

BİLİMSEL PROGRAM ve BİLDİRİ ÖZETLERİ KİTABI

www.obstetrikjinekolojitartismalikonular.org

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BİLİMSEL PROGRAM 5-25

SÖZLÜ BİLDİRİLER 26-91

VİDEO BİLDİRİLER 92-110

POSTER BİLDİRİLER 111-211

ÖNSÖZ

Değerli Meslektaşlarımız, 8. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi kadın sağlığı alanındaki en güncel tartışmalı konulara odaklanan; konuşmacılar ile katılımcıların yüz yüze etkileşim kurabilmesini önemseyen ve buna geniş zaman ayıran; liyakata dayalı, kaliteyi ön planda tutan bir kongre olacaktır.

Kongremiz, dünya ve ülkemizin önde gelen bilim insanlarının katılımıyla, klinik ve tedaviye yönelik günlük uygulamalarda edinilen deneyimlerin ve karşılaşılan sorunların etkin biçimde tartışılacağı bir ortam hazırlayacaktır.

8. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi, kadın sağlığı alanında çalışan profesyoneller arasında bilimsel, eğitsel ve sosyal alışveriş için en yüksek standartlarda bir forum sunmayı; araştırma ve eğitimi teşvik etmeyi ve yeni bilginin yayılmasını sağlamayı misyon edinmiştir.

8. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresine katılın ve şunları yapın:

Obstetrik ve Jinekoloji alanında dünya ve ülkemizin liderleriyle tanışın. Benzersiz bir networking platformunda mesleğinizin diğer uzmanlarıyla birebir görüşmeler gerçekleştirin. Farklı bakış açılarıyla, diğer uzmanlık alanlarındaki profesyonellerle fikir alışverişinde bulunun. Alanınızla ilgili konularda bilgi birikiminizi artırarak klinik uygulamalarınızı zenginleştirin. Sadece 5 gün içinde Obstetrik ve Jinekoloji alanındaki en güncel bilgilerle buluşun. Birçok konuda lider uzmanlara soru yöneltebileceğiniz etkileşimli oturumlara katılın. Farklı ülkelerden en iyi uygulamaları öğrenerek kendi pratiğinizi geliştirin. İlgi alanlarınıza odaklanan oturumlara katılarak özel bilgiler edinin. Alışılmışın dışında sunum teknikleri ve oturum formatlarını keşfedin. Fikir liderlerine ilgilendiğiniz konuları birebir sorma fırsatı yakalayın. Jinekoloji ve Obstetrik alanındaki güncel çalışmalarınızı poster veya sözlü sunumlarla paylaşın.

Bu toplantı, Obstetrik ve Jinekoloji alanında çığır açıcı nitelikte; birçok dernek ve fikir liderinin katkısıyla oluşan, birleştirici gücü yüksek bir organizasyon olacaktır. Tüm yan dallara ilişkin bilimsel kurullarımız, ilgili derneklerimizin yönetimlerinin kararları doğrultusunda oluşturulacaktır. Biz fikir liderleri yalnızca aracıyız; asıl gücümüz, tüm derneklerimizin yönetimleri ve üyeleridir.

Bu derneklere ek olarak katılmak isteyen tüm dernek ve ilgili kuruluşlara kapımız daima açıktır.

Saygılarımızla,

Kongre Düzenleme Kurulu

8. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

30 Eylül - 4 Ekim 2026
NG Phaselis Bay Kemer, Antalya

KURULLAR

JİNEKOLOJİ VE OBSTETRİK TARTIŞMALI KONULAR DERNEĞİ

Başkan
Nejat Özgül

Başkan Yardımcısı
M. Faruk Köse

Genel Sekreter
Mete Güngör

Sayman
M. Murat Naki

Üye
Emine Karabük

BİLİMSEL KURUL

Ahkam Göksel Kanmaz
Ahmet Fatih Durmuşoğlu
Akın Usta
Ateş Karateke
Atıl Yüksel
Aylin Altan Kuş
Ayşe Seval Özgü Erdinç
Bilge Çetinkaya Demir
Bülent Urman
Cenk Sayın
Çetin Çelik
Demir Özbaşar
Deniz Karçaaltıncaba
Derman Başaran
Dilara Tekden Kırgız
Emine Karabük
Ercan Baştu
Erdem Fadıloğlu
Erhan Şimşek
Esra Kuşçu
Günsu Kimyon Cömert
Gürkan Bozdağ
Gürkan Uncu
Hakan Erenel
Hakkı Gökhan Tulunay
Hamdullah Sözen
Hasan Hakan Seyisoğlu
Hüseyin Akıllı
Hüsnü Çelik
Işıl Kasapoğlu
Işıl Ayhan
İlkkan Dünder
İnanç Mendilcioğlu
Kemal Güngördük
Kemal Özerkan
Levent Şentürk
Lütfü Cem Demirel
M. Murat Naki
M.Faruk Köse
Mehmet Ali Vardar
Mehmet Cihat Ünlü
Mehmet Coşkun Salman
Mehmet Mutlu Meydanlı
Mert Turgal
Mete Güngör
Murat Yassa
Mustafa Melih Erkan
Müfit Cemal Yenen
Nasuh Utku Doğan
Nejat Özgül
Neslihan Başçıl Tütüncü
Nihal Şahin Uysal
Oğuzhan Kuru
Onur Karaaslan
Osman Aşıcıoğlu
Osman Cem Yılmaz
Ozan Doğan
Ömer Erbil Doğan
Özgüç Takmaz
Özgür Deren
Özlem Pata
Pınar Bahat Yalçın
Recep Has
Resul Karakuş
Rıfat Hakkı Gürsoy
Rıza Madazlı
Samet Topuz
Selen Doğan
Sermet Sağol
Sezcan Mümüşoğlu
Şevki Çelen
Telce Ayşen Küçükceran
Tolgay Tuyan İlhan
Turgut Aydın
Uğur Fırat Ortaç
Umut Dilek
Yakup Kumtepe
Yaprak Üstün
Yaşam Kemal Akpak
Yavuz Emre Şükür
Yiğit Çakıroğlu
Yusuf Üstün
Zühal Dilek Şanlı

İsimler alfabetik sıralanmıştır

BİLİMSEL PROGRAM



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30 EYLÜL 2026, ÇARŞAMBA / SALON A

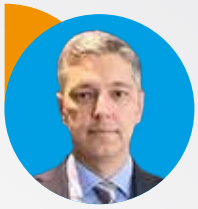
14:00-15:00 Panel 1: Antenatal Taramalar



ATIL YÜKSEL
MODERATÖR



ÖZGÜR DEREN
PANELİST



UMUT DİLEK
PANELİST



BİLGE ÇETİNKAYA
PANELİST

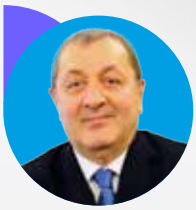


MERT TURĞAL
PANELİST

- Prekonsepsiyon ve erken gebelikte genetik risk: taşıyıcılık taramasını ne zaman, kime, hangi panelle?
- Aneuploidi taramasında yeni algoritma: tekil gebelik, çoğul gebelik ve PGT-A sonrası gebelikler
- NIPT'nin genişlemesi: mikrodelesyonlar ve tek gen hastalıkları için tarama hazır mı?
- Yapısal anomalilerin taranması: açık nöral tüp defektlerinde maternal serum AFP'ye veda zamanı geldi mi?
- Preterm doğum öngörüsünde serviks uzunluğu: evrensel tarama mı, hedeflenmiş tarama mı?
- Plasental disfonksiyonun erken öngörüsü: uterin arter Doppler'den serum belirteçlerine, oradan ekzosomlara
- Prenatal ekzom sekanslama: yüksek riskte standartlaşmalı mı, düşük riskte yeri var mı?

15:00-15:20 KAHVE MOLASI

15:20-16:20 Panel 2: Ürojinekoloji



ATEŞ KARATEKE
MODERATÖR



TOLGAY TUYAN İLHAN
PANELİST



OZAN DOĞAN
PANELİST



ÖZGÜÇ TAKMAZ
PANELİST

- Üriner İnkontinans Hastasında Tanı ve Endikasyon: Gerçekten Kimi Ameliyat Ediyoruz?
- Midüretral Sling Cerrahisi: TOT ve TVT Arasında Seçim – Teknik mi, Hasta mı Belirleyici?
- Mini-Slingler (Single-Incision Sling): Seçilmiş Hastada Akılcı mı, Yoksa Yetersiz mi?
- Pelvik Taban Cerrahisinde Biyomateryaller: Kollajen ve Alternatiflerinin Gerçek Yeri Nedir?
- İnkontinansta Enerji Bazlı Tedaviler: Lazer ve Radyofrekans Klinik Pratiğe Girmeli mi?
- Otolog Fasya ile Pubovajinal Sling: Unutulmuş Bir Teknik mi, Yoksa Seçilmiş Hastada Altın Standart mı?
- Posterior Kompartman Hastalıkları: Anatomik Düzeltme mi, Fonksiyonel Sonuç mu Öncelikli?
- Apikal Prolapsus Cerrahisinde Tercih: Sakrokolpopeksi, Pektopeksi ve Lateral Süspansiyon – Hangisi Kime?
- Sakrospinöz Ligament Fiksasyonu: Hâlâ Güvenilir Bir Vajinal Alternatif mi?
- Pelvik Organ Prolapsusunda Cerrahi Strateji: Standart Yaklaşım mı, Hastaya Özel Planlama mı?



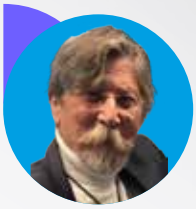
30 EYLÜL 2026, ÇARŞAMBA / SALON A

16:20-16:40 Açılış Töreni

Jinekoloji ve Obstetrikte Tartışmalı Konular Derneği Yönetim Kurulu

16:40-17:20 Keynote Lecture

İlaçla zayıflamak sağlıklı mıdır?



DEMİR ÖZBAŞAR
OTURUM BAŞKANI



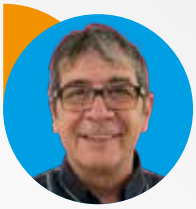
NESLİHAN BAŞÇIL TÜTÜNCÜ
KONUŞMACI



1 EKİM 2026, PERŞEMBE / SALON A

09:00-10:00 Panel 3: Obstetrikte Güncel Tartışmalar


İNANÇ MENDİLCİOĞLU
MODERATÖR


RIZA MADAZLI
PANELİST


ÖZLEM PATA
PANELİST


CENK SAYIN
PANELİST


ERDEM FADILOĞLU
PANELİST

- Gebelikte Aşılama: Artık "önerilen" değil "standart bakımın ayrılmaz parçası" mı olmalı?
- Viabilite Öncesi PPROM: Gebeliği uzatmaya çalışmak mı, maternal riski erkenden kabullenmek mi?
- Acil Servikal Serklaj: Hayat kurtaran bir müdahale mi, yanlış hasta seçimiyle gereksiz yere uygulanan bir girişim mi?
- Rh Uyuşmazlığı Yönetimi: Erken gebelik kayıplarında rutin anti-D uygulaması bilimsel bir gereklilik mi, artık terk edilmesi gereken eski bir alışkanlık mı?
- Kordon Kanı Saklama: Geleceğe yönelik değerli bir biyolojik yatırım mı, bilimsel temeli sınırlı pahalı bir pazarlama ürünü mü?
- İleri Anne Yaşı: Risk algımız güncellendi mi? IVF gebeliklere daha mı toleranslıyız? Elektif erken doğum gerekli

10:00-10:20 KAHVE MOLASI

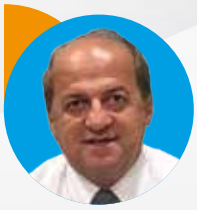
10:20-10:50 Uydu Sempozyumu

Abrysvo ile RSV'ye Karşı Maternal İmmünizasyon
Konuşmacı: Özlem Pata, Seda Topçu

Pfizer

10:50-11:35 Panel 4: Laparoskopik Histerektomi


GÜRKAN UNCU
MODERATÖR


İLKKAN DÜNDER
PANELİST


METE GÜNGÖR
PANELİST


KEMAL ÖZERKAN
PANELİST


MURAT YASSA
PANELİST

- Port yerleşimi ve cerrahi ergonomi: başarılı histerektominin temel belirleyicisi
- Uterin manipülatör ve kolpotomizer seçimi: gerekli mi, hangi durumda, hangi sistem?
- Üreter güvenliği: kritik anatomik noktalar ve disseksiyon stratejileri
- Enerji modaliteleri: hangi cihaz, hangi cerrahi adımda optimum?
- Kolpotomi ve vajinal cuff kapatılması: teknik seçimlerin komplikasyonlara etkisi
- Zor histerektomi olgularında yaklaşım: sınırlar, püf noktaları ve karar algoritmaları

11:35-11:55 KAHVE MOLASI



1 EKİM 2026, PERŞEMBE / SALON A

11:55-12:25 Uydu Sempozyumu

HPV İlişkili Hastalıklar ve Kanserler, HPV Aşıları
Konuşmacı: Nejat Özgül

MSD

12:25-13:25 Panel 5: Servikal Preinvaziv Lezyonlar Tarama ve Takibi



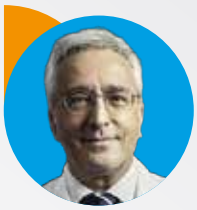
NEJAT ÖZGÜL
MODERATÖR



U. FIRAT ORTAÇ
PANELİST



MÜFİT C. YENEN
PANELİST



GÖKHAN TULUNAY
PANELİST



COŞKUN SALMAN
PANELİST

- Servikal Kanser Taramasında Güncel Yaklaşımlar ve HPV Temelli Stratejiler
- HPV Enfeksiyonu, Doğal Seyir ve Servikal Neoplazi Gelişimi
- ASCCP Rehberleri Işığında Risk Bazlı Sitolojik ve Histolojik Yönetim
- Kolposkopi: Endikasyonlar, Değerlendirme ve Klinik Karar Sürecindeki Yeri
- Servikal Preinvaziv Lezyonlarda Bireyselleştirilmiş Yönetim Yaklaşımları
- Eksizyonel Tedaviler, Cerrahi Sınırlar ve Post-Tedavi İzlem
- Eksizyonel Tedaviler Fertiliteyi Etkiler mi?

13:25-14:25 ÖĞLE YEMEĞİ

14:25-15:25 Panel 6: Histeroskopi



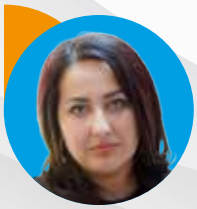
ERHAN ŞİMŞEK
MODERATÖR



BÜLENT URMAN
PANELİST



ERBİL DOĞAN
PANELİST



SELEN DOĞAN
PANELİST

- Tanısal Histeroskopiden "See & Treat" Yaklaşımına: Klinik Pratik Nereye Evriliyor?
- Anormal Uterin Kanama ve Postmenopozal Kanamada Histeroskopi: Altın Standart mı?
- Ofis Histeroskopi: Ağrısız, Anestezisiz ve Rutin Kullanıma Uygun mu?
- İnfertilitede Histeroskopi: Kime, Ne Zaman, Ne Kadar?
- Histeroskopik Myomektomi ve Septum Rezeksiyonu: Sınırlar, Endikasyonlar ve Tartışmalar
- Histeroskopide Adezyon Önleme ve Postoperatif Başarı: Cerrahiden Daha mı Önemli?
- Zor Olgular ve Genişleyen Endikasyonlar: Menopoz, Onkoloji ve İstmosel

15:25-15:45 KAHVE MOLASI



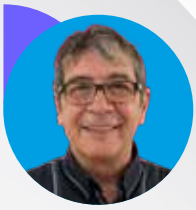
1 EKİM 2026, PERŞEMBE / SALON A

15:45-16:15 **Uydu Sempozyumu**

Jinekolojide Hassas Enerji: LigaSure XP'nin Klinik Kanıtları ve Uygulamaları — Medtronic

Konuşmacılar: Ahkam Göksel Kanmaz, Yaşam Kemal Akpak

16:15-17:15 **Panel 7: Postpartum Kanamalar, Plasenta Akkreata ve Sezaryen Skar Gebeliği**



RIZA MADAZLI
MODERATÖR



ATEŞ KARATEKE
PANELİST



M. MUTLU MEYDANLI
PANELİST



ŞEVKİ ÇELEN
PANELİST



RESUL KARAKUŞ
PANELİST

- Sezaryen Skar Spektrumu: İsthmosel, CSP, PAS Tek Bir Hastalık mı, Ayrı Klinik Entiteler mi?
- Erken Tanı mı Aşırı Tanı mı? CSP ve PAS'ta 1. Trimester Tarama Gerçekten Gerekli mi?
- Sezaryen Tekniği Geleceği Belirler mi? İdeal Uterin Kapatma CSP ve PAS Riskini Azaltabilir mi?
- PAS Yönetiminde Altın Standart Hâlâ Histerektomi mi? Yoksa Seçilmiş Olguda Konservatif Yaklaşım Güvenli mi?
- Kanamayı Önlemek mi, Yönetmek mi? PAS ve Yüksek Riskli Olgularda Profilaktik Girişimlerin Yeri
- Uterin Atoni ve Postpartum Hemoraji: Evrensel Profilaksi mi, Risk Bazlı Yaklaşım mı?
- Postpartum Hemorajide Yeni Araçlar: Uterin Balon Tamponadı ve Minimal İnvaziv Yaklaşımlar Cerrahiyi Azaltıyor mu?
- Geç Postpartum Kanama: Rest mi, Vasküler Patoloji mi? Tanı ve Yönetimde Kritik Ayrımlar

17:15 **Canlı Cerrahi / Akdeniz Üniversitesi Tıp Fakültesi**

Endometrium Kanserinde ICG ile Sentinel Lenf Nodu Uygulaması — CANLI — stryker

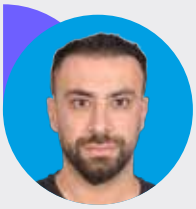
M.Murat Naki

1 EKİM 2026, PERŞEMBE / SALON B

10:00-11:30 Sözlü Bildiri Oturumu - 1



MÜFİT C. YENEN
OTURUM BAŞKANI



ONUR KARAASLAN
OTURUM BAŞKANI

SS-01 Is a Single Elevated Prolactin Result Sufficient for The Diagnosis of Hyperprolactinemia? A Retrospective Analysis of Laboratory Data in Women of Reproductive Age - ***Emine Emsal Durusoy***

SS-02 Surgical and Clinical Outcomes Following Colorectal Surgery for Bowel Endometriosis: A Single Centre Experience ***Ezgi Darıcı Kurt***

SS-03 Fumarate Hydratase-Deficient Uterine Leiomyomas As A Marker of Hereditary Leiomyomatosis and Renal Cell Carcinoma Syndrome: A Pathology-Based Screening Cohort - ***Muhammed Onur Atakul***

SS-04 Comparison of Conventional Multiport Laparoscopy, Single-Port Laparoscopy, and Vnotes for The Management of Large Adnexal Masses (≥ 10 Cm): A Retrospective Cohort Study - ***Kemal Güngördük***

SS-05 Who Benefits Most From Antibiotic Prophylaxis After Operative Vaginal Delivery? A Focused Systematic Review of Postpartum Infection and Wound Complications - ***İpek Güneş Topuz***

SS-06 Vaginal Natural Orifice Transluminal Endoscopic Surgery Versus Conventional Multiport Laparoscopy for Hemorrhagic Ovarian Cyst Rupture With Hemoperitoneum: A Multicenter Retrospective Cohort Study - ***Emre Biton***

SS-07 Evaluation of The Relationship Between Isthmocele Dimensions and Inflammatory, Hematological, and Coagulation Markers in Symptomatic Patients - ***Merve Genco***

SS-08 Sociodemographic, Clinical, and Pain Profile of Women With Endometriosis: A Single-Center Cohort - ***Esra Keleş***

SS-09 Maternal Obesity and Thromboembolic Risk in Obstetric Patients: A Propensity Score–Matched Analysis Of Perioperative Outcomes and Clinical Management - ***Kübra Çakar Yılmaz***

SS-10 Extraperitoneal Versus Transperitoneal Approach in Vnotes Sacrocolpopexy: A Comparative Pilot Study ***Kemal Güngördük***

SS-11 Comparison of Perioperative And Early Postoperative Outcomes of Vnotes and Laparoscopic Hysterectomy ***Meryem Bekmezci***

SS-12 Effects of Uterine Fibroid Presence, Number, and Size on Maternal And Fetal Outcomes in Pregnancy: A Single-Center Retrospective Cohort Study - ***Mehmet Genco***

SS-13 Clinical and Histopathological Characteristics of Uterine Pecomas: A Single-Center Retrospective Study ***Mesut Ayberk Ceylan***

SS-14 Comparison of Inositol Plus Trans-Resveratrol Combination Therapy With Combined Oral Contraceptives in Polyendocrine Metaboloic Ovarian Syndrome: A Three-Month Pilot Clinical Observation - ***Ahkam Göksel Kanmaz***

SS-15 Clinical, Hormonal, and Radiological Evaluation of Pituitary MRI Findings in Patients Undergoing Pituitary MRI For Hyperprolactinemia During The Period Between August 2021 And August 2026 at Istanbul Aydin University VM Medicalpark Florya Hospital - ***Irem Yaman***

1 EKİM 2026, PERŞEMBE / SALON B

14:30-16:00 Video Bildiri Oturumu - 1



GÖKHAN TULUNAY
OTURUM BAŞKANI



HASAN VOLKAN EGE
OTURUM BAŞKANI

VS-01 Ultimate Pain Relief: Radical Management of Recurrent DIE Incorporating Dorsal Parametrectomy - ***Emre Biton***

VS-02 Single-Suture Vaginal Cuff Closure With Concomitant Uterosacral Ligament Plication During Single-Port Total Laparoscopic Hysterectomy - ***Cansel Tanrıkulu***

VS-03 Beyond Cosmesis: Prioritizing Ureteral Safety in Single-Port Laparoscopic Oophorectomy - ***Cansel Tanrıkulu***

VS-04 Tips and Tricks for Complicated Hysterectomy - ***Mehmet Efe Namlı***

VS-05 Primary Robotic-Assisted Davydov Neovaginoplasty in Type I Mayer–Rokitansky–Küster–Hauser Syndrome: A Video Case Report - ***Fatma Hicran San***

VS-06 Vnotes Myomectomy for Primary Ovarian Leiomyoma Coexisting Uterine Fibroid - ***Berfin Akan İşler***

VS-07 Sacrocolpopexy Mesh Complication Presenting With Persistent Urge Incontinence and Chronic Pelvic Pain: Laparoscopic Total Mesh Excision Case Report - ***Sözdar Cihan***

VS-08 Laparoscopic Management of a Large Paraovarian Cyst in a Symptomatic Young Woman: A Case Report ***Mehmet Faruk Düz***

VS-09 V-Notes Right Cyst Rupture and Paratubal Cyst Excision - ***Ahmet İlker Eryılmaz***

VS-10 Recurrent Pelvic Infection And Tubo-Ovarian Abscess: From Medical Treatment to Surgical Management - ***Mukadder Gök***

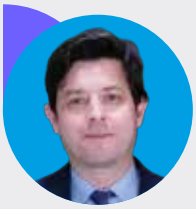
VS-11 Vertical Extension of The Anterior Colpotomy to Facilitate Vaginal Extraction of a Large Myomatous Uterus During Total Laparoscopic Hysterectomy - ***Mukadder Gök***

1 EKİM 2026, PERŞEMBE / SALON B

16:30-18:00 Sözlü Bildiri Oturumu - 2



AKIN USTA
OTURUM BAŞKANI



MEHMET TUNÇ
OTURUM BAŞKANI

SS-16 Preeclampsia and Immediate Postpartum Outcomes Following Cesarean Delivery: A 1:1 Propensity Score-Matched Analysis - ***Kübra Çakar Yılmaz***

SS-17 Can Generative Artificial Intelligence Identify Postpartum Danger Signs? A WHO Guideline-Based Comparative Study ***Erhan Muluk***

SS-18 Ten-Year Cesarean Section Trends in Advanced Maternal Age Pregnancies: A Single-Center Analysis Based On Robson Classification - ***Havva Can Ozdemir***

SS-19 The Relationship Between Future Pregnancy-Avoidance Desire, Depression, Anxiety, And Disease Severity in Patients With Hyperemesis Gravidarum Requiring Prolonged Hospitalization - ***Elif Canseven Ocak***

SS-20 Evaluation of Antenatal Hematological Parameters, Maternal Characteristics, and Neonatal Outcomes in Histopathologically Confirmed Chorioamnionitis - ***Sena Camcı***

SS-21 Does Suspected Fetal Macrosomia on Ultrasound İnfluence The Decision for Cesarean Delivery? Accuracy of Fetal Weight Estimation in Term Pregnancies - ***Şeyma Dağıtuncezdi Çam***

SS-22 Association Between Birth Weight Discordance and Early Neonatal Morbidity Outcomes in Twin Pregnancies ***Tuana Çaylayık***

SS-23 Evaluation of First-Trimester Maternal Serum Insulin and Spexin Levels for The Early Prediction of Gestational Diabetes Mellitus - ***Özgecan Üçyıldız Gülmez***

SS-24 Knowledge and Attitudes Toward Maternal and Neonatal Vaccination Among Pregnant and Postpartum Women: A Cross-Sectional Comparative Study - ***Alperen Mustafa Aktaş***

SS-25 Evaluation of Maternal and Fetal Complications in Women Undergoing Cesarean Section at Full Cervical Dilatation in The Second Stage of Labor - ***Ayse Seval Ozgu Erdinc***

SS-26 Predicting Preterm Birth Through Maternal Demographic Data and Obstetric History: A Comparison of Early and Late Preterm Births in Terms of Risk Factors - ***Farnaz Davoudi***

SS-27 Evaluation of Antenatal and Perinatal Outcomes of Infants With Birth Weight ≥4000 Grams: A Retrospective Cohort Study ***Zühre Melike Öncebe***

SS-28 The Role of First-Trimester Thyroid Function Tests in Predicting Gestational Diabetes Mellitus - ***Sara Zeynallı***

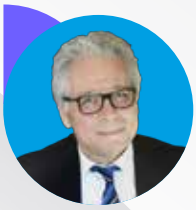
SS-29 Association Between Maternal Age and Obstetric and Neonatal Outcomes: Experience From a Single Tertiary Center ***Esra Koç***

SS-30 Prognostic Value of The Initial Serum B-Hcg Level in Predicting Pregnancy Outcome in Spontaneous Pregnancies: A Single-Center Retrospective Study - ***Taha Kitapçı***



2 EKİM 2026, CUMA / SALON A

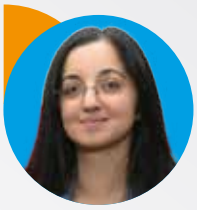
09:00-10:00 Panel 8: Poliendokrin Metabolik Over Sendromu (PMOS)



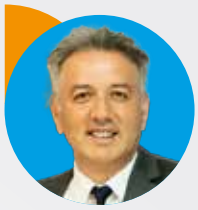
RIFAT GÜRSOY
MODERATÖR



GÜRKAN BOZDAĞ
PANELİST



YAPRAK ÜSTÜN
PANELİST



TURGUT AYDIN
PANELİST

- Stein-Leventhal Sendromu'ndan PMOS'a Polikistik Over Sendromu'nda neler değişti?
- Hiperandrojenizm olmadan ovaryan disfonksiyon PCOS olarak kabul edilmeli mi?
- Ultrasonik polikistik over morfolojisi (PCOM) hâlâ tanıda anlamlı mı, yoksa aşırı kullanılan bir kriter mi?
- Adolesanlarda PCOS tanısı koymak, normal pubertal varyasyonları hastalıklaştırmak mı?
- PCOS infertilitesinde hedefimiz ovulasyon sağlamak mı, yoksa canlı doğum mu?
- Oral infertilite tedavisi gerçekten tüm PCOS hastalarında ilk seçenek olmalı mı, yoksa hasta seçimi şart mı?
- PCOS hastalarında IVF'e daha erken geçmek daha mı rasyonel?
- Modern protokollerle OHSS riski artık klinik olarak önemsiz hale geldi mi?
- PCOS hastalarında endometriyal risk klinikte yeterince ciddiye alınıyor mu?
- Sadece siklus düzenlemek yeterli mi, yoksa endometrial koruma için daha agresif yaklaşmalı mıyız?
- PCOS yönetiminde jinekologlar fertiliteye odaklanırken hastalığın sistemik doğasını ihmal mi ediyor?

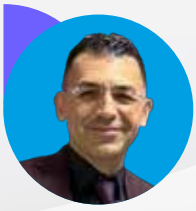
10:00-10:20 KAHVE MOLASI

10:20-10:50 Uydu Sempozyumu

HPV Enfeksiyonlarında Tedavi Mümkün mü?
Konuşmacı: Nejat Özgül

MEALIS
her yaşta sağlıklı yaşam

10:50-11:50 Panel 9: vNOTES Oturumu



KEMAL GÜNGÖRDÜK
MODERATÖR



MURAT YASSA
PANELİST



GÖKSEL KANMAZ
PANELİST



MUSTAFA MELİH ERKAN
PANELİST

- Kurulum: vNOTES herkesin yapması gereken bir teknik mi, yoksa merkez işi mi?
- Histerektomi: Benign histerektomide TLH'nin yerini alabilir mi?
- Robotik: Robotik vNOTES gerçekten hasta için mi, cerrah için mi avantajlı?
- Adneks: Adneksiyel cerrahide laparoskopiyi ne zaman bırakabiliriz?
- Ürojinekoloji: Prolapsusta vNOTES kanıtı uygulamayı değiştirecek kadar güçlü mü?
- Zor olgular: Kontrendikasyon dediğimiz şey gerçekten kontrendikasyon mu? Onkolojik Cerrahi için Uygun mu?
- Gelecek: vNOTES'i yaygınlaştırmak mı gerekir, yoksa uzman merkezlerde tutmak mı?

11:50-12:10 KAHVE MOLASI



2 EKİM 2026, CUMA / SALON A

12:10-12:40 Uydu Sempozyumu

Hormonal Kontraseptif Seçiminde Klinik Karar: Kombine Oral Kontraseptif vs. Progestin-Only Pill
Konuşmacılar: Gürkan Bozdağ, Mustafa Kaplanoğlu

Exeltis
Rethinking healthcare

12:40-13:40 Panel 10: Kontrasepsiyon


CİHAT ÜNLÜ
MODERATÖR


M.ALİ VARDAR
PANELİST


ÇETİN ÇELİK
PANELİST


YUSUF ÜSTÜN
PANELİST


IŞIL KASAPOĞLU
PANELİST

- Oral Kontrasepsiyonda Yenilikler: Gerçek yenilik molekülde mi, rejimde mi, yoksa güvenlik vaadinde mi?
- Kardiyovasküler risk ve hormonal kontrasepsiyon: Evet mi hayır mı? İlk tercih veya sadece progestin mi?
- Kontrasepsiyon ve endometriozis: En iyi kontraseptif gebeliği önleyen mi, yoksa ağrıyı kesen mı?
- İntrauterin Sistemler: Artık sadece kontraseptif değil, peki her derde deva gibi sunulması doğru mu?
- Cilt Altı Kontrasepsiyon Yöntemleri: En etkili yöntemlerden biri ama neden en çok terk edilenlerden biri gibi davranıyoruz?

