a degenerated myoma. The postoperative diagnosis of LMS emphasizes that malignancy should be considered in patients with uterine masses and atypical clinical findings. When clinical and laboratory results are inconsistent with benign conditions, surgical planning should follow oncologic principles.

Keywords: β-hCG elevation, diagnostic challenge, ectopic pregnancy, uterine leiomyosarcoma, uterine mass.

Figure 1



Surgical specimen of uterus with leiomyosarcoma and adnexal tissue removed during total abdominal hysterectomy.

SS-119

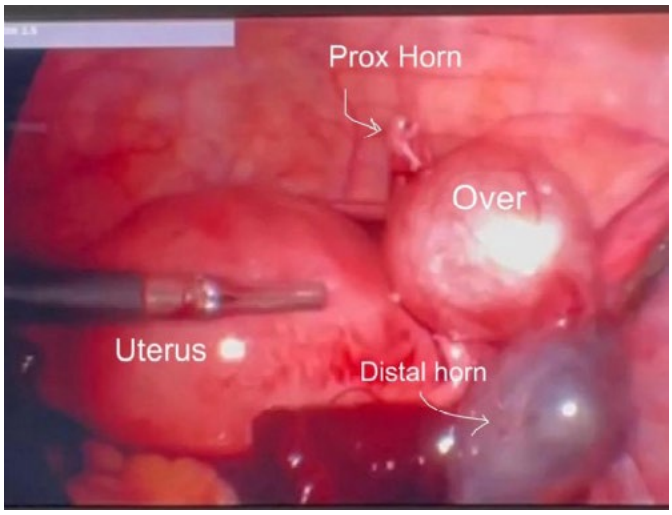
A case report of an ectopic pregnancy in the ipsilateral distal stump following partial salpingectomy

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This case report presents an ipsilateral ectopic pregnancy located in the distal stump (ampullary) of the fallopian tube following partial (isthmus) salpingectomy. A 31-year-old female patient presented with vaginal bleeding and right lower quadrant pain. Her medical history included partial removal of the right fallopian tube (salpingectomy) due to an ectopic pregnancy. Blood tests showed a positive pregnancy result, while ultrasound revealed an empty uterine cavity, a mass in the right adnexal region, and hemorrhagic fluid in the Douglas pouch. Laparoscopically, an ectopic pregnancy was confirmed in the distal stump (ampulla) resulting from a previous partial (isthmusectomy) salpingectomy. Total salpingectomy procedure was performed. This case demonstrates that ipsilateral ectopic pregnancy recurrence is possible in patients with a history of tubal ligation or partial salpingectomy. Therefore, to minimize risks in the surgical treatment of ectopic pregnancy, total salpingectomy is recommended for suitable patients.

Keywords: ectopic pregnancy, distal stump, partial salpingectomy

Picture 1



Laparoscopic view of the uterus, right over, right proximal fallopian tube and ectopic pregnancy within right distal fallopian tube

SS-120

Hysterectomy in a Patient with Bilateral Above-Knee Amputation: Clinical Management of a Rare Case

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INTRODUCTION: In female patients with a history of bilateral above-knee amputation following trauma, gynecological surgical procedures present specific perioperative challenges. Limited mobility, risk of chronic pressure ulcers, predisposition to venous thromboembolism, and accompanying psychosocial factors make surgical planning and postoperative care more complex in this patient group. In major gynecological procedures such as total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH-BSO), the presence of amputation requires individualized strategies for positioning, pressure ulcer prevention, respiratory physical therapy, and early mobilization. (2) Additionally, pelvic floor function, urinary complications, postoperative pain, and anti-embolism management should be monitored more closely in these patients. (3) Data regarding gynecological surgical experience in women with amputations are limited in the literature; the presented case holds clinical value in highlighting the importance of a multidisciplinary approach.

CASE PRESENTATION: A 50-year-old patient with a history of G5P3, three cesarean deliveries, and a prior abdominal surgery (appendectomy), who underwent bilateral above-knee amputation following a motor vehicle accident in 2000, was evaluated at our Gynecology Outpatient Clinic after presenting with a complaint of vaginal bleeding. The patient's ultrasound revealed an enlarged uterus with adenomyosis and multiple myomas. The control CVS result was negative for malignancy, and the control P/C result was reported as a product of glandular stromal breakdown. Laboratory values were as follows: Hb: 11.5 g/dL, WBC: 11, Plt: 278. A total abdominal hysterectomy with bilateral salpingectomy was planned and performed for the patient under the indication of Abnormal Uterine Bleeding + M Uteri. During the patient's preoperative and postoperative preparation and follow-up, consultations were obtained from Internal Medicine to avoid fluid overload, and from Physical Therapy and Rehabilitation to ensure proper positioning and protect against pressure ulcers. During the internal medicine consultation, a fluid maintenance rate of 50 cc/h was recommended to avoid fluid overload, and the physical therapy and rehabilitation consultation included planning for respiratory physiotherapy and mobilization. During the postoperative period, the patient's vital signs remained stable, and blood test results were within normal limits. The drain placed to monitor for intra-abdominal bleeding, given the patient's history of abdominal surgery, was removed 24 hours postoperatively. The patient was discharged in good health on the third postoperative day. At the 1-month postoperative follow-up, the control ultrasound was evaluated as normal, and the pathology report of the surgical specimen stated: "Adenomyoma, Leiomyoma, Right tubal endometriosis, Cervicitis; Hysterectomy + bilateral salpingectomy."

DISCUSSION AND CONCLUSION: Hysterectomy procedures in patients with a history of lower extremity amputation carry increased perioperative risks compared to standard gynecological surgeries. In our case, a multidisciplinary approach was prioritized regarding the risk of venous thromboembolism due to limited mobility, positioning difficulties, and the development of pressure ulcers. The limited number of direct case reports in the literature regarding hysterectomy in amputee patients highlights the clinical significance of this case. We believe that safe surgical outcomes can be achieved in this patient group through appropriate surgical planning, careful postoperative care, and early rehabilitation.

Keywords: Bilateral Above-Knee Amputation, Hysterectomy, Physical Therapy and Rehabilitation, Postoperative period, Multidisciplinary approach

SS-121

Mesenteric abscess mimicking an adnexal mass:a case presentation

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izmir şehir hastanesi

AIM: The differential diagnosis of acute abdominal pain in women of reproductive age is broad and may include both gynecological and gastrointestinal pathologies. Mesenteric lesions are rare and may mimic adnexal masses on imaging studies, leading to diagnostic challenges. In this report, we present a case of mesenteric abscess initially suspected to be an adnexal mass in a young woman presenting with acute abdominal pain.

METHODS: A 21-year-old female patient (G1P1L1) presented to the emergency department with right lower quadrant abdominal pain lasting for ten days. On physical examination, tenderness was noted in the right lower quadrant. Bimanual pelvic examination revealed minimal pain. Laboratory tests showed elevated inflammatory markers with C-reactive protein (CRP) of 280 mg/L and white blood cell count (WBC) of 15,000/mm³. Beta-human chorionic gonadotropin (β-hCG) level was 80 mIU/mL. Transvaginal ultrasonography revealed a 7×6 cm mass-like lesion in the right adnexal region and endometrial thickness of 14 mm. Due to the suspicion of early pregnancy and tubo-ovarian abscess, the patient was hospitalized for further evaluation.

RESULTS: Abdominal ultrasonography demonstrated a 76×76 mm cystic lesion with fluid levels located superior to the urinary bladder, accompanied by free fluid in the Douglas pouch. Magnetic resonance imaging revealed a thin-walled cystic lesion measuring approximately 75×76×70 mm within the mesenteric fat planes, containing a fat–fluid level. The lesion showed no clear relationship with gynecological organs and was initially suspected to be a mesenteric cystic teratoma. During clinical follow-up, the patient developed signs of acute abdomen. Emergency laparotomy was performed, revealing a cystic lesion adherent to the small bowel mesentery. Segmental small bowel resection with mass excision and primary anastomosis was performed. Histopathological examination demonstrated a 7.5×7.5×7 cm abscess formation with minimal ischemic changes in the bowel, with no evidence of neoplasia.

CONCLUSION: Mesenteric abscess is a rare condition that may mimic adnexal masses in women presenting with acute abdominal pain. Accurate diagnosis requires careful correlation of clinical, laboratory, and imaging findings. Awareness of this rare entity is important to avoid misdiagnosis and ensure timely surgical management.

Keywords: Mesenteric abscess, Adnexal mass mimicry, Acute abdomen, Mesenteric cystic lesion, Differential diagnosis

case photo

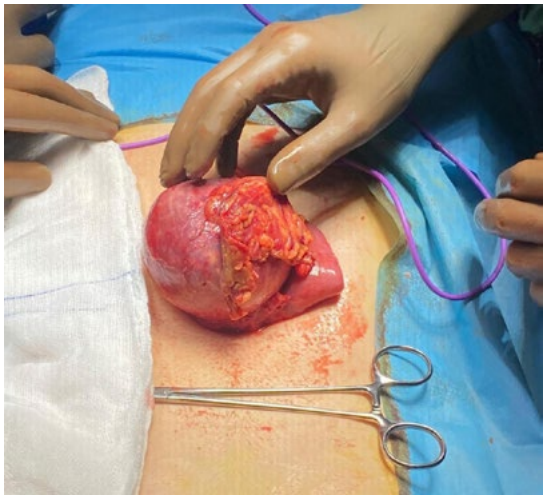


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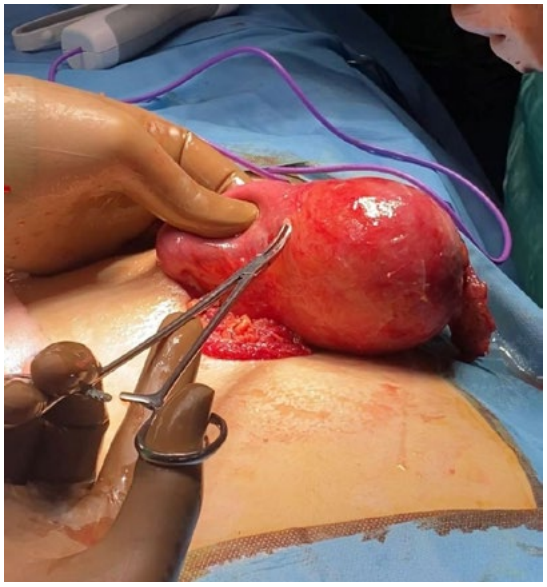
specimen



surgery



surgery



SS-122

A case of pyomyoma originating in the endometrial cavity and extending into the vagina, observed in the postmenopausal period

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Pyomyoma, also known as suppurative leiomyoma, is a rare but potentially life-threatening complication of uterine fibroids, characterized by the infarction and infection, subsequent abscess formation within a fibroid. The condition often presents with nonspecific symptoms such as abdominal pain, fever, and signs of sepsis, making early diagnosis challenging. A pyomyoma is rarely reported and can be a lethal complication of a uterine leiomyoma. If a classic triad of symptoms that includes abdominal pain, sepsis without an obvious source, and a history of leiomyoma, pyomyoma can be suspected. In majority of cases, total abdominal hysterectomy is required to avoid severe morbidity and potential mortality. Due to its rarity, pyomyoma can be easily overlooked, delaying appropriate treatment. Usually, it occurs after uterine artery embolization or postpartum. A strong clinical suspicion, early diagnosis, and appropriate management should be done to save the patient. This case report presents a rare occurrence of pyomyoma in a 53 years old postmenouposal woman, without any predisposing factors and discuss the clinical management and outcomes. The medical history of this 53-year-old patient revealed no risk factors.

Keywords: Leiomyoma, Myoma in status nascendi, Pyomyoma, vaginitis, pelvic inflammatory disease

Figure 1: During the removal of a myoma that appears to be infected and has a vaginal origin



Figure 1: During the removal of a myoma that appears to be infected and has a vaginal origin

SS-123

Accessory cavitated uterine malformation (ACUM): a rare cause of chronic pelvic pain

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Accessory Cavitated Uterine Malformation (ACUM) is a rare congenital uterine anomaly resulting from a developmental defect in the Müllerian ducts. It is typically characterized by severe dysmenorrhea and chronic pelvic pain, often beginning during adolescence. ACUM is defined by the presence of an accessory cavity with functional endometrium that lacks an external outlet and is located alongside a normal uterus. The accumulation of menstrual blood within this cavity can cause significant pain and occasionally a mass effect. Its clinical presentation often mimics other pelvic pathologies, particularly endometriosis, making diagnosis challenging. This report describes the clinical features, diagnostic process, and management of a patient with ACUM.

CASE REPORT: A 19-year-old nulliparous (G0P0) sexually active female presented to the emergency department with complaints of lower abdominal pain, who had a history of prior visits to the hospital for similar complaints.

Clinical findings in the emergency department were: negative β-hcg, no guarding or rebound tenderness in the abdominal examination.She was on the fourth day of her menstrual cycle. For further assesment contrast-enhanced pelvic computed tomography (CT) was performed, which revealed no abnormalities.

The patient was evaluated as having dysmenorrhea and was referred to the gynecology outpatient clinic after providing pain palliation.

During the gynecological examination, no additional background pathology was detected, except for dysmenorrhea, which had been present for the past two years. A single cervical os, nulliparous cervix appearance, and normal vaginal findings were reported during the vaginal examination. A cystic structure measuring 25*30 mm was identified adjacent to the left lateral uterine wall in TV USG (Figure 1).

Because the findings raised a suspicion of a uterine anomaly Magnetic Resonance Imaging (MRI) was ordered. Contrast-enhanced pelvic MRI revealed a lesion measuring 27*25 mm located at the level of the left uterine horn, adjacent to the round ligament. These findings were highly suggestive of ACUM (Figure 2). The patient was informed about the definitive treatment option of surgical excision of the accessory cavity. However, she expressed reluctance toward surgery due to associated risks. As an alternative, she was started on a combination of nonsteroidal anti-inflammatory drugs

(NSAIDs) and combined oral contraceptives (COCs) to manage symptoms. The patient was informed that these treatments were not curative but aimed at temporary symptom relief. She was scheduled for regular follow-up visits to monitor her condition and discuss surgical options if her symptoms persisted or worsened.

DISCUSSION: This case highlights the diagnostic challenges associated with ACUM, a rare congenital uterine anomaly. The condition often presents with non-specific symptoms such as dysmenorrhea and chronic pelvic pain. Imaging modalities such as ultrasound and MRI are crucial for identifying the anomaly, while invasive procedures like laparoscopy may be required for definitive diagnosis. Although surgical excision is the treatment of choice for ACUM, patient preferences and concerns about surgical risks should be carefully addressed. In cases where surgery is deferred, symptom management with NSAIDs and hormonal therapy can provide temporary relief, with close follow-up to monitor the patient's condition.