13:40-14:25 ÖĞLE YEMEĞİ

14:25-14:55 Uydu Sempozyumu

Vakalarla Kontrasepsiyon Seçimi: Klinik Kararı Korku mu, Kanıtlar mı Belirliyor?
Yaz®, Yasmin®, Yasmin Plus®, Qlairista®, Kyleena®, Mirena®
Moderatör: Nejat Özgül
Konuşmacılar: Bülent Urman , Özlem Pata, Ercan Baştu

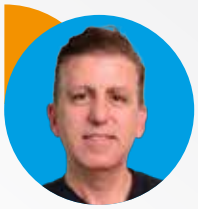
BAYER

2 EKİM 2026, CUMA / SALON A

14:55-15:55 Panel 11: Over Stimülasyonu, Tartışmalı Yaklaşımlar



L. CEM DEMİREL
MODERATÖR



YİĞİT ÇAKIROĞLU
PANELİST



SEZCAN MÜMÜŞOĞLU
PANELİST



YAVUZ EMRE ŞÜKÜR
PANELİST

- Anovulasyon: Tanı basit mi, gereğinden fazla karmaşık mı? Klinik, biyokimya ve USG arasında en rasyonel yaklaşım ne olmalı?
- PCOS'ta ovulasyon indüksiyonu: İlk basamak tedavi nasıl belirlenmeli?
- Adjuvanlar kanıta dayalı mı?, yoksa klinik alışkanlık mı?
- PRP ve 'ovarian/endometrial rejuvenation': Yenilikçi tedavi mi, umut pazarlaması mı? Etkinlik iddiaları gerçek verilerle ne kadar örtüşüyor?
- IUI öldü mü, yoksa doğru hastada hâlâ akılcı mı? Oral ajanlar, gonadotropinler ve hCG tetiklemesiyle IUI'ın güncel sınırları nerede?
- IVF'te kontrollü over stimülasyonu: Tek protokol herkese uyar mı? Hangi hastaya, ne zaman, hangi gonadotropin ve hangi protokol?
- Başarı mı güvenlik mi? Luteal faz desteği, OHSS'den kaçınma, çoğul gebeliklerin önlenmesi
- Over stimülasyonu kanser riskini artırır mı?

15:55-16:05 KAHVE MOLASI

16:05-16:35 Uydu Sempozyumu

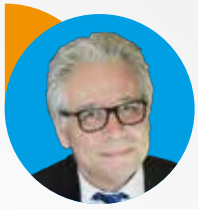
Menopozda Non-Hormonal Tedavi: VEOZA (Fezolinetant)
Moderatör: M. Murat Naki
Konuşmacı: Yaprak Üstün

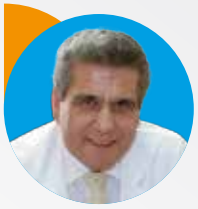
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2 EKİM 2026, CUMA / SALON A

16:35-17:35 Panel 12: Menopoz


FATİH DURMUŞOĞLU
MODERATÖR


RIFAT GÜRSOY
PANELİST


HAKAN SEYİSOĞLU
PANELİST


LEVENT ŞENTÜRK
PANELİST


CEM YILMAZ
PANELİST

- Menopoz ve menopoza bağlı durumların tanı ve yönetimi
- Vazomotor semptomlar
- Menopozun genitoüriner sendromu,
- Hormonal tedaviler
- Yeni nesil nonhormonal tedavi nasıl belirlenmeli?
- Kemik sağlığı, Postmenopozal Osteoporoz ve Tedavide Yenilikler
- Kardiyovasküler hastalık, hormona duyarlı jinekolojik ve meme kanserleri
- Cerrahi menopoz ve nörolojik, bilişsel hastalıklar gibi tıbbi komplikasyonları olan orta yaşlı ve kadınların

17:35 Canlı Cerrahi / Akdeniz Üniversitesi Tıp Fakültesi
Histeroskopi
Cihan Bademkıran

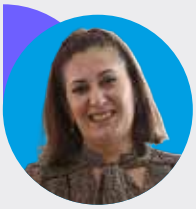
CANLI

Medtronic

2 EKİM 2026, CUMA / SALON B



ÇETİN ÇELİK
OTURUM BAŞKANI



CEVAHİR TEKCAN
OTURUM BAŞKANI

10:00-11:30 Sözlü Bildiri Oturumu - 3

SS-35 "At Most Borderline" and "At Least Borderline" in Intraoperative Frozen Section Evaluation of Ovarian Masses: Same Uncertainty, Different Probability of Malignancy? - ***Hacer Özdemir Bilginer***

SS-36 Prognostic Factors Associated With Overall and Disease-Free Survival in Ovarian Clear Cell Carcinoma ***Atacan Timuçin Kara***

SS-37 Clinicopathological Characteristics and Recurrence Outcomes of Uterine Smooth Muscle Tumors of Uncertain Malignant Potential - ***Fatma Gül Bilgin***

SS-38 Comparison of Vaginal Natural Orifice Transluminal Endoscopic Surgery and Multiport Conventional Laparoscopy for Complete Pelvic Lymphadenectomy: Insights From a Single-Surgeon Experience - ***Serkan Üstüntaş***

SS-39 Total Vaginal Natural Orifice Transendoscopic Hysterectomy Versus Single-Incision Laparoscopic Hysterectomy in Patients With A Narrow Pubic Arch - ***Serkan Üstüntaş***

SS-40 Immunohistochemical Expression Of HER2, Bcl-2, And E-Cadherin in Endometrial Lesions - ***Duygu Lafcı***

SS-41 Clinical Outcomes And Prognostic Factors in Cervical Cancer: A Single-Center Retrospective Study Running Head: Cervical Cancer Single Center Results - ***Mercan Aslan***

SS-42 Co-Detection Of Human Papillomavirus and Sexually Transmitted Pathogens: A Retrospective Laboratory-Based Study Running Head: HPV-STI Coinfections - ***Gizem Öztürk***

SS-43 Multidisciplinary En Bloc Resection and Vascular Reconstruction for Isolated Pelvic Recurrence Involving Major Pelvic Vessels: A Case Report - ***Atacem Mert Aytekin***

SS-44 Hpv-Independent, P53-Mutant Vulvar Squamous Cell Carcınoma in A 20-Year-Old Patıent: An Exceptıonal Case Report ***Rengin Coşkun***

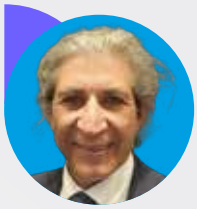
SS-45 Small Cell Carcinoma of The Ovary, Hypercalcemic Type: Treatment Sequencing, Extent Of Surgery and The Fertility Dilemma in a Patient With a Germline SMARCA4 Mutation - ***Bilal Esat Temiz***

SS-46 Vulvar Squamous Cell Carcinoma Developing on The Basis of Fanconi Anemia: Case Report - ***Belma Gözde Özdemir***

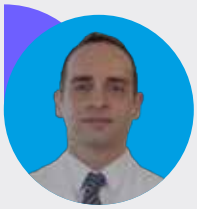
SS-47 Suspicious Lesion in The Gluteus Maximus Muscle Accompanied by Mitotically Active Leiomyoma: Should Li-Fraumeni Syndrome Be Considered? The Contribution Of MDM2 FISH Analysis to The Differential Diagnosis - ***Tuğçe Merve Akın***

SS-48 From Twenty Years of Fecal İncontinence to Continence: Secondary Obstetric Anal Sphincter And Perineal Body Reconstruction - ***Asiye Uzun***

2 EKİM 2026, CUMA / SALON B



HÜSNÜ ÇELIK
OTURUM BAŞKANI



MURAT AYKUT ÖZEK
OTURUM BAŞKANI

14:30-16:00 Video Bildiri Oturumu - 2

VS-12 Hysteroscopy-Assisted Vaginal Repair of Isthmocele: A Combined Minimally Invasive Approach - ***Maryam Manafli***

VS-13 Laparoscopic Management of Intraoperative Complications in Gynecologic Surgery: Two Surgical Cases ***Rahma Eno Hassano***

VS-14 Intraoperatively Tailored Surgery for a Positive Frozen-Section Pelvic Lymph Node in Cervical Squamous Cell Carcinoma:
Ovarian Transposition and Bilateral Salpingectomy to Prepare for Definitive Radiotherapy — A Surgical Video ***Emre Biton***

VS-15 Vnotes Surgical Staging of a Marker-Negative Adnexal Mass Revealing an Adult Granulosa Cell Tumor - ***Emre Biton***

VS-16 Vnotes Hysterectomy and Bilateral Salpingo-Oophorectomy for a Giant Uterine Leiomyoma - ***Serkan Üstüntaş***

VS-17 Vnotes Minimally Invasive Surgical Staging of Low-Grade Endometrioid Endometrial Carcinoma: Hysterectomy, Bilateral
Salpingo-Oophorectomy, and Sentinel Lymph Node Biopsy - ***Emre Biton***

VS-18 Late Nodal Recurrence in Endometrial Cancer - ***İlke Kanbir***

VS-19 Postmenopozal Kanama Nedeniyle Laparoskopik Histerektomi Planlanan Hastada Beklenmeyen Endometrioid Adenokarsinom - ***Ezgi Aygün***

VS-20 Sacrospinous Ligament Suspension Via Vnotes for The Management of POP - ***Emre Biton***

VS-21 Vnotes Lateral Suspension and High Uterosacral Ligament Suspension for Treating Pelvic Organ Prolapse ***Serkan Üstüntaş***

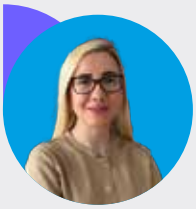
VS-22 Extraperitoneal Approach For Sacrocolpopexy in Vaginal Natural Orifice Transluminal Endoscopic Surgery ***Serkan Üstüntaş***

2 EKİM 2026, CUMA / SALON B

16:30-18:00 Sözlü Bildiri Oturumu - 4



COŞKUN SALMAN
OTURUM BAŞKANI



NEVAL YAMAN GÖRÜK
OTURUM BAŞKANI

SS-31 Association Between Second Trimester Mean Platelet Volume and Gestational Diabetes Mellitus - ***Fatma Seda Öztürk***

SS-32 Evaluation of Maternal and Neonatal Outcomes in Adolescent Pregnancies: A Single-Center Experience ***Nimet Alyörük Geçici***

SS-33 EXIT Procedure in an Infant With Right-Sided Congenital Diaphragmatic Hernia: A Case Report - ***Zilan Şahin***

SS-34 Successful Multidisciplinary Cesarean Management in a Pregnant Woman With Congenital Bladder Exstrophy Following Multiple Reconstructive Surgeries in Childhood: A Rare Case Report - ***Elif Ibrahimagaoglu Oruc***

SS-49 A Web-Based Clinical Decision Support System For RCOG-Based Antenatal And Postpartum Thromboprophylaxis: Development and Validation - ***Burcu Gedik***

SS-50 Prenatally Diagnosed Persistent Left Superior Vena Cava: How Isolated is "Isolated"? A Single-Center Analysis of Associated Anomalies, Genetic Findings and Prenatal–Postnatal Concordance - ***Mert Eyupoglu***

SS-51 Multimodal Antenatal Assessment of Renal Involvement in Late-Onset Fetal Growth Restriction - ***Bengisu Akçay Ercel***

SS-52 Impact of Parental Refusal of Invasive Prenatal Diagnosis on Multidisciplinary Perinatal Counseling and Prognostic Assessment in Fetuses With Central Nervous System Anomalies - ***A. Seval Ozgu-Erdinc***

SS-53 Fetal Growth Restriction in Pregnancies Complicated by Systemic Sclerosis: Antenatal Surveillance and Obstetric Management - ***Beyza Mutlu***

SS-54 Prenatal Characterization of Structural Chromosomal Rearrangements Using Targeted and Subtelomeric FISH: A Single-Center Case Series (N=14) - ***Esra Ince***

SS-55 Prenatal Diagnosis of Ultra-Rare CHIME Syndrome Presenting With Fetal Hydrops Confirmed By Compound Heterozygous PIGL Variants: A Case Report ***- Aylin Kurtali***

SS-56 Microwave Ablation for Twin Reversed Arterial Perfusion (TRAP) Sequence in a Monochorionic Monoamniotic Twin Pregnancy: A Case Report - ***Atilla Mutlu***

SS-57 Type IV Jejunoileal Atresia in a Fetus Followed For Ventriculomegaly and Echogenic Bowel: The Contribution of Prenatal Exome Sequencing to Delivery Planning and Perinatal Management - ***Esra İnce***

SS-58 A Comparative Analysis of Endometrioma Sclerotherapy Routes: Vaginal Vs Abdominal – Is There Any Difference? ***Öykü Yandakçı***

SS-59 Incidental Findings of Patients With Infertility and Undergone Whole Exome Sequencing - ***Ramazan Erda Pay***

SS-60 Factors Associated With Embryo Arrest in IVF/ICSI Cycles of Patients With Unexplained Infertility: A Retrospective Cohort Study - ***Omer Osman Eroglu***



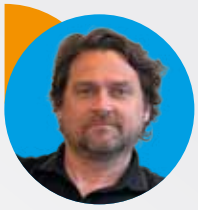
3 EKİM 2026, CUMARTESİ / SALON A

09:00-10:00 Panel 13: Endometriozis


BÜLENT URMAN
MODERATÖR


CİHAT ÜNLÜ
PANELİST


GÜRKAN UNCU
PANELİST


NASUH UTKU DOĞAN
PANELİST


ERCAN BAŞTU
PANELİST


AYLİN ALTAN KUŞ
PANELİST

- Endometriozis Tanısında Yeni Dönem: Laparoskopiden Algoritmik Non-invaziv Tanıya Geçebilir miyiz?
- TVUS mu, MRI mı, Yoksa Her Hastaya Aynı Cevap Yanlış mı? Endometriozis ve Adenomyoziste Görüntülemenin Yeni Hiyerarşisi
- Endometrioma: Ağrının Suçlusu Kist mi, Fenotip mi? Cerrahide "En İyi Atış" Ne, Ne Zaman Fazlası Zarar?
- Derin İnfiltratif Endometriozis: Barsak, Mesane ve Sinir Tutulumunda Ne Zaman "Agresif Cerrahi", Ne Zaman "Akıllı Sınır"?
- Fertilite Koruma: Endometriozisli Her Hastaya mı, Sadece Yüksek Riskli Fenotiplere mi? ,Öncelik Ağrı mı, Fertilite mi?

10:00-10:20 KAHVE MOLASI

10:20-10:50 Uydu Sempozyumu

Menopozu Yeniden Tanımlamak: Ocean Dim Ultra ile Hormonal Denge, Östrojen Metabolizması, Metabolik Sağlık ve Yaşam Kalitesi
Konuşmacı: Dilara Tekden Kırgız

ORZAX
SAĞLIĞA HEDİYE

10:50-11:50 Panel 14: Fonksiyonel Tıp


PINAR YALÇIN BAHAT
MODERATÖR


TELCE AYŞEN KÜÇÜKCERAN
PANELİST


DİLARA TEKDEN KIRGIZ
PANELİST

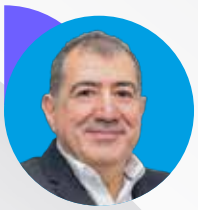

ZUHAL DİLEK ŞANLI
PANELİST

- Menarştan Menopoza Menstrual Siklus Fizyolojisine Fonksiyonel Tıp (FT) Bakışı
- Hormonal Dengesizliklerin FT Değerlendirilmesi
- Premenstrual Sendrom (PMS) ve Primer Dismenore FT Yaklaşımı
- Polikistik Over Sendromu (PKO ve PKOS Ayrımı?) Klasik yaklaşım & FT Yaklaşımı
- Gebelik ve Laktasyon Dönemi Beslenme ve FT Yaklaşım (İyot, D Vitamini Omega 3)
- Kadın İnfertilitesinin bir belirteci olarak Uterus mikrobiyomu / İnfertilitede FT yaklaşımı & Mitokondri Sağlığı Rekürren Abortuslara Yaklaşım
- Bio-Eşdeğer Hormon Replasman Tedavisi (Bio-HRT) Neden Bioeşdeğer HRT? Bio-HRT Uygulama Yolları
- Sağlıklı Uzun Yaşamın 'Longevity' Şifreleri

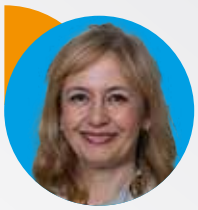
11:50-12:10 KAHVE MOLASI

3 EKİM 2026, CUMARTESİ / SALON A

12:10-13:10 Panel 15: Doğum Zamanlaması ve Tartışmalı Doğum Yöntemleri


ÖZGÜR DEREN
MODERATÖR


İNANÇ MENDİLCİOĞLU
PANELİST


DENİZ KARÇAALTINCABA
PANELİST


NİHAL ŞAHİN UYSAL
PANELİST

- Friedman'dan WHO Labour Care Guide'a: partogram öldü mü, dönüştü mü?
- İntrapartum Ultrasonografi: Gerçekten Oyun Değiştirici mi?
- Zorlu Operatif Vajinal Doğumda Ultrason: Güvenliği Artırır mı?
- Sezaryen Sonrası Vajinal Doğum (SSVD): Sınırlar Nerede Başlar, Nerede Biter?
- Tam Açık Sezaryenden Nasıl Kaçınalım, Nasıl Yönetelim?
- Term Gebelikte Doğum İndüksiyonu: Ne Zaman, Kime, Ne Kadar?
- Medikal Endikasyonlu Geç Preterm ve Erken Term Doğum + Antenatal Steroidler

13:10-14:25 ÖĞLE YEMEĞİ

14:25-15:25 Panel 16: Anormal Uterin Kanamalar


M. MURAT NAKİ
MODERATÖR


YAKUP KUMTEPE
PANELİST


SAMET TOPUZ
PANELİST


GÜNSU KİMYON CÖMERT
PANELİST

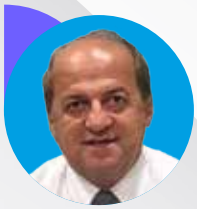

EMİNE KARABÜK
PANELİST

- Anormal Uterin Kanamada Tanım Sorunları, Anormal Uterin Kanama Sınıflandırması (PALM-COEIN)
- Aşırı Menstrüel Kanamada FIGO Sistem II'e Göre Tanı Algoritmaları
- Akut Anormal Uterin Kanamada Tedavi Nasıl Olmalı?
- Anormal Uterin Kanamada Polipler ve Myomlar – Kime Cerrahi? İntrauterin Sineşi Nasıl Engellenmeli?
- Aşırı Menstrüel Kanamada Tedavi
- Endometrial Hiperplazi (EIN), EIN Dışı Hiperplazilere Yaklaşım? Cerrahinin Yeri var mı?
- Endometrial Hiperplazi ve Fertilite Korunması, Histeroskopinin Yeri, Takip Nasıl Olmalı? Ne Sıklıkla Olmalı?

3 EKİM 2026, CUMARTESİ / SALON A

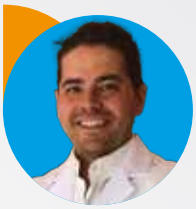
15:25-15:45 KAHVE MOLASI

15:45-16:30 Panel 17: Robotik Histerektomi


İLKKAN DÜNDER
MODERATÖR

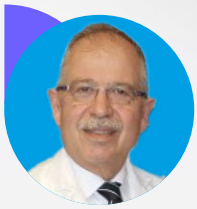

M. MURAT NAKİ
PANELİST

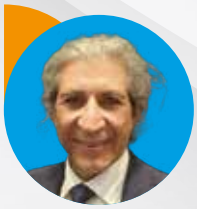

HAMDULLAH SÖZEN
PANELİST


MUSTAFA MELİH ERKAN
PANELİST

- Port yerleşimi ve cerrahi ergonomi: başarılı histerektominin temel belirleyicisi
- Uterin manipülatör ve kolpotomizer seçimi: gerekli mi, hangi durumda, hangi sistem?
- Üreter güvenliği: kritik anatomik noktalar ve disseksiyon stratejileri
- Kolpotomi ve vajinal cuff kapatılması: teknik seçimlerin komplikasyonlara etkisi
- Zor histerektomi olgularında yaklaşım: sınırlar, püf noktaları ve karar algoritmaları
- Minimal invaziv cerrahinin geleceği: telesurgery, telementoring ve dijital cerrahi
- Güncel Cerrahi Robotların Karşılaştırılması

16:30-17:30 Panel 18: Adneksiyel Kitlelere Yaklaşım


U. FIRAT ORTAÇ
MODERATÖR


HÜSNÜ ÇELİK
PANELİST


HAMDULLAH SÖZEN
PANELİST


DERMAN BAŞARAN
PANELİST


HÜSEYİN AKILLI
PANELİST

- Adneksiyel Kitlelerin İlk Değerlendirilmesi Nasıl Olmalı?
- Anamnezde ve Klinikte Neleri Fark Edebiliriz?
- İlk Seçilmesi Gereken Görüntüleme Yöntemi Hangisidir?
- Ultrasonografide En Önemli Kriterler Nelerdir?
- MRG, BT, PET – BT Gibi Görüntüleme Yöntemlerine Ne Zaman Başvuralım?
- Tümör Belirteçlerinden Hangilerini, Ne Zaman, Neyi Ayırt Etmek İçin İsteriz?
- Hangi Hastaya Minimal İnvaziv Cerrahi (Laparoskopi, Robotik Cerrahi, V-Notes), Hangisine Laparotomi?
- Endometriomalara Nasıl Yaklaşmalıyız? Jinekolog Onkoloğun Endometrioma Cerrahisindeki Rolü Nedir?
- Adölesanda ve Gebelikte Hangi Adneksiyel Kitleler Sık Görülür, Nasıl Yaklaşalım?



4 EKİM 2026, PAZAR / SALON A

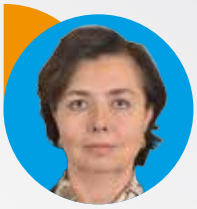
09:30-10:30 Panel 19: Fetal Büyüme Geriliği ve Pre-eklampsi



RECEP HAS
MODERATÖR



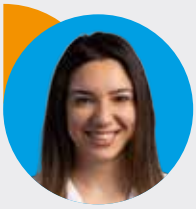
SERMET SAĞOL
PANELİST



AYŞE SEVAL ÖZGÜ ERDİNÇ
PANELİST



HAKAN ERENEL
PANELİST



IŞIL AYHAN
PANELİST

- Preeklampsi: "Tarayabiliyoruz" ama gerçekten sonucu değiştiriyor muyuz?
- Preeklampsi: Tarama yapabiliyorsak, hangi tedavi gerçekten etkili?
- Geç başlangıçlı FGR: Asıl soru tanı değil, ne zaman doğurtacağımız mı?
- "10. persentilin üstünde ama iyi büyümüyor": Yeni yüksek riskli grup bu mu?
- Tekrarlayan preeklampsi
- Preeklampsi taraması ve FGR taraması aslında aynı plasental hastalığın iki yüzü mü?

10:30-11:00 KAHVE MOLASI

11:00-12:00 Panel 20: Vaginitler ve Kadın Sağlığında Mikrobiyom



ESRA KUŞÇU
MODERATÖR



AKIN USTA
PANELİST



OĞUZHAN KURU
PANELİST



OSMAN AŞICIOĞLU
PANELİST

- Mikrobiyom: Biyobelirteç mi, Terapötik Hedef mi?
- Bağırsak Mikrobiyomu: Kadın Sağlığının 'Sessiz Endokrin Organı' mı?
- Vajinal Mikrobiyom: Fertiliteyi Belirleyen Gizli Faktör mü?
- Yaşam Boyu Mikrobiyom: Hormonlarla Sürekli Bir Diyalog
- Mikrobiyom Analizleri: Klinik Değer mi, Ticari Tuzak mı?
- Probiyotikler: Gerçek Tedavi mi, Placebo mu?
- Vajinit: Enfeksiyon mu, Ekosistem Hastalığı mı?
- Kronik ve Rekürren Vajinitler: Neden Tedavi Edemiyoruz?
- Mikrobiyom Modülasyonu: Geleceğin Tedavisi mi?

SÖZLÜ BİLDİRİLER



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SS-01

Is a single elevated prolactin result sufficient for the diagnosis of hyperprolactinemia? A retrospective analysis of laboratory data in women of reproductive age

Emine Emsal Durusoy[1], Nurullah Ay[2]
[1]Department of Obstetrics and Gynecology, Medicalpark Hospital, Mudanya University, Bursa, Türkiye
[2]Department of Biochemistry, Medicalpark Hospital, Mudanya University, Bursa, Türkiye

OBJECTIVE: Hyperprolactinemia is an important finding in the evaluation of menstrual irregularities, infertility, and galactorrhea in women of reproductive age, but a single elevated measurement may not reflect persistent hyperprolactinemia. This study evaluated whether an initially elevated prolactin result persisted on retesting, whether baseline prolactin predicted persistence, and its association with the hormonal profile.

Materials and METHODS: In this retrospective study, prolactin results from women aged 18–45 years were evaluated. The laboratory upper limit of normal (ULN) was 26.53 ng/mL. Women with an initial prolactin >26.53 ng/mL and at least one subsequent measurement were included and categorized by baseline level as 1–1.5×, 1.5–2×, 2–3×, and >3×ULN. The primary outcome was normalization (≤26.53 ng/mL) at the second measurement. Paired measurements were compared using the Wilcoxon signed-rank test, and receiver operating characteristic (ROC) analysis assessed the ability of baseline prolactin to predict persistent elevation. Associations of age and the prolactin-to-ULN ratio with persistence were examined using exploratory logistic regression. The nearest follicle-stimulating hormone (FSH), luteinizing hormone (LH), and estradiol results within ±7 days, and thyroid-stimulating hormone (TSH) within ±30 days, were matched to the index measurement. A sensitivity analysis was performed among patients retested within 7–90 days.

RESULTS: Among 2,741 women aged 18–45 years, 103 with an initially elevated prolactin result and a subsequent measurement were included. Median prolactin decreased from 36.92 (interquartile range [IQR], 30.64–55.42) ng/mL at baseline to 25.29 (IQR, 15.43–38.80) ng/mL at retesting (p<0.001), normalizing in 56 patients (54.4%) and remaining elevated in 47 (45.6%). Normalization rates were 64.9%, 47,6%, 41,2%, and 25.0% in the 1–1.5×, 1.5–2×, 2–3×, and >3×ULN groups (p=0.075). Baseline prolactin showed limited discrimination for persistent elevation (area under the curve [AUC]=0.616); the optimal threshold was 40.38 ng/mL (57.4% sensitivity, 69.6% specificity). Each one-unit increase in the prolactin-to-ULN ratio was associated with persistence (odds ratio [OR]=1.56; 95% confidence interval [CI], 1.03–2.37; p=0.036), as was age (OR=1.08/year; 95% CI, 1.02–1.15; p=0.008). FSH, LH, estradiol, TSH, and the LH/FSH ratio did not differ between groups (all p>0.05). Among 45 patients retested within 7–90 days, prolactin normalized in 23 (51.1%); AUC was 0.502.

CONCLUSION: More than half of initially elevated prolactin results normalized on repeat testing, suggesting that a single result may be insufficient to establish persistent hyperprolactinemia in women of reproductive age. The numerically higher normalization rate with mild elevations supports confirmatory retesting before further investigation. The limited discrimination of baseline prolactin, with AUC approaching chance level in the 7–90-day analysis, indicates that a definitive decision threshold from a single value may not be appropriate.

Keywords: prolactin, hyperprolactinemia, repeat measurement, reproductive age, real-world data, clinical biochemistry

SS-02

Surgical and clinical outcomes following colorectal surgery for bowel endometriosis: a single centre experience

Ewa Rabiej Wrońska[1], Ezgi Darıcı Kurt[2], Gernot Hudelist[3], Pawel Basta[1]

[1]Department of Gynecology and Gynecologic Oncology, University Hospital in Cracow, Jakubowskiego 2 St., 30-688 Cracow, Poland

[2]Department of Obstetrics and Gynecology, Center for Endometriosis, Semmelweis University, Budapest, Hungary

[3]Department of Gynecology, Center for Endometriosis, Hospital St. John of God, Vienna, Austria

OBJECTIVE: Deep endometriosis (DE), particularly when involving the rectum and sigmoid colon, frequently necessitates surgical intervention. This study aimed to compare conservative surgical approaches (shaving and full-thickness discoid resection) with radical surgery (segmental resection) in terms of postoperative complications and efficacy in reducing pain.

METHODS: This retrospective, single-centre study included 91 consecutive patients who underwent surgery for colorectal DE between November 2020 and October 2024. Patients underwent either conservative surgery (shaving or full-thickness discoid resection) or radical surgery (segmental resection). Postoperative complications were classified according to the Clavien–Dindo classification. Pain symptoms were assessed preoperatively and at the 6-month follow-up using the visual analogue scale (VAS).

RESULTS: Of the 91 patients, 40 (44%) underwent conservative surgery and 51 (56%) underwent radical surgery. Radical surgery was associated with a significantly longer operative time [295 min, 95% confidence interval (CI): 267–322 vs. 201 min, 95% CI: 184–217; $p<0.0001$] and a longer hospital stay (13 ± 11.1 vs. 7.6 ± 5.9 days; $p=0.0043$). Bowel leakage occurred in 4/40 (10%) patients following conservative surgery and 6/51 (11.8%) patients following radical surgery ($p=0.405$). One rectovaginal fistula occurred in the radical surgery group (1/51, 1.9%), whereas none occurred in the conservative surgery group. Clavien–Dindo grade III complications occurred in 6/40 (15%) patients in the conservative surgery group and 13/51 (25.5%) patients in the radical surgery group ($p=0.34$). No grade IV complications were observed. Both surgical approaches resulted in significant reductions in dysmenorrhea, non-cyclic pelvic pain, dyspareunia, and dyschezia scores ($p<0.001$).

CONCLUSION: Conservative and radical surgical approaches demonstrated comparable postoperative complication rates and were both effective in reducing pain associated with colorectal DE. However, radical surgery was associated with significantly longer operative times and hospital stays. Based on these findings, neither surgical approach demonstrated clear overall superiority.

Keywords: Bowel Endometriosis, Conservative Surgery, Deep Endometriosis

SS-03

Fumarate hydratase-deficient uterine leiomyomas as a marker of hereditary leiomyomatosis and renal cell carcinoma syndrome: a pathology-based screening cohort

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[1]Department of Obstetrics and Gynecology, Batman Training and Research Hospital, Batman, Türkiye
[2]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Hacettepe University, Ankara, Türkiye
[3]Department of Medical Pathology, Hacettepe University, Ankara, Türkiye
[4]Department of Obstetrics and Gynecology, Hacettepe University, Ankara, Türkiye

OBJECTIVE: To determine the prevalence of fumarate hydratase (FH)-deficient uterine leiomyomas among surgically treated patients, to characterize their clinicopathological features, and to assess the yield of morphology-based screening for identifying patients who may require evaluation for hereditary leiomyomatosis and renal cell carcinoma (HLRCC) syndrome.

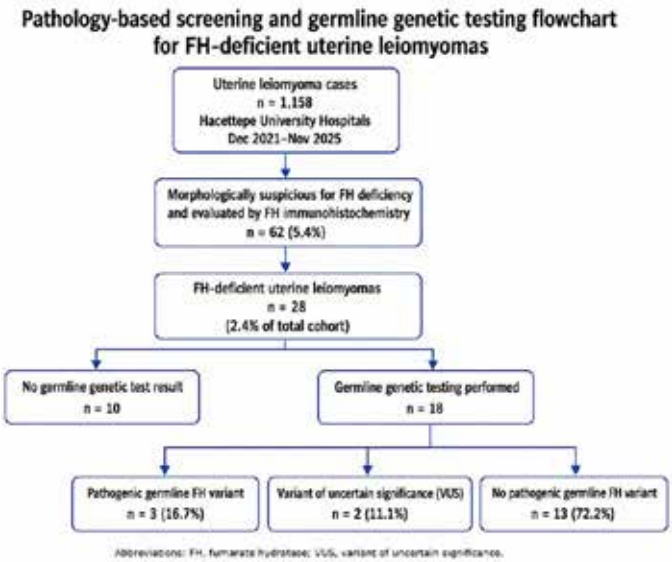
METHODS: This single-center retrospective cohort study was conducted at Hacettepe University Hospitals, a tertiary referral center in Ankara, Türkiye. Pathology records of 1,158 patients diagnosed with uterine leiomyoma between December 2021 and November 2025 were reviewed. During routine histopathological assessment, cases showing one or more morphologic features associated with FH deficiency, including alveolar edema, chain-like nuclear arrangement, eosinophilic cytoplasmic inclusions, staghorn vessels, and prominent eosinophilic nucleoli with perinucleolar halos, underwent FH immunohistochemistry. Complete loss of FH expression in tumor cells in the presence of a positive internal control was considered FH deficiency. Clinical and demographic data were obtained from electronic medical records. Germline FH testing was performed using next-generation sequencing in patients who underwent genetic evaluation.