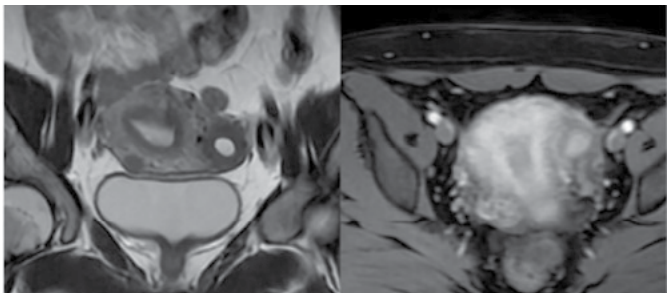
Keywords: Uterine Malformation, congenital uterine anomaly, chronic pelvic pain

figure 1



*TV USG: A cystic structure measuring 25*30 mm was identified adjacent to the left lateral uterine*

figure 2



*MRI: 27*25 mm located at the level of the left uterine horn, adjacent to the round ligament.*

VİDEO BİLDİRİLER

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

VS-01

Extensive Pelvic Lymph Node Dissection Through Vaginal Natural Orifice Transluminal Endoscopic Surgery

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OBJECTIVE: Sentinel lymph node (SLN) sampling is now advised for select patients presenting with apparent early-stage endometrial cancer (EC) as it strikes a balance between precise staging and reducing the morbidity linked to conventional lymph node dissection [1]. A recent systematic review highlights Vaginal Natural Orifice Transluminal Endoscopic Surgery (V-NOTES) as a promising approach for SLN staging in EC, demonstrating high detection rates, minimal complications, and favorable perioperative outcomes [2]. Nonetheless, if mapping fails, the surgeon is advised to proceed with a complete lymphadenectomy on the affected side [1]. Although international guidelines endorse the reliability of pelvic lymphadenectomy using conventional laparoscopy, there is limited evidence in English literature regarding its implementation through the vNOTES technique [3].

DESIGN: This video provides a detailed guide on performing a complete pelvic lymphadenectomy using vNOTES for women diagnosed with grade 2 endometrioid endometrial carcinoma through endometrial sampling.

PATIENT: A 48-year-old woman presented with postmenopausal bleeding, and an endometrial biopsy revealed grade 2 endometrioid endometrial carcinoma. PET-CT demonstrated mild FDG uptake localized to the uterine fundus, with no evidence of lymph node involvement or distant metastases. After an unsuccessful attempt at sentinel lymph node mapping, a complete pelvic lymphadenectomy was carried out via the V-NOTES technique, followed by a total hysterectomy with bilateral salpingo-oophorectomy. The procedure was completed without any intraoperative or postoperative complications, and the patient was discharged on the second postoperative day without the need for ICU care.

INTERVENTIONS: Step-by-Step Surgical Technique

1. Preparation and Positioning:

• After administering general anesthesia and ensuring full muscle relaxation, position the patient in a horizontal dorsal lithotomy position. Insert a bladder catheter.

2. Colpotomy and Accessing the Pelvic Retroperitoneal Space:

• Secure the right lateral vaginal wall with two forceps placed in the lateral vaginal fornix. Make a 4–5 cm incision between the forceps using a scalpel and grasp the edges with Allis forceps. Perform systematic lateral dissection with scissors and finger dissection to expose the paravesical space.

3. vNOTES Port Setup:

• Place the GelPoint V-Path Transvaginal Access Platform, including a 7 cm diameter Alexis retractor inner ring, to establish the vNOTES port.

4. Endoscopic Preparation and Lymph Node Removal:

• Insufflate CO_2 into the retroperitoneal space (10–15 mmHg working pressure). Using bipolar devices and vessel sealing instruments, begin directional dissection, identifying key landmarks such as the obturator nerve and vein. Remove lymph nodes sequentially, exposing and targeting regions around the external iliac artery, vein, iliac artery, and ureter (Fig 1).

5. Closure:

• After achieving hemostasis with a bipolar grasper, remove the vNOTES port and close the vaginal incision using simple Vicryl 0 sutures.

CONCLUSION: This video highlights that VNOTES pelvic lymphadenectomy is a reliable and effective procedure in cases where SLN mapping proves inadequate.

Keywords: KEYWORDS Sentinel lymph node, vaginal natural orifice transluminal endoscopic surgery, endometrial cancer.

VS-02

vNOTES Approach for the Surgical Management of a Large Intraligamentary Myoma

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OBJECTIVE: Intraligamentary myomas are rare variants of uterine leiomyomas that may mimic adnexal masses and pose technical challenges due to their close relationship with the ureter and pelvic vascular structures. Minimally invasive techniques are increasingly preferred for the management of complex pelvic masses; however, large intraligamentary fibroids may still raise concerns regarding surgical exposure and specimen extraction. This video aims to demonstrate the feasibility and safety of transvaginal natural orifice transluminal endoscopic surgery (vNOTES) hysterectomy with bilateral salpingo-oophorectomy (BSO) for the management of a giant intraligamentary myoma.

CASE PRESENTATION: A 50-year-old woman (BMI 24.6, G3P2A1) presented with a pelvic mass detected during routine gynecologic evaluation. The patient had no chronic systemic disease but had a history of splenectomy performed 40 years earlier.

Transvaginal ultrasonography demonstrated an enlarged uterus with heterogeneous myometrial architecture and an approximately 8-cm irregular mass located in the uterine fundus. Pelvic contrast-enhanced magnetic resonance imaging confirmed the presence of a roughly 8-cm lesion showing heterogeneous enhancement and focal diffusion restriction. The right ovary could not be clearly distinguished from the mass, and although the lesion was primarily thought to originate from the uterus, the possibility of an adnexal mass or malignancy could not be completely excluded. Surgical excision was therefore recommended.

SURGICAL TECHNIQUE: A vNOTES hysterectomy with bilateral salpingo-oophorectomy was planned. After establishing the transvaginal endoscopic access platform, pelvic exploration was performed under endoscopic visualization. Careful dissection of the intraligamentary mass was achieved with particular attention to the identification and protection of the ureter. Safe ureteral dissection and mobilization were ensured prior to the division of the uterine pedicles. The hysterectomy and bilateral oophorectomy were successfully completed using the vNOTES technique. Due to the absence of a power morcellator in our institution, specimen extraction through the vaginal route was not feasible. Therefore, the surgical specimen was removed through a mini-Pfannenstiel incision. The total operative time was 96 minutes. The procedure was conducted in accordance with preoperative and postoperative Enhanced Recovery After Surgery (ERAS) protocols.

RESULTS: The surgery was completed without intraoperative complications. Adequate visualization of pelvic anatomy and safe dissection of critical structures, particularly the ureter, were achieved using the vNOTES approach. Estimated blood loss was minimal. The postoperative course was uneventful, and the patient was discharged on postoperative day two.

CONCLUSION: This case demonstrates that vNOTES hysterectomy can be a safe and effective minimally invasive approach for the management of large intraligamentary myomas that may mimic adnexal tumors. The technique provides excellent pelvic visualization and facilitates safe ureteral identification and dissection. When vaginal specimen extraction is not feasible due to technical limitations such as the absence of a morcellator, a small Pfannenstiel incision can be used without compromising the minimally invasive nature of the procedure. This approach may expand the applicability of vNOTES in the treatment of complex pelvic masses.

Keywords: Intraligamentary myoma, Minimally invasive gynecologic surgery, vNOTES surgery

VS-03

Retroperitoneal sentinel lymph node biopsy via vNOTES in endometrial carcinoma: a case presentation

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OBJECTIVE: Endometrial cancer is the most common gynecologic malignancy in developed countries, representing 90% of uterine corpus cancers. It is often detected early due to abnormal uterine bleeding. Minimally invasive techniques such as laparoscopy and robotic surgery are now standard, with sentinel lymph node biopsy (SLNB) providing a reliable alternative for retroperitoneal staging. Transluminal endoscopic surgery via natural orifices (NOTES) is an evolving minimally invasive approach. The vaginal NOTES (vNOTES) technique is established as safe and effective in benign gynecology, and in oncology, retroperitoneal access for SLNB is increasingly applied.

METHODS: A 61-year-old patient, para 4, underwent endometrial biopsy with a diagnosis of postmenopausal bleeding, and Grade 1 endometrioid carcinoma was detected. The PET report noted “irregularity in uterine contours and mild diffuse FDG uptake (SUVmax = 6.3), prominent in the right lateral section.” Surgical technique: In the lithotomy position, after appropriate staining and draping, the cervix was grasped with a single-toothed instrument. 1 ml/1 ml of indocyanine green (ICG) was applied to the cervix at the 3 and 9 o’clock positions. A vertical incision was made proximal and distal to the vaginal free fold, keeping it above the bilateral ischial processes, using a coherent instrument. The bilateral obturator fossa was accessed with blunt dissection. A No. 7 Alexis minor ring was placed in the space, inflated with 10 mm Hg CO2, and trocars were inserted. Bilateral paraservical lateral vaginal fornix An incision was made to enter the retroperitoneal space. Bilateral obturator fossae were opened, and anatomical landmarks were identified (ureter, external iliac artery and vein, obliterated umbilical artery, obturator nerve). The right common iliac and left internal iliac sentinel lymph nodes were excised and sent to pathology for ultrastaging. Bleeding was controlled, the cervix was closed with vicryl sutures at external os no 1, and vNOTES hysterectomy and bilateral salpingo-oophorectomy were performed. There were no complications. The total operation time was determined to be 1 hour and 45 minutes. The final pathology report was G1 endometrial adenocarcinoma, tumor diameter 3.5 cm, myometrial invasion 10%, (pT1 pN0, FIGO I). No lymph node metastasis was detected by ultrastaging. Adjuvant radiotherapy or brachytherapy was not applied. Preoperative and postoperative Hb values were 13.0/11.7, respectively. It was reported. The patient was discharged on the first postoperative day.

CONCLUSION: The vNOTES (Vaginal Natural Orifice Transluminal Endoscopic Surgery) approach, particularly in patients with BMI >30 kg/m², provides safer visualization and easier access compared to laparoscopy. With no abdominal incisions, it offers superior cosmetic outcomes, shorter hospital stays, and faster recovery. Postoperative pain is reduced, and most patients are discharged within 24 hours. Unlike conventional laparoscopy requiring high-pressure pneumoperitoneum, vNOTES achieves pelvic exposure with low insufflation (8–10 mmHg), minimizing shoulder pain and opioid use. Retroperitoneal vNOTES with sentinel lymph node biopsy is a feasible, safe, and minimally invasive option for staging early endometrial cancer. This case confirms technical feasibility without complications, though larger studies and long-term follow-up are needed to validate oncologic safety.

Keywords: Endometrial carcinoma, Sentinel lymph node, vNOTES hysterectomy

VS-04

V-notes Sacrospinous Ligament Fixation

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Vaginal natural orifice transluminal endoscopic surgery (vNOTES) has increasingly been used as a minimally invasive approach in pelvic surgery. In pelvic organ prolapse surgery, it may facilitate surgical manipulation by providing improved visualization of deep pelvic structures. Sacrospinous ligament fixation (SSF) is a commonly used technique to provide apical support in uterine or apical prolapse surgery.

A 51-year-old woman presented with uterine prolapse. Pelvic examination using the POP-Q system revealed apical prolapse with the C point at +1. Surgical management was planned. First, using the vNOTES platform, the sacrospinous ligament was visualized and sutures were placed through the ligament. After placement of the sacrospinous sutures, a vNOTES hysterectomy was performed. Following completion of the hysterectomy, the vaginal cuff was suspended to the sacrospinous ligament using the previously placed sutures, thereby providing apical support.

The vNOTES approach allowed clear endoscopic visualization of the sacrospinous ligament and surrounding anatomical structures. Compared with conventional vaginal techniques, which often provide limited exposure in the deep pelvic space, the vNOTES platform facilitated easier dissection and more controlled surgical manipulation. In particular, direct visualization of the sacrospinous ligament enabled safer and technically easier placement of sutures.

This case demonstrates that vNOTES-assisted sacrospinous ligament fixation may offer several technical advantages in uterine prolapse surgery, including improved visualization, easier dissection, and more convenient suture placement in the sacrospinous ligament.

Keywords: V-notes, Apical prolapsus, Sacrospinous ligament fixation

VS-05

Minimally invasive surgical management of interstitial (cornual) pregnancy: a case report

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OBJECTIVE: Cornual pregnancy (CP) is a rare but diagnostically challenging condition that can lead to catastrophic hemorrhage, resulting in significant patient morbidity and even mortality. In recent years, however, minimally invasive laparoscopic techniques have been developed with favorable outcomes. Laparoscopy offers several advantages over laparotomy, such as significantly reduced blood loss, shorter hospital stay, and faster recovery. The aim of this case presentation is to demonstrate, step by step, hemorrhage prevention strategies for fertility-preserving laparoscopic treatment of CP.

METHODS: A 29-year-old primiparous patient was admitted to our department with cramping right lower quadrant pain. She had a history of three abortions and one ectopic pregnancy treated with methotrexate. She also had undergone an appendectomy via laparotomy five years earlier. The serum β-hCG level was 25,907 mIU/mL and her hemoglobin level was 14.5 g/dL. She was hemodynamically stable.

Transvaginal ultrasound findings were as follows: an empty uterine cavity with an endometrial thickness of 14 mm, an eccentrically located gestational sac corresponding to 6 weeks and 1 day of gestation located 1 cm from the most right lateral wall of the uterine cavity, and a thin myometrial layer (less than 5 mm) surrounding the gestational sac. These findings suggested a right CP. Laparoscopic right CP resection and right salpingectomy were recommended to the patient, and the operation was performed after obtaining informed consent.

Under general anesthesia, a non-traumatic cannula was inserted as a uterine manipulator. A standard three-port laparoscopic entry using the closed entry technique was performed. A circular suture serving as a tourniquet was placed around the cornual area, achieving hemostasis through compression. Right salpingectomy was performed using Ligasure, and the circumferential cornual incision was made with a Harmonic Scalpel. The gestational sac was extracted with grasping forceps, and the material was removed from the abdomen. The myometrium was sutured and closed continuously with 1 Vicryl. The postoperative period was uneventful, and the patient was discharged the next day. Neither perioperative nor postoperative complications were noted.

RESULTS: Histopathological examination confirmed cornual pregnancy. The β-hCG level decreased to undetectable levels, and the patient had a normal

postoperative course.

CONCLUSIONS: A laparoscopic approach with cornual excision of the ectopic pregnancy sac combined with hemostatic circumferential suturing is a safe and effective surgical method for the treatment of CP and allows preservation of the patient's future reproductive potential.

Keywords: cornual pregnancy, hemorrhage, laparoscopy

VS-06

Vulvar cancer: sentinel lymph node dissection and radical vulvectomy – case report

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INTRODUCTION: Vulvar squamous cell carcinoma (VSCC) is a rare malignancy, with global age-standardized incidence rates of approximately 0.83 per 100,000 women and an estimated 47,000–50,000 new cases annually [1]. Prognosis is strongly influenced by nodal status, and sentinel lymph node biopsy has emerged as a less morbid alternative to full inguinofemoral lymphadenectomy in early-stage disease [2]. This report presents our clinical experience with radical vulvectomy and sentinel lymph node dissection in a patient diagnosed with VSCC, emphasizing surgical technique, pathological findings, and postoperative outcomes.