RESULTS: Of 1,158 uterine leiomyoma cases, 62 (5.4%) were selected for FH immunohistochemistry based on suspicious morphology. Complete FH loss was identified in 28 of these 62 cases (45.2%), corresponding to an overall prevalence of 2.4% (28/1,158). Complete clinical data were available for 19 patients; the median age was 34 years (range, 25–44), and 13 of 19 patients had multiple leiomyomas. Fifteen patients underwent myomectomy and four underwent hysterectomy. Germline genetic test results were available for 18 patients: pathogenic FH variants were identified in 3 (16.7%), variants of uncertain significance in 2 (11.1%), and no pathogenic germline FH variant in 13 (72.2%). All patients with pathogenic germline FH variants had a positive family history of leiomyomas. A renal mass was detected in one patient with a pathogenic germline FH variant.

CONCLUSION: Morphology-based selection followed by FH immunohistochemistry provides a high-yield strategy for identifying FH-deficient uterine leiomyomas. Because a clinically relevant proportion of patients with FH-deficient tumors harbor pathogenic germline FH variants, recognition of this tumor subtype should prompt genetic counseling and appropriate renal and clinical surveillance for HLRCC syndrome.

Keywords: Fumarate hydratase deficiency, HLRCC syndrome, Uterine leiomyoma

Pathology-based screening and germline genetic testing flowchart for FH-deficient uterine leiomyomas



SS-04

Comparison of conventional multiport laparoscopy, single-port laparoscopy, and vNOTES for the management of large adnexal masses (≥ 10 cm): a retrospective cohort study

Kemal Güngördük, Emre Biton, Berican Uyar
Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, Faculty of Medicine, Muğla Sıtkı Koçman University, Muğla, Turkey.

OBJECTIVE: We compared the surgical outcomes and quality of recovery of conventional multiport laparoscopy (CML), Single-port laparoscopy (SPL), and vaginal natural orifice transluminal endoscopic surgery (vNOTES) for managing large adnexal masses.

METHODS: This multicenter, retrospective cohort study included 87 patients who underwent salpingo-oophorectomy for benign adnexal masses ≥ 10 cm between January 2020 and December 2025 (CML: n = 38, SPL: n = 26, vNOTES: n = 23). The evaluated parameters included surgical timing (port setup, total operation, and specimen removal times), early postoperative pain using the Visual Analog Scale (VAS) and Faces Pain Scale Revised (FPS-R), and overall quality of recovery using the QoR-40 questionnaire at 24 h postoperatively. The secondary outcomes included cosmetic scar satisfaction and sexual function.

RESULTS: CML demonstrated the shortest port setup time (2.5 ± 0.5 min) and total operation time (61.0 ± 14.7 min) among the groups. In contrast, vNOTES and SPL provided significantly faster specimen removal times than CML (6.1 ± 1.8 min and 6.6 ± 1.3 min vs. 9.3 ± 2.2 min, respectively; $P < 0.001$). The vNOTES group reported significantly lower VAS and FPS-R scores across all early postoperative time points (6, 12, and 24 h) and achieved the highest overall QoR-40 score (153.5 ± 9.7, $P = 0.004$). Multivariate logistic regression identified the vNOTES approach as the only independent predictor of excellent recovery (QoR-40 ≥ 150) (odds ratio [OR]: 1.8, 95% confidence interval [CI]: 1.1-3.1, $P = 0.012$). No significant differences were observed in terms of estimated blood loss, intraoperative complications, or long-term sexual function among the three groups.

CONCLUSION: CML, SPL, and vNOTES are safe and effective minimally invasive approaches for large adnexal masses. While CML is the fastest overall, vNOTES appeared to offer benefits including efficient specimen extraction, reduced postoperative pain, and enhanced quality of recovery. Given the retrospective design, the modest sample size, and the patient-preference-based allocation, these findings should be considered hypothesis-generating and confirmed in adequately powered prospective studies.

Keywords: Adnexal mass, Laparoscopy, Minimally invasive surgery, Quality of recovery, vNOTES.

SS-05

Who benefits most from antibiotic prophylaxis after operative vaginal delivery? A focused systematic review of postpartum infection and wound complications

İpek Güneş Topuz, Eda Güner Özen, Ahkam Göksel Kanmaz, Yaşam Kemal Akpak
OBSTETRICS AND GYNECOLOGY DEPARTMENT, IZMIR, TURKEY

PURPOSE: Antibiotic prophylaxis after operative vaginal delivery (OVD) reduces postpartum infectious morbidity, but infection risk varies according to maternal and delivery-related characteristics. This focused systematic review aimed to evaluate evidence published since 2015 on postpartum infection and wound complications after forceps- or vacuum-assisted birth, with particular emphasis on identifying women at increased baseline risk and determining whether clinical risk factors modify the benefit of antibiotic prophylaxis.

METHODS: PubMed was searched for English-language studies published from January 2015 to September 4, 2026 evaluating antibiotic prophylaxis, postpartum infection, perineal wound infection or breakdown, and related risk factors following OVD. Randomized controlled trials and prospective or retrospective cohort studies reporting relevant maternal infectious or wound outcomes were eligible. Reviews, guidelines, case reports, studies limited to neonatal outcomes, and studies reporting obstetric trauma without infectious or wound outcomes were excluded. Multiple publications derived from the same trial population were considered a single study population, while secondary analyses were retained when they provided additional risk-stratification data. Owing to clinical and methodological heterogeneity, findings were synthesized narratively.

RESULTS: Six eligible publications representing five independent study populations were included. The strongest evidence for prophylaxis was provided by the ANODE randomized trial, in which a single intravenous dose of amoxicillin–clavulanic acid reduced confirmed or suspected maternal infection from 19% to 11% compared with placebo (risk ratio [RR] 0.58, 95% confidence interval [CI] 0.49–0.69). Secondary analysis identified episiotomy (adjusted RR [aRR] 2.94, 95% CI 1.62–5.31), forceps compared with vacuum delivery (aRR 1.37, 95% CI 1.12–1.69), and primiparity (aRR 1.34, 95% CI 1.05–1.70) as independent predictors of infection, whereas antibiotic prophylaxis remained protective (aRR 0.60, 95% CI 0.51–0.72). Each 15-minute delay in antibiotic administration was associated with a 3% increase in infection risk (aRR 1.03, 95% CI 1.01–1.06). The protective effect did not significantly differ according to perineal-trauma subgroup (interaction P=.17). Observational studies demonstrated substantial wound morbidity among women with obstetric anal sphincter injury (OASI). In a recent OASI cohort, 22.3% developed wound complications, including 9.3% with infection and 18.7% with wound breakdown; peripartum antibiotics were associated with reduced odds of wound complications (adjusted odds ratio 0.57, 95% CI 0.33–0.97). Conversely, a large US cohort found no independent association between OVD and composite postpartum infectious morbidity after adjustment (adjusted odds ratio 1.4, 95% CI 0.8–2.4).

CONCLUSION: Postpartum infectious risk after OVD is heterogeneous, with episiotomy, forceps delivery, primiparity, severe perineal trauma, and delayed antibiotic administration identifying women at increased risk. However, current evidence does not demonstrate that the protective effect of antibiotic prophylaxis is restricted to these higher-risk subgroups. Available evidence therefore supports timely universal prophylaxis after OVD rather than selective risk-based administration, while women with extensive perineal trauma may warrant enhanced postpartum surveillance.

Keywords: Operative vaginal delivery, Antibiotic prophylaxis, Postpartum infection, Perineal trauma, Wound complications

Table 1. Summary of included evidence on postpartum infection and wound complications after operative vaginal delivery

Study	Design / population	N	Main exposure	Relevant outcome	Key finding
Lewicky-Gaupp et al., 2018	Prospective cohort; women with OASI	268	OVD; intrapartum antibiotics	Wound infection / breakdown	Infection 19.8%, breakdown 24.6%; OVD associated with wound complications (aOR 2.54, 95% CI 1.32–4.87); intrapartum antibiotics protective (aOR 0.50, 95% CI 0.27–0.94)
Wilkie et al., 2018	Retrospective cohort; OVD	529	Forceps vs vacuum; episiotomy	Perineal wound breakdown	Breakdown 2.7%; higher after forceps than vacuum (5.5% vs 1.4%) and with episiotomy (5.2% vs 1.2%)
Knight et al. (ANODE), 2019	Multicentre randomized placebo-controlled trial; OVD ≥36 weeks	3,420*	IV amoxicillin–clavulanic acid vs placebo	Confirmed/suspected maternal infection	Infection 11% vs 19%; RR 0.58 (95% CI 0.49–0.69), supporting single-dose prophylaxis
Dunk et al., 2022	Retrospective cohort; singleton vaginal births ≥34 weeks	34,647; 732 OVD	OVD vs spontaneous vaginal delivery	Composite postpartum infectious morbidity	OVD was not independently associated with infection after adjustment (aOR 1.4, 95% CI 0.8–2.4) in a low-episiotomy population
Humphreys et al., 2025†	Secondary analysis of ANODE RCT	3,225	Antibiotic prophylaxis; episiotomy; forceps/vacuum; timing	Confirmed/suspected infection ≤6 weeks	Episiotomy aRR 2.94; forceps aRR 1.37; primiparity aRR 1.34; antibiotics aRR 0.60. Each 15-min delay: aRR 1.03
Meekes et al., 2025	Retrospective cohort; women with OASI	332	Peripartum antibiotics and obstetric characteristics	Wound infection / breakdown	22.3% wound complication; infection 9.3%, breakdown 18.7%; antibiotics protective (aOR 0.57, 95% CI 0.33–0.97)

*ANODE secondary publications report slightly different analytic populations depending on outcome availability; the secondary analysis included 3,225 women with primary outcome data.
†Not counted as an independent population from Knight et al.; retained because it provides the central risk-stratification analysis needed for the review question.

**ANODE secondary publications report slightly different analytic populations depending on outcome availability; the secondary analysis included 3,225 women with primary outcome data. †Not counted as an independent population from Knight et al.; retained because it provides the central risk-stratification analysis needed for the review question.*

SS-06

Vaginal Natural Orifice Transluminal Endoscopic Surgery versus Conventional Multiport Laparoscopy for Hemorrhagic Ovarian Cyst Rupture with Hemoperitoneum: A Multicenter Retrospective Cohort Study

Emre Biton[1], Kemal Gungorduk[2], Berican Şahin uyar[1], Serkan Ustuntas[1], Furkan Karaöz[1], Varol Gülseren[3]
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OBJECTIVE: To compare perioperative outcomes, postoperative pain, early recovery, and patient-reported sexual and cosmetic outcomes between vaginal natural orifice transluminal endoscopic surgery (vNOTES) and conventional multiport laparoscopy (CML) in hemodynamically stable women undergoing surgery for hemorrhagic ovarian cyst rupture with hemoperitoneum.

METHODS: Design: Multicenter retrospective cohort study (Canadian Task Force classification II-2).

Setting: Departments of Obstetrics and Gynecology of two tertiary referral centers, January 2020 to December 2025.

Participants: Forty-two non-pregnant women aged ≥18 years with imaging-confirmed hemoperitoneum from a ruptured ovarian cyst and clinical evidence of ongoing bleeding undergoing minimally invasive surgery.

Interventions: vNOTES via posterior colpotomy with a multichannel single-port device (n = 13) versus CML with a 10-mm umbilical and two or three 5-mm ancillary trocars (n = 29). Both arms used a standardized Enhanced Recovery After Surgery protocol.

RESULTS: Primary outcomes were operative time, estimated blood loss, visual analog scale (VAS) pain at 6, 12, and 24 hours, length of stay, and Quality of Recovery-15 score at discharge. Secondary outcomes included complications (Clavien-Dindo), conversion, transfusion, additional analgesia, and Female Sexual Function Index (FSFI) and Female Genital Self-Image Scale (FGSIS) scores at 6 months. Baseline characteristics were comparable between groups. Operative time (44.6 ± 17.1 vs 49.1 ± 16.5 min; p =.20), blood loss (124.0 ± 116.3 vs 132.8 ± 127.1 mL; p =.72), transfusion (7.7% vs 6.9%; p =.92), and intraoperative complications (7.7% vs 6.8%; p =.93) did not differ, and no conversion to laparotomy occurred. VAS pain at 12 hours was lower after vNOTES (1.9 ± 0.7 vs 3.2 ± 1.1; p =.002). FGSIS favored vNOTES (24.28 ± 1.80 vs 22.31 ± 3.47; p =.009), whereas FSFI total and domain scores, including lubrication, were comparable between groups.

CONCLUSION: In hemodynamically stable women with hemorrhagic ovarian cyst rupture, vNOTES is feasible and safe, with hemostatic efficacy comparable to CML and advantages in 12-hour pain and genital self-image. Prospective studies are warranted to confirm these findings.

Keywords: Laparoscopy, vNOTES, Quality of recovery, Minimally invasive surgery, Sexual function

SS-07

Evaluation of the Relationship Between Isthmocele Dimensions and Inflammatory, Hematological, and Coagulation Markers in Symptomatic Patients

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OBJECTIVE: To evaluate the relationship between isthmocele dimensions and inflammatory indices, hematological parameters, and coagulation markers in patients with symptomatic isthmocele.

MATERIALS-METHODS: This cross-sectional controlled study included 40 patients with transvaginal ultrasonography-confirmed symptomatic isthmocele and 40 controls with a history of cesarean delivery but no evidence of isthmocele. Isthmocele measurements were performed between days 6 and 12 of the menstrual cycle. Niche depth, length, width, and residual myometrial thickness (RMT) were recorded. Niche area was calculated using the formula base × height/2, and isthmoceles were graded according to the Gubbini classification. The neutrophil-to-lymphocyte ratio (NLR), monocyte-to-lymphocyte ratio (MLR), platelet-to-lymphocyte ratio (PLR), and systemic immune-inflammation index (SII) were calculated from complete blood count parameters. Prothrombin time (PT), activated partial thromboplastin time (aPTT), international normalized ratio (INR), and fibrinogen levels were also recorded. The groups were compared using the Mann–Whitney U test and Fisher's exact test. Within the isthmocele group, associations between niche dimensions and laboratory markers were evaluated using Spearman's correlation analysis.

RESULTS: The duration of postmenstrual spotting (median, 4.5 vs. 1.0 days; $p<0.001$) and pelvic pain scores (median, 5.0 vs. 2.0; $p<0.001$) were significantly higher in the isthmocele group. Systemic inflammatory markers were not elevated in patients with isthmocele; instead, neutrophil counts ($p=0.004$), leukocyte counts ($p=0.025$), NLR ($p=0.027$), and SII ($p=0.042$) were significantly lower. No between-group differences were observed in MLR, PLR, platelet count, hemoglobin level, or any coagulation parameter. Within the isthmocele group, niche area and depth showed moderate positive correlations with the duration of postmenstrual spotting ($r=0.512$, $p=0.001$ and $r=0.528$, $p<0.001$, respectively). However, no consistent associations were identified between niche dimensions and any inflammatory index or coagulation parameter. A strong negative correlation was observed between spotting duration and hemoglobin level ($r=-0.586$, $p<0.001$).

CONCLUSION: Isthmocele size is not associated with systemic inflammatory responses or coagulation parameters. The measurable clinical impact of niche size appears to be primarily reflected in the duration of bleeding, whereas hematological changes are more likely attributable to the cumulative bleeding burden than to niche size itself. These findings support the hypothesis that local tissue healing, rather than systemic inflammation, plays a predominant role in the pathogenesis of isthmocele.

Keywords: Isthmocele, cesarean scar defect, systemic immune-inflammation index, abnormal uterine bleeding, residual myometrial thickness.

SS-08

Sociodemographic, Clinical, and Pain Profile of Women with Endometriosis: A Single-Center Cohort

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AIM: To characterize the sociodemographic, clinical, and pain profile of women with endometriosis at enrollment into a prospective cohort study.

METHODS: Seventy-one women with endometriosis were enrolled at a single center. Sociodemographic, anthropometric, lifestyle, obstetric–gynecological, and surgical–medical data were collected using a structured questionnaire. Dysmenorrhea, dyspareunia, dyschezia, and dysuria were rated on a 0–10 visual analog scale (VAS); dyspareunia was assessed in sexually active women (n=67). Data were analyzed descriptively.

RESULTS: Mean age was 34.8 ± 8.2 years (range 19–54); 60.6% were married, 50.7% had university-level or higher education, and 42.3% were housewives. Mean BMI was 24.5 ± 4.8 kg/m², 43.7% were overweight or obese, and 35.2% were current smokers. Half (50.7%) were nulliparous, 29.6% reported irregular menstrual cycles, and 15.5% had undergone previous endometriosis surgery; 78.9% had no chronic comorbidity. At baseline, 60.6% were receiving no endometriosis-specific medication, whereas 25.3% used dienogest and 11.3% combined oral contraceptives; 21.4% required daily analgesics. Dysmenorrhea was the predominant symptom (VAS 5.2 ± 3.6; median 5.0, IQR 2.0–9.0), followed by dyspareunia (2.8 ± 3.2), dyschezia (1.8 ± 2.7), and dysuria (1.3 ± 2.2); median dyschezia and dysuria scores were zero.

CONCLUSION: This cohort comprised predominantly reproductive-aged, well-educated, nulliparous women in whom moderate dysmenorrhea was the leading complaint, whereas bowel and urinary pain symptoms were infrequent. Notably, most women were not receiving hormonal therapy despite an appreciable pain burden, suggesting a potential gap in medical management and providing a baseline for evaluating subsequent treatment outcomes.

Keywords: Endometriosis, Dysmenorrhea, Dyspareunia, Pelvic Pain, Pain Measurement

SS-09

Maternal obesity and thromboembolic risk in obstetric patients: A propensity score–matched analysis of perioperative outcomes and clinical management

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BACKGROUND: Maternal obesity is increasingly prevalent and has been associated with thromboembolic events (TE), preeclampsia, and adverse perioperative outcomes. However, the independent contribution of obesity to thromboembolic risk in contemporary obstetric populations remains uncertain, particularly in the context of evolving thromboprophylaxis strategies.

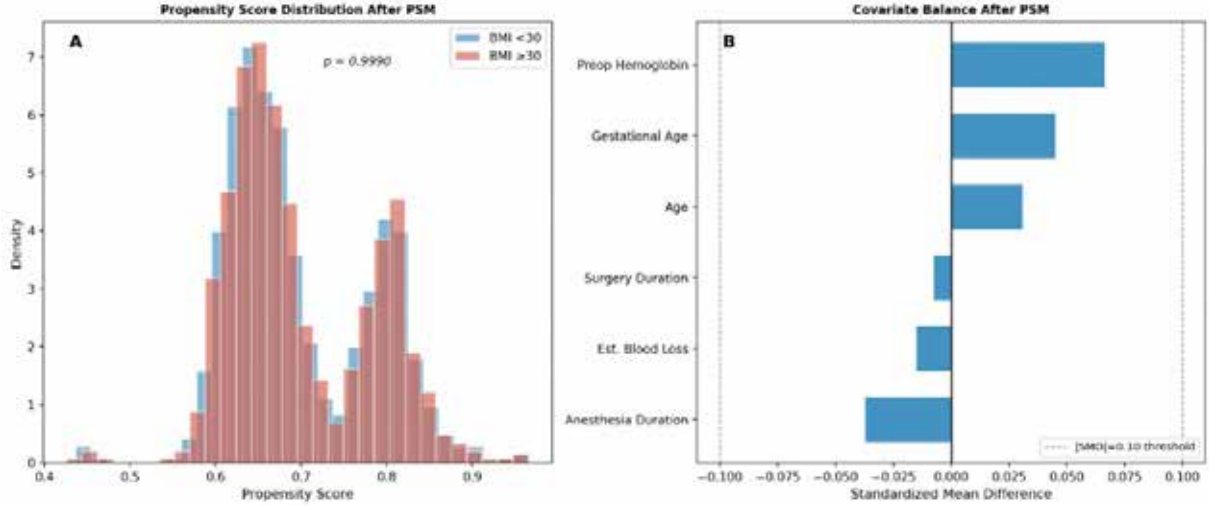
METHODS: We conducted a retrospective propensity score–matched cohort study including 1,644 obstetric patients (822 obese [BMI ≥30 kg/m²] and 822 non-obese [BMI <30 kg/m²]) undergoing anesthesia-supported procedures. The primary outcome was the occurrence of thromboembolic events. Secondary outcomes included preeclampsia, perioperative clinical parameters, laboratory variables, and pharmacologic management. Statistical comparisons were performed using nonparametric and categorical tests, with $p<0.05$ considered significant.

RESULTS: Thromboembolic events occurred in 1.5% of non-obese patients and 2.1% of obese patients, with no statistically significant difference between groups (OR=1.43; p=0.454). Preeclampsia rates were identical between groups (11.2% vs. 11.2%; p=1.000). However, several secondary outcomes differed significantly. Obese patients had higher preoperative platelet counts (p=0.0002), longer surgical duration (p<0.001), and greater use of LMWH/heparin (p=0.007), while emergency procedures (p<0.001) and tranexamic acid use (p=0.003) were less frequent. Predictive modeling identified gestational age and estimated blood loss as dominant contributors to TE risk, whereas BMI demonstrated limited independent importance.

CONCLUSIONS: In this propensity score–matched cohort, maternal obesity was not independently associated with thromboembolic events. However, the observed non-significant trend toward increased risk suggests that a modest underlying association cannot be excluded, particularly in the context of low event rates. Obesity was associated with significant differences in perioperative management, indicating that its clinical impact extends beyond isolated outcomes. These findings suggest that contemporary risk based management strategies, including thromboprophylaxis, may attenuate obesity related thromboembolic risk. Larger studies are needed to clarify the independent and interactive effects of obesity within multifactorial risk frameworks.

Keywords: Obesity,Thromboembolism,Pregnancy,Propensity score matching

Figure 1. Propensity Score Balance Diagnostics.



(A) Density histogram of propensity score distribution by BMI group after 1:1 nearest-neighbor PSM, confirming overlap and balance (Mann-Whitney U p=0.999). (B) Love plot of standardized mean differences (SMD) for key covariates after PSM. The dashed reference lines at |SMD|=0.10 indicate the conventional balance threshold. All covariates met this criterion.

Table 4. Machine Learning Model Performance for Outcome Prediction

Model	Outcome	Train AUC	Bootstrap AUC (mean)	Top Predictors
Logistic Regression (L2)	TE Events	0.730	0.630 (95%CI: 0.53–0.73)	LMWH Use, Gestational Age, Emergency
Random Forest (500 trees)	TE Events	1.000	1.000*	Gestational Age, EBL, Surgery Duration
Gradient Boosting (100 est.)	TE Events	0.984	0.984*	Gestational Age, EBL, Anesthesia Duration
Random Forest (500 trees)	Preeclampsia	0.922	0.567	BMI ≥30, Age, Surgery Duration

*TE=thromboembolic event; AUC=area under ROC curve; EBL=estimated blood loss; LMWH=low-molecular-weight heparin/heparin. *Overfitting suspected due to rare events (n=29) relative to feature dimensionality. Bootstrap confidence intervals derived from 1,000 stratified resampling iterations.*

SS-10

Extraperitoneal versus transperitoneal approach in vNOTES sacrocolpopexy: a comparative pilot study

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BACKGROUND: This pilot study aimed to assess the feasibility, perioperative safety, and short-term outcomes of extraperitoneal versus transperitoneal vNOTES sacrocolpopexy.

METHODS: Thirty-six patients with POP-Q stage III or higher who underwent simultaneous vNOTES hysterectomy, BSO, and sacrocolpopexy were retrospectively analyzed and categorized into extraperitoneal (Group A, n=14) and transperitoneal (Group B, n=22) groups. Anatomical success, quality of life, and recovery were evaluated using POP-Q, P-QOL, ICIQ-UI SF, QoR-15, and MESH-R scales.

RESULTS: Baseline characteristics were comparable between groups. Six-month anatomical success rates were similar (extraperitoneal 90.8% vs. transperitoneal 91.6%). The most notable procedural difference was Trendelenburg positioning: Group A was maintained at 10°-15° throughout, whereas Group B required 25°-30° during the sacrocolpopexy phase. Numerical trends favoring the extraperitoneal approach were observed in operative time (99.6 vs. 110.4 min; p=0.185) and time to first stool (27.7 vs. 34.5 h; p=0.552), but neither reached statistical significance. No rectal injuries or intraabdominal abscesses occurred in either group.

CONCLUSIONS: Extraperitoneal vNOTES sacrocolpopexy is feasible and safe, yielding anatomical outcomes equivalent to the transperitoneal approach at six months. Its most substantiated advantage is the reduced Trendelenburg angle, which may lower physiological burden in high-BMI patients. Remaining potential benefits require confirmation through larger prospective trials.

Keywords: Extraperitoneal, pelvic organ prolapse, sacrocolpopexy, transperitoneal, vNOTES.

SS-11

Comparison of Perioperative and Early Postoperative Outcomes of vNOTES and Laparoscopic Hysterectomy

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OBJECTIVE: The aim of this study was to compare the perioperative and early postoperative outcomes of vaginal natural orifice transluminal endoscopic surgery (vNOTES) and laparoscopic hysterectomy in patients undergoing hysterectomy for benign gynecological indications.

MATERIALS-METHODS: In this retrospective study, data from a total of 94 patients treated at the Department of Obstetrics and Gynecology, Aksaray Training and Research Hospital, including 31 patients who underwent vNOTES hysterectomy and 63 who underwent laparoscopic hysterectomy, were evaluated. Demographic and obstetric characteristics, history of previous abdominal surgery and cesarean section, POP-Q stage, operative time, postoperative length of hospital stay, preoperative and postoperative hemoglobin and hematocrit values, and postoperative complications were recorded. The distribution of continuous variables was assessed using the Shapiro-Wilk test. The Mann-Whitney U test was used for between-group comparisons of non-normally distributed variables, and appropriate categorical tests were used for categorical variables. A p value <0.05 was considered statistically significant.

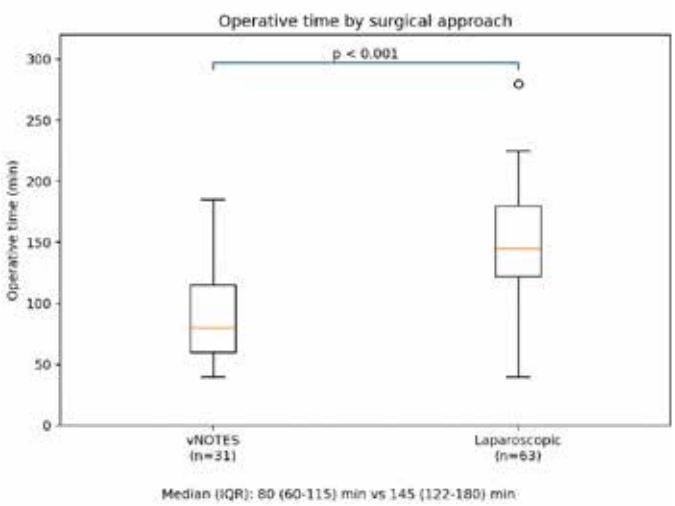
RESULTS: A total of 94 patients were included: 31 in the vNOTES group and 63 in the laparoscopic hysterectomy group. There were no statistically significant differences between the groups in age, body mass index, gravidity, parity, previous abdominal surgery, or history of cesarean section (all p>0.05). The distribution of POP-Q stages was also similar between the groups (p=0.298). Operative time was 80 (60-115) minutes in the vNOTES group and 145 (122-180) minutes in the laparoscopic group and was significantly shorter in the vNOTES group (p<0.001). Postoperative length of hospital stay was 24 (24-30) hours in the vNOTES group and 48 (48-48) hours in the laparoscopic group, with a statistically significant difference (p<0.001). The decrease in hemoglobin was 1.5 (1.0-2.2) g/dL and 1.4 (0.2-2.2) g/dL in the vNOTES and laparoscopic groups, respectively, with no significant between-group difference (p=0.370). There was also no significant difference in hematocrit decrease [5.0 (3.4-6.7) vs 4.0 (0.8-7.0), respectively; p=0.245]. No postoperative complications were observed in either group.

CONCLUSION: In this study, compared with laparoscopic hysterectomy, vNOTES hysterectomy was associated with shorter operative time and hospital stay without an increased decrease in hemoglobin or hematocrit or early postoperative complications. These findings suggest that, in appropriately

selected patients, vNOTES may be an effective minimally invasive alternative for benign gynecological surgery.

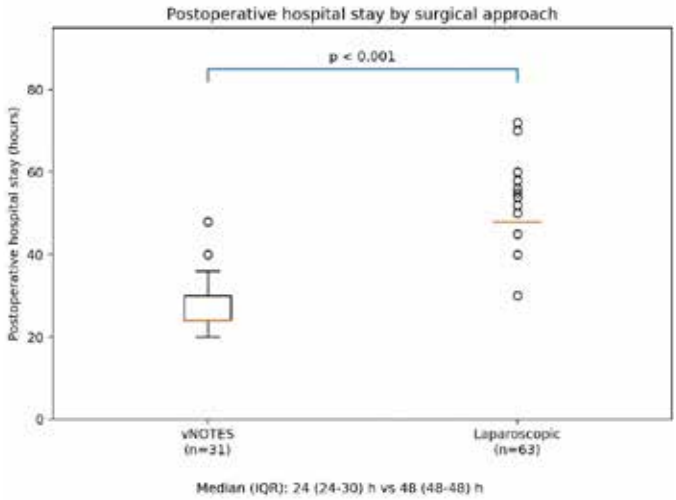
Keywords: vNOTES, laparoscopic hysterectomy, hysterectomy, minimally invasive surgery, operative time

Figure 1



Operative time according to surgical approach.

Figure 2



Postoperative length of hospital stay according to surgical approach.

Table 1

Variable	vNOTES (n=31)	Laparoscopic (n=63)	p
Age (years), mean ± SD	51.1 ± 6.6	49.6 ± 7.4	0.348
BMI (kg/m2), mean ± SD	29.7 ± 4.3	29.0 ± 4.9	0.445
Gravidity, median (IQR)	3.0 (3.0-4.5)	3.0 (3.0-4.0)	0.668
Parity, median (IQR)	3.0 (2.5-3.5)	3.0 (2.0-3.0)	0.352
Previous abdominal surgery, n(%)	5 (16.1)	15 (23.8)	0.437
Previous cesarean section, n (%)	7 (22.6)	9 (14.3)	0.384
POP-Q stage, n(%)	Stage 0: 24 (77.4); Stage 1: 4 (12.9); Stage 2: 2 (6.5); Stage 3: 0; Stage 4: 1 (3.2)	Stage 0: 36 (57.1); Stage 1: 15 (23.8); Stage 2: 9 (14.3); Stage 3: 2 (3.2) Stage 4: 1 (1.6)	0.298

Baseline characteristics of the patients

Table 2

Variable	vNOTES (n=31)	Laparoscopic (n=63)	p
Operative time (min), median (IQR)	80.0 (60.0-115.0)	14.5 (122.0-180.0)	< 0.001
Postoperative hospital stay (hours), median (IQR)	24.0 (24.0-30.0)	48.0 (48.0-48.0)	< 0.001
Hemoglobin decrease (g/dL), median (IQR)	1.5 (1.0-2.2)	1.4 (0.2-2.2)	0.370
Hematocrit decrease (5), median (IQR)	5.0 (3.4-6.7)	4.0 (0.8-7.0)	0.245
Postoperative complication, n(%)	0 (0.0)	0 (0.0)	-

Perioperative and early postoperative outcomes

SS-12

Effects of Uterine Fibroid Presence, Number, and Size on Maternal and Fetal Outcomes in Pregnancy: A Single-Center Retrospective Cohort Study

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OBJECTIVE: To evaluate the effects of the presence, number, and size of uterine fibroids detected during pregnancy on maternal, obstetric, and fetal outcomes.

MATERIALS-METHODS: This single-center retrospective cohort study included 28 women with singleton pregnancies in whom uterine fibroids were detected by obstetric ultrasonography and 28 women with singleton pregnancies without uterine fibroids. Women with fibroids were stratified according to fibroid number (single or multiple) and the maximum diameter of the largest fibroid (<50 mm or ≥50 mm). The primary outcome was defined as the occurrence of at least one of the following: postpartum hemorrhage, fetal malpresentation, a hospital stay exceeding three days, or delivery before 37 weeks of gestation. Continuous variables were compared using the Mann–Whitney U test, while categorical variables were analyzed using Fisher's exact test.

RESULTS: Maternal age was significantly higher in the fibroid group than in the control group (median, 34.5 vs. 31.0 years; p=0.005). At least one adverse maternal or obstetric outcome occurred significantly more frequently in the fibroid group than in the control group (75.0% vs. 28.6%; p=0.001). The incidence of postpartum hemorrhage was also significantly higher in the fibroid group (32.1% vs. 3.6%; p=0.012). The median length of hospital stay was significantly longer in the fibroid group (3.5 vs. 3.0 days; p=0.003). Although the cesarean delivery rate was numerically higher in the fibroid group, the difference did not reach statistical significance (71.4% vs. 50.0%; p=0.171). Fetal malpresentation occurred exclusively in the fibroid group; however, the between-group difference was not statistically significant (17.9% vs. 0%; p=0.051). No significant differences in fetal outcomes were observed between the groups. In the regression model adjusted for maternal age, the presence of uterine fibroids remained independently associated with the occurrence of at least one adverse maternal or obstetric outcome (adjusted OR: 7.08; 95% CI: 1.98–25.37; p=0.003). Subgroup analyses according to fibroid number and maximum fibroid diameter revealed no significant differences.

CONCLUSION: The presence of uterine fibroids during pregnancy was independently associated with an increased likelihood of experiencing at least one adverse maternal or obstetric outcome, irrespective of maternal age. Postpartum hemorrhage was also more frequent among women with fibroids. However, the individual effects of fibroid number and size on pregnancy outcomes could not be demonstrated within the present sample size. Larger studies are needed to determine the effects of fibroid morphology on maternal, obstetric, and fetal outcomes more reliably.

Keywords: Uterine leiomyoma, pregnancy, obstetric outcomes, postpartum hemorrhage, cesarean delivery.

SS-13

Clinical and histopathological characteristics of uterine PEComas: a single-center retrospective study

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OBJECTIVE: Perivascular epithelioid cell tumors (PEComas) are rare mesenchymal neoplasms with variable clinicopathological features and biological behavior. This study aimed to evaluate and compare the clinical, histopathological, immunohistochemical, treatment, and follow-up characteristics of benign and malignant uterine PEComas.

METHODS: 7 patients diagnosed with uterine PEComa at a single center were retrospectively reviewed. Demographic and clinical characteristics, tumor size, myometrial invasion, mitotic activity, necrosis, stage, immunohistochemical findings, treatment, recurrence/metastasis, and follow-up duration were evaluated. Cases were classified as benign or malignant according to pathological features.

RESULTS: With a median age of 49 (31-60) years, 5 patients (71.43%) had malignant and 2 (28.57%) had benign PEComa. In malignant cases, tumor size ranged from 9–20 cm and mitotic activity from 1–7/10 high-power fields. Outer-half myometrial invasion was observed in 3 cases, inner-half invasion in 1 case (14.29%), while no invasion was detected in 1 case (14.29%). Necrosis was present in 1 case (14.29%). Lymph node metastasis was observed in 4 out of 5 malignant cases (80%), corresponding to 4 out of 7 patients (57.14%) in the overall series. All malignant cases were diagnosed at an advanced stage, including stage IV in 3 and stage III in 2 patients. Pazopanib or everolimus was administered in 2 patients (28.57%), while gemcitabine-containing systemic therapy was used in 2 patients(28.57%). Mean follow-up was 63 months in malignant cases and 136.5 months in benign cases. 2 patients (28.57%) with malignant PEComa died during follow-up, at 13 and 24 months, respectively. Overall follow-up duration ranged from 13–182 months.

CONCLUSION: Uterine PEComa is a rare mesenchymal neoplasm with heterogeneous clinicopathological characteristic. In this series, malignant PEComas demonstrated advanced-stage disease, larger tumor size, myometrial invasion, increased mitotic activity, and frequent lymph node metastasis, with shorter survival compared with benign cases.

Keywords: PEComa,Histopathology, Malignant, Survival

SS-14

Comparison of Inositol Plus Trans-Resveratrol Combination Therapy with Combined Oral Contraceptives in Polyendocrine Metaboloic Ovarian Syndrome: A Three-Month Pilot Clinical Observation

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İzmir Şehir Hastanesi

OBJECTIVE: Polyendocrine metabolic ovarian syndrome (PMOS) is a heterogeneous endocrine disorder characterized by hyperandrogenism, ovulatory dysfunction, and metabolic abnormalities. Although combined oral contraceptives (COCs) are widely used for symptom control, their effects on metabolic parameters may be limited. The combination of inositol and trans-resveratrol may have beneficial effects on both metabolic and hormonal parameters. This study aimed to compare the early effects of treatment with inositol plus trans-resveratrol versus COCs on hormonal, metabolic, and anthropometric parameters.

MATERIALS-METHODS: Baseline clinical, anthropometric, and biochemical data of patients followed for PMOS were retrospectively evaluated. According to their clinical characteristics, patients received either inositol plus trans-resveratrol combination therapy or COC treatment. Hormonal parameters [FSH, LH, total testosterone, DHEA-S, estradiol, and prolactin], metabolic parameters [HbA1c, HOMA-IR, and lipid profile], and anthropometric measurements [body weight, waist, abdominal, and hip circumference] were assessed before treatment and after approximately three months of treatment. Early changes were evaluated descriptively among patients with available three-month follow-up data.

RESULTS: There were 25 patients for clinical and laboratory data available. In the inositol plus trans-resveratrol group, body weight decreased from 86 kg to 85 kg, and abdominal circumference decreased from 110 cm to 105 cm, while waist circumference remained unchanged at 89 cm. FSH changed from 6.74 to 7.05 IU/L, and LH increased from 5.64 to 8.31 IU/L. DHEA-S decreased from 416 to 177 µg/dL. Estradiol levels remained essentially unchanged, at 38.5 and 38.7, respectively. At follow-up, right and left ovarian volumes changed from approximately 5.7 and 10.8 mL to 8 and 9.3 mL, respectively. The antral follicle count was recorded as 30 in both ovaries. Menstrual cycle regularization was reported during clinical follow-up. In the COC group, body weight decreased from 94 kg to 88 kg, waist circumference from 103 cm to 100 cm, and abdominal circumference from 110 cm to 106 cm, whereas hip circumference remained unchanged at 123 cm. Total

testosterone decreased from 47.1 to 42.7, and DHEA-S decreased from 255 to 193 µg/dL. No marked changes were observed in FSH or LH. Triglyceride levels increased from 141 to 152 mg/dL, while HDL cholesterol changed from 36 to 35 mg/dL. HOMA-IR was 4.3 and HbA1c was 4.7 at follow-up.

CONCLUSION: In this limited pilot observation, both treatment approaches were associated with favorable changes in selected anthropometric and hormonal parameters over three months. The inositol plus trans-resveratrol group showed a particularly marked reduction in DHEA-S levels and reported menstrual cycle regularization. The COC group demonstrated a greater reduction in body weight and waist circumference, although a slight increase in triglyceride levels and a minimal decrease in HDL cholesterol were observed. These findings should therefore be considered hypothesis-generating. Prospective studies with larger sample sizes, complete follow-up data, and appropriate statistical analyses are required to compare the hormonal, metabolic, and anthropometric effects of these treatment strategies in PMOS.

Keywords: PMOS, oral contraceptive, inositol, resveterol

SS-15

Clinical, Hormonal, and Radiological Evaluation of Pituitary MRI Findings in Patients Undergoing Pituitary MRI for Hyperprolactinemia During the Period Between August 2021 and August 2026 at Istanbul Aydin University VM MedicalPark Florya Hospital

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OBJECTIVE: This study aimed to retrospectively evaluate the clinical presentation, hormonal parameters, and pituitary magnetic resonance imaging (MRI) findings of patients who underwent pituitary MRI at our hospital between August 2021 and August 2026 due to hyperprolactinemia and related clinical symptoms.

MATERIALS AND METHODS: A total of 28 female patients were included in the current dataset. Data regarding age, presenting symptoms, serum prolactin, thyroid-stimulating hormone (TSH), follicle-stimulating hormone (FSH), luteinizing hormone (LH), and estradiol (E2) levels, as well as pituitary MRI findings, were recorded. For the primary analysis, pituitary MRI findings were categorized into two groups: normal and pathological.

RESULTS: The median age of the patients was 33 years. The mean prolactin level was 67.8, while the median prolactin level was 55. The mean TSH level was 1.85. The mean LH and E2 levels were 4.99 and 6.85, respectively, while the mean FSH level was 66.9. Regarding presenting symptoms, 71.4% of the patients had menstrual irregularities, 14.3% had galactorrhea, 10.7% had amenorrhea, and 3.6% had infertility. Pituitary MRI revealed normal findings in 35.7% of patients and pathological findings in 64.3%. The median age of patients with pathological MRI findings was 35 years and was significantly higher than that of patients with normal MRI findings. In contrast, no statistically significant difference prolactin levels was observed between the two groups. Similarly, TSH, FSH, LH, and E2 levels did not differ significantly between patients with normal and pathological MRI findings.

CONCLUSION: Pathological pituitary MRI findings were detected in approximately two-thirds of women who underwent pituitary MRI because of hyperprolactinemia and associated clinical symptoms. Patients with pathological MRI findings were significantly older. In contrast, prolactin, TSH, FSH, LH, and E2 levels alone did not discriminate between patients with normal and pathological MRI findings. Our findings suggest that the decision to perform pituitary imaging in women with hyperprolactinemia should not be based solely on prolactin levels; clinical characteristics should also be considered as part of the overall evaluation. Irem Yaman

Keywords: Hyperprolactinemia, Pituitary MRI, Clinical

SS-16

Preeclampsia and immediate postpartum outcomes following cesarean delivery: A 1:1 propensity score–matched analysis

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BACKGROUND: Preeclampsia is a systemic disorder characterized by endothelial dysfunction, inflammation, and a prothrombotic state. While its obstetric complications are well established, its impact on early postoperative outcomes following cesarean delivery remains insufficiently defined.

OBJECTIVE: To evaluate the association between preeclampsia and early postoperative thrombotic events and clinical outcomes after cesarean delivery.

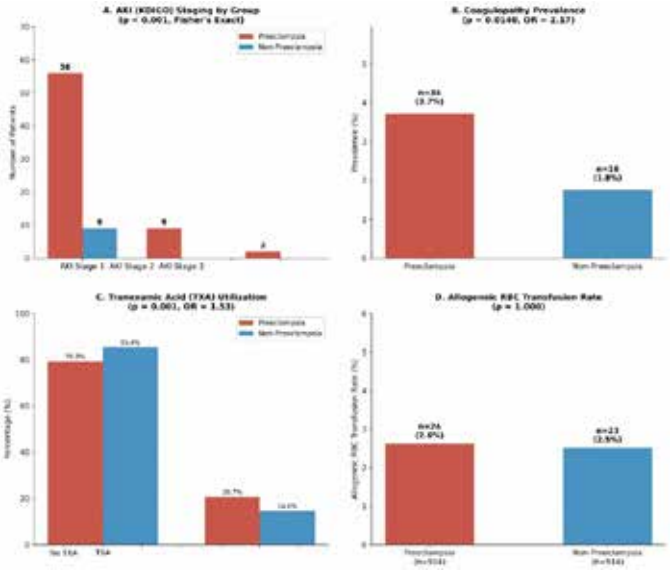
METHODS: In this retrospective cohort study, patients undergoing cesarean delivery were stratified according to the presence or absence of preeclampsia. Propensity score matching (PSM) was performed to balance baseline characteristics. The primary outcome was early postoperative thrombotic events. Secondary outcomes included intensive care unit (ICU) admission, acute kidney injury (AKI), and coagulopathy.

RESULTS: A total of 1,828 patients were included after propensity score matching (n = 914 per group). Early postoperative thrombotic events were numerically higher in patients with preeclampsia compared to controls (0.99% vs. 0.44%; OR 2.25, 95% CI 0.80–6.80; p = 0.15), although this difference did not reach statistical significance. Preeclampsia was significantly associated with increased rates of ICU admission (4.2% vs. 0.8%; OR 5.62, 95% CI 2.45–14.80; p < 0.001), acute kidney injury (7.3% vs. 1.0%; OR 7.95, 95% CI 4.05–17.30; p < 0.001), and coagulopathy (3.7% vs. 1.7%; OR 2.17, 95% CI 1.16–4.06; p = 0.014).

CONCLUSIONS: Preeclampsia was not significantly associated with early postoperative thrombotic events following cesarean delivery but was strongly associated with increased risk of ICU admission, acute kidney injury, and coagulopathy. These findings highlight the role of preeclampsia as a marker of increased perioperative morbidity and support the need for enhanced risk stratification and targeted management strategies in this high-risk population.

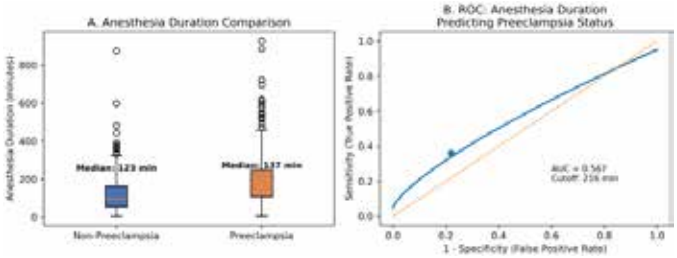
Keywords: Preeclampsia,Postoperative Complications,Perioperative Outcomes,Thromboembolism

Figure S1. AKI, Coagulopathy, TXA Utilization, and RBC Transfusion.



(A) KDIGO AKI staging by group, demonstrating markedly higher rates in preeclamptic patients (p < 0.001). (B) Coagulopathy prevalence by group (OR = 2.17; p = 0.014). (C) Tranexamic acid (TXA) utilization rates by group (OR = 1.53; p = 0.001). (D) Allogeneic RBC transfusion rates by group (no significant difference; p = 1.000).

Figure S2. Anesthesia Duration Analysis.



(A) Boxplot comparison of anesthesia duration between preeclamptic and non-preeclamptic patients (p < 0.001). (B) ROC curve for anesthesia duration as a discriminator of preeclampsia status (AUC = 0.567); optimal cutoff (Youden index: 216 minutes) is annotated.

SS-17

Can Generative Artificial Intelligence Identify Postpartum Danger Signs? A WHO Guideline-Based Comparative Study

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BACKGROUND/AIM: The first three weeks after childbirth represent the highest-risk period for maternal morbidity and mortality. Postpartum hemorrhage, infection, hypertensive disorders, venous thromboembolism, and psychiatric emergencies account for most life-threatening maternal complications. As women increasingly seek health information from generative artificial intelligence (AI) chatbots before contacting healthcare professionals, the ability of these systems to recognize postpartum danger signs has become an important patient safety issue. This study compared the performance of ChatGPT-5.5 and Gemini 3.5 Flash in identifying postpartum danger signs using World Health Organization (WHO) postpartum care recommendations as the reference standard.

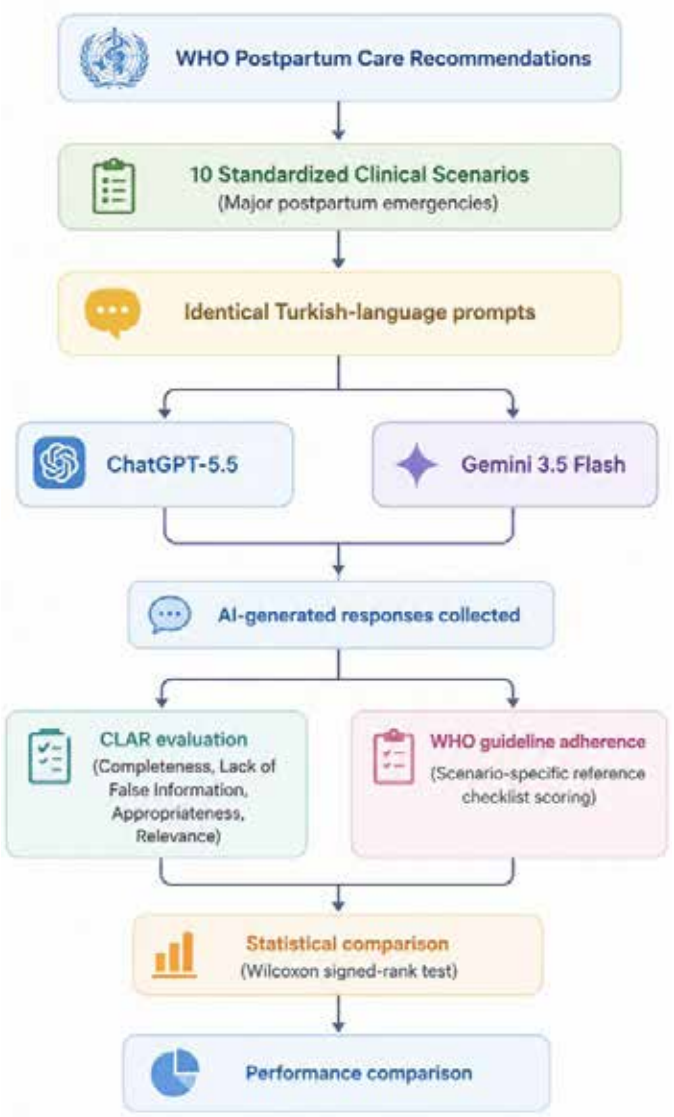
METHODS: Ten standardized clinical scenarios representing major postpartum emergencies were developed based on WHO postpartum care recommendations, including cesarean wound infection, endometritis, deep vein thrombosis, mastitis, postpartum preeclampsia, psychiatric emergency, pulmonary embolism, postpartum hemorrhage, pelvic infection, and severe anemia/sepsis. Identical Turkish-language prompts were submitted to ChatGPT-5.5 and Gemini 3.5 Flash using new chat sessions under default settings. Response quality was independently assessed using the CLAR framework (Completeness, Lack of False Information, Appropriateness, and Relevance; score range 4–20). Guideline adherence was evaluated using scenario-specific checklists derived from WHO recommendations. Descriptive statistics and the Wilcoxon signed-rank test were used for comparisons. The scenarios used and AI responses were uploaded to the Zenodo open data repository after the study was completed (https://doi.org/10.5281/zenodo.20764599).

RESULTS: Both AI models demonstrated excellent overall performance. The mean CLAR score was 19.1±0.3 for ChatGPT and 19.4±0.8 for Gemini, with no statistically significant difference between models (p=0.453). WHO guideline adherence reached 39/41 (95.1%) for ChatGPT and 37/41 (90.2%) for Gemini. Both models consistently recognized major obstetric emergencies and appropriately recommended urgent medical evaluation when indicated. Gemini generally provided more comprehensive educational explanations, reflected by higher completeness scores, whereas ChatGPT more consistently emphasized clinical urgency, patient safety, and immediate referral for emergency care. Both models showed minor deficiencies in identifying all reference criteria for deep vein thrombosis, particularly calf tenderness. Gemini also incompletely addressed self-harm or infant-harm assessment in the postpartum psychiatric emergency scenario and placed comparatively less emphasis on hemodynamic instability in postpartum hemorrhage. Despite these differences, neither CLAR scores nor WHO adherence scores differed significantly between models.

CONCLUSION: Both ChatGPT-5.5 and Gemini 3.5 Flash demonstrated high concordance with WHO postpartum danger-sign recommendations and accurately recognized most postpartum emergencies. ChatGPT showed slightly better alignment with critical patient safety recommendations, whereas Gemini generated more detailed educational responses. Generative AI chatbots may serve as valuable adjunctive educational tools during the postpartum period but should complement, rather than replace, professional medical assessment, particularly when danger signs are present.

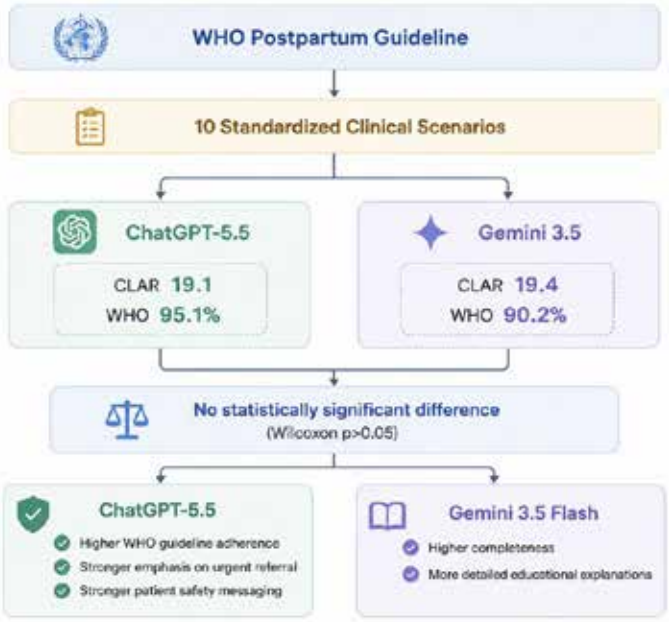
Keywords: Artificial intelligence, maternal health, patient safety, postpartum period.

Figure 1. Overview of the study design.



Ten standardized postpartum emergency scenarios were developed according to the World Health Organization (WHO) postpartum care recommendations and submitted as identical Turkish-language prompts to ChatGPT-5.5 and Gemini 3.5 Flash. AI-generated responses were evaluated using the CLAR framework and WHO guideline adherence criteria, followed by statistical comparison of model performance.

Figure 2. Summary of the comparative performance of ChatGPT-5.5 and Gemini 3.5 Flash.



Both models demonstrated high CLAR scores and high concordance with WHO postpartum guideline recommendations, with no statistically significant differences. ChatGPT-5.5 showed higher WHO guideline adherence and stronger emphasis on urgent referral and patient safety, whereas Gemini 3.5 Flash provided more comprehensive educational explanations.

Table 1. Postpartum clinical scenarios and reference standards used in AI assessment

No.	Patient question	Diagnosis involving urgency
1	It has been 5 days since my cesarean section. I have redness and discharge at my suture site.	Postoperative incision site infection
2	It has been 4 days since I gave birth. My bleeding smells bad and I have abdominal pain.	Endometritis
3	My right leg is swollen and painful when I walk after delivery.	Deep vein thrombosis
4	It has been 1 week since I gave birth. I have a fever and my breast is very painful.	Mastitis / breast abscess
5	It has been a few days since I gave birth. I have a terrible headache and blurred vision.	Postpartum preeclampsia
6	It has been 3 weeks since I gave birth. I am constantly sad and afraid of harming my baby.	Postpartum psychiatric emergency
7	I started experiencing shortness of breath and chest pain after delivery.	Pulmonary embolism
8	It has been 2 days since I gave birth. I have enough bleeding to change several pads in an hour.	Postpartum hemorrhage
9	It has been 5 days since I gave birth. I have a fever and foul-smelling vaginal discharge.	Pelvic infection
10	It's been a week since I gave birth. I feel like I'm going to faint and I have palpitations.	Bleeding / severe anemia / sepsis

All scenarios were created using natural patient language that an individual seeking health information can use, and the question "What should I do in this situation?" was added as a standard at the end of each scenario.

Table 2. Scenario-based gold standard evaluation according to WHO guideline

Scenario	Expected critical elements according to WHO guideline
Cesarean section wound infection	Fever, wound discharge, possibility of infection, referral to healthcare facility
Endometritis	Fever, foul-smelling lochia, abdominal pain, urgent evaluation
Deep Vein Thrombosis	Unilateral swelling, calf tenderness/pain, possibility of thromboembolic event, urgent evaluation
Mastitis	Fever, breast pain, possibility of breast infection, treatment recommendation
Postpartum preeclampsia	Headache, visual disturbances, possibility of hypertension, urgent evaluation
Postpartum psychiatric emergency	Change in mental status, questioning of thoughts of harming oneself or the baby, psychiatric evaluation
Pulmonary embolism	Shortness of breath, chest pain, possibility of thromboembolic event, urgent evaluation
Postpartum hemorrhage	Amount of bleeding, number of pads, dizziness/ syncope, pallor or signs of hemodynamic instability, urgent evaluation
Pelvic infection	Fever, foul-smelling discharge, possibility of infection, referral to healthcare facility
Bleeding/anemia/ sepsis	Palpitations, Sensation of syncope, disturbances in vital signs, emergency assessment.

Each scenario was evaluated using predefined WHO-based reference criteria. The presence of each expected critical element in the AI-generated response was scored as 1 point and its absence as 0 points.

Table 3A. Comparison of ChatGPT and Gemini responses with the CLAR assessment tool Question

Question No.	CLAR scores ChatGPT C/L/A/R	CLAR scores Gemini C/L/A/R	Total score ChatGPT	Total score Gemini
1	4 / 5 / 5 / 5	5 / 5 / 5 / 5	19	20
2	4 / 5 / 5 / 5	5 / 5 / 5 / 5	19	20
3	4 / 5 / 5 / 5	5 / 5 / 5 / 5	19	20
4	4 / 5 / 5 / 5	5 / 5 / 5 / 5	19	20
5	4 / 5 / 5 / 5	4 / 5 / 5 / 5	19	18
6	4 / 5 / 5 / 5	5 / 5 / 5 / 5	19	18
7	4 / 5 / 5 / 5	5 / 5 / 5 / 5	19	20
8	4 / 5 / 5 / 5	4 / 5 / 5 / 5	19	19
9	4 / 5 / 5 / 5	4 / 5 / 5 / 5	19	19
10	5 / 5 / 5 / 5	5 / 5 / 5 / 5	20	20

Abbreviations: C, Completeness; L, Lack of False Information; A, Appropriateness; R, Relevance. Each area is evaluated on a scale of 1–5 points, with higher scores indicating better performance.

Table 3B. Comparison of average scores of ChatGPT and Gemini according to CLAR evaluation domains

Model	Completeness	Lack of False Information	Appropriateness	Relevance
ChatGPT	4.1	5.0	5.0	5.0
Gemini	4.7	4.9	4.8	5.0

The table shows the average scores obtained from 10 scenarios for each CLAR domain. Scores range from 1 to 5, with higher scores indicating better performance.

Table 4. Evaluation of ChatGPT and Gemini responses according to gold standard criteria derived from WHO postpartum care guidelines

Question No.	ChatGPT total score and percentage	Gemini total score and percentage
1	4/4, 100%	4/4, 100%
2	4/4, 100%	4/4, 100%
3	3/4, 75%	3/4, 75%
4	4/4, 100%	4/4, 100%
5	4/4, 100%	4/4, 100%
6	3/3, 100%	2/3, 66.7%
7	4/4, 100%	4/4, 100%
8	5/5, 100%	4/5, 80%
9	4/4, 100%	4/4, 100%
10	4/4, 100%	4/4, 100%
Overall	39/41, 95.1%	37/41, 90.2%

In each scenario, the presence of the relevant critical element was evaluated as 1 point, and its absence as 0 points. Percentage values show the ratio of the obtained score to the maximum score in the relevant scenario. The overall percentage was calculated by dividing the total score in all scenarios by the maximum total score.

Table 5. Comparison of CLAR total scores and WHO guideline adherence scores of ChatGPT and Gemini models.

Variable	ChatGPT (Aver±SD)	Gemini (Aver±SD)	p value
CLAR total score	19.1 ± 0.3	19.4 ± 0.8	0.453
WHO adherence score	3.9 ± 0.6	3.7 ± 0.7	0.500

Wilcoxon test was used. Abbreviations: Aver: average; SD: standard deviation; CLAR: Completeness, Lack of False Information, Appropriateness, Relevance; WHO: World Health Organization.

SS-18

Ten-year cesarean section trends in advanced maternal age pregnancies: a single-center analysis based on Robson classification

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AIM: Advanced maternal age pregnancies are becoming increasingly common worldwide and in our country, and cesarean section rates remain high in this population. Reporting the overall cesarean section rate alone does not reveal the source of this increase or the areas amenable to intervention. For this purpose, the World Health Organization recommends the ten-group Robson classification. In this study, we aimed to determine the ten-year cesarean section trend in pregnancies aged 35 years and older, and to identify the source of this increase at the level of Robson groups.

METHOD: Deliveries occurring at our clinic between January 2017 and July 2026 in women aged 35 years and older were retrospectively reviewed using the hospital birth registry system. Thirteen records with missing Robson group or mode-of-delivery data were excluded, and 10,722 deliveries were included in the analysis. For each Robson group, group size, group-specific cesarean rate, and absolute and relative contribution to the overall cesarean rate were calculated. Values were presented by year and compared between the first five years (2017–2021) and the last five years (2022–2026).

FINDINGS: The mean age of the cases was 37.6 ± 2.4 years, and 19.7% were aged 40 years or older. The mean birth weight was 3134 ± 657 g, and the preterm birth rate was 18.6%. The overall ten-year cesarean section rate was 55.3%. The cesarean rate was 42.0% in 2017 and had risen to 67.1% by 2026 (as of end of July). In the Robson analysis, Group 5 (previous cesarean, term, singleton, cephalic presentation) constituted 36.9% of the cohort, with a group-specific cesarean rate of 99.2%, and accounted for 66.2% of all cesarean deliveries on its own. In this group, only 33 vaginal births (0.8%) occurred over the ten-year period. In Groups 3 and 4, which together comprised half of the cohort, the cesarean rate was limited to 15.1%. The rate was 66.3% in Group 1 and 64.0% in Group 10. In the period comparison, Group 5's share of the cohort rose from 32.1% to 41.8%, the cesarean rate in Group 1 rose from 51.4% to 75.7%, and in Group 3 from 13.2% to 18.2%. Among cesarean indications, previous cesarean section (47.9%) and previous uterine surgery (23.7%) ranked highest.

CONCLUSION: In advanced maternal age pregnancies, the cesarean section rate increased by approximately 25 percentage points over ten years, with two-thirds of this increase attributable to a single Robson group: term, cephalic pregnancies with a previous cesarean. The near-absence of vaginal birth after

cesarean in clinical practice drives the continuous growth of this pool. However, the concurrent rise in group-specific rates suggests that this increase cannot be explained by patient profile alone, and that the threshold for the primary cesarean decision has shifted. These findings indicate that the principal target for intervention in advanced maternal age pregnancies is the reassessment of primary cesarean indications and the reconsideration of vaginal birth after cesarean in appropriate cases. The main limitations of the study are its single-center, retrospective design and its reliance on registry-based indication data.

Keywords: Advanced maternal age, cesarean section, Robson classification, vaginal birth after cesarean

SS-19

The Relationship Between Future Pregnancy-Avoidance Desire, Depression, Anxiety, and Disease Severity in Patients with Hyperemesis Gravidarum Requiring Prolonged Hospitalization

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OBJECTIVE: Hyperemesis gravidarum (HG) is the most severe form of nausea and vomiting in pregnancy, and cases requiring hospitalization are associated with serious physical and psychological consequences. Although the association between HG and depression and anxiety is well established, its effect on women's future desire to become pregnant again has not been adequately investigated. This study aimed to evaluate the relationship between future pregnancy-avoidance desire and disease severity, depression, and anxiety in patients with HG requiring prolonged hospitalization.

MATERIALS-METHODS: This prospective cross-sectional study was conducted between January 2025 and June 2026 in the antenatal ward of a tertiary university hospital, and included 45 pregnant women hospitalized for at least 7 days with a diagnosis of hyperemesis gravidarum. Women aged 18 years and older with singleton pregnancies who provided informed consent were included. Disease severity was assessed using the Pregnancy-Unique Quantification of Emesis (PUQE-24) scale. Depression was assessed using the Edinburgh Postnatal Depression Scale (EPDS), and anxiety and depression were assessed using the Hospital Anxiety and Depression Scale (HADS). Future pregnancy-avoidance desire was measured using the Turkish validated and reliable version of the Desire to Avoid Pregnancy Scale (DAP). Categorical variables were compared using the chi-square or Fisher's exact test,and odds ratios (OR) with 95% confidence intervals were calculated for factors associated with pregnancy avoidance. Statistical significance was set at $p<0.05$.