METHODS: Patient: A 60-year-old woman, gravida 1, para 1, postmenopausal for 16 years, presented with persistent vulvar ulceration and pruritus. Her medical history included treatment for lichen sclerosus over the past five years. Gynecological examination revealed hypopigmented areas consistent with lichen sclerosus around the clitoris. A 2–3 cm exophytic, irregular, ulcerated mass was noted on the right posterior labium majus extending toward the perianal region. Histopathology confirmed squamous cell carcinoma. PET-CT demonstrated a 28×10 mm hypermetabolic vulvar lesion (SUVmax=20.75). A suspected metastatic lymph node, approximately 1 cm in size, with an inoptimal hilum, was observed in the left inguinal region with low-to-moderately elevated metabolism (SUVmax = 3.9). A tumor lesion approximately 2 cm in size was observed in the posterior aspect of the left labium minora, 1 cm from the introitus. A total of 2 cc of ICG was injected around the tumor in four quadrants. An oblique incision of approximately 8 cm was made between the pubic symphysis and the ASIS, passing through the skin and subcutaneous tissue to access the superficial and deep inguinal lymph nodes. ICG camera observation showed no involvement on the right side, while involvement was observed in two deep inguinal lymph nodes on the left side, which were excised and sent for frozen section analysis; the result was reported as a reactive lymph node. Bilateral superficial and deep inguinal lymph node dissection was completed according to procedure. Subsequently, a wide surgical excision was performed in the labiocrural region, leaving a 2 cm distance from the lateral aspect of the tumor and a 1 cm distance from the urethral meatus; this included the bilateral labium minus, the medial half of the labium majus, and the Fourchette's

till basal layer, and no complications were encountered. The final pathology report stated: "Vulvectomy material revealed keratinized, well-differentiated squamous cell carcinoma (2.5 × 1.7 cm, depth of invasion 0.7 cm). Surgical margins were intact, and no lymphovascular or perineural invasion was observed. All examined right and left superficial/deep inguinal lymph nodes were reactive, and no metastasis was observed."

RESULTS: The postoperative course was uneventful, with no wound complications observed. Sentinel lymph node biopsy revealed no metastatic involvement, and the patient recovered without morbidity.

This case demonstrates that radical vulvectomy combined with sentinel lymph node dissection is a safe and effective approach in early-stage vulvar squamous cell carcinoma. Our experience supports the integration of sentinel lymph node techniques into routine practice, highlighting their contribution to improved patient outcomes and reduced surgical complications.

Keywords: Inguinal lymph node dissection, Sentinel lymph node biopsy, Radical vulvectomy, Vulvar squamous cell carcinoma

VS-07

First experience with the Doğan anterior colpotomy first technique in a rural secondary hospital: A case report

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OBJECTIVE: Total laparoscopic hysterectomy (TLH) is widely used for the management of benign gynecological diseases. However, surgical dissection may become challenging in patients with suspected posterior compartment adhesions or obliteration of the Douglas pouch. The anterior colpotomy first technique has recently been described as an alternative approach that may facilitate surgical dissection in complex pelvic anatomy. In this study, we aimed to present a case of total laparoscopic hysterectomy with bilateral salpingo-oophorectomy using the anterior colpotomy first technique in a patient with suspected Douglas pouch obliteration in a rural secondary care hospital.

METHODS: A 57-year-old nulliparous woman, menopausal for two years, presented with postmenopausal bleeding. She had no history of chronic disease or previous surgery. HPV testing performed in October 2024 was negative. Transvaginal ultrasonography demonstrated multiple uterine fibroids, with the largest measuring 6 cm on the anterior wall and 5 cm on the posterior wall. The patient initially underwent hysteroscopic myomectomy, and pathology confirmed leiomyoma. After counseling, definitive surgical management was planned. Preoperative ultrasonography revealed a negative sliding sign, suggesting Douglas pouch obliteration; therefore, a vNOTES approach was not considered suitable. A total laparoscopic hysterectomy with bilateral salpingo-oophorectomy (TLH-BSO) was planned using the anterior colpotomy first technique. Written informed consent was obtained from the patient for the surgical procedure and for the scientific use of intraoperative images and video recordings.

RESULTS: Intraoperatively, the uterus was approximately 12-week size. Pelvic exploration revealed complete obliteration of the Douglas pouch. The sigmoid colon was adherent to the lateral pelvic wall, round ligament, and uterus on the left side, while on the right side bowel loops formed a conglomerate mass involving the right adnexa and ureteral course, preventing clear visualization of the right ovary.

Dissection was initiated by opening the left pararectal space, and the sigmoid colon was mobilized from the lateral pelvic wall. The left paravesical space was subsequently developed following transection of the round ligament. On the right side, the peritoneum over

the sacral promontory was incised and ureterolysis performed, allowing identification of the right ureter. Bowel loops were deviated to the left, and dissection was advanced toward the rectovaginal space. The right paravesical space was then opened and connected with the pararectal space. After the ureters were clearly identified, bilateral uterine arteries were sealed and transected at their origin from the hypogastric (internal iliac) artery using LigaSure.

Due to dense posterior adhesions and Douglas pouch obliteration, safe posterior dissection could not be achieved. Therefore, the procedure was continued using the anterior colpotomy first technique, and the hysterectomy was completed laparoscopically without intraoperative complications.

Preoperative hemoglobin was 14.4 g/dL, decreasing to 12.3 g/dL at postoperative 6 hours and 11.7 g/dL at 24 hours. No blood transfusion was required. The postoperative course was uneventful, and the patient was discharged 24 hours after surgery.

CONCLUSION: In patients with suspected posterior pelvic adhesions or Douglas pouch obliteration, the anterior colpotomy first technique may facilitate safer total laparoscopic hysterectomy when posterior dissection is difficult and appears feasible even in a rural secondary care hospital setting.

Keywords: Anterior colpotomy first technique, Total laparoscopic hysterectomy, Douglas pouch obliteration, Pelvic adhesions, Minimally invasive gynecologic surgery

VS-08

Beyond the Vaginal Route: vNOTES Sentinel Lymph Node Mapping and Pelvic Lymphadenectomy in Endometrial Cancer with Laparoscopic Confirmation of Retroperitoneal Dissection

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BACKGROUND: Endometrial cancer remains the most prevalent gynecologic malignancy, and precise surgical staging is critical for prognosis and tailoring adjuvant therapy. Sentinel lymph node (SLN) mapping has emerged as a standard strategy in selected patients, minimizing morbidity while maintaining diagnostic accuracy. Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) represents a novel minimally invasive approach that allows direct access to the retroperitoneal space without abdominal incisions. Despite its potential advantages—reduced postoperative pain, faster recovery, and improved cosmesis—concerns persist regarding reproducibility, retroperitoneal anatomical orientation, and completeness of lymphadenectomy. This video demonstrates vNOTES SLN mapping and pelvic lymphadenectomy, emphasizing critical retroperitoneal landmarks and confirming dissection adequacy through laparoscopic visualization.

METHODS: A 60-year-old female patient with two prior vaginal deliveries and comorbidities including diabetes and hypertension (BMI 38.2) presented with postmenopausal bleeding. Endometrial biopsy revealed grade 1 endometrioid adenocarcinoma; PET-CT showed no distant metastases. The patient underwent vNOTES-based surgical staging, including SLN mapping and systematic pelvic lymphadenectomy. Key retroperitoneal anatomical landmarks were identified throughout the procedure. Following the vNOTES dissection, laparoscopic visualization was performed to confirm completeness and anatomical precision. Total operative time was 141 minutes.

RESULTS: The procedure was completed successfully without intraoperative complications. The patient was discharged on postoperative day 4. Pathology confirmed FIGO grade 1 endometrioid adenocarcinoma, maximum tumor diameter 3.1 cm, with focal lymphovascular invasion. Tumor infiltration was less than half of the myometrium. A total of 26 pelvic lymph nodes, including

the sentinel node, were harvested; all were negative for metastasis. Laparoscopic confirmation revealed a fully cleared retroperitoneal space with preservation of critical anatomical structures, demonstrating the technical feasibility and reproducibility of vNOTES for pelvic lymphadenectomy.

CONCLUSION: vNOTES sentinel lymph node mapping and pelvic lymphadenectomy is a safe, effective, and reproducible minimally invasive approach for endometrial cancer staging. The transvaginal route allows direct retroperitoneal access while avoiding abdominal incisions, potentially reducing perioperative morbidity. Identification of key anatomical landmarks is essential to ensure safe dissection, and laparoscopic confirmation provides an invaluable educational perspective. This video underscores both the technical steps and anatomical clarity of vNOTES, offering a model for surgeons aiming to adopt this innovative minimally invasive strategy for endometrial cancer staging.

Keywords: vnotes, lymphadenectomy, sentinel lymph node mapping

VS-09

Laparoscopic management of antibiotic-resistant tubo-ovarian abscess and postoperative ıleus: a case report

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OBJECTIVE: Tubo-ovarian abscess (TOA) is a severe complication of pelvic inflammatory disease requiring hospitalization due to risks of rupture, peritonitis, and sepsis. First-line treatment is broad-spectrum antibiotics, but resistant or ruptured cases need surgery. Antibiotics alone succeed in 34–88% of TOA cases. Traditionally, laparotomy has been preferred because of extensive adhesions, though laparoscopy offers faster recovery and less pain.

METHODS: 45 years old female patient presented to the gynecology outpatient clinic with complaints of left lower quadrant pain, fever, chills, and foul-smelling vaginal discharge. Gynecological examination revealed profuse leukorrhea, cervical motion tenderness, and left adnexal fullness with marked tenderness. Ultrasonography demonstrated an intrauterine device (IUD) and a left adnexal cystic lesion measuring approximately 8 cm. Computed tomography confirmed an 8×6 cm soft tissue–fluid density mass in the left adnexal region, with surrounding fat stranding. Laboratory findings were: Hb 12.8 g/dL, WBC 17,300/µL, CRP 291 mg/L, and fever 38.1 °C. The patient was admitted with a presumptive diagnosis of tubo-ovarian abscess (TOA). Broad-spectrum intravenous antibiotics were initiated per infectious disease consultation. On day 1, the IUD was removed. Despite antibiotic therapy, CRP levels plateaued. On day 6, percutaneous abscess drainage was performed, but the patient's septic condition persisted and the mass size did not decrease. On day 11, laparoscopic intestinal adhesiolysis and left salpingo-oophorectomy were performed.

Operative Findings The uterus was of normal size but adherent to the anterior abdominal wall and the abscess cavity. The left ovary and tube were densely adherent to the sigmoid colon, forming a conglomerate mass, while the right adnexa appeared normal. Blunt dissections were performed to separate the left adnexa and sigmoid colon from the abscess wall. A consultant from general surgery was invited intraoperatively, and the bowel loops were carefully inspected. As no additional intervention was deemed necessary from the general surgery perspective, abscess drainage and left salpingo-oophorectomy were performed. The abscess cavity and peritoneal cavity were thoroughly irrigated with saline, and a Nelaton drain was placed in the pouch of Douglas.Cultures from blood, cervical discharge, urine,

tissue, and abscess fluid showed no bacterial growth. Postoperatively, the patient's clinical status improved, with resolution of fever and declining CRP levels. However, on the 5th postoperative day she developed abdominal distension, absence of flatus and stool passage, and radiographic evidence of air-fluid levels consistent with postoperative ileus. This condition, likely due to local contamination and inflammation delaying the recovery of intestinal motility, was observed. Normal electrolyte levels confirmed that the ileus was related to localized tissue healing rather than systemic imbalance. Supportive management—including bowel rest, intravenous fluids, and enemas—was initiated, and with close monitoring the ileus resolved spontaneously within 10 days.

Conclusion In this report, we aimed to demonstrate that a multiloculated, organized, antibiotic-resistant tubo-ovarian abscess with extensive bowel can be effectively managed with minimally invasive surgery, and that postoperative ileus may resolve spontaneously under conservative supportive care without the need for further invasive intervention.

Keywords: Laparoscopic adhesiolysis, postoperative ileus, Tuboovarian abcess

VS-10

Sentinel lymph node mapping in a patient with a didelphys uterus who has endometrial carcinoma in one of its cavities

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INTRODUCTION: Endometrial carcinoma is the most common gynaecological malignancy in our country and the fourth most common cancer in women. Diagnosis is based on histology. Metastatic disease is depending on the histological type and grade, assessed using imaging studies. Treatment involves hysterectomy combined with lymphadenectomy in patients at high risk of metastasis. Lymph node assessment is considered an important part of the staging procedure as it provides prognostic information and helps determine the need for adjuvant therapy. As there is no consensus on the optimal approach to lymph node assessment so methods vary considerably; include omitting lymph node dissection(LND), performing systematic LND or applying sentinel lymph node mapping(SLND). Macroscopic examination and/or frozen section analysis of uterus during surgery may be used to decide whether to perform LND. The decision regarding lymphadenectomy should be individualised based on the absence of lymph node metastasis, the feasibility of surgical access to nodes and the risk of lymphoedema. SLND prevents the morbidity associated with radical lymphadenectomy in patients with negative nodes whilst providing a high degree of diagnostic accuracy. Anomalies of the Müllerian ducts may be associated not only with uterine, cervical and vaginal, but also with other anomalies(e.g.of the kidneys, skeleton, heart and abdominal wall). The prevalence of uterus didelphys (failure of the Müllerian ducts to fuse) is 8% in population.

We present the surgical management of a case of uterus didelphys with endometrial carcinoma in one cavity, utilising sentinel lymph node mapping(SLNM).

CASE: A 63-year-old woman who had undergone endometrial sampling twice due to postmenopausal bleeding, pathology results were benign. As the bleeding persisted, she was referred to us. Transvaginal ultrasound revealed two separate uterine cavities; endometrial thickness on the left was 18mm and vaginal examination revealed two distinct cervical os. Biopsies were taken from both cavities, the left side was reported as poorly differentiated adenocarcinoma. There was marked increased fluorodeoxyglucose(FDG) uptake predominantly in the left endometrial cavity(SUVmax:19.7), distribution in other body regions was within physiological limits on PET-CT. There were no accompanying midline/organ anomalies&duplications,

the left kidney was atrophic. The patient underwent total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, SLNM.

CONCLUSION: In lymphatic mapping technique; 1%methylene blue was injected to visualise lymphatic channels and sentinel nodes. Using 27-gauge needle; 1mL(0.5 mg) superficially(2 mm) and 1 mL(0.5 mg) deeply(1 cm) into cervical stroma, at 3 o'clock position on left cervix and 9 o'clock position on right cervix. As seen in our video recording, using the injection technique we applied in the patient with uterine fusion anomaly; right obturator and external iliac (1st and 2nd) and the left obturator sentinel lymph nodes were marked. Final pathology report indicated a grade 1 endometrioid adenocarcinoma in the left cavity, involving less than half of outer myometrium, with no cervical or lymphovascular invasion, sentinel lymph nodes were reported as reactive in ultrastaging assessment. Adjuvant radiotherapy has been planned for the patient, who is classified as surgical stage1A1.

DISCUSSION: In patients with uterine anomalies, samples should be taken from both cavities. SLNM can be successfully performed with uterine anomalies.

Keywords: endometrial carcinoma, Müllerian anomalies, postmenopausal bleeding, sentinel lymph node mapping, ultrastaging assessment, uterus didelphys.

VS-11

vNotes Lateral Suspension and High Uterosacral Ligament Suspension for Treating Pelvic Organ Prolapse

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A 56 year old woman, gravida 3 para 3, came to our university hospital with reporting pelvic pressure and the sensation of a vaginal bulge.

Both her personal and family medical histories were unremarkable.