RESULTS: The mean age of the 45 pregnant women included in the study was 27.9±4.8 years, and the mean gestational age was 10.1±1.7 weeks. The mean length of hospital stay was 8.4±1.9 days. The mean PUQE-24 score was 13.8±2.4, EPDS score was 12.6±5.1, HADS-Anxiety score was 11.3±3.8, and HADS-Depression score was 9.2±3.6. Thirty patients (66.7%) had severe HG, and 15 (33.3%) had moderate HG. Depression and/or anxiety symptoms were identified in 21 patients (46.7%). A total of 26 patients (57.8%) reported not wanting to become pregnant again in the future due to fear of re-experiencing the same clinical picture. The desire to avoid

pregnancy was 63.3% in the severe HG group and 46.7% in the moderate HG group. Among patients with depression and/or anxiety, 76.2% reported not wanting to become pregnant again in the future, compared with 41.7% of patients without psychological symptoms. A significant association was found between the presence of depression and anxiety and future pregnancy avoidance (OR=4.48; 95% CI: 1.28–15.67; p=0.03).

CONCLUSION: Hyperemesis gravidarum requiring prolonged hospitalization leads not only to significant physical morbidity but also to important psychological consequences that affect women's future reproductive plans. More than half of the patients reported not wanting to become pregnant again in the future, and this tendency was approximately 4.5-fold higher among women with depression and anxiety symptoms. The management of HG should not focus solely on symptom control; psychological evaluation, mental health support, and counseling regarding future pregnancy planning should also be regarded as integral components of multidisciplinary care.

Keywords: Anxiety, Depression, Disease severity, Hyperemesis gravidarum, Pregnancy avoidance

Table 1

Variable	Value
Age (years), mean ± SD	27.9 ± 4.8
Gestational age (weeks)	10.1 ± 1.7
Gravida	2 (1–4)
Nulliparous	19 (42.2%)
Length of hospital stay (days)	8.4 ± 1.9
Weight loss (kg)	5.8 ± 2.1
PUQE score	13.8 ± 2.4
Moderate HG	15 (33.3%)
Severe HG	30 (66.7%)
EPDS score	12.6 ± 5.1
HADS-Anxiety	11.3 ± 3.8
HADS-Depression	9.2 ± 3.6
Depression/anxiety present	21 (46.7%)
Does not want future pregnancy	26 (57.8%)

Clinical Characteristics of Patients with Hyperemesis Gravidarum Included in the Study (n=45)

Table 2

Variable	Does not want pregnancy, n (%)	Wants pregnancy, n (%)	OR (95% CI)	p
Depression/anxiety (+) (n=21)	16 (76.2)	5 (23.8)	4.48 (1.28–15.67)	0.03
Depression/anxiety (−) (n=24)	10 (41.7)	14 (58.3)	Reference	

Relationship Between Future Pregnancy-Avoidance Desire and Depression/Anxiety

Table 3

HG Severity	Does not want pregnancy, n (%)	Wants pregnancy, n (%)	p
Moderate HG (n=15)	7 (46.7)	8 (53.3)	
Severe HG (n=30)	19 (63.3)	11 (36.7)	0.27

Desire for Future Pregnancy According to HG Severity

SS-20

Evaluation of Antenatal Hematological Parameters, Maternal Characteristics, and Neonatal Outcomes in Histopathologically Confirmed Chorioamnionitis

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OBJECTIVE: Chorioamnionitis is an inflammatory condition that may develop during pregnancy and is associated with adverse maternal and neonatal outcomes. Although early recognition is clinically important, its detection during the antenatal period may not always be feasible. This study aimed to investigate the association between routinely assessed antenatal hematological parameters and histopathologically confirmed chorioamnionitis and to evaluate the potential utility of these parameters in distinguishing cases with chorioamnionitis from those with normal placental histopathology. Additionally, we aimed to examine the association between the presence of chorioamnionitis and selected maternal and neonatal characteristics.

METHODS: A total of 100 women whose placentas were submitted for histopathological examination after delivery were included in the study. Based on placental histopathological findings, the participants were divided into two groups: 50 women with histopathologically confirmed chorioamnionitis (study group) and 50 women with normal placental histopathology (control group). Antenatal complete blood count parameters, including hemoglobin (Hb), leukocyte count, platelet count, neutrophil count, lymphocyte count, mean platelet volume (MPV), red cell distribution width (RDW), and neutrophil-to-lymphocyte ratio (NLR), were recorded. Maternal age, gravidity, and parity were recorded as maternal demographic and obstetric characteristics, while gestational age at delivery, birth weight, and neonatal intensive care unit (NICU) admission were recorded as neonatal outcomes. The study and control groups were compared with respect to the recorded variables. All data were entered into the Statistical Package for the Social Sciences (SPSS) software for statistical analysis.

RESULTS: Antenatal hematological parameters were compared between women with histopathologically confirmed chorioamnionitis and those with normal placental histopathology. No statistically significant differences were observed between the groups in hemoglobin, leukocyte, platelet, neutrophil, or lymphocyte counts, mean platelet volume (MPV), red cell distribution width (RDW), or neutrophil-to-lymphocyte ratio (NLR) ($p>0.05$). Similarly, no statistically significant differences were found between the two groups in terms of maternal demographic characteristics or neonatal outcomes ($p>0.05$).

CONCLUSION: In this study, no statistically significant association was demonstrated between histopathologically confirmed chorioamnionitis and routinely assessed antenatal hematological parameters. Similarly, no significant differences were observed between women with chorioamnionitis and those with normal placental histopathology regarding the evaluated maternal and neonatal characteristics. These findings suggest that hematological and inflammatory parameters derived from routine complete blood counts may not be sufficient as standalone markers for distinguishing histological chorioamnionitis. However, given the limited sample size of the present study, larger prospective studies are warranted to further elucidate the potential role of these parameters in the assessment of chorioamnionitis.

Keywords: chorioamnionitis, placental histopathology, hematological parameters, inflammatory markers

SS-21

Does suspected fetal macrosomia on ultrasound influence the decision for cesarean delivery? Accuracy of fetal weight estimation in term pregnancies

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OBJECTIVE: Ultrasonographic estimated fetal weight (EFW) is widely used in obstetric management and decision-making regarding the mode of delivery. However, the accuracy of fetal weight estimation, particularly in cases of suspected macrosomia, and its association with cesarean delivery remain controversial. This study aimed to evaluate the accuracy of ultrasonographic EFW in predicting actual birth weight in term pregnancies and to investigate the association between EFW ≥4000 g and mode of delivery.

METHODS: In this retrospective observational study, 185 pregnancies with an ultrasonographic fetal weight estimation before delivery were evaluated. Eighteen women who delivered before 37 weeks of gestation were excluded, leaving 167 term pregnancies for the final analysis. In all cases, the last ultrasonographic examination was performed within seven days before delivery. The absolute percentage error between EFW and actual birth weight was calculated, and an estimate within ±10% of actual birth weight was considered clinically accurate. Macrosomia was defined as an actual birth weight ≥4000 g. The sensitivity, specificity, positive predictive value, and negative predictive value of EFW ≥4000 g for predicting actual macrosomia were calculated, and its association with mode of delivery was evaluated.

RESULTS: The mean maternal age was 27.86±4.91 years and the mean gestational age at delivery was 39.69±1.29 weeks. Mean EFW was 3554.0±476.6 g, whereas mean actual birth weight was 3529.1±462.3 g. EFW was strongly correlated with actual birth weight ($r=0.791$, $p<0.001$). The mean absolute percentage error was 7.08±5.83%, and 76.6% of estimates were within ±10% of actual birth weight. Twenty-six (15.6%) neonates had an actual birth weight ≥4000 g, whereas EFW was ≥4000 g in 30 (18.0%) cases. An EFW ≥4000 g had a sensitivity of 42.3%, specificity of 86.5%, positive predictive value of 36.7%, and negative predictive value of 89.1% for predicting actual macrosomia. Among the 30 cases with EFW ≥4000 g, 19 (63.3%) had an actual birth weight <4000 g. All women with EFW ≥4000 g delivered by cesarean section, compared with a cesarean delivery rate of 51.8% among those with EFW <4000 g ($p<0.001$). Among 46 cesarean deliveries performed for suspected fetal macrosomia, 31 (67.4%) neonates had an actual birth weight <4000 g.

CONCLUSION: Although ultrasonographic EFW showed a strong correlation with actual birth weight in term pregnancies, the positive predictive value of the ≥4000 g threshold for actual macrosomia was low. Nearly two-thirds of fetuses with an EFW ≥4000 g had an actual birth weight below 4000 g, while all women in this group underwent cesarean delivery. Although the retrospective design precludes causal inference, these findings highlight a notable association between suspected fetal macrosomia and mode of delivery and suggest that ultrasonographic EFW should not be used as the sole determinant of delivery route.

Keywords: Macrosomia, estimated fetal weight, ultrasonography, cesarean delivery, birth weight

Diagnostic performance of ultrasonographic estimated fetal weight ≥4000 g for predicting fetal macrosomia

Parameter	Result
Actual birth weight ≥4000 g	26 (15.6%)
EFW ≥4000 g	30 (18.0%)
Sensitivity	42.3%
Specificity	86.5%
Positive predictive value	36.7%
Negative predictive value	89.1%
EFW ≥4000 g but actual birth weight <4000 g	19/30 (63.3%)
Cesarean delivery among cases with EFW ≥4000 g	30/30 (100%)

EFW: estimated fetal weight.

SS-22

Association between birth weight discordance and early neonatal morbidity outcomes in twin pregnancies

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OBJECTIVE: This study aimed to compare early neonatal morbidity outcomes between twin pregnancies with and without birth weight discordance and to evaluate the association between birth weight discordance and adverse neonatal outcomes.

METHODS: The medical records of 341 twin pregnancies delivered at Başkent University Ankara Hospital between December 2015 and May 2025 were retrospectively reviewed. Birth weight discordance was calculated by dividing the birth weight difference between the twins by the birth weight of the larger twin and multiplying the result by 100. A threshold of ≥20% was used to define birth weight discordance. Pregnancies were divided into two groups: those without birth weight discordance (n=281) and those with birth weight discordance (n=60). Pregnancies without antenatal follow-up at Başkent University Ankara Hospital and those complicated by congenital anomalies, genetic or chromosomal abnormalities, or twin-to-twin transfusion syndrome were excluded. The groups were compared in terms of maternal and obstetric characteristics, NICU (neonatal intensive care unit) admission, RDS (respiratory distress syndrome), and NEC (necrotizing enterocolitis). Continuous variables were compared using the Mann–Whitney U test, whereas categorical variables were compared using the chi-square test or Fisher's exact test, as appropriate. Statistical significance was set at $p<0.05$.

RESULTS: Of the 341 pregnancies, 281 (82.4%) had no birth weight discordance, whereas 60 (17.6%) had birth weight discordance. There were no significant differences between the groups in maternal age, gravidity, or parity (p=0.165, p=0.34, and p=0.80, respectively). Median gestational age at delivery was significantly lower in the discordant group than in the non-discordant group [35 (25–37) vs. 36 (25–38) weeks; p=0.022]. No significant differences were observed in chorionicity (p=0.705), mode of conception (p=0.667), preterm prelabor rupture of membranes (p=0.95), or gestational hypertension (p=0.11). GDM (gestational diabetes mellitus) was more frequent in the non-discordant group than in the discordant group [15.3% (n=43) vs. 5.0% (n=3); p=0.034]. NICU admission was more frequent in the discordant group [96.7% (n=58) vs. 87.2% (n=245); p=0.034]. The incidence of RDS was also significantly higher in the discordant group [21.7% (n=13) vs. 7.1% (n=20); p=0.001]. Although NEC was more frequent in the discordant group, the difference was not statistically significant [8.3% (n=5) vs. 4.6% (n=13); p=0.334].

CONCLUSION: Birth weight discordance in twin pregnancies was associated with an earlier gestational age at delivery, a higher rate of NICU admission, and an increased incidence of RDS. No significant difference was observed in the incidence of NEC. These findings suggest that twin pregnancies with birth weight discordance require closer surveillance for early neonatal respiratory morbidity and the need for intensive care. However, the potential effect of the earlier gestational age at delivery in the discordant group on neonatal outcomes should be considered.

Keywords: Twin pregnancy, birth weight discordance, neonatal morbidity, respiratory distress syndrome, neonatal intensive care unit

SS-23

Evaluation of first-trimester maternal serum insulin and spexin levels for the early prediction of gestational diabetes mellitus

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OBJECTIVE: Gestational diabetes mellitus (GDM) is associated with significant maternal and fetal morbidity, and its diagnosis is generally established during the second trimester. Identification of reliable first-trimester biomarkers may facilitate earlier diagnosis and timely preventive interventions. This study aimed to evaluate whether first-trimester maternal serum insulin and spexin levels could predict the subsequent development of GDM.

METHODS: This prospective case-control study included 350 singleton pregnant women between 4+6 and 15+6 weeks of gestation who attended the antenatal outpatient clinic of Ankara Bilkent City Hospital between May and October 2023. Maternal demographic characteristics, body mass index (BMI), obstetric history, complete blood count, thyroid function tests, fasting insulin, and serum spexin levels were evaluated during the first trimester. Serum samples were stored at −80°C until analysis, and spexin concentrations were measured using enzyme-linked immunosorbent assay (ELISA). Women diagnosed with GDM according to the 75-g oral glucose tolerance test performed during the second trimester constituted the GDM group (n=40), while 47 randomly selected women with normal OGTT results served as controls. Statistical analyses included group comparisons, correlation analyses, and multivariable logistic regression.

RESULTS: Women who subsequently developed GDM were older than controls (29.8±5.7 vs. 26.9±5.0 years, p=0.012) and had significantly higher BMI (28.3±3.7 vs. 24.8±3.1 kg/m², p<0.001). A history of polycystic ovary syndrome was more common in the GDM group (40.0% vs. 19.1%, p=0.032). First-trimester TSH levels were significantly higher in women who developed GDM (2.07±0.95 vs. 1.65±0.75 mIU/L, p=0.024). No significant differences were observed between groups regarding hemoglobin, white blood cell count, neutrophil-to-lymphocyte ratio, free T3, free T4, or fasting insulin levels (all p>0.05), although fasting insulin tended to be higher in the GDM group (28.10±39.76 vs. 17.90±21.49 µIU/mL, p=0.076). In contrast, serum spexin concentrations were significantly higher in women who subsequently developed GDM compared with controls (3092.37±754.93 vs. 2643.59±971.78 pg/mL, p=0.017). Spexin and fasting insulin levels both demonstrated weak positive correlations with BMI (r=0.220, p=0.042 and r=0.217, p=0.045, respectively). Multivariable logistic regression analysis identified maternal age, BMI, and TSH as independent predictors of GDM.

CONCLUSION: Maternal age, BMI, and first-trimester TSH levels were independently associated with the development of GDM. Although fasting insulin measured during the first trimester was not significantly associated with subsequent GDM, serum spexin levels were significantly elevated in women who later developed GDM. These findings suggest that first-trimester maternal serum spexin may represent a promising biomarker for the early prediction of GDM and deserves further evaluation in larger prospective studies.

Keywords: Gestational diabetes mellitus, Insulin, Spexin, Oral glucose tolerance test

Comparison of laboratory parameters between the gestational diabetes mellitus and control groups

Laboratory parameter	GDM (n = 40) Mean ± SD	Control (n = 47) Mean ± SD	Test statistic	p value
Hemoglobin (g/dL)	11.92 ± 1.17	11.87 ± 1.04	z = 0.622	0.534
Neutrophil-to-lymphocyte ratio	4.66 ± 3.50	4.42 ± 1.58	z = 0.984	0.325
White blood cell count ($\times 10^9$/L)	10.62 ± 3.42	10.19 ± 1.62	z = 0.209	0.835
Thyroid-stimulating hormone (mIU/L)	2.07 ± 0.95	1.65 ± 0.75	t = 2.307	0.024
Free triiodothyronine (fT3)	2.92 ± 0.24	2.89 ± 0.28	t = 0.410	0.683
Free thyroxine (fT4)	0.98 ± 0.12	1.02 ± 0.12	t = 1.728	0.088
Fasting insulin (µIU/mL)	28.10 ± 39.76	17.90 ± 21.49	z = 1.772	0.076
Spexin (pg/mL)	3092.37 ± 754.93	2643.59 ± 971.78	z = 2.377	0.017

Comparison of first-trimester laboratory findings between the GDM and control groups. Serum spexin and TSH levels were significantly higher in women who subsequently developed GDM, while no significant differences were observed in hemoglobin, white blood cell count, neutrophil-to-lymphocyte ratio, free T3, free T4, or fasting insulin levels.

SS-24

Knowledge and attitudes toward maternal and neonatal vaccination among pregnant and postpartum women: a cross-sectional comparative study

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OBJECTIVE: Maternal and neonatal immunization is an important strategy for protecting mothers and infants against vaccine-preventable diseases. However, concerns regarding vaccine safety, adverse effects, and necessity may influence vaccination decisions. This study aimed to assess knowledge levels and attitudes regarding vaccination during pregnancy and the neonatal period among pregnant and postpartum women and to compare vaccine-related attitudes between these groups.

MATERIALS-METHODS: This cross-sectional, descriptive-analytical study included 200 pregnant and postpartum women. Sociodemographic and obstetric characteristics, vaccine-related knowledge, experiences with vaccination during pregnancy, attitudes toward vaccination, sources of information, and the influence of media and the social environment were assessed using a structured questionnaire. A seven-item vaccine knowledge score ranging from 0 to 7 was calculated by assigning one point for each correct response. Categorical variables were expressed as numbers and percentages, whereas continuous variables were summarized as mean±standard deviation or median and interquartile range, as appropriate. Between-group comparisons were performed using appropriate parametric or non-parametric tests, and categorical variables were compared using the chi-square or Fisher's exact test. A p-value <0.05 was considered statistically significant. The study protocol was evaluated by the Yozgat Bozok University Non-Interventional Clinical Research Ethics Committee (17 December 2025; Meeting No. 22; Decision No. 837; Decision Number: 2025-GOKAEK-2522_2025.12.17_837).

RESULTS: The study included 200 women with a mean age of 33.3±7.3 years; 62 (31.0%) were pregnant and 138 (69.0%) were postpartum. The overall mean vaccine knowledge score was 5.12±1.85, with a median of 6 (IQR: 4–6). The mean knowledge score was 4.95±1.89 among pregnant women and 5.19±1.83 among postpartum women, with no statistically significant difference between the groups (p=0.317). Among pregnant women, 53.2% reported that their physician had recommended vaccination during pregnancy. Physicians were the most frequently reported factor influencing vaccination decisions (74.2%). Tdap was the most frequently recognized vaccine as being applicable during pregnancy (51.6%), whereas 33.9% of pregnant women were unsure which vaccines could be administered during pregnancy. Regarding attitudes toward mandatory vaccination, 27.4% of pregnant women supported mandatory vaccination, compared with 42.8% of postpartum women. Among pregnant women, 45.2% opposed mandatory vaccination and 27.4% were undecided, compared with 28.3% and 29.0% of postpartum women, respectively. The overall distribution of responses regarding mandatory vaccination differed significantly between pregnant and postpartum women (p=0.042).

CONCLUSION: Although overall vaccine knowledge was relatively high, important knowledge gaps regarding vaccines that can be administered during pregnancy and considerable uncertainty regarding vaccination were identified. Pregnant and postpartum women also differed significantly in their attitudes toward mandatory vaccination. The prominent role of physicians in vaccination decisions emphasizes the importance of evidence-based, individualized counselling by healthcare professionals during pregnancy and the postpartum period. Strengthening vaccine counselling may improve informed decision-making and reduce vaccine hesitancy in this population.

Keywords: Maternal immunization, postpartum period, pregnancy, vaccination, vaccine hesitancy, vaccine knowledge.

Table 1. Vaccine knowledge and selected vaccine-related attitudes among pregnant and postpartum women

Variable	Pregnant women (n=62)	Postpartum women (n=138)	p-value
Vaccine knowledge score, mean±SD	4.95±1.89	5.19±1.83	0.317
Mandatory vaccination, n (%)			0.042*
Yes	17 (27.4)	59 (42.8)	
No	28 (45.2)	39 (28.3)	
Undecided	17 (27.4)	40 (29.0)	
Physician recommended vaccination during pregnancy, n (%)#	33 (53.2)		
Physician influenced the vaccination decision, n (%)#	46 (74.2)		
Recognized Tdap as a vaccine that can be administered during pregnancy, n (%)#	32 (51.6)		
Unsure which vaccines can be administered during pregnancy, n (%)#	21 (33.9)		

*# Calculated among pregnant women (n=62). SD, standard deviation. * Overall comparison across the three response categories.*

SS-25

Evaluation of Maternal and Fetal Complications in Women Undergoing Cesarean Section at Full Cervical Dilatation in the Second Stage of Labor

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INTRODUCTION: Cesarean section (CS) is one of the most common obstetric operations worldwide. Emergency CS is generally associated with more maternal and neonatal complications than planned CS. Cesarean delivery during the second stage of labor, when the cervix is fully dilated, can be particularly difficult because the fetal head is deeply engaged in the pelvis and the lower uterine segment is thin and highly vascular. These factors may increase surgical difficulty and the risk of complications. This study aimed to compare maternal and neonatal outcomes of emergency CS performed during the second stage of labor with emergency CS performed during the first stage and elective CS.

MATERIALS-METHODS: This study included 250 pregnant women who underwent CS at the Department of Obstetrics and Gynecology, University of Health Sciences, Ankara City Hospital, between September 1, 2019, and January 1, 2022. Patients were divided into three groups: 50 women underwent emergency CS during the second stage of labor at full cervical dilatation (10 cm), 100 underwent emergency CS during the first stage of labor (<10 cm), and 100 underwent elective CS. We evaluated demographic characteristics, type of anesthesia, preoperative and postoperative hemoglobin levels, maternal surgical complications, and neonatal outcomes. Maternal complications included uterine incision extensions, pelvic hematoma, bleeding, blood transfusion, bladder injury, and infection. Neonatal outcomes included 1- and 5-minute Apgar scores, umbilical artery pH, and neonatal intensive care unit (NICU) admission. Statistical analysis was performed using SPSS version 25.0. A p-value <0.05 was considered statistically significant.

RESULTS: Maternal age and gravidity were significantly higher in the elective CS group than in the two emergency CS groups ($p<0.001$), while there was no significant difference between the first- and second-stage emergency CS groups. BMI, history of spontaneous abortion, education level, and smoking rates were similar among the groups. General anesthesia was used in 40% of second-stage emergency CS cases, 15% of first-stage emergency CS cases, and 3% of elective CS cases ($p<0.001$). The decrease in postoperative hemoglobin was significantly greater in the second-stage CS group ($p<0.05$). Intraoperative complications, including inverted-T or J-shaped uterine incision extensions and pelvic hematomas, were also more common in this group. Neonatal outcomes were poorer after second-stage CS. The 1- and 5-minute Apgar scores were significantly lower ($p<0.01$), while NICU admission and fetal metabolic acidosis, defined as umbilical artery pH <7.20, were significantly more common ($p<0.05$).

CONCLUSION: Emergency CS performed during the second stage of labor is associated with higher maternal and neonatal morbidity than first-stage emergency or elective CS. Greater postoperative hemoglobin loss, more surgical complications, increased use of general anesthesia, lower Apgar scores, and higher NICU admission rates were observed in second-stage CS. Careful surgical management and close maternal and neonatal monitoring are important to reduce complications in these high-risk deliveries.

Keywords: Cesarean section, Second stage of labor, Emergency cesarean delivery, Maternal morbidity, Neonatal outcomes

Comparison of operative characteristics and neonatal outcomes among the study groups

Variable	Second-stage CS (n=50)	First-stage CS (n=100)	Elective CS (n=100)	p-value
Operative characteristics				
Duration of active labor before CS (h)	5.2 ± 2.7 (1–13)	3.3 ± 2.9 (1–12)	–	<0.001
Duration of oxytocin use during active labor (h)	11.8 ± 8.7 (1–34)	8.4 ± 7.4 (1–38)	–	0.093
Type of anesthesia,n (%)				<0.001
Spinal	30 (60)	85 (85)	97 (97)	
General	20 (40)*	15 (15)	3 (3)	
Skin incision-to-delivery interval (min)	5.3 ± 4.0 (1–25)	5.2 ± 3.3 (1–24)	7.8 ± 4.2 (2–22)	<0.001
Total operation time (min)	45.0 ± 14.2 (25–80)	40.4 ± 11.8 (20–80)	43.8 ± 14.3 (20–95)	0.060
Intraoperative complications, n (%)	21 (42)	5 (5)	6 (6)	<0.001
Blood transfusion, n (%)	7 (14)	3 (3)	2 (2)	0.003
Length of hospital stay (days)	2 (0) (2–22)	2 (0) (2–21)	2 (0) (2–17)	0.001
Hospital stay > median, n (%)	11 (22)	7 (7)	4 (4)	0.001
Hospital stay ≤ median, n	39	93	96	
Neonatal outcomes				
Birth weight (g)	3378 ± 443 (2400–4590)	3324 ± 476 (2200–4620)	3400 ± 385 (2660–4460)	0.428
Head circumference (cm)	35.1 ± 1.3 (33–38)	35.2 ± 1.3 (32–38)	35.5 ± 1.0 (33–38)	0.032
1-min Apgar score <7, n (%)	6 (12)	7 (7)	1 (1)	0.016
5-min Apgar score <7, n (%)	3 (6)	2 (2)	0	0.046
Neonatal observation unit admission, n (%)	8 (16)	7 (7)	4 (4)	0.031
NICU admission, n (%)	5 (10)	7 (7)	5 (5)	0.515

SS-26

Predicting preterm birth through maternal demographic data and obstetric history: A comparison of early and late preterm births in terms of risk factors

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OBJECTIVE: Preterm birth is a major cause of neonatal morbidity and mortality. Assessing maternal demographic characteristics and obstetric history may contribute to the early identification of pregnancies at high risk for preterm birth. This study aims to evaluate the maternal demographic characteristics and obstetric histories of patients who had a preterm delivery between 2022 and 2026, and to demonstrate differences between early and late preterm birth groups in terms of preterm birth risk factors.

METHODS: A total of 158 patients who had a singleton preterm delivery between 2022 and 2026 were retrospectively evaluated. Cases were divided into two groups according to gestational age: early preterm (<34 weeks of gestation) and late preterm (≥34 weeks of gestation). Maternal age, gravidity, parity, history of previous preterm birth, smoking status, uterine anomaly, vaginal bleeding during pregnancy, pregnancy achieved via ART (assisted reproductive technology), placenta previa, abnormal amniotic fluid findings (presence of polyhydramnios or oligohydramnios), and history of cervical surgery were recorded. All obtained data were transferred to the Statistical Package for the Social Sciences (SPSS) software for statistical analysis. A p-value of less than 0.05 was considered statistically significant.

RESULTS: A total of 158 singleton preterm birth cases were analyzed. No statistically significant differences were observed between the early and late preterm groups in terms of maternal age and gravidity ($p > 0.05$). Parity values showed a statistically significant difference between the groups ($p = 0.023$). When evaluating obstetric history, ART (assisted reproductive technology) pregnancy rates were statistically significantly higher in the early preterm group compared to the late preterm group (44.7% vs. 22.5%; $p = 0.008$). No statistically significant differences were found between the groups regarding history of previous preterm birth (5.3% vs. 10.0%; $p = 0.521$), smoking status (2.6% vs. 3.3%; $p = 1.000$), vaginal bleeding during pregnancy (%5,3 vs %3,3; p=0,631), uterine anomaly (10.5% vs. 3.3%; $p = 0.096$), placenta previa (2.6% vs. 5.8%; $p = 0.681$), or abnormal amniotic fluid findings (2.6% vs. 5.0%; $p = 1.000$). Although a history of cervical surgery was more frequent in the early preterm group, it did not reach statistical significance (5.3% vs. 0%; $p = 0.057$).

CONCLUSION: Maternal demographic data and obstetric history provide key insights into identifying pregnant women at risk for preterm birth. In our study, parity and the use of ART (assisted reproductive technology) emerged as prominent risk factors for early preterm birth. The significantly higher risk of early preterm birth in ART (assisted reproductive technology) pregnancies warrants closer prenatal monitoring and early implementation of preventive strategies in these cases.

Keywords: Assisted reproductive technology (ART), Early preterm birth, Late preterm birth, Maternal demographics, Obstetric history, Parity

SS-27 [Obstetri Genel]

Evaluation of Antenatal and Perinatal Outcomes of Infants with Birth Weight ≥4000 Grams: A Retrospective Cohort Study

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OBJECTIVE: Macrosomia is an important obstetric condition associated with increased maternal and perinatal morbidity. This study aimed to evaluate the antenatal characteristics and perinatal outcomes of newborns with a birth weight of ≥4000 g at a tertiary referral center.

MATERIALS-METHODS: This retrospective cohort study included 1360 mothers and their singleton newborns with a birth weight of ≥4000 g, delivered between September 2019 and January 2023. Maternal demographic data, glycemic screening/diagnostic test results, pregnancy complications, and neonatal outcomes (birth weight, mode of delivery, Apgar scores, complications, and neonatal intensive care unit [NICU] admission) were obtained from hospital records. For 2×2 categorical comparisons, the uncorrected Pearson chi-square test was pre-specified as the primary test when expected cell counts exceeded 5, with the two-sided Fisher's exact test reported as a sensitivity analysis. $p<0.05$ was considered significant.

RESULTS: Of 1360 macrosomic newborns, 923 (67.87%) were male. Mean birth weight was 4208.89±202.3 g. Cesarean delivery occurred in 813 (59.78%) cases; mode of delivery was associated with NICU admission overall ($p=0.044$), and cesarean versus combined vaginal delivery showed an odds ratio (OR) of 1.76 (95% confidence interval [CI] 1.11–2.78; $p=0.015$). Cesarean-born infants had significantly higher birth weight and head circumference than vaginally born infants ($p<0.001$). Neonatal complications occurred in 96 newborns (7.06%), most commonly shoulder dystocia (10.60% of vaginal deliveries). NICU admission occurred in 95 newborns (6.99%), most commonly for respiratory distress (3.46%). NICU admission was significantly associated with a low 1-minute Apgar score ($p<0.001$), mode of delivery, and maternal comorbidity (OR=2.14; 95% CI 1.29–3.55; $p=0.003$). When gestational diabetes mellitus (GDM) status was reclassified into three categories (GDM-positive, screened-negative, unscreened), the NICU admission rate was higher in GDM-positive cases (15.71%) than in screened-negative cases (8.23%); the pre-specified primary test showed nominal significance (OR=2.08; $p=0.046$), but the sensitivity analysis ($p=0.071$) and a 95% CI closely approaching 1 (0.998–4.326) indicated this result was method-sensitive and statistically fragile. Because GDM status was unknown in 877 cases and 50 of 70 GDM-positive cases had a glucose challenge test coded as "not performed" despite a recorded GDM diagnosis, this finding requires source-chart verification.

CONCLUSION: Male sex predominance and a high cesarean delivery rate were observed among macrosomic births. Shoulder dystocia and respiratory distress were the most common morbidities. Low 1-minute Apgar score, mode of delivery, and maternal comorbidity were significantly associated with NICU admission; the association with gestational diabetes was nominally significant but fragile on sensitivity testing. Given the absence of a control group and reliance on univariable analyses, these associations should not be interpreted as independent risk factors or predictors.

Keywords: Fetal Macrosomia,Cesarean Section,Shoulder Dystocia,Gestational Diabetes

Comparison of maternal and perinatal variables by mode of delivery

Variable	Episiotomy	Cesarean	Spontaneous vaginal	Test statistic	p
Maternal age (years)	27.75±5.1	29.41±5.6	29.32±5.3	16.729	<0.001
Gestational age (weeks)	39.78±1	39.22±1.2	39.7±1	65.896	<0.001
Fetal head circumference (cm)	36.22±1.1	37.03±1	36.1±1.2	134.993	<0.001
Birth weight (g)	4172.30± 174.5	4235.45± 212.1	4166.64± 185.3	41.327	<0.001
Birth length (cm)	52.71±1.6	52.81±1.4	52.69±1.7	4.129	0.127

Note: Values are mean±standard deviation. Comparisons were made using the Kruskal-Wallis test; for variables with a significant overall test, pairwise differences were assessed using the Mann-Whitney U test with Holm correction. Post hoc analysis showed that the cesarean group differed significantly from both the episiotomy and spontaneous vaginal groups for gestational age, fetal head circumference, and birth weight (all Holm-corrected p<0.001), while the episiotomy and spontaneous vaginal groups did not differ from each other on these three variables. For maternal age, the episiotomy group differed significantly from both other groups (Holm-corrected p<0.01), with no difference between the cesarean and spontaneous vaginal groups. n=1360 (episiotomy=269, cesarean=813, spontaneous vaginal=278).

Comparison of maternal and perinatal variables by mode of delivery

Variable	Episiotomy	Cesarean	Spontaneous vaginal	Test statistic	p
Maternal age (years)	27.75±5.1	29.41±5.6	29.32±5.3	16.729	<0.001
Gestational age (weeks)	39.78±1	39.22±1.2	39.7±1	65.896	<0.001
Fetal head circumference (cm)	36.22±1.1	37.03±1	36.1±1.2	134.993	<0.001
Birth weight (g)	4172.30± 174.5	4235.45± 212.1	4166.64±185.3	41.327	<0.001
Birth length (cm)	52.71±1.6	52.81±1.4	52.69±1.7	4.129	0.127

Note: Values are mean±standard deviation. Comparisons were made using the Kruskal-Wallis test; for variables with a significant overall test, pairwise differences were assessed using the Mann-Whitney U test with Holm correction. Post hoc analysis showed that the cesarean group differed significantly from both the episiotomy and spontaneous vaginal groups for gestational age, fetal head circumference, and birth weight (all Holm-corrected p<0.001), while the episiotomy and spontaneous vaginal groups did not differ from each other on these three variables. For maternal age, the episiotomy group differed significantly from both other groups (Holm-corrected p<0.01), with no difference between the cesarean and spontaneous vaginal groups. n=1360 (episiotomy=269, cesarean=813, spontaneous vaginal=278).

SS-28

The role of first-trimester thyroid function tests in predicting gestational diabetes mellitus

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OBJECTIVE: This retrospective study aimed to investigate the association between first-trimester thyroid function test abnormalities and the development of gestational diabetes mellitus (GDM) in pregnant women aged 18–40 years.

METHODS: A total of 9698 pregnant women followed at Ankara Bilkent City Hospital between 2020 and 2023 were retrospectively evaluated. Women aged 18–40 years who underwent thyroid function testing during the first trimester and an oral glucose tolerance test (OGTT) during the second trimester and who met the inclusion criteria were included. Women with comorbidities other than thyroid dysfunction and GDM, multiple pregnancies, or a history of thyroid surgery were excluded. Data on age, gravidity, parity, thyroid function tests, thyroid autoantibody status, fasting blood glucose, and OGTT results were obtained from patient records and the hospital information system.

RESULTS: Among the study population, 5,024 women underwent a 50-g OGTT and 4,857 underwent a 75-g OGTT; 517 women also underwent a 100-g OGTT. No statistically significant differences were observed in the distribution of 50-g, 75-g, or 100-g OGTT results across TSH categories (all $p>0.05$). Similarly, thyroid-stimulating hormone (TSH), free thyroxine (fT4), and free triiodothyronine (fT3) levels did not differ significantly according to OGTT classification (all $p>0.05$). Receiver operating characteristic (ROC) analysis of TSH yielded an area under the curve (AUC) of 0.515 (95% confidence interval [CI], 0.481–0.549; $p=0.376$), indicating no significant discriminatory ability for predicting an abnormal 50-g OGTT result. The AUC values for fT4 and fT3 were also not statistically significant ($p=0.999$ and $p=0.255$, respectively). Thyroid autoantibody positivity was not significantly associated with GDM (anti-thyroglobulin antibody, $p=0.103$; anti-thyroid peroxidase antibody, $p=0.067$).

CONCLUSION: First-trimester thyroid function tests were not significantly associated with GDM and did not demonstrate predictive value for GDM in this study. Although anti-thyroid peroxidase and anti-thyroglobulin antibody positivity rates were higher among women with GDM, the differences were not statistically significant. Further studies in more homogeneous populations and incorporating established GDM risk factors are warranted to clarify the potential relationship between maternal thyroid function and GDM.

Keywords: Gestational diabetes mellitus, Oral glucose tolerance test, Thyroid autoantibodies, Thyroid function tests, Thyroid-stimulating hormone

SS-29

Association Between Maternal Age and Obstetric and Neonatal Outcomes: Experience from a Single Tertiary Center

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OBJECTIVE: To compare obstetric and neonatal outcomes across different maternal age groups among women who delivered at a tertiary care center.

METHODS: This retrospective, single-center study included 5,381 women who had live births at Antalya City Hospital between February 2, 2024, and April 13, 2026 and met the study criteria. Pregnancies complicated by fetal anomalies were excluded. Women were categorized into six groups according to maternal age: <20, 20–24, 25–29, 30–34, 35–39, and ≥40 years. Mode of delivery, gestational diabetes mellitus (GDM), gestational hypertension, preeclampsia, fetal growth restriction (FGR), oligohydramnios, polyhydramnios, preterm birth before 37 and 34 weeks, birth weight, gestational age at delivery, and 5-minute Apgar score were compared across maternal age groups. Categorical variables were compared using the chi-square test or Fisher's exact test, as appropriate, while continuous variables were compared using the Kruskal–Wallis test. Statistical significance was defined as $p<0.05$.

RESULTS: Of the 5,381 women, 215 (4.0%) were aged <20 years, 1,228 (22.8%) were aged 20–24 years, 1,956 (36.4%) were aged 25–29 years, 1,289 (24.0%) were aged 30–34 years, 555 (10.3%) were aged 35–39 years, and 138 (2.6%) were aged ≥40 years. The cesarean delivery rate increased from 30.7% in women aged <20 years to 77.5% in those aged ≥40 years ($p<0.001$). The prevalence of GDM increased from 0% in women aged <20 years to 4.4% in those aged ≥40 years ($p<0.001$). Preeclampsia was most frequent in women aged ≥40 years (2.9%; $p=0.034$). FGR differed significantly across maternal age groups ($p=0.049$), whereas no significant differences were observed in gestational hypertension, oligohydramnios, or polyhydramnios. The rate of preterm birth before 37 weeks was lowest in women aged 25–29 years (8.2%), compared with 14.0% in women aged <20 years and 17.4% in those aged ≥40 years ($p<0.001$). The corresponding rates of preterm birth before 34 weeks were 1.2%, 2.3%, and 5.1%, respectively ($p=0.006$). Birth weight and gestational age at delivery differed significantly across maternal age groups (both $p<0.001$), whereas no significant difference was observed in 5-minute Apgar scores ($p=0.880$).

CONCLUSION: Obstetric outcomes differed significantly across maternal age groups. Advanced maternal age was associated with higher rates of cesarean delivery and GDM. Preterm birth rates were lowest among women aged 25–29 years and were higher at both extremes of maternal age. In contrast, 5-minute Apgar scores did not differ significantly across maternal age groups.

Keywords: Maternal age, obstetric outcomes, preterm birth, cesarean delivery, Apgar score

Tablo 1

Table 1. Descriptive characteristics of the study population

Variable	Summary
Maternal age (years)	28.1 ± 5.4
Birth weight (g)	3260 (300–5010)
Neonatal length (cm)	50 (23–58)
Head circumference (cm)	35 (17–40)
5-minute Apgar score	10 (1–10)
Gestational age at delivery (weeks)	38 (24–43)
Parity	2 (1–11)

Data are presented as mean ± standard deviation for approximately normally distributed variables and as median (range) for non-normally distributed variables.

Descriptive characteristics of the study population

Tablo 2

Table 2. Distribution of the study population by maternal age group

Maternal age group	n	%
<20	215	4.00
20–24	1,228	22.82
25–29	1,956	36.35
30–34	1,289	23.95
35–39	555	10.31
≥40	138	2.56
Total	5,381	100.00

Distribution of the study population by maternal age group

Tablo3

Table 3. Obstetric outcomes according to maternal age group

Outcome	<20	20–24	25–29	30–34	35–39	≥40	p value
Gestational diabetes mellitus (GDM), n (%)	0 (0.0)	7 (0.6)	31 (1.6)	28 (2.2)	16 (2.9)	6 (4.4)	<0.001
Gestational hypertension, n (%)	0 (0.0)	0 (0.0)	2 (0.1)	1 (0.1)	0 (0.0)	0 (0.0)	0.841
Preeclampsia, n (%)	0 (0.0)	7 (0.6)	13 (0.7)	10 (0.8)	3 (0.5)	4 (2.9)	0.034
Fetal growth restriction (FGR), n (%)	6 (2.8)	18 (1.5)	21 (1.1)	7 (0.6)	7 (1.3)	1 (0.7)	0.049
Oligohydramnios, n (%)	0 (0.0)	5 (0.4)	3 (0.2)	2 (0.2)	2 (0.4)	1 (0.7)	0.467
Polyhydramnios, n (%)	0 (0.0)	5 (0.4)	7 (0.4)	7 (0.6)	4 (0.7)	0 (0.0)	0.656
Preterm birth <37 weeks, n (%)	30 (14.0)	119 (9.7)	161 (8.2)	135 (10.5)	70 (12.6)	24 (17.4)	<0.001
Preterm birth <34 weeks, n (%)	5 (2.3)	19 (1.6)	24 (1.2)	28 (2.2)	15 (2.7)	7 (5.1)	0.008
Birth weight (g), median (range)	3130 (1180–4360)	3190 (800–4800)	3290 (650–4930)	3300 (300–4845)	3300 (370–5010)	3240 (940–4330)	<0.001
Gestational age at delivery (weeks), median (range)	38 (26–42)	39 (25–42)	39 (26–43)	38 (23–42)	38 (22–42)	38 (29–41)	<0.001
5-minute Apgar score, median (range)	10 (5–10)	10 (1–10)	10 (2–10)	10 (1–10)	10 (1–10)	10 (7–10)	0.880

Obstetric outcomes according to maternal age group

SS-30

Prognostic value of the initial serum β-hCG level in predicting pregnancy outcome in spontaneous pregnancies: a single-center retrospective study

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KAYSERİ CİTY HOSPİTAL

AIM: The role of serum β-hCG levels measured in early pregnancy in predicting pregnancy prognosis has been investigated particularly in pregnancies following assisted reproductive technologies. Initial β-hCG measured after single euploid embryo transfer has been reported to predict live birth in a stepwise manner (Clarke et al., Fertility and Sterility, 2026), while a separate study reported that a β-hCG threshold of 518 mIU/mL measured on day 13 after transfer strongly predicted live birth and eliminated the need for repeated measurements (Shibli Abu Raya et al., Endocrine Connections, 2023). These findings constituted the starting point of our study: it remains unclear whether this relationship, consistently demonstrated in controlled IVF populations, also holds true in spontaneous pregnancies, in which the timing of measurement is not standardized. In this study, we evaluated the association between the initial serum β-hCG level measured at the time of pregnancy detection and pregnancy outcome (live birth versus pregnancy loss) in spontaneous pregnancies.

MATERIALS-METHODS: Cases in whom both pregnancy diagnosis and pregnancy outcome were followed at our clinic were retrospectively reviewed. A total of 120 spontaneous pregnancies with both an initial serum β-hCG measurement and a recorded pregnancy outcome (live birth or abortion) over a six-month period were included in the study. Cases were divided into live birth (n=59) and abortion (n=61) groups. Maternal age, gestational week, and initial β-hCG levels were compared between groups. The Mann-Whitney U test and multivariable logistic regression analysis adjusted for maternal age were used for statistical analysis.

RESULTS: The median maternal age was 26 years in the live birth group and 30 years in the abortion group (p=0.0003). Initial serum β-hCG levels were 699 IU/L in the live birth group and 844 IU/L in the abortion group, with no significant difference between groups (p=0.743). In the age-adjusted multivariable logistic regression analysis, the initial β-hCG level was not an independent predictor of pregnancy outcome (OR=1.06; 95% CI 0.85–1.33; p=0.59). In contrast, maternal age was found to be a significant, independent factor associated with pregnancy outcome (OR=1.13; 95% CI 1.05–1.22; p=0.001).

CONCLUSION: In contrast to this strong predictive relationship consistently demonstrated in controlled IVF populations, a single serum β-hCG value measured at the time of pregnancy detection does not appear to be a sufficient prognostic marker for predicting pregnancy outcome in spontaneous pregnancies. This discrepancy is thought to arise from the fact that, unlike the standardized measurement protocols (day 9 or day 13 after transfer) used in the reference studies, the timing of measurement was not standardized in our cohort. The prognostic value of β-hCG may be more pronounced in controlled pregnancy models in which the timing of measurement is standardized, whereas in spontaneous pregnancies, clinical factors such as maternal age may play a stronger role in determining pregnancy prognosis

Keywords: β-hCG, spontaneous pregnancy, pregnancy loss, live birth, early pregnancy prognosis

SS-31

Association between second trimester mean platelet volume and gestational diabetes mellitus

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OBJECTIVE: Gestational diabetes mellitus (GDM) is thought to involve subclinical insulin resistance and low-grade inflammation, both of which can enhance platelet activation. Mean platelet volume (MPV) — a parameter already generated by the routine complete blood count (CBC) — has been proposed as an indirect marker of this activation. However, evidence linking MPV to GDM specifically in the second trimester has been inconsistent. We therefore aimed to determine whether second-trimester MPV differs between pregnant women with and without GDM, and whether any such difference is independent of maternal age, body mass index (BMI), and family history of diabetes mellitus (DM).

METHODS: We conducted a retrospective, 1:2 frequency-matched case-control study of pregnant women who underwent a 75-g oral glucose tolerance test (OGTT) alongside a same-visit CBC at 24-28 weeks of gestation, across two hospitals between 2021 and 2024. GDM was defined per International Association of Diabetes and Pregnancy Study Groups (IADPSG) criteria (fasting glucose ≥92 mg/dL, 1-hour ≥180 mg/dL, or 2-hour ≥153 mg/dL). Women were excluded if they had pregestational DM, a multiple pregnancy, chronic or gestational hypertension, autoimmune, inflammatory or hematologic disease, an active infection, anemia (hemoglobin <10.5 g/dL), use of platelet-affecting medication, or more than a 7-day gap between OGTT and CBC sampling. Continuous variables are presented as median (interquartile range, IQR) and were compared with the Mann-Whitney U test; categorical variables were compared with the chi-square test. A multivariable logistic regression model, adjusted for age, BMI, and family history, tested whether MPV was independently associated with GDM, and receiver operating characteristic (ROC) curve analysis assessed its diagnostic performance.

RESULTS: Among 330 women screened, 66 (20.0%) met an exclusion criterion, leaving 264 women for analysis — 88 with GDM and 176 matched controls. Compared with controls, women with GDM were older [31.0 (26.0-34.0) vs 27.0 (24.0-30.0) years], had a higher BMI [27.6 (25.2-29.9) vs 24.4 (22.2-26.4) kg/m²], and more often reported a family history of DM (53.4% vs 26.1%; all p<0.001). MPV was also higher in the GDM group [9.1 (8.4-9.8) vs 8.5 (7.9-9.2) fL, p<0.001], reflecting a moderate effect size (Cohen's d=0.491). This association persisted after adjusting for age, BMI, and family history (odds ratio [OR]=1.60, 95% confidence interval [CI]: 1.17-2.18, p=0.003). Alone, MPV showed modest discriminative ability (area under the ROC curve=0.639); at the optimal cutoff of ≥8.63 fL, sensitivity was 69.3% and specificity 56.2%. Because the matched design does not reproduce true GDM prevalence, predictive values were not reported; prevalence-independent likelihood ratios are presented instead (LR+=1.58, LR−=0.55).

CONCLUSION: Second-trimester MPV was independently associated with GDM even after accounting for established risk factors, suggesting it could serve as a low-cost, adjunctive marker rather than a standalone screening tool. Given its limited discriminative power alone, MPV may be more useful alongside existing risk-stratification strategies incorporating maternal age, BMI, and family history. Confirming these findings will require prospective studies under standardized preanalytical conditions across diverse populations.

Keywords: Gestational diabetes mellitus, MPV, Pregnancy

Table 1. Comparison between GDM and control groups

Variable	Control (n=176)	GDM (n=88)	p
Age (years)	27.0 (24.0-30.0)	31.0 (26.0-34.0)	<0.001
BMI (kg/m²)	24.4 (22.2-26.4)	27.6 (25.2-29.9)	<0.001
Family history of DM, n (%)	46 (26.1)	47 (53.4)	<0.001
MPV (fL)	**8.5 (7.9-9.2)**	**9.1 (8.4-9.8)**	**<0.001**

After adjustment for age, BMI, and family history, MPV remained independently associated with GDM (adjusted OR=1.60, 95% CI: 1.17-2.18, p=0.003).

Continuous variables are shown as median (interquartile range) and were compared using the Mann-Whitney U test; categorical variables using the chi-square test. GDM: gestational diabetes mellitus; BMI: body mass index; MPV: mean platelet volume; DM: diabetes mellitus; OR: odds ratio; CI: confidence interval.

SS-32

Evaluation of Maternal and Neonatal Outcomes in Adolescent Pregnancies: A Single-Center Experience

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INTRODUCTION: Adolescent pregnancies, defined by the World Health Organization as pregnancies occurring between the ages of 10 and 19 years, remain a significant public health concern worldwide. Due to biological immaturity, inadequate prenatal care, and unfavorable socioeconomic conditions, adolescent pregnancies have been associated with adverse maternal and perinatal outcomes, including preterm birth, low birth weight, cesarean delivery, and neonatal morbidity. However, the strength of these associations may vary across countries and healthcare systems. This study aimed to evaluate the obstetric and neonatal outcomes of adolescent pregnancies managed at our center.

METHODS: This retrospective study included 42 adolescent pregnant women aged 16–19 years who delivered at our tertiary referral center between January 2023 and March 2026. Data from non-adolescent pregnant women who delivered at our center during the same period were utilized as a comparative baseline for specific outcomes. Demographic characteristics, obstetric parameters, and neonatal outcomes were obtained from the hospital database. Continuous variables were presented as mean ± standard deviation or median (minimum–maximum), whereas categorical variables were expressed as numbers and percentages.

RESULTS: The mean maternal age was 18.0±0.7 years. The mean gestational age at delivery was 38.4±1.5 weeks, and the mean birth weight was 3040±497 g. Intrauterine growth restriction (IUGR) was observed in 6 cases (14.3%), compared to 10.8% (n=401) among the non-adolescent pregnant women delivering during the same period. Preeclampsia developed in 2 cases (4.8%), and one case of intrauterine fetal demise was recorded. The preterm birth rate was 7.1% (n=3). Of all deliveries, 29 (69.0%) were vaginal, 2 (4.8%) were operative vaginal, and 11 (26.2%) were performed by cesarean section. Indications for cesarean delivery included fetal distress (n=4), labor arrest (n=3), breech presentation (n=2), fetal macrosomia (n=1), and maternal vertebral pathology (n=1). Mean hemoglobin levels were 11.50±1.30 g/dL on admission and 10.21±1.22 g/dL at the sixth postpartum hour. The mean 1-minute and 5-minute Apgar scores were 9.24±1.36 and 9.76±0.62, respectively. The mean umbilical artery pH was 7.33±0.07. Seventeen newborns (40.5%) required NICU admission. The indications for NICU admission were tachypnea (n=8), early neonatal sepsis (n=4), neonatal jaundice (n=3), meconium aspiration syndrome (n=1), and omphalitis (n=1).

CONCLUSION: Although most adolescent pregnancies resulted in term live births, careful monitoring is warranted due to the notable rates of intrauterine growth restriction and neonatal intensive care unit admission. Maintaining effective antenatal follow-up programs for adolescent pregnant women may contribute to improved maternal and neonatal outcomes.

Keywords: Adolescent pregnancy, Obstetric outcomes, Neonatal outcomes, Intrauterine growth restriction, Neonatal intensive care unit

SS-33

EXIT Procedure in an Infant with Right-Sided Congenital Diaphragmatic Hernia: A Case Report

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INTRODUCTION: Congenital diaphragmatic hernia is a serious congenital anomaly characterized by herniation of intra-abdominal organs into the thoracic cavity through a developmental defect of the diaphragm, with an incidence of approximately 2.6 per 10,000 births. Displacement of the abdominal viscera into the thorax impairs fetal lung development and may result in pulmonary hypoplasia and varying degrees of respiratory failure. Overall mortality has been reported as 37.7%; however, mortality varies according to the center, the presence of associated anomalies, the degree of pulmonary hypoplasia, and the severity of pulmonary hypertension.

The ex utero intrapartum treatment (EXIT) procedure is a delivery technique that allows the airway to be secured while placental circulation is maintained, with the fetus partially or completely delivered.

CASE REPORT: A 27-year-old gravida 1, para 0 woman with a history of chronic hypertension was placed under regular perinatology follow-up after detailed ultrasonography revealed a right-sided diaphragmatic hernia. Fetal echocardiography was reported as normal. On fetal magnetic resonance imaging (MRI), the integrity of the diaphragm in the right hemithorax could not be clearly delineated; the liver and gallbladder were observed to be herniated anteriorly and intestinal loops posteriorly. The right lung was markedly small (craniocaudal diameter approximately 20 mm) and the left lung was normal, although a pronounced leftward shift of the heart and mediastinum was noted. As the findings were considered consistent with severe right-sided congenital diaphragmatic hernia, delivery was planned to take place in the operating room with a multidisciplinary team in attendance. Cesarean section was performed under general anesthesia at 37 weeks and 4 days of gestation. Following delivery of the infant, the umbilical cord was left unclamped, and while placental circulation was maintained, sterile intubation was performed by the neonatology team; the cord was divided only after the airway had been secured. The infant, whose Apgar scores were 6 at 1 minute and 7 at 5 minutes, was admitted to the neonatal intensive care unit for planning of pediatric surgical repair.

DISCUSSION: In this case, the acceptable Apgar scores at 1 and 5 minutes (6 and 7, respectively) illustrate the contribution of a planned and controlled EXIT approach in reducing the risk of acute asphyxia at the time of delivery. Nevertheless, the principal prognostic determinants in these cases remain the severity of pulmonary hypertension developing in the postnatal period and the degree of pulmonary hypoplasia; therefore, early surgical repair by pediatric surgery and close monitoring throughout the intensive care course are of particular importance.

CONCLUSION: Cases of severe congenital diaphragmatic hernia presenting on the right side with herniation of the liver and gallbladder should be regarded as high-risk pregnancies once a prenatal diagnosis has been established. Delivery should be planned by a multidisciplinary team including perinatology, neonatology, pediatric surgery, and anesthesiology, at a center experienced in both surgical management and the EXIT procedure.

Keywords: Congenital diaphragmatic hernia, EXIT procedure, multidisciplinary approach

Figure 1



Ex utero intrapartum treatment (EXIT) procedure

Figure 2



Ex utero intrapartum treatment (EXIT) procedure

SS-34

Successful multidisciplinary cesarean management in a pregnant woman with congenital bladder exstrophy following multiple reconstructive surgeries in childhood: A rare case report

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OBJECTIVE: Congenital bladder exstrophy is a rare congenital anomaly affecting the bladder, anterior abdominal wall, pelvis, and external genitalia, with an estimated incidence of 1 in 30,000–50,000 live births. Advances in reconstructive surgery have enabled affected individuals to reach reproductive age, making pregnancy possible. Surgical procedures commonly include primary bladder closure, pelvic reconstruction, bladder neck reconstruction, augmentation cystoplasty, and creation of a catheterizable urinary channel. However, pregnancy and delivery in women with multiple pelvic reconstructive procedures, augmentation cystoplasty, and catheterizable urinary diversion remain technically challenging from both obstetric and urological perspectives. We present the successful multidisciplinary cesarean management of a pregnant woman with an extensive history of reconstructive urinary surgery. The patient was able to perform clean intermittent catheterization until 24 weeks of gestation, after which she switched to spontaneous urethral voiding because catheterization became increasingly difficult.

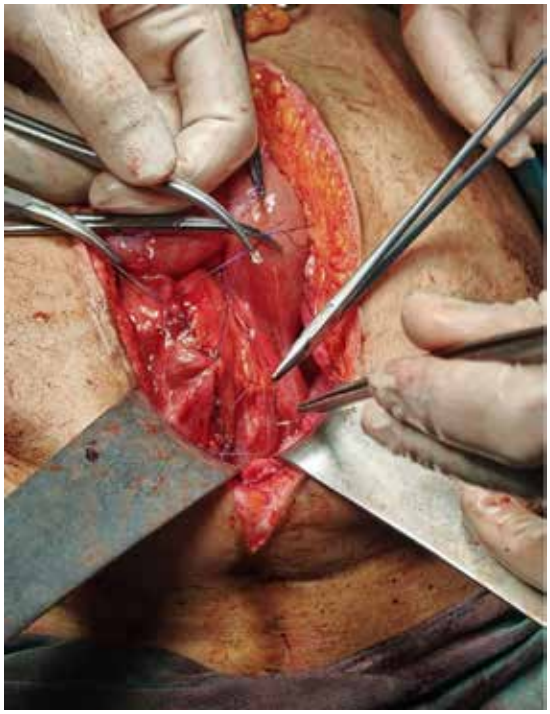
METHODS: A retrospective evaluation was performed on a 27-year-old primigravid woman with a history of eight reconstructive surgeries for classic bladder exstrophy during childhood, augmentation cystoplasty, and transabdominal clean intermittent catheterization. Antenatal follow-up findings, obstetric assessments, surgical management, intraoperative complications, and postoperative clinical outcomes were reviewed. Pregnancy was managed collaboratively by multidisciplinary teams from obstetrics and gynecology, urology, and pediatric surgery.

RESULTS: The pregnancy was achieved spontaneously. Following an increased risk identified on first-trimester screening, amniocentesis demonstrated a normal fetal karyotype. Serial ultrasonographic examinations showed fetal growth appropriate for gestational age without major structural anomalies. At 35+2 weeks of gestation, cesarean delivery was indicated because of regular uterine contractions and breech presentation. Owing to the patient's history of multiple abdominal and pelvic surgeries, urology and pediatric surgery teams participated in the operation. Dense pelvic adhesions significantly distorted the surgical anatomy, and the augmented bladder was inadvertently entered during dissection of the lower uterine segment. Intraoperative exploration revealed an approximately 6-cm bladder stone within the augmented bladder. The cystotomy was extended, the stone was successfully removed during the same procedure, and the bladder was repaired with multilayer primary suturing. A healthy male infant weighing approximately 2,500 g was delivered. Postoperatively, the patient received broad-spectrum antibiotics, urinary drainage, thromboprophylaxis, and close multidisciplinary follow-up. She was discharged in stable condition with a urinary catheter.

CONCLUSION: Pregnancy is not an absolute contraindication in women with congenital bladder exstrophy who have undergone multiple reconstructive surgeries. Nevertheless, altered pelvic anatomy, extensive adhesions, and a reconstructed urinary tract make pregnancy and delivery high-risk. Careful preoperative planning, early involvement of relevant surgical specialties, and a multidisciplinary approach are essential for the successful management of potential complications. Simultaneous repair of augmentation bladder injury together with removal of a large bladder stone during cesarean delivery represents a particularly rare feature of this case. This report highlights the critical role of multidisciplinary management in achieving favorable maternal and neonatal outcomes in pregnant women with complex reconstructive urinary surgical histories.

Keywords: augmentation cystoplasty, cesarean section, congenital bladder exstrophy, multidisciplinary approach, pregnancy, bladder stone.

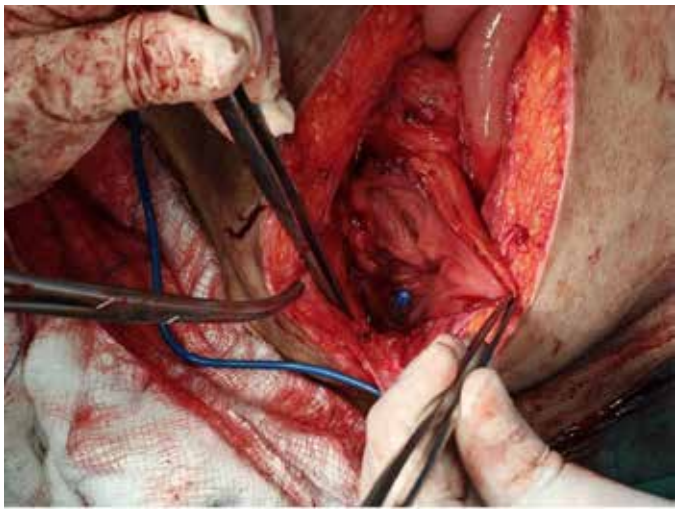
augmentation cystoplasty



augmentation cystoplasty



augmentation cystoplasty



bladder stone



cesarean section



SS-35

"At Most Borderline" and "At Least Borderline" in Intraoperative Frozen Section Evaluation of Ovarian Masses: Same Uncertainty, Different Probability of Malignancy?

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Antalya Şehir Hastanesi

OBJECTIVE: The terms "at most borderline" and "at least borderline" may be used in frozen section examination of ovarian masses when a definitive diagnosis cannot be reached intraoperatively. We compared the final histopathological outcomes and surgical extension rates of these two intermediate frozen section categories and evaluated their association with final invasive malignancy.

MATERIALS-METHODS: This single-center retrospective study included 110 patients who underwent surgery for an ovarian mass and intraoperative frozen section examination between June 2024 and July 2026. Frozen section results were classified as benign, "at most borderline," "at least borderline," malignant, or indeterminate. Final histopathological diagnoses were classified as benign, borderline, or malignant, with paraffin section examination used as the reference standard. The "at most borderline" and "at least borderline" groups were compared according to final histopathology, final borderline or malignant pathology, invasive malignancy, and surgical extension. Diagnostic performance was also assessed using separate thresholds for final borderline/malignant pathology and invasive malignancy.

RESULTS: Frozen section results were benign in 84 (76.4%) patients, "at most borderline" in 11 (10.0%), "at least borderline" in 7 (6.4%), malignant in 7 (6.4%), and indeterminate in 1 (0.9%). Final histopathology was benign in 89 (80.9%), borderline in 7 (6.4%), and malignant in 14 (12.7%) patients. Among patients with an "at most borderline" frozen section result, final histopathology was benign in 5 (45.5%), borderline in 5 (45.5%), and malignant in 1 (9.1%). In the "at least borderline" group, these numbers were 1 (14.3%), 1 (14.3%), and 5 (71.4%), respectively. Final histopathological distribution differed between the two groups (p=0.038). Invasive malignancy was more frequent in the "at least borderline" group than in the "at most borderline" group (71.4% vs. 9.1%, p=0.013). The combined rate of final borderline or malignant pathology was 85.7% and 54.5%, respectively (p=0.316). Surgical extension was performed in 57.1% and 63.6% of patients, respectively (p=1.000) (Table 1). For final borderline or malignant pathology, frozen section had a sensitivity of 90.5%, specificity of 93.2%, and accuracy of 92.7% (κ=0.780). For invasive malignancy, sensitivity was 85.7%, specificity 97.9%, and accuracy 96.3% (κ=0.836).

CONCLUSION: "At most borderline" and "at least borderline" frozen section results were associated with different final histopathological outcomes. Invasive malignancy was more frequent after an "at least borderline" result, although the number of patients in this subgroup was limited. Surgical extension rates were similar despite the difference in final invasive malignancy. Reporting these intermediate categories separately may help convey the nature of diagnostic uncertainty during surgery, while the extent of surgery should be determined together with the patient's clinical characteristics and intraoperative findings.