Bmı:34 kg/m2

Clinical evaluation confirmed a diagnosis of Stage 3 apical vaginal prolapse based on the POP-Q system. A pelvic ultrasound demonstrated a uterus of normal size with no abnormalities in the endometrium.

Keywords: suspansion, prolapse, laparoscopy

VS-12

Single-port laparoscopic myomectomy after intraoperative decision making: A minimally invasive approach

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OBJECTIVE: Single-port laparoscopy has gained increasing attention in minimally invasive gynecologic surgery due to its potential advantages, including reduced postoperative pain, improved cosmetic outcomes, and faster recovery. Various access platforms have been developed to facilitate single-port procedures. In this report, we present a case of single-port laparoscopic myomectomy using the Applied GelPOINT® (GelPath) platform performed in a patient with symptomatic uterine fibroid in a rural secondary care hospital.

METHODS: A 39-year-old woman presented with complaints of dysuria, pollakiuria, and chronic pelvic pain. She had no history of chronic disease or previous surgery. Obstetric history revealed gravida 1, para 1 with a previous spontaneous vaginal delivery. HPV testing performed in August 2025 was negative. Pelvic ultrasonography demonstrated a 44 × 40 mm anterior wall subserosal uterine fibroid (FIGO type 6). Magnetic resonance imaging performed at an external center six months earlier was reviewed and included in the surgical video documentation.

The patient was counseled regarding different surgical options, including Pfannenstiel myomectomy, vNOTES anterior colpotomy approach, and laparoscopic myomectomy, and informed consent was obtained for the procedure and the scientific use of imaging and intraoperative video recordings.

Surgery was initially started using a 10-mm umbilical trocar with a conventional laparoscopic approach. After intraoperative evaluation of the myoma localization and pelvic anatomy, the procedure was converted to a single-port laparoscopic approach using the Applied GelPOINT® (GelPath) platform, although this had not been planned preoperatively.

RESULTS: Single-port laparoscopic myomectomy was successfully completed without intraoperative complications. The patient's preoperative hemoglobin level was 14.8 g/dL, decreasing to 12.7 g/dL at postoperative 6 hours. No blood transfusion was required. The postoperative course was uneventful, and the patient was discharged 20 hours after surgery.

CONCLUSION: Single-port laparoscopic myomectomy appears to be a safe and feasible minimally invasive approach in selected patients. This case highlights the importance of the surgeon's familiarity with different minimally invasive techniques and the ability to make appropriate intraoperative decisions to achieve the least invasive surgical approach tailored to the patient.

Keywords: Single-port laparoscopy, Laparoscopic myomectomy, Minimally invasive gynecologic surgery

VS-13

Title: Laparoscopic Hysterectomy in an Unexpected Uterus Didelphys: Surgical Strategy Without a Uterine Manipulator

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INTRODUCTION: Uterus didelphys is a rare Müllerian duct anomaly caused by complete failure of fusion of the paired Müllerian ducts, resulting in two separate uterine cavities and two cervices. It represents approximately 5–11% of Müllerian anomalies and its prevalence in the general population is estimated to be 0.1–0.5%. Such anomalies may occasionally remain undiagnosed until surgery.

CASE PRESENTATION: A 53-year-old postmenopausal woman was scheduled for hysterectomy due to abnormal uterine bleeding. Preoperative endometrial sampling via pipelle biopsy revealed benign histopathology. Preoperative imaging did not demonstrate any anatomical uterine variation. However, intraoperative findings revealed uterus didelphys.

SURGICAL TECHNIQUE: Due to the duplicated uterine anatomy, a uterine manipulator could not be utilized. The procedure was therefore performed using a meticulous retroperitoneal dissection technique. The ureter was carefully identified and its anatomical relationship with the uterine artery was clearly visualized before vascular control. Stepwise dissection of the retroperitoneal space allowed safe ligation of the uterine vessels and completion of the hysterectomy.

CONCLUSION: This video demonstrates that laparoscopic hysterectomy in patients with previously undiagnosed uterus didelphys can be safely performed without a uterine manipulator by applying systematic retroperitoneal dissection and careful identification of ureter–uterine artery anatomy.

Keywords: Uterus didelphys, Müllerian anomaly, Laparoscopic hysterectomy, Retroperitoneal dissection, Ureter identification, Abnormal uterine bleeding

VS-14

Minimally invasive management of a rudimentary horn presenting with refractory dysmenorrhea: a video case report

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INTRODUCTION: Rudimentary horn is a rare Müllerian anomaly that may cause dysmenorrhea, hematometra, endometriosis, infertility, and potentially life-threatening obstetric complications if left untreated. Surgical excision is the definitive treatment, and laparoscopy offers advantages such as magnified visualization, precise dissection, and faster recovery. In this video presentation, we aim to demonstrate the step-by-step laparoscopic excision of a non-communicating rudimentary horn and highlight the key surgical landmarks and technical considerations for safe resection.

CASE PRESENTATION: This surgical video demonstrates the laparoscopic management of a 32-year-old woman, gravida 3 para 3, presenting with dysmenorrhea and chronic pelvic pain. Although her menstrual cycles were regular, the patient experienced dysmenorrhea refractory to medical therapy. Two of her previous deliveries were preterm, and all children were healthy. Her surgical history included three previous cesarean sections, laparoscopic bilateral tubal ligation, and laparotomic appendectomy. Transvaginal ultrasonography revealed a smaller-than-normal uterus and a right rudimentary uterine horn containing a 3-cm hematometra, with no communication between the normal uterine cavity and the rudimentary horn. Both ovaries appeared normal. Abdominal MRI demonstrated a complex cystic lesion with a solid wall adjacent to the right lateral aspect of the uterus, compatible with a non-communicating rudimentary horn. No urinary system anomalies were detected on MRI. Based on clinical and radiologic findings, the anomaly was classified as an ESHRE/ESGE class U4a Müllerian anomaly. Laparoscopic excision of the rudimentary horn was performed, including pelvic exploration, identification of the anatomical relationship between the unicornuate uterus, rudimentary horn, adnexa, and ureter, followed by careful dissection and complete excision of the right rudimentary horn. The surgical procedure and early postoperative course were uneventful. In the late postoperative period, the patient experienced

significant relief from dysmenorrhea. Histopathological examination demonstrated proliferative endometrium and adenomyosis in the rudimentary horn, and endometriosis in the pelvic peritoneal biopsy.

CONCLUSION: Laparoscopic excision of a non-communicating rudimentary horn is a safe and effective minimally invasive approach that provides both symptomatic relief and definitive treatment. Although rudimentary horn anomalies may present with various clinical manifestations, our patient had regular fertility but suffered from dysmenorrhea refractory to medical therapy. This case highlights the importance of individualized evaluation and demonstrates the advantages of laparoscopy in the management of complex Müllerian anomalies.

Keywords: laparoscopy, müllerian anomaly, rudimentary horn

VS-15

Extraperitoneal Approach for Sacrocolpopexy in Transvaginal Natural-Orifice Transluminal Endoscopic Surgery

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Sacrocolpopexy remains the gold standard for the surgical management of pelvic organ prolapse (POP), typically approached abdominally or laparoscopically. vNOTES (Vaginal Natural-Orifice Transluminal Endoscopic Surgery) leverages the benefits of minimally invasive surgery through a scarless approach. This video presentation aims to illustrate the technical stages and feasibility of the extraperitoneal sacrocolpopexy procedure conducted via the vNOTES platform for apical prolapse repair.

Keywords: vNOTES,Sacrocolpopexy,Extraperitoneal

VS-16

Laparoscopic Management of an Adnexal Mass with Retroperitoneal Extension

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INTRODUCTION: Adnexal masses with retroperitoneal extension are uncommon and may represent both diagnostic and surgical challanges. Even when preoperative findings suggest benign disease, an atypical intraoperative appearance may raise concern regarding the origin of the lesion and the possibility of malignancy. We present the laparoscopic management of a retroperitoneally extending adnexal mass with hydrosalpinx-like appearance in a 51-year-old women.

CASE: A 51-year-old woman presented with left-sided pelvic pain and treatment-resistant abnormal uterine bleeding. Preoperative evaluation included Pipelle endometrial biopsy, which revealed benign histopathology. Serum tumor markers were negative. On gynecologic examination, a hydrosalpinx-like lesion was identified in the left adnexal region. Based on the patient's symptoms and the adnexal findings, laparoscopic hysterectomy was planned.

During laparoscopy, a left adnexal mass extending into the retroperitoneal space was identified. The lesion demonstrated an unusual anatomical distribution, making its precise origin difficult to define at initial inspection. Given the unexpected intraoperative findings, careful dissection and assessment of the mass were performed laparoscopically. To guide the extent of surgery, frozen-section analysis was obtained intraoperatively and demonstrated benign pathology. Following confirmation of benign disease, laparoscopic hysterectomy with bilateral salpingo-oophorectomy was completed. The procedure was completed laparoscopically without conversion to laparotomy.

DISCUSSION: This case highlights the fact that not all adnexal lesions with atypical retroperitoneal extension are malignant; however, their intraoperative appearance may necessitate a cautious and systematic surgical strategy. Preoperative benign endometrial sampling and negative tumor markers may support a low-risk profile, but they do not eliminate the need for intraoperative assessment. Frozen-section analysis remains a valuable tool in determining the extent of surgery, particularly in cases with unexpected pelvic anatomy or unusual lesion morphology. In selected patients, laparoscopy provides excellent visualization of pelvic structures and allows meticulous dissection even in the presence of retroperitoneal involvement.

CONCLUSION: Retroperitoneal extension of an adnexal mass may mimic more complex pelvic pathology and challange surgical planning. In selected patients, laparoscopic management combined with intraoperative frozen-section evaluation can enable safe completion of definitive surgery while preserving the advantages of minimally invasive approach.

Keywords: adnexal mass, hysterectomy, laparoscopy, retroperitoneal approach

VS-17

vNOTES High Uterosacral Ligament Suspension and Bilateral Salpingo-Oophorectomy Following Total Vaginal Hysterectomy: Video Case Report

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BACKGROUND: Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) combines the benefits of traditional vaginal surgery -such as the absence of abdominal incisions, reduced postoperative pain, and improved cosmetic outcomes- with enhanced endoscopic visualization and working space compared to conventional vaginal instrumentation. The vNOTES approach is particularly advantageous in urogynecological procedures as it provides superior visualization and direct access to the adnexal structures, thereby facilitating complex pelvic organ prolapse repairs and apical suspension surgeries through a scarless vaginal route. We present the feasibility of vNOTES-assisted high uterosacral ligament suspension (HUS) with concomitant bilateral salpingo-oophorectomy.

METHODS: A 62-year-old multiparous patient (G4P2A2) presented with symptomatic Stage III pelvic organ prolapse (POP), according to the Pelvic Organ Prolapse Quantification (POP-Q) system. Preoperative clinical examination revealed a total vaginal length of 6 cm. Given the presence of a concomitant apical support defect, an apical suspension procedure was planned to achieve durable anatomical and functional outcomes. Consequently, a vaginal hysterectomy followed by vNOTES-assisted high uterosacral ligament suspension and bilateral salpingo-oophorectomy was performed. The vNOTES technique was specifically utilized to optimize visualization for the apical suspension and adnexal surgery.

RESULTS: Following an uncomplicated vaginal hysterectomy, the vNOTES (Vaginal Natural Orifice Transluminal Endoscopic Surgery) phase was initiated. Utilizing specialized endoscopic instrumentation, bilateral adnexal regions were comprehensively visualized, allowing for a clear assessment of the ovaries and fallopian tubes. Under direct endoscopic guidance, a bilateral salpingo-oophorectomy was performed using a bipolar vessel-sealing device. The apical suspension was subsequently executed by identifying the uterosacral ligaments through direct traction. High uterosacral ligament suspension (HUS) was achieved by placing suspension sutures through the cranial portion of the ligaments to ensure robust apical support. The total operative time was 50 minutes, with minimal estimated blood loss. Postoperative clinical assessment demonstrated a significant anatomical improvement, with the vaginal length increased to 9 cm. No intraoperative or immediate postoperative complications were observed.

CONCLUSION: In conclusion, vNOTES-assisted high uterosacral ligament suspension is a feasible and minimally invasive approach for the management of apical pelvic organ prolapse. It provides enhanced visualization of the uterosacral ligaments, allowing precise suture placement and facilitating concomitant adnexal procedures without abdominal incisions. This technique may represent an effective alternative in selected patients.

Keywords: Pelvic organ prolapse, Uterosacral ligament suspension, vNOTES

VS-18

Morcellation-Free Laparoscopic Multiple Myomectomy for Symptomatic Degenerated Uterine Fibroids

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OBJECTIVE: Uterine leiomyomas represent the most common benign tumors of the female reproductive tract and may cause pelvic pain, dyspareunia, and bowel symptoms, depending on their size, number, and location. Laparoscopic myomectomy is widely recognized as an effective minimally invasive treatment for symptomatic fibroids. However, concerns regarding the potential dissemination of occult uterine sarcoma have resulted in increasing restrictions on the use of power morcellation during minimally invasive surgery. This report presents the laparoscopic management of multiple degenerated uterine fibroids without the use of power morcellation.

METHODS: A 40-year-old woman presented with chronic pelvic pain, dyspareunia, and constipation. Pelvic imaging demonstrated multiple uterine fibroids with degenerative changes. Given the persistence of symptoms and the presence of multiple myomas, surgical intervention was indicated. Laparoscopic multiple myomectomy was performed using a minimally invasive approach. Several fibroids of varying sizes were identified and excised laparoscopically. To mitigate potential oncologic risks associated with power morcellation, the specimens were retrieved using an alternative technique that did not involve power morcellation.

RESULTS: The procedure was completed successfully without intraoperative complications. The postoperative course was uneventful, and the patient was discharged in stable condition. Histopathological analysis confirmed benign leiomyomas with degenerative changes. At follow-up, the patient reported significant improvement in pelvic pain, dyspareunia, and bowel symptoms.

CONCLUSION: Morcellation-free laparoscopic multiple myomectomy is a safe and feasible surgical approach for patients with symptomatic multiple fibroids. This technique maintains the benefits of minimally invasive surgery while reducing potential oncologic risks associated with tissue morcellation. Alternative specimen retrieval strategies offer valuable options for preserving minimally invasive surgery in the context of restricted power morcellation.

Keywords: leiomyoma, Laparoscopic myomectomy, Morcellation-free surgery, Degenerated fibroids

VS-19

Hysteroscopic Excision of Polyp-Associated Endometrioid Endometrial Carcinoma and Concurrent Myomectomy: A Surgical Video

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Hysteroscopic Excision of Polyp-Associated Endometrioid Endometrial Carcinoma and Concurrent Myomectomy: A Surgical Video

BACKGROUND: Endometrioid endometrial carcinoma (EC) confined to endometrial polyps may be amenable to complete hysteroscopic resection; however, the predictability of residual disease remains uncertain.

CASE DESCRIPTION: A 37-year-old woman undergoing in vitro fertilization (IVF) was found to have an endometrial polyp during pre–embryo transfer evaluation. Endometrial sampling revealed Grade 1 endometrial carcinoma (EC) with a p53 wild-type (wt) expression pattern. Hysteroscopic management was planned. During the procedure, a 1.5 cm lesion located on the mid-posterior wall near the isthmus was resected using bipolar electrosurgical resection, including the adjacent endometrial tissue, lesion margins, and approximately 1 mm of underlying myometrium. Subsequently, a 2 cm FIGO type 3 submucosal leiomyoma was excised. Hysteroscopic assessment suggested that the tumor was confined to the polyp.