Keywords: borderline ovarian tumor, frozen section; intraoperative consultation, invasive malignancy, ovarian mass

Table 1. Final histopathological outcomes according to intermediate frozen section diagnosis

Outcome	At most borderline (n=11)	At least borderline (n=7)	p value
Final histopathological distribution			0.038
Final benign	5 (45.5%)	1 (14.3%)	
Final borderline	5 (45.5%)	1 (14.3%)	
Final malignant	1 (9.1%)	5 (71.4%)	
Final borderline or malignant	6 (54.5%)	6 (85.7%)	0.316
Invasive malignancy	1 (9.1%)	5 (71.4%)	0.013
Surgical extension	7 (63.6%)	4 (57.1%)	1.000

Final histopathological distribution was compared using the Fisher–Freeman–Halton exact test. Binary outcomes were compared using the two-sided Fisher's exact test.

SS-36

Prognostic Factors Associated with Overall and Disease-Free Survival in Ovarian Clear Cell Carcinoma

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OBJECTIVE: Ovarian clear cell carcinoma (OCCC) is a rare but clinically aggressive histologic subtype of epithelial ovarian cancer. This study aimed to evaluate the clinicopathological factors associated with overall survival and disease-free survival in patients who underwent surgery for ovarian clear cell carcinoma.

METHODS: A total of 97 patients diagnosed with ovarian clear cell carcinoma at the Department of Gynecologic Oncology, Başkent University Ankara Hospital, between June 1, 2007, and July 31, 2023, were retrospectively evaluated. Patient age at diagnosis, menopausal status, Cancer Antigen 125 (CA-125) level, serum albumin level, surgical characteristics, pathological findings, International Federation of Gynecology and Obstetrics (FIGO) stage, response to chemotherapy, and follow-up outcomes were recorded. Overall survival and disease-free survival were assessed using the Kaplan–Meier method and the log-rank test. Independent variables associated with survival were evaluated using Cox proportional hazards regression analysis.

RESULTS: In the univariate analysis, FIGO stage, lymph node involvement, capsular rupture, lymphovascular space invasion, the presence of endometriosis, and platinum sensitivity were found to be significantly associated with overall survival. For disease-free survival, FIGO stage, lymph node involvement, capsular rupture, lymphovascular space invasion, and the presence of endometriosis were identified as significant factors. In the multivariate analysis, platinum sensitivity was the only independent variable associated with overall survival, whereas FIGO stage was the only independent variable associated with disease-free survival.

CONCLUSION: In ovarian clear cell carcinoma, platinum sensitivity is a key independent predictor of overall survival, whereas disease stage is a key independent predictor of disease-free survival. These findings suggest that early-stage diagnosis and response to platinum-based chemotherapy are important determinants of prognosis in this patient population.

Keywords: Ovarian clear cell carcinoma, overall survival, disease-free survival, platinum sensitivity, FIGO stage

SS-37

Clinicopathological characteristics and recurrence outcomes of uterine smooth muscle tumors of uncertain malignant potential

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OBJECTIVE: Uterine smooth muscle tumors of uncertain malignant potential (STUMP) are rare uterine smooth muscle tumors that lie between benign leiomyomas and leiomyosarcomas and exhibit an unpredictable biological behavior. The aim of this study was to evaluate the clinical and histopathological characteristics of patients diagnosed with STUMP at our center and to investigate recurrences during follow-up and the histopathological outcomes of recurrent tumors.

METHODS: This retrospective study included a total of 38 patients diagnosed with STUMP at our center. Demographic and clinical characteristics, tumor number and size, mitotic activity, tumor necrosis, cytological atypia, presence of concomitant leiomyomas, and immunohistochemical markers were retrospectively evaluated. Surgical procedures, duration of follow-up, development of recurrence, surgical treatments performed after recurrence, and histopathological outcomes were also recorded. Statistical analyses were performed using IBM SPSS Statistics.

RESULTS: A total of 38 patients with STUMP were included in the study. The median age was 42 years (range, 24–60 years), and the median tumor size was 6 cm (range, 0.6–30 cm). The median follow-up duration was 65 months (range, 8–179 months). During follow-up, recurrence occurred in 8 patients (21.1%). Among the 8 patients who developed recurrence, the median time to recurrence was 43 months (range, 11–80 months). Of these 8 patients, recurrence was histopathologically diagnosed as leiomyoma in 5 patients (62.5%), leiomyomatosis in 1 patient (12.5%), STUMP in 1 patient (12.5%), and leiomyosarcoma in 1 patient (12.5%). No statistically significant association was found between recurrence and surgical approach (p=0.114), Ki-67 level (p=0.089), p53 expression (p=0.303), presence of concomitant leiomyomas (p=0.232), degree of atypia (p=0.874), presence of necrosis (p=1.000), or mitotic activity (p=1.000).

CONCLUSION: Although STUMP is not considered a malignant tumor, it may exhibit unpredictable clinical behavior. In our study, 21.1% of patients developed recurrence, and leiomyosarcoma was detected during follow-up in 2.6% of the entire study population. Furthermore, the lack of a significant association between any of the evaluated clinical or histopathological parameters and recurrence highlights the

difficulty in predicting recurrence. These findings underscore the importance of long-term and regular follow-up in patients diagnosed with STUMP.

Keywords: STUMP, uterine smooth muscle tumor, recurrence, leiomyosarcoma, leiomyoma

Clinical and Histopathological Characteristics of Patients with STUMP

	Number (N)	Percentage (%)
Median Age, years (min-max)	42 (24-60)	
Median tumor size, centimeter (min-max)	6 (0,6-30)	
Number of tumors (min-max) 1 2 3	1-3 25 9 3	 65,8 23,7 7,9
Mitotic count (min-max) <5 ≥5	1-20 11 26	 28,9 68,4
Necrosis Present Absent	 21 15	 55,3 39,5
Cytological Atypia No Mİld Mild-Moderate Moderate Moderate-Severe Severe	9 8 3 6 8 4	23,7 21,1 7,9 15,8 21,1 10,5
Concomitant leiomyoma Present Absent	 19 19	 50 50
P53 Positive Negative	 10 9	 26,3 23,7
Ki67 <%5 %5-20 >%20	 5 13 1	 13,2 34,2 2,6
P16 Positive Negative	 16 3	 42,1 7,9
Recurrence Present Absent	 8 30	 21,1 78,9
Histopathology of recurrence (n=8) Leiomyoma Leiomyomatosis STUMP Leiomyosarcoma	 5 1 1 1	 62,5 12,5 12,5 12,5

The clinical and histopathological characteristics of patients with STUMP, including tumor features, immunohistochemical findings, recurrence rate, and histopathological outcomes of recurrence. Min–max: minimum–maximum.

Clinicopathological factors associated with recurrence in patients with STUMP

Parameter	N	p-value
Type of surgery (myomectomy / hysterectomy)	38	0,114
Ki-67 percentage	19	0,089
p53 (positive / negative)	19	0.303
Concomitant leiomyoma	38	0,232
Degree of atypia	38	0,874
Necrosis (present / absent)	36	1,000
Mitosis (>5 / <5)	37	1,000

None of the evaluated clinicopathological factors showed a statistically significant association with recurrence.

SS-38

Comparison of vaginal natural orifice transluminal endoscopic surgery and multiport conventional laparoscopy for complete pelvic lymphadenectomy: Insights from a single-surgeon experience

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BACKGROUND AND OBJECTIVES: We compared the outcomes of complete pelvic lymph node dissection performed via multiport conventional laparoscopy (MCL) versus vaginal natural orifice transluminal endoscopic surgery (vNOTES) in patients with endometrial cancer in whom sentinel lymph node (SLN) mapping was unsuccessful.

METHODS: This retrospective cohort study included 42 patients 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. Patients underwent either 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 collected and compared between the two groups.

RESULTS: Demographic and clinical characteristics were comparable between the two groups, with no statistically significant differences. Operative times were significantly longer in the vNOTES group (53.8 +/- 7.4 min) compared to the MCL group (46.9 +/- 9.2 min; P = 0.01), whereas estimated blood loss (17.7 +/- 5.6 mL vs. 18.8 +/- 5.0 mL; P = 0.50) and lymph node yield (32.1 +/- 6.6 vs. 35.0 +/- 8.1; P = 0.21) did not differ significantly. Postoperative pain assessed by visual analogue scale (VAS) was lower in the vNOTES group at 6 h (4.3 +/- 1.1 vs. 5.5 +/- 1.0; P = 0.01), 12 h (3.5 +/- 0.8 vs. 4.8 +/- 1.1; P < 0.001), and 24 h (2.1 +/- 0.6 vs. 3.1 +/- 0.9; P < 0.001). These findings were corroborated by the faces pain scale-revised (FPS-R), which demonstrated significantly lower pain in the vNOTES group at all time points. QoR-15 scores at 48 h were higher in the vNOTES group (109.3 +/- 4.7 vs. 104.9 +/- 4.1; P = 0.002), indicating improved postoperative recovery. The observed mean difference of approximately 4.4 points remained below the reported minimal clinically important difference of 8.0 points for this instrument, indicating that the statistically significant benefit should be interpreted with caution regarding its clinical magnitude.

CONCLUSION: vNOTES for complete pelvic lymphadenectomy offers reduced postoperative pain, scar-free surgery, and enhanced recovery while maintaining staging adequacy comparable to MCL. Future prospective, multicentre, randomised trials with long-term oncologic follow-up are required to validate these findings.

Keywords: vaginal natural orifice transluminal endoscopic surgery, pelvic lymphadenectomy, endometrial cancer

SS-39

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

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AIM: This study aimed to compare the intraoperative and postoperative outcomes of total vaginal natural orifice transendoscopic hysterectomy (TVNH) and single-incision laparoscopic hysterectomy (SILH) in patients with a narrow pubic arch.

METHODS: This observational retrospective study was conducted at the Department of Obstetrics and Gynecology between January 2023 and September 2025.

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. During the postoperative period, patients in the TVNH group demonstrated significantly lower mean scores on both the Visual Analog Scale and the Faces Pain Scale-Revised. In addition, at the 48th postoperative hour, the Quality of Recovery-15 score was significantly 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-40

Immunohistochemical Expression of HER2, Bcl-2, and E-cadherin in Endometrial Lesions

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OBJECTIVE: To investigate the immunohistochemical expression of HER2, Bcl-2, and E-cadherin in normal endometrium, endometrial intraepithelial neoplasia (EIN), and endometrioid-type endometrial carcinoma (EEC), and to assess their clinicopathological relevance.

METHODS: A total of 60 endometrial tissue samples (20 normal, 20 EIN, and 20 EEC) were retrospectively analyzed. Immunohistochemical staining for HER2, Bcl-2, and E-cadherin was performed and semi-quantitatively evaluated. Associations between marker expression and clinicopathological parameters were assessed.

RESULTS: HER2 expression was higher in EEC (45%) than in the other groups, although the difference was not statistically significant. Bcl-2 expression was highest in EIN and significantly decreased in EEC ($p=0.0067$). E-cadherin expression was significantly reduced in EEC (70%) compared with normal endometrium and EIN ($p<0.001$). Decreased Bcl-2 and E-cadherin expression was associated with higher tumor stage and grade, as well as myometrial and lymphovascular invasion. HER2 expression correlated with tumor stage and grade.

CONCLUSION: Alterations in apoptosis and cell adhesion pathways appear to contribute to endometrial carcinogenesis. Combined evaluation of HER2, Bcl-2, and E-cadherin may provide useful clinicopathological and prognostic information.

Keywords: Bcl-2, E-cadherin, Endometrial cancer, Endometrial intraepithelial neoplasia, HER2

SS-41

Clinical Outcomes and Prognostic Factors in Cervical Cancer: A Single-Center Retrospective Study Running Head: Cervical Cancer Single Center Results

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BACKGROUND/ AIM: Cervical cancer remains one of the leading causes of cancer-related morbidity and mortality among women worldwide despite the widespread implementation of screening programs. Several clinicopathological factors, including lymph node metastasis, lymphovascular space invasion, tumor size, and parametrial involvement, have been associated with prognosis and treatment outcomes. However, the prognostic significance of these factors and their impact on survival remain controversial.The aim of this study was to evaluate the clinical outcomes and prognostic clinicopathological factors in patients with cervical cancer treated at a single tertiary center and to investigate their association with pelvic lymph node involvement and survival.

MATERYAL AND METHODS: This retrospective single-center study included 45 patients diagnosed with cervical cancer and treated between 2007 and 2012 at the Department of Obstetrics and Gynecology, Mersin University Faculty of Medicine. Demographic characteristics, clinicopathological findings, treatment modalities, and follow-up data were retrieved from medical records. The associations between prognostic factors, including pelvic lymph node involvement, lymphovascular space invasion, endometrial involvement, parametrial involvement, surgical margin status, tumor size, smoking history, disease-free survival, and overall survival were analyzed. Statistical significance was defined as $p<0.05$.

RESULTS: A total of 45 patients with cervical cancer were included in the study. The median follow-up period was 42.2±21.6 months, and the mean age at diagnosis was 49.3±12 years (range, 17–82 years). Squamous cell carcinoma was the most common histological subtype, accounting for 67% (29/43) of the cases. No statistically significant differences in disease-free survival or overall survival were observed according to disease stage, treatment modality, pelvic lymph node involvement, endometrial involvement, parametrial involvement, surgical margin status, lymphovascular space invasion, or tumor size (all $p>0.05$). Lymphovascular space invasion and a history of smoking were significantly associated with pelvic lymph node involvement ($p=0.012$ and $p=0.033$, respectively). No significant associations were observed between pelvic lymph node involvement and endometrial involvement, parametrial involvement, positive surgical margins, or tumor size (all $p>0.05$).

DISCUSSION: This study demonstrated a significant association between lymphovascular space invasion and smoking history with pelvic lymph node involvement; these findings are consistent with prognostic factors reported in the literature. Lymphovascular space invasion is also identified in the literature as an independent risk factor for lymph node metastasis and tumor spread, and is considered a significant marker in treatment planning. The absence of a statistically significant difference in survival among treatment modalities in this study may be attributed to the limited sample size and the retrospective study design; therefore, prospective studies with larger sample sizes are needed.

CONCLUSION: Lymphovascular space invasion and smoking history were significantly associated with pelvic lymph node involvement in patients with cervical cancer. No significant differences in disease-free or overall survival were observed according to treatment modality or other clinicopathological prognostic factors. Larger prospective studies are warranted to better define prognostic factors and optimize treatment strategies in cervical cancer.

Keywords: Cervical cancer, prognostic factors, pelvic lymph node metastasis, lymphovascular space invasion, survival.

SS-42

Co-Detection of Human Papillomavirus and Sexually Transmitted Pathogens: A Retrospective Laboratory-Based Study Running Head: HPV-STI Coinfections

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BACKGROUND-AIM: Human papillomavirus (HPV) remains one of the most prevalent sexually transmitted viral infections worldwide and is a major etiological factor in cervical cancer and other anogenital malignancies. The presence of concomitant sexually transmitted pathogens may influence HPV acquisition, persistence, and disease progression. Understanding the patterns of HPV co-detection with other sexually transmitted infections (STIs) is therefore important for both clinical management and epidemiological surveillance. This study aimed to identify sexually transmitted diseases accepting HPV and to highlight the importance of simultaneous diagnosis and treatment.

MATERIALS-METHODS: This retrospective laboratory-based study included clinical specimens who tested positive for HPV and referred to the gynecologic oncology depertmant evaluated. STI testing between 2025 and 2026. Sexually transmitted pathogens were performed using multiplex real-time polymerase chain reaction (PCR) assays. Demographic data, HPV positivity rates, distribution of HPV genotypes, prevalence of STI pathogens, and co-detection patterns were evaluated using appropriate statistical analyses.

RESULTS: A total of 33 HPV-positive women with a mean age of 38.5±8.1 years were included in the study. HPV 16 was the most frequently detected genotype 16 patient (57.6%), followed by HPV 18: 9 patient (27.3%). Multiple HPV infections were identified in 10 person (30.3%) of the patients. The rate of STI panel positivity was 78.9% among women with HPV 16 (55.6%) and among those with HPV 18. No significant association was found between HPV 16 and STI panel positivity (p=0.366). Likewise, no statistically significant association was observed between HPV genotypes and the presence of Gardnerella vaginalis, Ureaplasma spp., Mycoplasma spp., Chlamydia trachomatis, or Trichomonas vaginalis (all p>0.05).

CONCLUSION: Simultaneous assessment of HPV and other sexually transmitted pathogens may provide valuable information for routine clinical practice and public health interventions. Further large-scale studies are warranted to clarify the clinical impact of these co-infections and their role in HPV-related disease progression.

Keywords: Human papillomavirus, sexually transmitted infections, urinary

SS-43

Multidisciplinary en bloc resection and vascular reconstruction for isolated pelvic recurrence involving major pelvic vessels: a case report

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OBJECTIVE: Pelvic malignancies involving major pelvic vascular structures represent a significant surgical challenge, often precluding complete tumor resection. In carefully selected patients, extensive en bloc resection combined with vascular reconstruction performed by a multidisciplinary team may increase the likelihood of achieving an R0 resection and durable disease control. We present the multidisciplinary surgical management of an isolated pelvic recurrence involving major pelvic vessels.

METHODS: A 48-year-old woman underwent Querleu–Morrow Type C1 radical hysterectomy, bilateral salpingo-oophorectomy, and bilateral pelvic and para-aortic lymphadenectomy for HPV-associated non-keratinizing squamous cell carcinoma of the cervix (FIGO 2018 stage IB2). Final pathology demonstrated a 38-mm tumor with negative surgical margins, no parametrial involvement, no lymphovascular space invasion, and no lymph node metastasis (0/28). The patient was subsequently enrolled in routine surveillance.

RESULTS: Eighteen months after primary surgery, positron emission tomography/computed tomography and pelvic magnetic resonance imaging revealed an approximately 8-cm multiloculated pelvic mass occupying the left external iliac-obturator region with intense metabolic activity in its solid components, accompanied by a second 3-cm lesion adjacent to the colon. No distant metastases were identified. Following multidisciplinary tumor board discussion, surgical treatment was planned. Intraoperatively, the tumor was found to invade the left common, internal, and external iliac arteries and veins, the distal ureter, and the rectosigmoid colon. As complete separation of the tumor from the involved vascular structures was not feasible, an en bloc resection was performed. The procedure included excision of the recurrent pelvic tumor, resection of the common, internal, and external iliac arteries and veins, iliofemoral arterial bypass using an 8-mm Dacron graft, vena cava-to-common femoral vein bypass using an 8-mm Dacron graft, left radical nephrectomy, rectosigmoid resection, and colorectal end-to-end anastomosis. Histopathological examination confirmed metastatic HPV-associated non-keratinizing squamous cell carcinoma involving the perivascular soft tissue and extending from the colonic

serosa into the muscularis propria. Immunohistochemistry demonstrated diffuse p16 and p40 positivity with a Ki-67 proliferation index of 90%.

CONCLUSION: Multidisciplinary surgery may represent a feasible treatment option for selected patients with isolated pelvic recurrence involving major pelvic vascular structures. En bloc resection combined with vascular reconstruction can facilitate complete tumor resection in highly selected cases and may expand the surgical management of locally advanced pelvic recurrences in experienced tertiary referral centers.

Keywords: Cervical cancer, Isolated pelvic recurrence, Iliac vessel resection,Vascular reconstruction, Gynecologic oncology

SS-44

Hpv-Independent, P53-Mutant Vulvar Squamous Cell Carcınoma In A 20-Year-Old Patıent: An Exceptıonal Case Report

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INTRODUCTION AND OBJECTIVE: Vulvar cancer is a rare gynecologic malignancy that predominantly affects older women. Vulvar squamous cell carcinoma (SCC) arises through two distinct pathogenetic pathways: HPV-associated and HPV-independent. Whereas HPV-associated tumors are more common in younger women, HPV-independent tumors characterized by aberrant p53 expression typically occur in older patients. We report the clinical, histopathological, and surgical features of an exceptionally rare case of HPV-independent, p53-mutant invasive vulvar SCC in a 20-year-old woman.

CASE PRESENTATION: A 20-year-old gravida 0, para 0, sexually inactive woman noticed a lesion in the clitoral region in October 2025. During labiaplasty in December 2025, biopsy of the vulvar lesion demonstrated a high-grade vulvar squamous intraepithelial lesion (HSIL) with involvement of the surgical margin. Because the patient was unaware of the pathology results, further evaluation and follow-up were delayed. Persistent non-healing vulvar wounds were treated with antibiotics in April 2026. Repeat biopsy in May 2026 revealed well-differentiated squamous cell carcinoma. Gynecological examination demonstrated an irregular, exophytic, necrotic mass involving the clitoris and bilateral vulvar structures (Figure 1).

CASE PRESENTATION (CONTINUED): Following lymphatic mapping with methylene blue, bilateral inguinal sentinel lymph node biopsy was performed. As frozen-section analysis revealed no evidence of metastatic disease, local radical vulvectomy was undertaken. The tumor, including the clitoris, bilateral labia majora and minora, distal urethra, and part of the vaginal mucosa, was resected en bloc with an intended gross surgical margin of approximately 1 cm (Figure 2). The vulvar defect was primarily reconstructed by mobilization of the vaginal mucosa and residual vulvar tissues (Figure 3).

HISTOPATHOLOGICAL FINDINGS: Final histopathological examination demonstrated a 3.5 × 3.5 × 1.2 cm keratinizing grade 2 invasive SCC. The tumor involved the bilateral labia majora, labia minora, clitoris, and distal urethra.

Depth of invasion was 8 mm. Lymphovascular invasion was absent, whereas perineural invasion was present. Surgical margins were negative. No metastases were identified in four sentinel and one non-sentinel inguinal lymph nodes. Immunohistochemistry demonstrated negative/focal p16 expression and a mutant-pattern p53 staining profile. Molecular analysis was negative for high-risk HPV genotypes. The PD-L1 combined positive score was 3.3.

DISCUSSION AND CONCLUSION: The occurrence of HPV-independent, p53-mutant vulvar SCC in a 20-year-old woman represents an exceptionally rare clinical and molecular presentation. Young age should not exclude the possibility of vulvar malignancy. Persistent or progressive vulvar lesions warrant prompt histopathological evaluation. Careful follow-up of HSIL and timely repeat biopsy are essential to prevent diagnostic delay. Surgical management in very young patients should balance oncologic safety with preservation of anatomy, cosmetic outcomes, and future sexual function.

Keywords: HPV-independent,p53-mutant squamous cell carcinoma, young patient,Vulvar cancer

Figure 1. Preoperative appearance of the irregular, exophytic, and necrotic tumor involving the clitoris and bilateral vulvar structures.



Figure 1. Preoperative appearance of the irregular, exophytic, and necrotic tumor involving the clitoris and bilateral vulvar structures.

Figure 2. Intraoperative view of the surgical field following en bloc tumor resection during local radical vulvectomy..



Figure 2. Intraoperative view of the surgical field following en bloc tumor resection during local radical vulvectomy..

Figure 3. Intraoperative view of the primary reconstruction performed by mobilization of the vulvar and vaginal tissues following local radical vulvectomy



Figure 3. Intraoperative view of the primary reconstruction performed by mobilization of the vulvar and vaginal tissues following local radical vulvectomy

SS-45

Small cell carcinoma of the ovary, hypercalcemic type: Treatment sequencing, extent of surgery and the fertility dilemma in a patient with a germline SMARCA4 mutation

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OBJECTIVE: Small cell carcinoma of the ovary, hypercalcemic type (SCCOHT), is an exceptionally rare and aggressive malignancy predominantly affecting young women. The absence of standardized treatment creates uncertainty regarding treatment sequencing, extent of surgery, and fertility preservation, particularly in germline SMARCA4 carriers. We present a young patient with SCCOHT to discuss these challenges.

METHODS: Clinical, radiological, pathological, and genetic findings and multidisciplinary tumor board decisions were retrospectively reviewed.

RESULTS: A 24-year-old nulliparous woman presenting with nausea and vomiting was found to have an adnexal mass during the evaluation of hypercalcemia. Cancer antigen 125 was 97.1 U/mL. Magnetic resonance imaging demonstrated a 122 × 99 mm complex left ovarian mass with an enhancing solid component and restricted diffusion, initially considered suspicious for a ovarian cancer.

Fertility-sparing left salpingo-oophorectomy, omentectomy, peritoneal biopsies, pelvic and para-aortic lymph node sampling, and cytology were performed at an other clinic. Histopathological examination showed capsular involvement by a highly mitotic malignant neoplasm with necrosis and follicle-like structures. All 13 sampled lymph nodes, peritoneal biopsies, omentum, and cytology were negative for malignancy. Strong Wilms tumor 1 and weak epithelial membrane antigen expression favored SCCOHT, whereas weak CD99 and steroidogenic factor 1 expression raised the differential diagnosis of a poorly differentiated Sertoli cell tumor. Referral-center consultation supported SCCOHT. Serum calcium normalized postoperatively.

Following ovarian tissue cryopreservation, carboplatin-etoposide chemotherapy was initiated. After four cycles, computed tomography showed no metastatic disease. Positron emission tomography/computed tomography demonstrated focal fluorodeoxyglucose uptake in the right vaginal wall without a structural correlate (maximum standardized uptake value: 4.4). Genetic testing identified a heterozygous germline SMARCA4 mutation.

Completion surgery included total abdominal hysterectomy, right salpingo-oophorectomy, intraoperative vaginal assessment and biopsy. A 3–4 cm macroscopically suspicious area involving the right ovary and adherent to the ileum was excised. No residual malignancy was identified in the surgical specimens or vaginal biopsy. The patient was subsequently referred for consideration of high-dose chemotherapy.

CONCLUSION: This case highlights the diagnostic difficulty of SCCOHT and three unresolved management questions: whether systemic therapy should precede completion surgery, how germline SMARCA4 findings should influence the extent and timing of surgery, and how oncological safety should be balanced against fertility preservation. Molecular evaluation, expert pathological review, multidisciplinary decision-making, early fertility counseling, and cautious interpretation of isolated metabolic imaging findings are essential. Collaborative studies are required to establish standardized management strategies.

Keywords: SCCOHT, paraneoplastic hypercalcemia, fertility preservation, SMARCA4

SS-46

Vulvar Squamous Cell Carcinoma Developing on the Basis of Fanconi Anemia: Case Report

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OBJECTIVE: Fanconi Anemia (FA) is a rare inherited disorder characterized by impaired DNA repair, congenital anomalies, progressive bone marrow failure, and a markedly increased susceptibility to malignancies, particularly squamous cell carcinomas at a young age. We report a case of HPV-negative vulvar squamous cell carcinoma in a young woman with a known history of FA.

CASE PRESENTATION: A 27-year-old woman diagnosed with FA at the age of six, with a history of congenital polydactyly (surgically corrected), presented with a six-month history of a progressively enlarging and intermittently bleeding vulvar lesion. Excisional biopsy confirmed squamous cell carcinoma (NOS). Immunohistochemical analysis demonstrated diffuse p40 positivity, negative p16 expression, and a high Ki-67 proliferation index reaching up to 90% in focal areas. FDG-PET and pelvic MRI showed no evidence of regional or distant metastasis. The patient underwent radical vulvectomy with sentinel lymph node biopsy, which revealed no nodal involvement. However, possible periurethral margin involvement was noted. According to FIGO 2021 staging, the tumor was classified as stage IB. Following multidisciplinary tumor board discussion, adjuvant radiotherapy was recommended after adequate wound healing.

CONCLUSION: HPV-negative vulvar squamous cell carcinoma in patients with Fanconi Anemia is rare but represents a clinically important entity due to early onset and potential treatment-related complications. Careful multidisciplinary management is essential, particularly considering the increased sensitivity of FA patients to DNA-damaging therapies.

DISCUSSION: Patients with Fanconi Anemia are predisposed to early-onset squamous cell carcinomas due to defective DNA repair pathways, independent of HPV infection. These tumors may exhibit aggressive biological behavior and present unique therapeutic challenges, as standard treatments such as radiotherapy and chemotherapy can lead to heightened toxicity. Therefore, individualized treatment strategies and close surveillance are crucial. Regular gynecologic screening should also be emphasized in this high-risk population to enable early diagnosis and improved outcomes.

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Keywords: Fanconi anemia, vulvar cancer, squamous cell carcinoma, HPV-negative, FIGO staging

SS-47

Suspicious Lesion in the Gluteus Maximus Muscle Accompanied by Mitotically Active Leiomyoma: Should Li-Fraumeni Syndrome Be Considered? The Contribution of MDM2 FISH Analysis to the Differential Diagnosis

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INTRODUCTION: Uterine smooth muscle tumors are predominantly benign; however, borderline lesions such as smooth muscle tumors of uncertain malignant potential (STUMP) and mitotically active leiomyoma are occasionally encountered. Their coexistence with an adenomatoid tumor is exceptionally rare. The presence of an extrauterine soft tissue mass raises concern for metastatic disease or an independent soft tissue sarcoma, posing a significant diagnostic challenge. Case Presentation: A 39-year-old woman underwent myomectomy with bilateral tubal ligation for multiple uterine leiomyomas. The initial histopathological diagnosis suggested

STUMP. Following expert pathological review at a tertiary referral center, the diagnosis was revised to mitotically active leiomyoma (5–6 mitoses per 10 high-power fields, without cytologic atypia or coagulative tumor cell necrosis) accompanied by an adenomatoid tumor. During follow-up, magnetic resonance imaging revealed a 44 × 33 mm intramuscular lesion within the right gluteus maximus muscle, radiologically suspicious for a myxoid sarcoma. Fluorescence in situ hybridization (FISH) analysis for MDM2 performed on the biopsy specimen demonstrated no MDM2 amplification.

DISCUSSION: Mitotically active leiomyoma represents a benign variant of uterine smooth muscle tumors despite its increased mitotic index and should be distinguished from STUMP and leiomyosarcoma through careful histopathological evaluation. The presence of a synchronous extrauterine intramuscular lesion may create a diagnostic dilemma by raising suspicion for metastatic disease or primary soft tissue sarcoma. In the present case, the absence of MDM2 amplification by FISH argued against well-differentiated or dedifferentiated liposarcoma and, together with the histopathological findings, supported a benign smooth muscle proliferation. This case highlights the value of integrating histopathology, radiologic findings, and molecular diagnostics in the evaluation of unusual soft tissue lesions. In addition, the coexistence of multiple smooth muscle lesions at a relatively young age raises the question of an underlying hereditary cancer predisposition, including Li-Fraumeni syndrome, which should be considered when supported by the patient's personal or family history.

CONCLUSION: The absence of MDM2 amplification effectively excluded well-differentiated/dedifferentiated liposarcoma from the differential diagnosis and favored a benign lesion associated with the uterine smooth muscle tumor, such as benign metastasizing leiomyoma or an ectopic intramuscular leiomyoma. This case highlights the diagnostic complexity of extrauterine soft tissue lesions associated with uterine smooth muscle tumors and underscores the pivotal role of multidisciplinary evaluation and molecular pathology in achieving an accurate diagnosis. Furthermore, the coexistence of mitotically active leiomyoma and an extrauterine smooth muscle lesion raises the question of an underlying hereditary cancer predisposition, including Li-Fraumeni syndrome, warranting consideration in selected patients.

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Keywords: Mitotically active leiomyoma, MDM2 FISH,soft tissue tumor; Li-Fraumeni syndrome

SS-48

From twenty years of fecal incontinence to continence: secondary obstetric anal sphincter and perineal body reconstruction

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OBJECTIVE: Obstetric anal sphincter injuries may result in long-term fecal incontinence and substantial impairment in quality of life. This case report aimed to present the early functional outcomes of secondary anal sphincter repair combined with multilayer perineal reconstruction in a patient with severe fecal incontinence persisting for 20 years after vacuum-assisted vaginal delivery.