CONCLUSION: In patients with polyp-associated endometrioid EC, complete tumor excision may be achieved during hysteroscopy; however, the presence or absence of residual disease cannot be reliably predicted preoperatively.

Keywords: Endometrial carcinoma, endometrial polyp, hysteroscopy, leiomyoma, myomectomy.

VS-20

Surgical Management of Deep Infiltrating Endometriosis with Ureteral and Bladder Involvement: Hysterectomy and Bilateral Salpingo-Oophorectomy

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BACKGROUND: The surgical treatment of deep infiltrating endometriosis involving the bladder and ureters remains unstandardized, with techniques differing widely across medical centres. In such cases, performing a hysterectomy with bilateral salpingo-oophorectomy along with total excision of endometriotic nodules can result in serious complications, including ureterovaginal and vesicovaginal fistulas, which have a profound impact on a patient's quality of life. These complications are often the result of inadequate bladder repair following perforations or improperly executed ureteral reanastomosis.

This video presents a laparoscopic approach to treating deep infiltrating endometriosis, focusing on a partial bladder resection and the removal of ureteral endometriotic lesions. The patient provided informed consent for the use of the video, and the authors report no conflicts of interest.

METHODS: A 45-year-old woman, gravida 1 para 1, with a 15-year history of endometriosis presented with symptoms of pelvic pain, dysuria, and dyspareunia, particularly aggravated during menstruation. Her medical history includes a prior laparoscopic procedure for endometriosis, an appendectomy, and a caesarean section. MRI findings revealed two clearly defined nodular lesions measuring 5 mm and 4 mm on the posterior wall of the bladder. Preoperative cystoscopy showed normal ureteral orifices and bladder mucosa, but areas of extrinsic compression were observed beneath the left ureteral orifice and along the left lateral bladder wall. The patient's CA-125 level was elevated at 170 u/mL. Considering her reported pain significantly impairing her social life and her preference to prioritize daily function over fertility, a laparoscopic bilateral salpingo-oophorectomy was scheduled, along with excision of endometriotic lesions involving the bladder and ureter.

RESULTS: The operation took 158 minutes to complete, with a blood loss of 240 mL. The patient was discharged five days after surgery without any complications. Pathological examination confirmed the presence of endometriosis and an endometriotic nodule affecting the bladder and ureter.

CONCLUSIONS: Laparoscopic surgery is a viable option for treating deep infiltrating endometriosis in carefully chosen patients. This technique, which demands both technical expertise and perseverance, provides substantial benefits, particularly in cases involving genitourinary tract invasion.

Keywords: Endometriosis,Hysterectomy,Salpingo-Oophorectomy

VS-21

vNOTES Myomectomy for Primary Ovarian Leiomyoma Coexisting Uterine Fibroid

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OBJECTIVE: Primary ovarian leiomyoma is an exceptionally rare tumor, comprising only 0.5%–1% of all benign ovarian neoplasms, with limited cases documented in the literature.[1,2] Its origin remains a subject of debate, with theories proposing it may arise from ovarian hilar blood vessels, cells of the ovarian ligament, smooth muscle cells, or multipotent cells within the ovarian stroma.Preoperative diagnosis is often difficult due to the nonspecific nature of imaging and laboratory findings. Moreover, its similarity to fibromas frequently leads to diagnostic challenges. Vaginal natural orifice transluminal endoscopic surgery (vNOTES) presents numerous benefits, such as superior cosmetic outcomes, quicker return of flatus, and reduced hospital stays. This minimally invasive technique has gained significant and growing acceptance across various gynecologic procedures. vNOTES appears to be a feasible option based on the limited evidence currently available for gynecological indications that preserve the uterus and ovaries.This video demonstrates the surgical removal of a left ovarian tumor, identified alongside an intramural leiomyoma, performed using vNOTES. Design: A comprehensive case report complemented by a video presentation showcasing the stepbystep process of a surgical technique aimed at treating ovarian and uterine myomas.

PATIENT: A 42yearold nulligravida female presented with complaints of lower abdominal pain and expressed a desire to conceive. She had a body mass index of 23 kg/m2. Both physical and abdominal examinations were normal, but on vaginal examination, a mobile mass measuring approximately 4 cm × 5 cm was identified in the left lower abdomen. Laboratory investigations, including complete blood count and biochemical tests, showed normal results, and tumor markers such as CA 125, HE4, inhibin B, and CEA were within normal limits. Transvaginal ultrasonography revealed a homogeneously isoechoic mass in the left adnexa (measuring 41 mm × 36 mm) along with a homogeneous posterior intramural lesion within the uterine wall. Pelvic magnetic resonance imaging (MRI) demonstrated a welldefined 4 cm × 3 cm solid tumor in the left adnexa and a posterior intramural uterine leiomyoma on T2weighted sequences. The MRI signal findings suggested that the ovarian tumor was likely consistent with a fibroma or thecoma.

INTERVENTION: A vNOTES procedure was conducted to remove both lesions, and histopathological examination afterward confirmed the presence of a primary ovarian leiomyoma and a uterine leiomyoma, with no signs of malignancy. Following the ERAS guidelines, oral intake and patient ambulation were initiated on the day of surgery.
Step 1: Opening the posterior culdesac
• Step 2: Preparing the Gelport system
• Step 3: Gaining entry into the abdominal cavity
• Step 4: Removal of uterine fibroid
• Step 5: Closing the surgical incision
• Step 6: Dissection and removal of adnexal fibroid
• Step 7: Coagulation and fluid aspiration
• Step 8: Chromopertubation process
• Step 9: Closing the posterior colpotomy

CONCLUSION: The coexistence of a primary ovarian leiomyoma with a uterine leiomyoma is an exceptionally rare occurrence. While ovarian leiomyomas are typically asymptomatic findings, they should be included in the differential diagnosis when assessing solid ovarian masses.

Keywords: Vaginal natural orifice transluminal endoscopic surgery, primary ovarian leiomyoma, myomectomy.

VS-22

Laparoscopic Isthmocele Repair Guided by Hysteroscopic Transillumination in a Patient with Post-Cesarean Abnormal Bleeding: A Case-Based Surgical Video

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Isthmocele (cesarean scar defect) is a condition that may be associated with postmenstrual spotting/abnormal uterine bleeding, pelvic pain, and secondary infertility. In symptomatic cases, laparoscopic repair represents a minimally invasive and effective treatment option. Accurate intraoperative localization of the defect is one of the key determinants of surgical success.A 33 year old, G3P2 patient with a history of two cesarean deliveries presented with postmenstrual spotting and abnormal uterine bleeding persisting for six months. Transvaginal ultrasonography and/or sonohysterography revealed a niche appearance at the cesarean scar site consistent with an isthmocele. Due to the persistence of symptoms, minimally invasive surgical management was planned.In this video presentation, the combined hysteroscopy–laparoscopy approach is demonstrated step by step. Following identification of the scar niche during hysteroscopy, the hysteroscopic light is used for transillumination to clearly delineate the defect margins on laparoscopic visualization. The lower uterine segment is exposed through bladder dissection. The fibrotic tissue surrounding the niche is excised until healthy myometrium is reached. The uterine wall is then closed using meticulous multilayer suturing to restore myometrial integrity.

Hysteroscopic transillumination facilitated the rapid and accurate delineation of the isthmocele margins, thereby contributing to complete excision and secure planning of the suture line. The procedure was completed laparoscopically, and no perioperative complications were observed. At early follow-up, a clinical improvement in the patient's bleeding symptoms was noted.Laparoscopic isthmocele repair supported by hysteroscopic transillumination is a safe and effective minimally invasive technique for the management of symptomatic cesarean scar defects. Transillumination enhances visualization, facilitating complete excision and precise multilayer uterine closure; it may contribute to the restoration of myometrial integrity and the preservation of future reproductive potential.

Keywords: Istmocele, Cesarean scar defect, Laparoscopy, Hysteroscopy, Transillumination, Abnormal uterine bleeding

VS-23

Restoring Continence and Anatomy: Video Demonstration of Layered Anal Sphincter, Perineal, and Vaginal Reconstruction After Difficult Vaginal Delivery

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BACKGROUND: Postpartum anal sphincter injuries (OASIS) and accompanying perineal and vaginal traumas cause postpartum morbidity, including fecal incontinence, sexual dysfunction, and impaired quality of life. Rapid diagnosis and meticulous layered repair are essential to restore both continence and anatomical integrity. Complex injuries following difficult vaginal deliveries present surgical challenges due to disrupted anatomy and tissue loss. This video aims to demonstrate a comprehensive approach to layered repair of anal sphincter, perineal, and vaginal injuries, highlighting technical nuances and functional restoration.

METHODS: A 31-year-old patient, having her first child, suffered a grade four perineal tear and extensive perineal and vaginal damage involving the external and internal anal sphincters as well as the rectal mucosa during a prolonged vaginal delivery. The patient underwent primary layered repair under regional anesthesia in the lithotomy position. The procedure involved careful identification, approximation, and repair of the sphincter fibers, meticulous reconstruction of the perineal body, and precise closure of the vaginal and rectal mucosa. Priority was given to preserving neurovascular structures throughout the procedure. The surgical field was recorded with high-resolution video to demonstrate the step-by-step technique, anatomical guidance, and precise suture placement for educational and reproducibility purposes.

RESULTS: The repair was successfully completed without intraoperative complications. Postoperative evaluation confirmed the restoration of anal sphincter continuity, perineal tissue integrity, and vaginal and rectal wall anatomy. The patient reported minimal pain and was discharged on day 3 postoperatively. At six weeks of follow-up, sphincter function remained intact, perineal, vaginal, and rectal tissues healed well, and the patient demonstrated excellent continence. She reported satisfactory sexual function and overall quality of life.

CONCLUSION: Layered repair of anal sphincter, perineal, vaginal, and rectal injuries following complex

vaginal delivery is a safe, effective, and reproducible approach when performed with meticulous anatomical reconstruction. High-definition video demonstration enhances understanding of critical anatomical landmarks and stepwise technique, providing an invaluable educational resource for surgeons managing complex obstetric injuries.

Keywords: Anal sphincter, perineal reconstruction, vaginal delivery

VS-24

vnotes hysterectomy and bilateral sapling-oopherectomy for a giant adnexal mass: a case report

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vNOTES Hysterectomy and Bilateral Salpingo-Oophorectomy for a Giant Adnexal Mass: A Case Report

BACKGROUND AND OBJECTIVES: Vaginal natural orifice transluminal endoscopic surgery (vNOTES) has emerged as a minimally invasive surgical approach in gynecologic surgery. It offers several advantages, including reduced postoperative pain, shorter hospital stay, faster recovery, and the absence of visible abdominal scars. Despite these benefits, the management of large adnexal masses using the vNOTES approach remains technically demanding. This report aims to present the feasibility and clinical outcomes of vNOTES in the management of a giant adnexal mass.

METHODS: A 76-year-old postmenopausal woman (gravida 3, para 3) with a medical history of hypertension and prior thyroidectomy was admitted with a pelvic mass. Her height was 157 cm, and her weight was 66 kg (BMI 26.8 kg/m²). Laboratory evaluation revealed CA-125: 16 U/mL, CA19-9: 28.7 U/mL, and HE4: 96 pmol/L. The calculated ROMA score was 21.5%, which is below the postmenopausal cut-off value (29.9%). Radiological assessment included contrast-enhanced abdominal computed tomography and pelvic magnetic resonance imaging, demonstrating a large multiloculated cystic adnexal mass measuring approximately 29 × 15 × 27 cm, classified as O-RADS 3. Based on these findings, surgical management with vNOTES hysterectomy and bilateral salpingo-oophorectomy, with intraoperative frozen-section analysis, was planned.

RESULTS: The giant adnexal mass was successfully removed via the vaginal route using the vNOTES approach. The procedure was completed without intraoperative complications. No conversion to conventional laparoscopy or laparotomy was required, and no additional surgical intervention was necessary.

CONCLUSION: This case demonstrates that vNOTES is a feasible, safe, and effective minimally invasive surgical option for selected patients with large adnexal masses when performed by experienced surgeons. It may represent a valuable alternative to conventional laparoscopy in appropriately selected cases. Key Words: vNOTES; minimally invasive surgery; adnexal mass; hysterectomy; salpingo-oophorectomy; gynecologic surgery

Keywords: adnexal mass,hysterectomy,vnotes

VS-25

Recurrent Pelvic Pain After Oophoropexy Mimicking Ovarian Torsion: A Video Case Report of Laparoscopic Adhesiolysis

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BACKGROUND: Recurrent acute pelvic pain in women with a history of ovarian torsion presents a significant diagnostic challenge. Preserved Doppler flow on transvaginal ultrasound may obscure intermittent torsion or alternative pathology, particularly in patients with prior oophoropexy. This video case illustrates the limitations of imaging and underscores the value of laparoscopy in symptomatic women with previous torsion surgery.

METHODS: A 24-year-old woman presented with sudden-onset unilateral groin pain and a history of prior laparoscopic detorsion with oophoropexy. Transvaginal ultrasound demonstrated preserved bilateral ovarian vascularity with unilateral ovarian enlargement. Due to escalating pain and inconclusive imaging, urgent diagnostic laparoscopy was undertaken.

RESULTS: Intraoperative assessment revealed no evidence of torsion. Both ovaries were fixed in abnormal positions, densely adherent, partially peritonealized, and encased in extensive pelvic adhesions involving bowel loops and pelvic sidewalls, consistent with sequelae of prior oophoropexy. Advanced laparoscopic adhesiolysis was performed to restore normal pelvic anatomy, mobilize both ovaries, and release surrounding structures while preserving vascular supply and cortex. The procedure was completed without complications. Postoperatively, pain resolved, and ovarian morphology and mobility normalized on follow-up ultrasound.

CONCLUSIONS: This case highlights that recurrent pelvic pain after ovarian torsion surgery may result from severe post-oophoropexy adhesions rather than re-torsion, and that normal Doppler flow does not exclude clinically significant pathology. Diagnostic laparoscopy remains essential in patients with persistent symptoms despite reassuring imaging. Fertility-preserving adhesiolysis can restore adnexal anatomy, relieve symptoms, and may help mitigate long-term reproductive sequelae.

Keywords: oophoropexy, ovarian torsion, pelvic adhesion

VS-26

Diffuse Miliary Nodules Mimicking Peritoneal Carcinomatosis in a Patient with Cold Agglutinin Disease: A Case Report

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INTRODUCTION: Postmenopausal bleeding accompanied by increased endometrial thickness represents a clinical scenario in which malignancy must be primarily excluded in gynecological practice. In such patients, extensive peritoneal involvement or a carcinomatosis-like appearance encountered intraoperatively often suggests advanced-stage malignancy and directly influences surgical management. However, in rare cases, inflammatory processes related to benign or systemic diseases may produce similar macroscopic findings. In the present case, a patient operated on for postmenopausal bleeding demonstrated diffuse peritoneal involvement mimicking carcinomatosis intraoperatively; however, histopathological evaluation revealed non-necrotizing granulomatous inflammation. These findings were considered potentially associated with the patient's underlying cold agglutinin disease.

CASE PRESENTATION: A 66-year-old gravida 2 para 2 woman, postmenopausal for approximately 15 years, was evaluated for postmenopausal bleeding and increased endometrial thickness. Her medical history was notable for cold agglutinin disease diagnosed in 2011; following treatment with rituximab and fludarabine, she had been in hematological remission since 2013. Comorbidities included hypertension, type 2 diabetes mellitus, and obesity. Transvaginal ultrasonography demonstrated an endometrial thickness of 17–18 mm, with no adnexal pathology or pelvic free fluid. Endometrial sampling was consistent with an endometrial polyp, and surgical management was planned.

The patient underwent total laparoscopic hysterectomy with bilateral salpingo-oophorectomy. Intraoperatively, diffuse peritoneal involvement characterized by nodular and irregular surfaces was observed, mimicking advanced peritoneal carcinomatosis. Given these unexpected findings, intraoperative frozen section analysis was performed. The frozen section revealed an endometrial polyp without evidence of malignancy. Consequently, the planned procedure was completed, and peritoneal washings and biopsies were obtained. Definitive histopathological examination demonstrated an endometrial polyp with necrotic areas, without additional pathology in the endometrium, and benign ovarian tissue. Non-necrotizing granulomatous

inflammation was identified in the peritoneum and bilateral fallopian tubes, while peritoneal cytology was benign. Immunohistochemical analysis showed CD68 positivity in histiocytes, with negative staining for keratin and S100. The postoperative course was uneventful, with no early or late complications.

DISCUSSION: Despite intraoperative findings suggestive of carcinomatosis, histopathological evaluation revealed benign non-necrotizing granulomatous inflammation, highlighting a discordance between macroscopic and pathological findings. Granulomatous inflammation may arise from infectious causes (particularly tuberculosis) or non-infectious conditions (such as sarcoidosis and immune-mediated processes), and may rarely mimic peritoneal carcinomatosis. In this case, the presence of an underlying systemic disease and immunological background suggested the possibility of an atypical inflammatory response. Intraoperative frozen section analysis played a critical role in preventing unnecessary extensive surgery.

CONCLUSION: This case demonstrates that a carcinomatosis-like peritoneal appearance does not invariably indicate malignancy and that granulomatous inflammation should be considered in the differential diagnosis. Intraoperative frozen section analysis is pivotal in guiding surgical decision-making, particularly in patients with a history of systemic disease, where findings should be interpreted within a broader clinical context.

Keywords: granulomatous inflammation, peritoneal carcinomatosis, cold agglutinin disease

VS-27

Fertility-Preserving Laparoscopic Salpingostomy for Tubal Ectopic Pregnancy with Fetal Cardiac Activity: A Video Case Report

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BACKGROUND: Tubal ectopic pregnancy remains a major cause of first-trimester maternal morbidity. In women desiring future fertility, the choice between salpingostomy and salpingectomy should balance reproductive potential against the risks of persistent trophoblastic tissue and recurrent ectopic pregnancy. Current approaches favour surgical management when fetal cardiac activity is present and recommend salpingostomy mainly in selected patients with fertility concerns, particularly when preservation of the affected tube may be clinically meaningful.

METHODS: We present the laparoscopic management of a tubal ectopic pregnancy in a 36-year-old multiparous patient (G2P1). The patient's obstetric history was otherwise unremarkable, with one prior uncomplicated delivery. Diagnosis was established with transvaginal ultrasonography, which demonstrated a tubal ectopic gestation characterized by visible fetal cardiac activity (embryonic heartbeat). Preoperative laboratory evaluation revealed a serum beta-hCG level of 5945 mIU/mL. In light of the patient's fertility-preserving expectations, a laparoscopic antimesenteric salpingostomy was performed. The surgical procedure focused on the meticulous extraction of trophoblastic tissue while ensuring the maximum possible preservation of tubal anatomy and integrity.

RESULTS: The procedure was completed without intraoperative complications. Postoperatively, serial serum beta-hCG levels showed an appropriate decline; therefore, adjuvant methotrexate was not administered.

CONCLUSIONS: Laparoscopic salpingostomy is a fertility-preserving option in selected ectopic pregnancies requiring surgical intervention. Careful patient selection and close postoperative beta-hCG surveillance are essential due to the risk of persistent trophoblastic tissue and recurrence. According to current guidelines, methotrexate following salpingostomy is generally reserved for cases in which beta-hCG levels rise or plateau, rather than being used routinely as prophylaxis. Patients should be counseled regarding the potential need for further treatment and the higher risk of recurrent ectopic pregnancy compared with salpingectomy, while the fertility benefit may be limited when the contralateral

tube is normal. Therapeutic decisions should be strictly tailored to the patient's specific reproductive goals and clinical profile.

Keywords: Ectopic pregnancy, fertility preservation, salpingostomy, tubal pregnancy

VS-29

Hysteroscopic Management of Organized and Calcified Retained Products of Conception: A Video Case Report

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BACKGROUND: Retained products of conception (RPOC) are a leading cause of prolonged or heavy uterine bleeding after pregnancy termination or delivery and may result in anaemia, infection, and intrauterine adhesions. Suction curettage may be insufficient, particularly in organized, densely adherent, or calcified lesions. Management should be individualized based on clinical symptoms, lesion size and vascularity; when clinically appropriate, intervention may be delayed for 6–8 weeks to allow adequate lesion evaluation.

METHODS: We present a case of heavy vaginal bleeding secondary to suspected RPOC. Initial probe curettage was unsuccessful. Preoperative ultrasound demonstrated an intrauterine lesion suggestive of organized tissue. Operative hysteroscopy revealed a firm, partially calcified, myoma-like mass. A fertility-preserving technique was applied, prioritizing mechanical dissection and tissue extraction, with minimal bipolar energy reserved for hemostasis and safe separation.

RESULTS: Complete removal was achieved under direct visualization without intraoperative complications. Limited thermal energy use allowed preservation of the surrounding endometrium. Postoperative bleeding resolved, and recovery was uneventful, with no requirement for repeat intervention.

CONCLUSIONS: Hysteroscopy is an effective, fertility-preserving option for RPOC, particularly in persistent or structurally complex lesions. It facilitates complete, single-step removal and reduces repeat procedures. Hysteroscopy and suction curettage are associated with comparable pregnancy and live birth rates; however, hysteroscopic removal may achieve more complete evacuation and fewer intrauterine adhesions, which is particularly relevant for patients prioritizing future fertility.

Keywords: abnormal uterine bleeding, Retained products of conception, hysteroscopy

VS-30

Laparoscopic Removal of an Intra-abdominal Migrated Intrauterine Device: A Case Report

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Laparoscopic Removal of an Intra-abdominal Migrated Intrauterine Device: A Case Report

OBJECTIVE: Intrauterine devices (IUDs) are widely used long-acting reversible contraceptive methods. Although rare, uterine perforation and subsequent migration of the device into the abdominal cavity may occur. In this report, we aimed to present the diagnostic process and laparoscopic management of a migrated intra-abdominal intrauterine device.

METHODS: A 58-year-old woman, gravida 9 parity 9, with a history of eight vaginal deliveries and one cesarean section, presented with a suspected missing intrauterine device. The patient reported that the IUD (Intrauterine devices) had been inserted approximately 24 years ago. During gynecological examination, the IUD (Intrauterine devices) string was not visualized on speculum examination. Transvaginal ultrasonography (TVUS) did not demonstrate an IUD (Intrauterine devices) within the uterine cavity. An upright abdominal radiograph was subsequently obtained and revealed the presence of an intrauterine device within the abdominal cavity. To determine the exact localization, abdominal computed tomography (CT) imaging was performed.

RESULTS: Computed tomography demonstrated a density compatible with an intrauterine device located at the level of the L2–L3 vertebrae, superior to the umbilicus, in the midline of the abdomen, anterior to the transverse colon. Diagnostic laparoscopy was planned. During laparoscopic exploration, the intrauterine device was found to be attached to the omentum without adhesion to the colon. The device was carefully dissected from the omentum and removed in a single piece. No intraoperative complications or bowel injury occurred.

CONCLUSION: Migrated intrauterine devices located in the abdominal cavity may lead to potential complications if left untreated. When the IUD (Intrauterine devices) string is not visible and the device cannot be detected within the uterine cavity with ultrasonography, imaging modalities should be used to determine its localization. Laparoscopic surgery represents a safe and minimally invasive approach for the removal of migrated intrauterine devices.

Keywords: Migrated intrauterin device, IUD complications, laparoscopy

VS-31

Laparoscopic management of a uterine mass presenting with acute abdomen: A case report

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OBJECTIVE: To present the laparoscopic management of a patient presenting with acute abdominal pain in whom imaging studies suggested a large uterine mass with suspicion of malignancy.

METHODS / CASE PRESENTATION: A 47-year-old woman (gravida 3, abortus 3) presented to the emergency department with diffuse abdominal pain and tenderness that had started one day earlier. Her medical history revealed menometrorrhagia, urinary frequency, and dyspareunia. She had undergone a right unilateral salpingo-oophorectomy in 2021 due to an ovarian cyst and pathology result was benign.

Physical examination demonstrated tenderness in the lower abdominal quadrants. Initial ultrasonography revealed a heterogeneous hyperechoic nodular lesion measuring approximately 6×4 cm located at the anterior corpus of the uterus, suggesting a possible uterine myoma. The right ovary was not visualized due to previous surgery. In the left ovary, anechoic cystic lesions measuring approximately 5 cm and 3 cm were detected, causing compression of the ovarian parenchyma. Doppler examination demonstrated weak peripheral vascular signals. Minimal free fluid was observed in the Douglas pouch. Transvaginal ultrasonography demonstrated a 70×50 mm lesion at the anterior uterine corpus, suggestive of either a myoma or adenomyosis. Additionally, a bilobulated anechoic cystic lesion measuring approximately 83×60 mm was identified in the left ovary. Minimal pelvic free fluid was present. Contrast-enhanced abdominal computed tomography was performed for further evaluation. The appendix measured approximately 6 mm in diameter with mild wall edema; periappendiceal fat planes appeared normal. A heterogeneous irregular mass measuring approximately 9×7.5 cm extending from the uterine corpus toward the fundus and displacing the endometrial cavity was identified. Further evaluation with pelvic MRI was recommended due to the possibility of malignancy. Minimal pelvic free fluid was also noted. Based on the clinical and radiological findings, laparoscopic surgery was planned. During the operation, total laparoscopic hysterectomy, left unilateral salpingo-oophorectomy, and concurrent appendectomy were performed.

RESULTS: The surgical procedure was completed laparoscopically without complications. The patient had an uneventful recovery and was also observed during the postoperative period.

CONCLUSION: Pelvic masses presenting with acute abdominal symptoms require careful differential diagnosis. In appropriately selected patients, minimally invasive surgical approaches can provide both diagnostic and therapeutic benefits while ensuring safe management.

Keywords: uterin mass, acute abdomen, diagnostic laparoscopy

VS-32

Laparoscopic Management of a Large Left Ovarian Endometrioma with Concomitant Left Uterosacral Ligament Deep Infiltrating Endometriosis: A Video Case Presentation

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OBJECTIVE: The surgical management of ovarian endometrioma in young patients requires a careful balance between complete excision of disease, preservation of ovarian reserve, and recognition of associated deep infiltrating endometriosis (DIE). We present the laparoscopic management of a large left ovarian endometrioma associated with a left uterosacral ligament DIE nodule in a young woman with treatment-resistant dysmenorrhea.

CASE: A 24-year-old virginal woman was referred to our clinic for treatment-resistant dysmenorrhea. On physical examination, the abdomen was soft, without guarding or rebound tenderness. Transvaginal ultrasonography demonstrated a normal uterus and right adnexa, and a 10 cm left adnexal cyst with regular borders, homogeneous ground-glass echogenicity, and no solid component, consistent with an endometrioma. The sliding sign was positive. Pelvic magnetic resonance imaging performed at an outside institution revealed a 10 cm ovarian cystic lesion that was hyperintense on T1-weighted images, remained hyperintense on fat-suppressed T1-weighted sequences, and showed low to heterogeneous low signal intensity on T2-weighted images with a characteristic "T2 shading sign," without mural nodules, papillary projections, or solid components. These findings were consistent with an endometrioma. Additionally, a 1.7 cm T2-hypointense fibrotic nodule involving the left uterosacral ligament was identified, consistent with DIE. Serum CA-125 was 30 U/mL. According to the #ENZIAN classification, the lesion was classified as O3/ left + B2(left). Preoperative laboratory findings were as follows: hemoglobin 12.4 g/dL, white blood cell count $7.8\times10^3/\mu L$, platelet count 240,000/µL, blood group O Rh-positive, and anti-Müllerian hormone level 5.5 ng/ mL.

SURGİCAL PROCEDURE: The patient underwent laparoscopic left ovarian endometrioma cystectomy, adhesiolysis, retroperitoneal dissection, and excision of the left uterosacral ligament DIE nodule. Intraoperatively, a large left ovarian endometrioma with surrounding adhesions was identified. Adhesiolysis was first performed to mobilize the ovary and restore normal pelvic anatomy. The cyst was then opened, and typical

chocolate-colored content was drained. Retroperitoneal dissection along the ovarian fossa and pelvic sidewall allowed safe identification of the dissection plane and exposure of the left uterosacral ligament. The 1.7 cm DIE nodule involving the left uterosacral ligament was identified, carefully dissected from surrounding tissues, and completely excised. The cleavage plane between the cyst capsule and ovarian cortex was then developed, and cystectomy was completed using a traction-countertraction stripping technique. Hemostasis was achieved with selective bipolar coagulation. After irrigation and reassessment of the ovarian bed, reconstruction was performed with suturing when required. The specimen was removed in an endobag.

CONCLUSION: No early postoperative complications were observed. Postoperative laboratory values showed hemoglobin 11.9 g/dL, white blood cell count 10.3×10^3/µL, and platelet count 238,000/µL. The patient was discharged on postoperative day 3. In young patients with reproductive potential, large ovarian endometriomas associated with DIE can be managed safely and effectively by laparoscopic surgery when meticulous retroperitoneal dissection, ovarian tissue-preserving cystectomy, and selective hemostatic techniques are applied.

Keywords: Endometrioma; Deep infiltrating endometriosis; Laparoscopic cystectomy

VS-34

Sacrospinous ligament suspension via vNOTES for the management of pelvic organ prolapse

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OBJECTIVE: Pelvic organ prolapse (POP) can result in urinary and fecal incontinence, among other symptoms that greatly diminish quality of life, often leading to anxiety, depression, and emotional distress for many patients [1]. The trans-vaginal sacrospinous ligament suspension (VSSLS) procedure involves attaching the apex of the prolapsed vagina to the sacrospinous ligament [2-4]. This technique works to reestablish the natural alignment of the vaginal axis, repair defects in the pelvic floor, and restore its normal function, contributing to a reduction in patients' anxiety and depressive symptoms. While VSSLS offers certain benefits, such as avoiding the need for an abdominal approach (whether open or minimally invasive),eliminating the use of mesh or grafts, and preserving vaginal anatomy, it also has limitations, including restricted visualization and the potential for risks associated with blind dissection [2-4]. On the other hand, transvaginal natural orifice transluminal endoscopic surgery (vNOTES) provides a minimally invasive technique with improved anatomical visualization.

DESIGN: A comprehensive case report supplemented by a video demonstration showcasing a step-bystep approach to performing a surgical technique for treating POP. The patient has given her consent for her images and other clinical information to be reported in the journal.

PATIENT: We assessed a 67-year-old woman with a history of two vaginal births who visited our clinic reporting sensations of pelvic pressure and vaginal fullness (Figure 1a). Her personal and family medical history was uneventful. A pelvic ultrasound showed a uterus of normal size with no abnormalities in the endometrium.

INTERVANTION:

(1) The patient was positioned in the lithotomy position. After successfully administering general anesthesia and performing endotracheal intubation, a Foley catheter was placed.

(2) A horizontal incision was created in the posterior vaginal fornix, followed by blunt dissection to gain

access to the right paravaginal space.

(3) A GelPOINT system was utilized, and the cavity was insufflated with CO_2 to a pressure of 8 mmHg, enabling visualization using a 30° laparoscope.

(4) Dissection of the paravaginal space was performed until the sacrospinous ligament was exposed.

(5) A figure-eight suture was placed on the sacrospinous ligament at a point 1.5–2 cm medial to the ischial spine, using a #1 Surgilon non-absorbable braided nylon suture. This suture was left untied until other procedures were completed.

(6) A vaginal hysterectomy with salpingo-oophorectomy followed.

(7) Once the vaginal hysterectomy was complete, the vaginal cuff was closed. Before concluding the closure, the apex of the right vaginal wall was anchored to the sacrospinous ligament with the previously untied non-absorbable suture.

Postoperative period was uneventful and patient was discharge in satisfactory condition.

CONCLUSION: The V-Notes sacrospinous ligament suspension approach to offers a minimally invasive and anatomically precise method for addressing POP repair.

Keywords: Pelvic organ prolapse, vNOTES, sacrospinous ligament suspension.

VS-35

Dorsolateral parametrectomy and oopherectomy for deep endometriosis with a suspicious adnexial mass

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A 38-year-old woman, gravida 1 para 1, had been experiencing endometriosis for the past decade.

She previously underwent two laparoscopic procedures for endometriosis and a cesarean delivery.

BMI: 29 kg/m?

She was referred to our gynecologic oncology clinic due to a suspected adnexal mass. Her symptoms included pelvic and distal vaginal pain, particularly during menstruation.

MRI findings showed a 70x60mm hyperdense lesion with mixed solid and cystic components located in the right adnexal region

CA-125: 290 u/mL

ROMA score was %10 BMI: 29 kg/m2

A laparoscopic right salpingo-oophorectomy along with bilateral dorsolateral parametrectomy was planned. MRI findings showed a 70×60 mm hyperdense lesion with mixed solid and cystic components located in the right adnexal region (ORADS-3). The procedure is demonstrated in the accompanying video

Keywords: endometrioma,laparoscopy,hysterectomy

VS-36

Deep Infiltrating Endometriosis: Laparoscopic Dissection of the Rectovaginal Space and Distal Vagina

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OBJECTIVE: Deep infiltrating endometriosis (DIE) involving multiple pelvic compartments poses a significant surgical challenge. This video presentation aims to demonstrate a systematic laparoscopic approach for the excision of extensive DIE nodules while prioritizing the preservation of reproductive potential and restoration of pelvic anatomy.

CASE PRESENTATION: A 38-year-old patient (BMI 20, G2P2) presented with debilitating chronic pelvic pain and severe dyspareunia refractory to two years of medical management. Preoperative imaging revealed bilateral endometriomas ($5\text--7$ cm) and markers showed an elevated CA-125 (132 U/mL) and ROMA index (14.5). Intraoperative mapping confirmed extensive disease involving the uterosacral ligaments, bilateral ovaries, rectovaginal septum, and distal vaginal wall, necessitating a multidisciplinary surgical strategy.

Surgical Technique

Extensive adhesiolysis to restore distorted pelvic anatomy.

Systematic dissection of the pararectal and paravesical spaces.

En-bloc excision of endometriotic nodules from the uterosacral ligaments and the rectovaginal space.. The total operative time was 132 minutes. Perioperative management strictly followed Enhanced Recovery After Surgery (ERAS) protocols.

RESULTS: The estimated blood loss was 260 ml, with no intraoperative or postoperative complications. The patient was discharged following an uneventful recovery. At the 5-month follow-up, she reported a significant clinical improvement in quality of life, with a near-complete resolution of dyspareunia and pelvic pain. Postoperative recurrence prophylaxis was maintained via a levonorgestrel-releasing intrauterine device (LNG-IUD).

CONCLUSION: Fertility-preserving laparoscopic surgery for advanced DIE is feasible and safe when performed by experienced surgical teams. A compartment-based dissection approach ensures the complete removal of infiltrative disease while safeguarding reproductive organs. Integrating ERAS protocols further optimizes postoperative recovery, making minimally invasive radical surgery a viable option for symptomatic patients desiring fertility preservation.

Keywords: Deep infiltrating endometriosis, Laparoscopic endometriosis surgery, Rectovaginal endometriosis

VS-39

Four-Arm Transvaginal Mesh for Vaginal Vault Prolapse in Distorted Pelvic Anatomy: A Video Case Report

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BACKGROUND: Vaginal cuff prolapse is a severe late complication following hysterectomy, particularly in postmenopausal, multiparous women. Advanced-stage prolapse combined with distorted pelvic anatomy poses significant surgical challenges, especially when native tissue support is insufficient. Vaginal reconstructive techniques using mesh and alternative anchoring points such as the sacrospinous ligament (SSL) offer an effective approach.

METHODS: We present a 56-year-old multiparous woman (three prior vaginal deliveries) with a history of total abdominal hysterectomy and bilateral salpingo-oophorectomy performed seven months earlier for postmenopausal bleeding. She presented with symptomatic pelvic organ prolapse. Pelvic examination revealed stage IV anterior compartment prolapse and stage IV vaginal cuff prolapse. Vaginal mesh-based reconstruction was performed. The ischial spine was identified by palpation, and surrounding soft tissues were displaced digitally to expose the SSL. The anterior mesh arms were bilaterally fixed to the obturator internus muscles using anchor-based insertion systems. Suture-loaded anchors were placed approximately 2 cm medial to the ischial spine on the SSL. The posterior mesh arms were secured by passing sutures through their distal ends and tying them to the SSL anchors, ensuring tension-free fixation.

RESULTS: The procedure was completed successfully without intraoperative complications. Adequate apical and anterior compartment support was achieved despite distorted pelvic anatomy. The postoperative course was uneventful.

CONCLUSIONS: Vaginal mesh-based sacrospinous ligament fixation is a safe and effective approach for advanced vaginal cuff prolapse. Anchor-assisted techniques enable precise and durable reconstruction, particularly in patients with deficient native tissue support.

Keywords: mesh repair, sacrospinous ligament, vaginal cuff prolapse, vaginal surgery

VS-40

Robotic Surgical Management of Endometrial Cancer with Sentinel Lymph Node Mapping: A Case Report

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INTRODUCTION: Robotic surgery has become an established minimally invasive approach in the management of endometrial cancer, particularly when sentinel lymph node mapping is incorporated into surgical staging. The robotic platform provides enhanced visualization, improved dexterity and precise pelvic dissection, facilitating comprehensive staging while preserving the benefits of minimally invasive surgery. We present a case of grade 2 endometrial cancer managed with robotic surgery and indocyanine green-guided bilateral sentinel lymph node mapping.

CASE PRESENTATION: A 54-year-old woman with a body mass index of 29 presented with abnormal uterine bleeding. Endometrial biopsy performed and demonstrated grade 2 endometrioid carcinoma. Pelvic magnetic resonance imaging in December 2025 revealed a lesion arising from the left side of the endometrial cavity and extending centrally, measuring 69*23 mm, without obvious myometrial invasion. Positron emission tomography - computed tomography demonstrated increased fluorodeoxyglucose uptake within the uterine cavity, corresponding to a 38*15 mm lesion with a maximum standardized uptake value of 13. In view of these findings, robotic surgical staging with indocyanine green-guided sentinel lymph node mapping was undertaken. Bilateral sentinel lymph node detection was achieved, and the procedure was completed using a minimally invasive approach. Final histopathologic evaluation was pending at the time of presentation.

DISCUSSION: This case illustrates the value of robotic surgery in the management of endometrial cancer. Robotic surgery facilitates meticulous pelvic dissection and provides technical advantages for sentinel lymph node mapping, an increasingly adopted component of surgical staging. Successful bilateral sentinel lymph node detection supports the adequacy of nodal assessment while potentially reducing the need for systematic lymphadenectomy in selected patients. In such situations, robotic surgery allows standard oncologic staging procedures to be performed through a minimally invasive route while maintaining surgical precision.

CONCLUSION: Robotic surgical management with sentinel lymph node mapping is a feasible and effective approach in selected patients with endometrial cancer. In cases with atypical preoperative imaging findings, a robotic platform may facilitate comprehensive surgical evaluation and treatment while preserving the advantages of minimally invasive surgery.

Keywords: endometrial cancer, indocyanine green, robotic surgery, sentinel mapping

VS-41

Laparoscopic Endometrioma Excision and Pelvic Restoration Surgery in Deep Infiltrating Endometriosis: A Case Report of Primary Infertility

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Endometriosis, particularly its deep infiltrating form, is a significant gynecological condition that disrupts pelvic anatomy and leads to infertility. Cases presenting with both bilateral endometriomas and deep infiltrating endometriosis represent one of the most severe phenotypes, characterized by advanced anatomical distortion and reduced reproductive potential, making surgical management particularly challenging. Although the impact of surgical treatment on fertility outcomes in this patient group remains controversial, restoration of pelvic anatomy is thought to improve both spontaneous conception and assisted reproductive outcomes.

A 28-year-old nulligravid woman with a history of primary infertility presented with pelvic pain. Hormonal evaluation revealed an anti-Müllerian hormone (AMH) level of 4.34 ng/mL, while CA-125 and CA 19-9 levels were markedly elevated. Pelvic magnetic resonance imaging demonstrated bilateral endometriomas, a “kissing ovaries” appearance, and findings consistent with deep infiltrating endometriosis in the rectouterine pouch. Flexible sigmoidoscopy revealed a hyperemic rectal lesion, and biopsy was performed.

Laparoscopic surgery was performed with extensive adhesiolysis, resulting in separation of the bilateral ovaries and restoration of pelvic anatomy. Deep infiltrating endometriotic lesions were excised with careful ureteral preservation. Bilateral endometrioma capsules were removed while aiming to preserve ovarian tissue. Chromopertubation confirmed bilateral tubal patency, indicating successful anatomical restoration.

Histopathological examination confirmed endometriosis involving the bilateral ovaries, uterosacral ligaments, rectovaginal space, and pelvic peritoneum.

Laparoscopic excision and pelvic restoration surgery in patients with deep infiltrating endometriosis and bilateral endometriomas may enhance reproductive potential by restoring pelvic anatomy. However, particularly in bilateral endometrioma cases, careful fertility-preserving surgical techniques are essential due to the risk of diminished ovarian reserve. Current evidence suggests that appropriate patient selection and individualized

fertility strategies, including spontaneous conception or assisted reproductive techniques, are critical determinants of treatment success. This approach may represent an effective strategy to support spontaneous fertility in selected patients.

Keywords: Deep infiltrating endometriosis, Endometrioma, Laparoscopy, Pelvic restoration, Infertility, Fertility preservation

VS-42

Laparoscopic Laser Ablation for Endometrioma: A Fertility-Preserving Approach with Preserved Ovarian Reserve

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BACKGROUND: Ovarian endometriomas represent a common pathology in reproductive-age women and present significant challenges in balancing effective treatment with preservation of ovarian function. The primary objectives of surgery include maximal conservation of healthy ovarian tissue, complete removal of endometriotic lesions, and acquisition of adequate material for histopathological evaluation. While cystectomy is widely accepted as the standard approach due to its low recurrence rates and diagnostic accuracy, it has been associated with a decline in ovarian reserve, as evidenced by reductions in serum anti-müllerian hormone (AMH) levels and antral follicle count (AFC). In response, alternative techniques such as laser ablation, ethanol sclerotherapy, and electrocoagulation have been introduced. Among these, laser ablation allows precise and superficial tissue vaporization with minimal thermal spread, making it a potentially less traumatic option, particularly in patients with bilateral disease or reduced ovarian reserve.

METHODS: A 41-year-old patient, presenting with chronic pelvic pain and diagnosed with an ovarian endometrioma, underwent laparoscopic laser ablation. Given the persistence of symptoms despite various pharmacological interventions, the condition was classified as resistant to medical therapy. Consequently, the surgical procedure was designed as a fertility-preserving intervention, emphasizing the selective ablation of endometriotic tissue while meticulously minimizing thermal damage to the surrounding ovarian cortex.

RESULTS: The surgical procedure was completed successfully without any perioperative complications. At the 3-month postoperative follow-up, clinical improvement was observed, with the dysmenorrhea VAS score decreasing from a baseline of 9 to 3, indicating effective pain management. Furthermore, postoperative assessment demonstrated stable ovarian reserve; serum Anti-Müllerian Hormone (AMH) levels showed only a limited decline from 2.97 ng/mL to 2.52 ng/mL.

CONCLUSIONS: Laser ablation provides a controlled and superficial tissue effect, potentially reducing ovarian damage compared to cystectomy. It represents a fertility-preserving alternative, particularly in patients with

diminished ovarian reserve or bilateral disease. Surgical management should be individualized to optimize reproductive outcomes.

Keywords: AMH, Laser ablation, ovarian endometrioma

VS-43

Laparoscopic Abdominal Cerclage in a 10-week Pregnant Patient

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OBJECTIVE: Cervical insufficiency is an important cause of second-trimester pregnancy loss. In cases where transvaginal cerclage is insufficient, abdominal cerclage may be considered as an alternative surgical approach. We present a case of laparoscopic abdominal cerclage performed during pregnancy.

CASE: "A 35-year-old woman at 10 weeks of gestation (G7P0A6) presented with a history of five first-trimester pregnancy losses and one second-trimester loss at 18 weeks of gestation. The second-trimester loss was attributed to cervical insufficiency. In a previous pregnancy, rescue transvaginal cerclage was performed; however, it was unsuccessful.Laparoscopic abdominal cerclage was performed during the current pregnancy. The procedure was carried out under general anesthesia using a laparoscopic approach, with placement of a non-absorbable suture at the cervico-isthmic level. Additionally, the patient was found to have bilateral cervical myomas, further complicating the cervical anatomy. No intraoperative or early postoperative complications were observed.

The postoperative course was uneventful, and the patient is under close obstetric follow-up.

CONCLUSION: Laparoscopic abdominal cerclage is a safe and effective option, particularly in selected patients with cervical insufficiency who have a history of second-trimester pregnancy loss. When performed in experienced centers, it highlights the potential to support the continuation of pregnancy.

Keywords: Laparoscopic Abdominal Cerclage, Recurrent Pregnancy Loss, Laparoscopy in Pregnancy

VS-44

Laparoscopic Management of Pelvic Abscess with Concomitant Deep Infiltrating Endometriosis Excision in a Contaminated Surgical Field: A Video Case Report

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OBJECTIVE: To demonstrate the feasibility of performing laparoscopic deep infiltrating endometriosis (DIE) excision during surgery for pelvic abscess in a contaminated surgical field.

SETTING: This surgical video was recorded at a tertiary referral center specializing in minimally invasive gynecologic surgery and advanced endometriosis management.

PARTICIPANTS: A 43-year-old woman presented with persistent severe pelvic and lower abdominal pain following drainage of a pelvic abscess at an outside center. Physical examination revealed posterior uterine fullness and nodularity. Transvaginal ultrasonography demonstrated an intrauterine device in situ and a 5-cm right adnexal abscess suspicious for endometriosis-related infection with possible hydrosalpinx. Laboratory findings showed elevated inflammatory markers (CRP 22.2). Despite medical management, the patient's symptoms persisted, and deep infiltrating endometriosis was suspected due to a palpable bowel-associated nodule.

INTERVENTIONS: Diagnostic laparoscopy revealed dense adhesions with bowel loops conglomerated behind the uterus, resulting in a frozen pelvis. A large abscessed right ovarian endometrioma measuring approximately 8–10 cm was identified. After trocar placement, retroperitoneal dissection and bilateral ureterolysis were performed to identify and protect the ureters. During dissection, the right ovarian abscess was perforated, and purulent material was drained and aspirated. Adhesiolysis allowed mobilization of the bowel from the posterior uterine wall while preserving the rectal boundary. A 3-cm posterior vaginal DIE nodule and bilateral sacrouterine ligament nodules measuring approximately 3–4 cm were excised. Bilateral salpingectomy and partial ovarian resections were performed. All excised specimens were removed laparoscopically. Hemostasis was achieved and the procedure was completed without complications.

CONCLUSION: This case demonstrates that comprehensive laparoscopic DIE excision can be safely performed even in the presence of pelvic abscess and contaminated surgical conditions when appropriate surgical expertise and retroperitoneal dissection techniques are employed. Simultaneous treatment of infection and advanced endometriosis may improve symptom control and reduce the need for repeat surgeries.

Keywords: Deep infiltrating endometriosis, pelvic abscess, contaminated surgery, laparoscopic excision, frozen pelvis

VS-45

Emergency Laparoscopic Management of Ruptured Ectopic Pregnancy with Concomitant Deep Infiltrating Endometriosis Resection: A Video Case Report

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OBJECTIVE: To demonstrate the feasibility and surgical steps of performing laparoscopic deep infiltrating endometriosis (DIE) excision during emergency surgery for ruptured ectopic pregnancy in a patient with advanced endometriosis.

SETTING: This video was recorded in a tertiary referral center for minimally invasive gynecologic surgery.

PARTICIPANTS: A 36-year-old woman with a history of infertility and stage IV endometriosis presented with a ruptured ectopic pregnancy following in vitro fertilization (IVF). Her medical history included previous laparoscopic myomectomy and dermoid cystectomy, with known bilateral hydrosalpinx and severe pelvic endometriosis. She reported intermittent pelvic pain and diarrhea. Pelvic examination revealed a 2-cm nodule behind the cervix on the right side. Transvaginal ultrasonography demonstrated a retroverted uterus with adenomyosis features, endometrioma in the right ovary, diminished ovarian reserve (AMH 0.2), and a frozen pelvis with negative sliding sign.

INTERVENTIONS: Emergency laparoscopy revealed approximately 1500 cc hemoperitoneum and extensive pelvic adhesions consistent with severe endometriosis. After aspiration of intra-abdominal blood, bilateral ureterolysis was performed to identify and protect the ureters. Adhesiolysis was carried out to mobilize the bowel from the posterior uterine wall and restore pelvic anatomy. Bilateral salpingectomy was performed due to ectopic pregnancy and hydrosalpinx. A 4-cm deep infiltrating endometriosis nodule involving the sacrouterine region was excised. A 2-cm bowel serosal defect was identified following dissection; a general surgeon joined the procedure and repaired the defect using continuous V-Lock suturing. Integrity testing with air–fluid and methylene blue confirmed no leakage. Hemostasis was achieved and a drain was placed.

CONCLUSION: Advanced endometriosis surgery, including DIE excision, can be safely performed during emergency laparoscopic procedures when appropriate expertise and multidisciplinary support are available. Addressing endometriosis at the time of emergency surgery may improve pelvic anatomy, alleviate symptoms, and optimize subsequent fertility treatment planning.

Keywords: Deep infiltrating endometriosis, Emergency laparoscopy, Ruptured ectopic pregnancy

VS-46

Surgical Technique and Experience in a Challenging vNOTES Hysterectomy: A Video-Assisted Case Presentation

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OBJECTIVE: Vaginal natural orifice transluminal endoscopic surgery (vNOTES) is a minimally invasive surgical technique that has been increasingly used in gynecologic surgery in recent years. The absence of abdominal incisions, reduced postoperative pain, faster recovery, and improved cosmetic outcomes represent its major advantages. However, in the presence of a myomatous uterus, increased uterine volume, reduced mobility, and distortion of anatomical structures may make the surgical procedure technically challenging. In particular, uterine enlargement caused by intramural myomas may narrow the surgical field and require meticulous dissection techniques. The aim of this video presentation is to demonstrate the surgical technique and key operative steps of a challenging vNOTES hysterectomy performed in a patient with a 6-cm intramural myoma.

METHODS: A 46-year-old patient, gravida 3 para 3, who had completed her fertility, presented with complaints of menometrorrhagia, pelvic pressure, and dysmenorrhea for approximately one year. Transvaginal ultrasonography revealed a posterior wall intramural myoma measuring approximately 6×5 cm. No adnexal pathology was detected. As the patient did not respond to medical treatment, surgical management was planned. A total hysterectomy with bilateral salpingectomy was performed using the vaginal natural orifice transluminal endoscopic surgery (vNOTES) approach. After posterior colpotomy, a vNOTES port was inserted and pneumoperitoneum was established. Under endoscopic visualization, the uterosacral ligaments, uterine vessels, and parametrial tissues were carefully dissected using an energy-based surgical device. Due to the increased uterine volume related to the myoma, uterine manipulation, gradual traction, and meticulous tissue exposure were applied in areas with limited visualization to facilitate safe surgical progression. The video demonstrates the operative steps in detail.

RESULTS: The procedure was successfully completed using the vNOTES approach without conversion to laparotomy or the need for additional trocars. The operative time was 92 minutes, and the estimated blood loss was approximately 100 mL. No intraoperative complications such as bladder, bowel, ureteral, or major vascular injury occurred. The uterus was removed transvaginally. Histopathological examination confirmed a benign myometrial lesion consistent with leiomyoma. The postoperative hemoglobin decrease was 1.2 g/dL. The postoperative course was uneventful, and the patient was discharged on postoperative day one.

CONCLUSION: vNOTES hysterectomy may be technically challenging in the presence of a myomatous uterus. However, with appropriate patient selection, careful surgical planning, and an experienced surgical team, it can be performed safely and effectively. This video presentation aims to demonstrate the feasibility of the vNOTES approach in uteri containing a 6-cm intramural myoma and to highlight important surgical tips that may contribute to the advancement of minimally invasive gynecologic surgery.

Keywords: Hysterectomy, minimally invasive surgery, transvaginal endoscopic surgery, uterine leiomyoma, vNOTES

POSTER BİLDİRİLER

KADIN SAĞLIĞI DERNEKLERİ FEDERASYONU

PS-01

Thoraco-omphalopagus conjoined twins with a shared heart diagnosed at 12 weeks of gestation: early prenatal diagnosis and counseling

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Thoraco-omphalopagus conjoined twins with a shared heart diagnosed at 12 weeks of gestation: early prenatal diagnosis and counseling

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OBJECTIVE: Conjoined twins are a rare complication of monozygotic twinning resulting from incomplete embryonic division, with an estimated incidence of approximately 1 in 50,000–100,000 pregnancies. Thoraco-omphalopagus is among the most common types and frequently involves shared vital organs, particularly the heart, which significantly worsens prognosis. Early prenatal diagnosis plays a crucial role in appropriate counseling and pregnancy management. This report presents a case of thoraco-omphalopagus conjoined twins with a shared heart diagnosed at 12 weeks of gestation during routine first-trimester screening.

METHODS: A 38-year-old pregnant woman in her second pregnancy (gravida 2, parity 1) presented for routine first-trimester screening. Transabdominal ultrasonography was performed at 12 weeks and 3 days of gestation, followed by color Doppler evaluation of fetal cardiac structures. After establishing the prenatal diagnosis, the family received multidisciplinary counseling regarding the prognosis and management options. Pregnancy termination was subsequently performed, and fetopathological examination was carried out to confirm the prenatal findings.

RESULTS: Ultrasonography demonstrated two fetuses within a single amniotic sac with crown-rump length measurements of 55 mm, consistent with the gestational age. The fetuses were ventrally fused from the sternum to the umbilicus. Two separate heads and necks were visualized. Each fetus had two upper and two lower extremities (tetrapus, dibrachius configuration), and the externally located limbs appeared anatomically normal. A shared pericardial sac containing a single cardiac structure was identified, along with fused hepatic tissue. No increased nuchal translucency or cystic hygroma was detected. Color Doppler confirmed a single cardiac unit without independent cardiac activity.

CONCLUSION: Thoraco-omphalopagus conjoined twins with a shared heart carry an extremely poor prognosis, and surgical separation is generally not feasible. Early first-trimester ultrasonography enables reliable diagnosis and allows timely multidisciplinary counseling regarding prognosis and pregnancy management.

Keywords: conjoined twins,Thoraco-omphalopagus, termination

makroskopik



xray



PS-02

Determinants of Women's Attitudes Toward Gynecological Examination: A Cross-Sectional Study

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OBJECTIVE: This study aimed to investigate the multidimensional factors influencing women's attitudes toward gynecological examination (GE), focusing on socioeconomic determinants, physician-related factors, personal knowledge and motivation, and environmental conditions of the examination setting.

METHODS: From four Family Health Centers in Sariyer, 137 women were invited to participate. Out of 137 women, 82 agreed to take part in the study. Data were collected using a structured questionnaire assessing sociodemographic characteristics, physician attributes and communication, knowledge and attendance patterns, and environmental concerns. Descriptive statistics were calculated, and associations between categorical variables were analyzed.

RESULTS: Although 97% of participants reported that GE should be performed at least annually, 59% had not undergone GE within the previous year, indicating a discrepancy between perceived recommendations and actual attendance. Increasing age was significantly associated with longer intervals since the last GE ($p=0.02$). University graduates demonstrated significantly higher knowledge regarding contraception and examination instruments compared to women with lower educational attainment ($p=0.03$ and $p<0.01$, respectively). Satisfaction with previous physicians was high (92%) and was positively associated with intention to attend future routine examinations ($p=0.03$). However, 71% of women reported that they would seek GE only in case of necessity. Nearly half of participants preferred only the physician to be present during examination. High levels of concern were reported regarding hygiene (48%) and examination instruments (31%). A significant inverse association was observed between knowledge of examination tools and anxiety related to their use ($p<0.01$). Institutional satisfaction was significantly associated with both physician satisfaction and examination room conditions ($p<0.01$).

CONCLUSION: Despite high satisfaction with physicians and awareness of recommended examination frequency, preventive GE attendance remains suboptimal. Environmental concerns, limited knowledge regarding examination instruments, hygiene anxiety, and gender-related sensitivities appear to play significant roles in shaping reluctance. Addressing modifiable factors through improved patient education, communication, and environmental reassurance may enhance adherence to preventive gynecological care.

Keywords: gynecological examination, women's health, preventive health

Sociodemographic Characteristics of the Study Population (n=82)

Variable	Distibution
Age in years	16–20 (7), 21–25 (9), 26–30 (13), 31–35 (11), 36–40 (12), 41–45 (11), ≥45 (37)
Personal Income	Yes (54), No (46)
Household Income*	< minimum wage (23), 1-2x minimum wage (49), ≥2x minimum wage (28)
Education Level	Not literate (3), Primary (30), Middle (17), High school (30), University (20)
Marital Status	Single (28), Married (72)
Occupation	Housewife (41), Officer (14), Retired (11), Other (11), Worker (8), Self-employed (6), Employer (4), Director (4), Unemployed (1)

Income categories were defined according to the Turkish monthly net minimum wage during the study period (January–February 2015), which was 949 Turkish Lira (TRY). Categories were defined as: < minimum wage (<949 TRY), 1–2× minimum wage (949–1898 TRY), and ≥2× minimum wage (≥1898 TRY).

PS-03

Complexity-Dependent Performance Gradient of Artificial Intelligence in Endometriosis Management: A Guideline-Concordance Study

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OBJECTIVE: To critically evaluate the concordance of artificial intelligence (AI)-generated clinical recommendations with established international guidelines in the management of endometriosis using structured clinical scenarios.

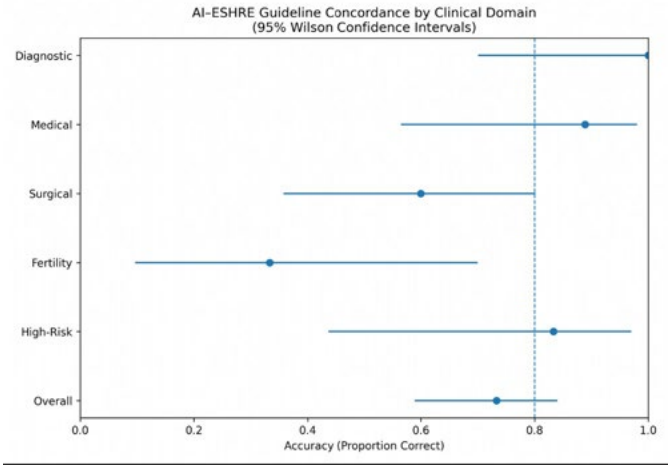
MATERIALS-METHODS: This document-based analytical study assessed the alignment between AI-generated responses and evidence-based recommendations outlined in the 2022 European Society of Human Reproduction and Embryology (ESHRE) Endometriosis Guideline. Fifteen predefined clinical scenarios representing core domains of endometriosis management—including diagnosis, medical therapy, surgical indications, infertility management, deep infiltrating endometriosis, recurrence, and adolescent presentation—were developed. Each scenario was submitted using a standardized prompt to ensure consistency in response generation. Guideline-derived evaluation matrices were constructed a priori for each case, incorporating essential diagnostic and therapeutic decision elements. Responses were examined within a structured concordance framework to determine the presence of key guideline components and domain-specific alignment patterns.

RESULTS: AI-generated recommendations demonstrated substantial concordance with guideline-based principles in diagnostic evaluation and first-line medical management scenarios. Alignment was comparatively reduced in complex clinical contexts, particularly those involving advanced surgical planning, fertility preservation strategies, and management of deep infiltrating disease. Variability in comprehensiveness and prioritization of clinical decision elements was observed across scenarios, with occasional omission of high-complexity safety considerations.

CONCLUSION: Artificial intelligence systems show meaningful alignment with contemporary evidence-based guidance in foundational aspects of endometriosis management. However, performance variability in nuanced and high-complexity scenarios highlights important limitations. While AI tools may serve as supportive educational or decision-support adjuncts, they should not substitute expert clinical judgment in specialized gynecologic practice.

Keywords: Endometriosis, Artificial Intelligence, Guideline Concordance

AI ESHRE Guideline Concordance



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