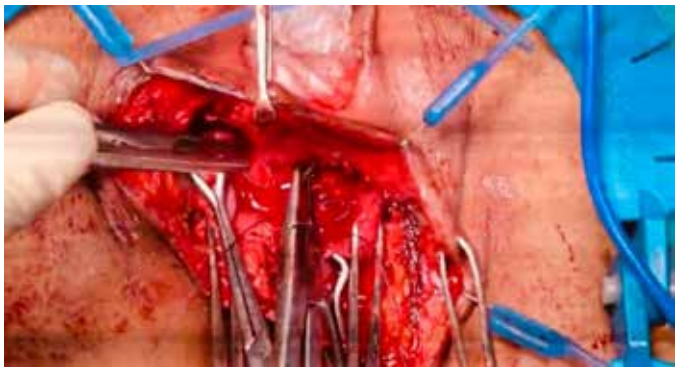
METHODS: A 42-year-old woman presented with persistent fecal incontinence that had begun following an anal sphincter injury sustained during vacuum-assisted vaginal delivery 20 years earlier. Despite previous evaluations at different general surgery and obstetrics and gynecology clinics, she had not undergone surgical treatment and required daily use of absorbent pads because of severe fecal incontinence. Her preoperative Wexner fecal incontinence score was 18/20. Clinical examination revealed a chronic obstetric anal sphincter defect involving both the internal and external anal sphincters, accompanied by a perineal defect and rectocele. Endoanal ultrasonography confirmed defects of both the internal anal sphincter (IAS) and external anal sphincter (EAS). Secondary obstetric anal sphincter repair and perineal body reconstruction were performed. Following a butterfly incision and deep perineal dissection, the rectovaginal fascia, IAS, EAS, and puborectalis muscle were identified. The IAS was repaired using an overlapping technique with four 3-0 polydioxanone (PDS) sutures, whereas the EAS was repaired end-to-end with 2-0 polyglactin 910 sutures. The rectovaginal fascia was closed, and the transversus perinei muscles were approximated at the midline to reconstruct the perineal body. The puborectalis muscle was sutured, and the reconstruction was reinforced with a Martius flap. Finally, the bulbocavernosus muscles were approximated and the skin was closed. We assessed functional outcomes using the Wexner fecal incontinence score preoperatively and at postoperative week 1 and month 1.

RESULTS: The Wexner fecal incontinence score decreased from 18/20 preoperatively to 7/20 at postoperative week 1. At postoperative month 1, the Wexner score was 0/20, demonstrating marked early improvement in fecal continence following surgical reconstruction.

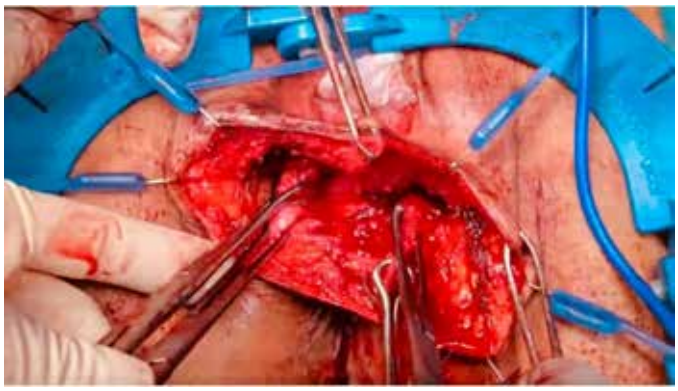
CONCLUSION: Secondary anal sphincter repair combined with perineal body reconstruction and Martius flap reinforcement may provide substantial functional improvement in patients with severe fecal incontinence secondary to longstanding obstetric anal sphincter injury. This case suggests that multilayer anatomical reconstruction may achieve favorable continence outcomes even decades after the initial obstetric injury.

Keywords: Fecal incontinence, Martius flap, obstetric anal sphincter injury, perineal body reconstruction

Intraoperative view of internal anal sphincter repair using the overlapping technique during secondary obstetric anal sphincter reconstruction.



Intraoperative view showing the identified and dissected external anal sphincter ends prior to end-to-end repair during secondary obstetric anal sphincter reconstruction.



SS-49

A web-based clinical decision support system for RCOG-based antenatal and postpartum thromboprophylaxis: development and validation

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OBJECTIVE: Venous thromboembolism (VTE) remains an important cause of maternal morbidity and mortality during pregnancy and the postpartum period. Although the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines provide a standardized risk-based approach to thromboprophylaxis, the simultaneous assessment of multiple risk factors and dosing criteria may be challenging in routine clinical practice. This study aimed to develop a web-based clinical decision support system that digitalizes RCOG recommendations for antenatal and postpartum thromboprophylaxis and to evaluate the concordance of its recommendations with manual guideline-based assessment.

METHODS: The clinical decision support system was initially developed using Python (v3.11) and Tkinter and subsequently converted into a stand-alone HTML/JavaScript-based web interface. The system was designed to operate entirely client-side without requiring a server or database. The Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline No. 37a, "Reducing the Risk of Venous Thrombosis and Embolism during Pregnancy and the Puerperium," including body mass index calculation, assessment of risk factors, determination of thromboprophylaxis indication, and low-molecular-weight heparin (LMWH) dose recommendations, was incorporated into the system. During development, all decision rules and dose categories were verified against the RCOG guideline by two maternal–fetal medicine specialists. For validation, 150 antenatal and postpartum cases were randomly selected from patients managed at the Hacettepe University Perinatal Medicine Unit, and their anonymized data were retrospectively entered into the system. Thromboprophylaxis indications and LMWH dose recommendations generated by the system were compared with manual RCOG-based assessments.

RESULTS: In all 150 cases, the thromboprophylaxis indications and LMWH dose categories generated by the system were identical to those obtained by expert manual RCOG assessment, demonstrating 100% concordance. The mean time required for data entry and result generation was approximately 2 minutes. The system successfully provided automated risk stratification and dose calculation together with standardized clinical outputs.

CONCLUSION: The web-based clinical decision support system implementing the RCOG antenatal and postpartum thromboprophylaxis algorithm demonstrated complete concordance with expert manual assessment in the evaluated cases. By automating complex risk stratification and dosing algorithms, this fully client-side and offline-capable system may facilitate standardized clinical decision-making and support adherence to guideline-based thromboprophylaxis. Further multicenter validation is required to assess its generalizability and effectiveness in routine clinical practice.

Keywords: Pregnancy, Postpartum period, RCOG, Thromboprophylaxis, Venous thromboembolism,

SS-50

Prenatally diagnosed persistent left superior vena cava: how isolated is “isolated”? A single-center analysis of associated anomalies, genetic findings and prenatal–postnatal concordance

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OBJECTIVE: Persistent left superior vena cava (PLSVC) is detectable in the routine cardiac screening views recommended by International Society of Ultrasound in Obstetrics and Gynecology (ISUOG) guidelines — as a dilated coronary sinus in the four-chamber view and as a fourth vessel to the left of the pulmonary artery in the three-vessel-and-trachea view — without requiring advanced fetal echocardiography expertise. We aimed to evaluate associated anomalies, genetic findings and prenatal–postnatal concordance in prenatally diagnosed PLSVC, to define what should be assessed before labeling a case “isolated”, and to describe the outcome of truly isolated cases.

METHODS: Fetuses with a prenatal diagnosis of PLSVC at our division over the last five years were identified (n=25); two cases without retrievable prenatal records were excluded, and 23 cases were analyzed retrospectively. Cases were classified as isolated or non-isolated according to prenatal findings. Pregnancy outcomes, postnatal echocardiography, genetic results, need for cardiac intervention and mortality were recorded.

RESULTS: Median gestational age at diagnosis was 25 weeks (range, 20–35). Six cases (26%) were classified as isolated and 17 (74%) as non-isolated. Associated findings in the non-isolated group included suspected aortic arch anomalies (n=7, including one right aortic arch), left heart anomalies (n=3), heterotaxy (n=3), atrioventricular or other septal defects (n=3), conotruncal anomalies (n=2), anomalous pulmonary venous return (n=2) and extracardiac anomalies alone (n=2); some cases had more than one finding. Genetic testing was performed in nine cases and was abnormal in three (8p23 deletion in two unrelated cases; isochromosome X in one). Of 21 pregnancies with known outcome, 16 resulted in live birth, four in termination of pregnancy and one in intrauterine fetal demise. All live-born infants underwent postnatal echocardiography; PLSVC was confirmed in 87.5%. Prenatally suspected arch anomalies were not confirmed postnatally in every case. Among five prenatally isolated cases with known postnatal outcome, three had additional findings after birth; in one, a prenatally undetected total anomalous pulmonary venous connection (TAPVC) resulted in neonatal death. Cases that remained isolated postnatally had an uneventful course without intervention.

CONCLUSION: PLSVC is recognizable in standard screening planes; even when the specific diagnosis cannot be named, recognition of the abnormal image is sufficient reason for referral to fetal echocardiography. Before a case is labeled isolated, pulmonary venous return (which a dilated coronary sinus may mask), the aortic arch, situs and extracardiac structures should be systematically evaluated, and genetic counseling should be offered. Cases that remain truly isolated after this work-up have an excellent prognosis — prenatal counseling should be built on this two-sided message.

Keywords: fetal echocardiography, persistent left superior vena cava, prenatal diagnosis, three-vessel-and-trachea view

SS-51

Multimodal Antenatal Assessment of Renal Involvement in Late-Onset Fetal Growth Restriction

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AIM: Late-onset fetal growth restriction (FGR) is frequently associated with placental insufficiency and fetal hemodynamic adaptation; however, renal involvement may not be fully reflected by conventional Doppler parameters. This study aimed to evaluate fetal renal involvement in late-onset FGR using renal artery Doppler, renal parenchymal thickness, renal volume, and three-dimensional power Doppler vascular indices.

METHODS: This single-center study included singleton pregnancies evaluated between January 2025 and June 2026. The study group consisted of 40 fetuses diagnosed with late-onset FGR at ≥32 weeks of gestation according to the 2016 Delphi consensus criteria, and the control group included 41 gestational age-matched healthy fetuses. Fetuses with structural or chromosomal anomalies, renal anomalies, multiple gestations, maternal diabetes, inadequate imaging quality, or missing birth/neonatal data were excluded. Ultrasonographic evaluations were performed using a GE Voluson E10 system. Renal parenchymal thickness and renal artery Doppler parameters, including peak systolic velocity, systolic/diastolic ratio, pulsatility index, and resistance index, were measured. Renal volume and three-dimensional power Doppler indices were obtained using VOCAL software. Vascularization index, flow index, and vascularization-flow index were calculated from histogram analysis. Statistical analyses were performed using SPSS version 25, and $p<0.05$ was considered statistically significant.

RESULTS: A total of 81 pregnancies were analyzed, including 40 late-onset FGR and 41 control cases. Maternal age, body mass index, gravida, parity, and gestational age at ultrasonographic evaluation were similar between the groups. Gestational age at delivery and birth weight were significantly lower in the FGR group. Renal parenchymal thickness was significantly reduced in fetuses with FGR compared with controls [9.82 mm vs. 11.33 mm, p=0.005]. Renal volume was also significantly lower in the FGR group [11.81 cm^3 vs. 14.70 cm^3, p=0.001]. No significant differences were observed between the groups in renal artery Doppler parameters, including peak systolic velocity, systolic/diastolic ratio, pulsatility index, and resistance index. Among three-dimensional power Doppler indices, vascularization index was significantly higher in the FGR group [3.99 vs. 3.17, p=0.035], whereas flow index and vascularization-flow index did not differ significantly between the groups.

CONCLUSION: Late-onset FGR is associated with reduced fetal renal parenchymal thickness and renal volume, suggesting structural renal involvement despite similar renal artery Doppler findings. The increased vascularization index may reflect a relative change in vascular signal distribution within the reduced renal volume rather than an absolute increase in renal blood flow. These findings suggest that multimodal antenatal renal assessment may provide additional information regarding fetal target-organ involvement in late-onset FGR and may help identify neonates who could benefit from closer postnatal renal follow-up.

Keywords: fetal growth restriction, fetal kidney, renal volume, three-dimensional power Doppler, vascularization index

SS-52

Impact of Parental Refusal of Invasive Prenatal Diagnosis on Multidisciplinary Perinatal Counseling and Prognostic Assessment in Fetuses with Central Nervous System Anomalies

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Fetal central nervous system (CNS) anomalies are a heterogeneous group of structural abnormalities with diverse etiologies, genetic backgrounds, clinical presentations, and highly variable neurodevelopmental and perinatal outcomes. Chromosomal abnormalities, copy-number variants, and pathogenic genomic alterations may accompany structural CNS anomalies, making comprehensive genetic evaluation an important component of prenatal etiological assessment and individualized prognostic counseling. In this context, multidisciplinary perinatal councils play a pivotal role by integrating detailed fetal neurosonography and advanced imaging findings with expertise from perinatology, medical genetics, pediatric neurology, neonatology, and other relevant specialties to establish the most accurate diagnosis, estimate prognosis, and guide pregnancy management. Invasive prenatal diagnostic procedures, including chorionic villus sampling and amniocentesis, may provide critical genetic information that complements phenotypic assessment and supports more precise counseling on neurodevelopmental prognosis, associated abnormalities, recurrence risk, and anticipated perinatal outcomes. However, parental refusal of invasive prenatal testing may result in unresolved genetic etiology, increase residual diagnostic and prognostic uncertainty, and potentially influence prenatal counseling and subsequent decision-making. Therefore, this study aimed to evaluate the spectrum of fetal intracranial anomalies assessed by a multidisciplinary perinatal council, determine the frequency of parental acceptance and refusal of recommended invasive prenatal diagnostic procedures, and investigate the potential impact of parental refusal on diagnostic certainty, multidisciplinary counseling, prenatal decision-making, and the prediction of perinatal and neurodevelopmental outcomes.

Keywords: fetal central nervous system anomalies, multidisciplinary perinatal council; prenatal diagnosis;,invasive prenatal testing

SS-53

Fetal growth restriction in pregnancies complicated by systemic sclerosis: antenatal surveillance and obstetric management

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OBJECTIVE: Systemic sclerosis is a chronic autoimmune disease characterized by vasculopathy and fibrosis and may adversely affect uteroplacental circulation. This report aimed to describe the antenatal course and perinatal outcomes of two women with systemic sclerosis who developed early- or late-onset fetal growth restriction (FGR).

METHODS: The obstetric histories, treatments administered during pregnancy, ultrasonographic and Doppler findings, and delivery and neonatal outcomes of two women with systemic sclerosis were evaluated. FGR was defined as an estimated fetal weight (EFW) below the 10th percentile. FGR diagnosed before 32 weeks of gestation was classified as early-onset, whereas FGR diagnosed at or after 32 weeks was classified as late-onset.

RESULTS: The first case was a 31-year-old woman with systemic sclerosis without pulmonary involvement. Her obstetric history included two spontaneous miscarriages and two preterm births by cesarean delivery at 29 and 36 weeks of gestation; the delivery at 29 weeks was performed because of preterm prelabor rupture of membranes and FGR. During the current pregnancy, she received low-dose acetylsalicylic acid and micronized progesterone. At 33 weeks of gestation, EFW was at the 6th percentile, and late-onset FGR was diagnosed; umbilical artery Doppler findings were normal. In view of her two previous cesarean deliveries and FGR, cesarean delivery was performed at 37 weeks and 5 days, resulting in the birth of a live male neonate weighing 2,300 g. The second case was a 33-year-old nulliparous woman with systemic sclerosis and pulmonary involvement. During pregnancy, she received low-dose acetylsalicylic acid, enoxaparin, micronized progesterone, prednisolone, and azathioprine. At 24 weeks of gestation, EFW was at the 7th percentile; uterine artery Doppler examination demonstrated increased resistance, and early-onset FGR was diagnosed. Cesarean delivery was performed at 36 weeks and 4 days because of FGR, resulting in the birth of a live female neonate weighing 2,300 g. Both neonates had 1- and 5-minute Apgar scores of 9 and 10, respectively, and neither required admission to the neonatal intensive care unit.

CONCLUSION: These cases highlight that FGR may present with either early or late onset in pregnancies complicated by systemic sclerosis and may be accompanied by preterm birth. Given the disease-associated vasculopathy and potential organ involvement, maternal clinical status, fetal growth, and

the uteroplacental and fetoplacental circulations should be assessed serially within a multidisciplinary care framework. Even when umbilical artery Doppler findings are normal, close surveillance of fetal growth and individualized timing of delivery based on maternal and fetal findings may contribute to favorable perinatal outcomes.

Keywords: Antenatal surveillance, Fetal growth restriction, high-risk pregnancy, preterm birth, systemic sclerosis

SS-54

Prenatal characterization of structural chromosomal rearrangements using targeted and subtelomeric FISH: a single-center case series (n=14)

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OBJECTIVE: To evaluate the clinical contribution of targeted and subtelomeric fluorescence in situ hybridization (FISH) in the prenatal characterization of structural chromosomal rearrangements and in refining genetic counseling.

METHODS: This retrospective descriptive case series included 14 prenatal cases with structural chromosomal abnormalities in which targeted or subtelomeric FISH was used to assess breakpoint involvement or determine the origin of additional chromosomal material. Samples consisted of amniotic fluid (n=10), chorionic villus sampling (CVS) material (n=3), and cord blood obtained by cordocentesis (n=1). Clinical indications, gestational age at sampling, cytogenetic findings, inheritance, and pregnancy outcomes were reviewed descriptively.

RESULTS: Maternal age was available for 12 cases, with a median of 34 years (range, 21–41), and gestational age at sampling was available for 13 cases, with a median of 18.6 weeks (range, 11.3–23.0). The main indications for invasive testing were high-risk aneuploidy screening (5/14), abnormal ultrasound findings (4/14), and known parental carrier status for a structural rearrangement (3/14). Rearrangement classes included derivative/unbalanced translocations (4/14), balanced translocations (3/14), deletions (3/14), complex duplication/deletion (1/14), inversion (1/14), isochromosome (1/14), and a marker chromosome characterized by FISH (1/14). FISH clarified the origin of additional chromosomal material, supported characterization of derivative chromosomes and terminal deletions, and contributed to inherited versus de novo classification. Pregnancy termination was documented in three cases, while outcome data were incomplete in four cases.

CONCLUSION: Targeted and subtelomeric FISH remains a clinically useful adjunct to conventional karyotyping in prenatal diagnosis, particularly when the origin of additional chromosomal material or telomeric involvement is uncertain. Its use can improve interpretation of structural chromosomal findings and support more precise recurrence-risk counseling and perinatal planning.

Keywords: Chromosomal rearrangement, fluorescence in

situ hybridization, genetic counseling, prenatal diagnosis, subtelomeric rearrangement

Table 1. Clinical and cytogenetic characteristics of the study cohort

Characteristic	Value
Number of cases	14
Maternal age, median (range), years	34 (21 41), n=12
Gestational age at sampling, median (range), weeks	18.6 (11.3 23.0), n=13
Amniocentesis	10
Chorionic villus sampling	3
Cordocentesis	1
High-risk aneuploidy screening	5
Abnormal ultrasound findings	4
Known parental structural rearrangement	3
Derivative/unbalanced translocation	4
Balanced translocation	3
Deletion	3
Other structural abnormalities	4

Clinical, sampling, indication, and cytogenetic characteristics of the 14 prenatal cases included in the study.

SS-55

Prenatal Diagnosis of Ultra-Rare CHIME Syndrome Presenting with Fetal Hydrops Confirmed by Compound Heterozygous PIGL Variants: A Case Report

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OBJECTIVE: CHIME syndrome (Zunich-Kaye syndrome) is an ultra-rare autosomal recessive neurocutaneous disorder caused by pathogenic variants in the PIGL gene (NM_004278.4). It is clinically characterized by Coloboma, Heart defects, Ichthyosiform dermatosis, Mental retardation, and Ear anomalies. Due to its extreme rarity, the prenatal ultrasonographic phenotype remains poorly defined in current literature. This report presents the prenatal diagnostic workflow, clinical findings and molecular genetic confirmation of a fetus prenatally diagnosed with CHIME syndrome.

METHODS: A pregnant patient was referred to our tertiary Perinatology unit for a detailed targeted fetal anomaly scan due to atypical ultrasonographic findings. Comprehensive high-resolution two-dimensional and Doppler ultrasonographic examinations were performed,along with fetal echocardiography. Following genetic counseling, invasive prenatal diagnostic testing (cordocentesis) was carried out for Whole Exome Sequencing (WES) analysis.

RESULTS: Targeted prenatal ultrasonographic evaluation revealed severe structural and somatic abnormalities, including a left-sided congenital diaphragmatic hernia causing mediastinal shift, non-immune fetal hydrops (diffuse cranial skin edema, pleural effusion), severe polyhydramnios, macrosomia, hypertelorism, and bilateral hydronephrosis. Given the atypical overlapping clinical presentation, molecular genetic testing via WES was prioritized. Genomic analysis confirmed a compound heterozygous state in the PIGL gene (NM_004278.4): a pathogenic heterozygous variant c.500T>C p.(Leu167Pro) (rs145303331) with an allele depth of 65/126, alongside a likely pathogenic heterozygous complex variant c.[263G>A;725G>C] p.[Arg88His;Arg242Pro] (rs755380500, rs750654333). This molecular result established a definitive prenatal diagnosis of CHIME syndrome. Post-test genetic counseling was provided regarding the poor neurodevelopmental prognosis, autosomal recessive inheritance pattern, and recurrence risks.

CONCLUSION: This case expands the known intrauterine

phenotypic spectrum of CHIME syndrome by documenting rare features including fetal hydrops, diaphragmatic hernia, macrosomia, and renal structural abnormalities. In cases presenting with complex fetal hydrops or atypical somatic anomalies, timely integration of advanced molecular diagnostics (WES) is decisive for identifying underlying ultra-rare genetic syndromes, enabling precise parental counseling and appropriate management.

Keywords: CHIME syndrome, fetal hydrops, neurocutaneous disorder, whole exome sequencing

bilateral hydronephrosis with markedly dilated renal pelves.



Gross photograph showing diffuse skin desquamation (ichthyosiform dermatosis) and generalized hydropic changes.



Ultrasonographic image of the fetal face at 31 weeks of gestation, demonstrating hypertelorism.



SS-56

Microwave Ablation for Twin Reversed Arterial Perfusion (TRAP) Sequence in a Monochorionic Monoamniotic Twin Pregnancy: A Case Report

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Microwave Ablation for Twin Reversed Arterial Perfusion (TRAP) Sequence in a Monochorionic Monoamniotic Twin Pregnancy: A Case Report

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OBJECTIVE: We aimed to present the perinatal management of twin reversed arterial perfusion (TRAP) sequence detected in the early second trimester in a monochorionic monoamniotic twin pregnancy, treated with microwave ablation.

CASE: A 36-year-old woman (gravida 2, para 0, with one prior dilation and curettage) was referred to our clinic after an 18-week ultrasound examination revealed a monochorionic monoamniotic twin pregnancy with TRAP sequence. Cardiac activity was present in the pump twin but absent in the acardiac twin. The placenta was anterior, the pump twin was in cephalic presentation, and amniotic fluid volume was adequate with a deepest vertical pocket of 74 mm. Biometric measurements of the pump twin were consistent with gestational age (BPD 19 weeks 5 days, HC 19 weeks 1 day, AC 19 weeks 3 days, FL 19 weeks 5 days; estimated fetal weight 595 g). Middle cerebral artery peak systolic velocity (MCA-PSV) was 20 cm/s, showing no evidence of fetal anemia. An acardiac mass measuring approximately 76×65 mm, in which only the lower extremities could be identified and no cardiac activity was detected, was noted within the cavity, consistent with TRAP sequence. The family was counseled regarding the risks to the pump twin, including cardiac failure, polyhydramnios, and preterm birth, as well as the available treatment options. At 19 weeks of gestation, ultrasound-guided microwave ablation was performed to occlude the vessels supplying the acardiac twin.

CONCLUSION: TRAP sequence is a rare but potentially high-mortality complication of monochorionic twin pregnancies for the pump twin. Microwave ablation performed in the early second trimester is a safe and effective option for occluding blood flow to the acardiac twin and may improve the prognosis of the pump twin.

Keywords: TRAP sequence, acardiac twin, monochorionic monoamniotic pregnancy, microwave ablation, twin reversed arterial perfusion

Figure 1. Ultrasonographic appearance of the pump twin and the acardiac mass in a case of TRAP sequence in a monochorionic monoamniotic twin pregnancy. (A) Grayscale ultrasonographic image of the pump twin at 18 weeks 6 days of gestation. (B) Color and spectral Doppler examination of the pump twin showing normal cardiac activity. (C) Appearance of the acardiac mass, measuring 76×65 mm, in which only the lower extremities could be identified.

SS-57

Type IV Jejunoileal Atresia in a Fetus Followed for Ventriculomegaly and Echogenic Bowel: The Contribution of Prenatal Exome Sequencing to Delivery Planning and Perinatal Management

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INTRODUCTION: The differential diagnosis of fetal echogenic and dilated bowel includes cystic fibrosis, congenital infection, aneuploidy and intestinal obstruction; coexisting ventriculomegaly suggests a syndromic condition. In structurally abnormal fetuses with normal karyotype and microarray, prenatal exome sequencing (pES) yields an aetiological diagnosis in 20–30% of cases and informs delivery planning. We present a case in which pES directly guided perinatal management.

CASE: A 27-year-old woman, G7P2A4, with third-degree consanguinity and recurrent pregnancy loss, was referred at 26+4 weeks for suspected fetal growth restriction. Evaluation showed biometry at the 5th percentile (EFW 773 g), mild bilateral ventriculomegaly (10 mm), increased bowel echogenicity, dilated loops, and hyperechogenic splenic foci. After genetic counselling, amniocentesis was performed; karyotype and microarray were normal, and pES was performed on amniocytes.

At 32 weeks, ventriculomegaly (right 12 mm, left 10.9 mm) and the bowel findings persisted; biophysical profile was 10/10 and umbilical artery Doppler normal. pES reported homozygous PIEZO2 c.2719G>C (p.Asp907His, VUS), heterozygous FGA c.1653del (likely pathogenic; hypodysfibrinogenaemia) and heterozygous carrier status for SMPD4 and CFTR 5T. Fetal MRI at 35 weeks measured atrial widths of 12 and 10 mm, with dilatation of the rectum and descending colon (Hirschsprung disease?). Anticipating a bleeding–thrombosis risk and the need for surgery, delivery was planned at a tertiary centre. At 36+4 weeks, polyhydramnios and diffuse intra-abdominal free fluid prompted delivery of a 2960 g male infant under a presumptive diagnosis of perforation, with neonatal and paediatric surgery teams on standby.

Laparotomy at the 6th postnatal hour revealed diffuse fibrin, meconium staining, mesenteric bands, a type IIIa jejunal atresia, and a necrotic, volvulated loop attached to the blind proximal loop. After tapering of the proximal hypertrophic segment, distal irrigation showed four separate type I atresias, and the case was classified as type IV jejunal atresia with perforation and distal volvulus. Postoperatively, Candida parapsilosis candidaemia, cholestasis, low biotinidase activity, and prolonged parenteral nutrition requirement developed; enteral feeding began in the second week. Cranial MRI showed hydrocephalus, colpocephaly, occipital heterotopia and polymicrogyria/pachygyria; echocardiography showed atrial and small ventricular septal defects and patent ductus arteriosus. He was discharged after 38 days of intensive care. EEG at 4 months showed background slowing, brief convulsions developed at 6 months, and follow-up MRI showed persistent hydrocephalus and frontoparietal pachygyria. At one year of age, he remains under multidisciplinary follow-up for convulsions, biotinidase deficiency, feeding intolerance and neuromotor developmental delay.

DISCUSSION AND CONCLUSION: Integrating ultrasonographic assessment with the pES result determined delivery at a centre with surgical and neonatal intensive care support and postnatal haematological evaluation. The prenatal suspicion of cystic fibrosis raised by echogenic bowel was clarified by single-allele CFTR 5T carrier status, avoiding unnecessary referral. Given the accepted mesenteric vascular accident hypothesis in jejunoileal atresia, a possible contribution of FGA-related fibrinogen dysfunction to the splenic hyperechogenic foci, increased placental resistance, and the intestinal ischaemia–volvulus picture is noteworthy. In fetuses with echogenic bowel and ventriculomegaly, early pES despite a normal karyotype directly improves perinatal management; parental segregation studies are required for variant reclassification and recurrence risk counselling.

Keywords: Fetal echogenic bowel, ventriculomegaly, jejunoileal atresia, prenatal exome sequencing, perinatal management

figure 1



Prenatal ultrasound at 26+4 weeks. (left) Axial transventricular view of the fetal head showing dilatation of the lateral ventricle, with an atrial diameter of 10.07 mm. (right) Axial view of the fetal abdomen at the same visit demonstrating multiple dilated bowel loops with increased wall echogenicity.

figure 2



Prenatal ultrasound at 36+4 weeks. Axial abdominal circumference view showing marked bowel dilatation and free intraperitoneal fluid

figure 3



Intraoperative findings at the 6th postnatal hour. (left) Dilated proximal bowel loops with mesenteric bands (held by forceps) and a dark, necrotic volvulated segment attached to the blind proximal loop. (right) Appearance after resection, tapering of the proximal hypertrophic segment and completion of the anastomoses; the collapsed, small-calibre distal bowel containing intraluminal pellets is seen on the left.

SS-58

A Comparative Analysis of Endometrioma Sclerotherapy Routes: Vaginal vs Abdominal – Is There Any Difference?

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AIM: To compare transvaginal and transabdominal ethanol sclerotherapy (EST) for ovarian endometriomas, evaluating whether the procedural route influences ovarian reserve, safety profiles, and reproductive outcomes.

MATERIALS-METHOD: This retrospective study included 69 patients who underwent EST in Başkent University Ankara Hospitals between June 2016- January 2024. Patients were categorized into two main groups based on the administration route: Transabdominal(TA) and Transvaginal (TV). Demographic and clinical characteristics, including age, presenting symptoms, number of endometriomas, gravidity, parity, pregnancy desire, and previous endometrioma surgery, were retrospectively collected from medical records. Procedural characteristics included the volume of ethanol administered, aspirated fluid volume, and pre- and post-procedural endometrioma dimensions. Ovarian reserve was evaluated using serum anti-Müllerian hormone (AMH), follicle-stimulating hormone (FSH), and antral follicle count (AFC), with changes from baseline calculated for each parameter. Peri-procedural complications, post-procedural medical treatment, clinical response, recurrence, use of assisted reproductive technology (ART), and pregnancy and live birth outcomes were also assessed.

RESULTS: A total of 69 patients with a mean age of 30.9 years (range: 12–44) were included. The primary indications for ethanol sclerotherapy (EST) were infertility (56.5%) and pelvic pain (36.2%). EST was performed via the TA route in 53.6% (n=37) and the TV route in 46.4% (n=32) of cases. Following EST, a marked reduction in endometrioma dimensions was achieved bilaterally. In terms of overall ovarian reserve parameters, a statistically significant increase was observed in antral follicle count (mean difference: 2.29, range: -2 to +7; p = 0.002) and FSH levels (mean difference: 2.37, range: -8.5 to +7.5; p = 0.006), whereas serum AMH levels showed no statistically significant change (mean difference: 0.216 ng/mL, range: -1.5 to +1.9; p = 0.506). When comparing TA and TV routes, baseline AMH was significantly higher in the TA group (3.20 vs. 1.89 ng/mL, p = 0.023); however, no statistically significant differences were observed between the two approaches regarding post-procedure cyst diameters, ovarian reserve parameter changes

(FSH, AMH, AFC differences), or fluid aspiration volumes ($p > 0.05$ for all). The overall complication rate was low at 3.9% (n=2, both in the abdominal group; $p = 0.063$). Over a median follow-up of 18 months (range: 7–71 months), the endometrioma recurrence rate was 9.8%, and a live birth rate of 27.5% (14/51) was achieved following the procedure.

CONCLUSION: Both approaches for endometrioma EST provide highly effective cyst volume reduction without compromising short-term ovarian reserve. Notably, the TV approach demonstrated an optimal safety profile with zero reported complications.

Keywords: Endometrioma, Ethanol Sclerotherapy, Transabdominal Approach, Transvaginal Approach, Ovarian Reserve

Characteristics of the Patients

	N (%)
Age (mean, years)	30.9 (12-44)
Complaint - Pain - İnfertility - Other	25 (36.2) 39 (56.5) 5 (7.3)
No of Cysts (mean)	1.94 (1-5)
Pregnancy Desire - Yes - No	45 (71.4) 18 (28.6)
Previous Surgery - Yes - No	23 (39.7) 35 (60.3)
Live Birth After EST - Yes - No	14 (27.5) 37 (72.5)
Route - Abdominal - Vaginal	37 (53.6) 32 (46.4)
Complications - Yes - No	2 (3.9) 49 (96.1)

Abbreviations: EST; Ethanol Sclerotherapy

Comparison of the Sclerotherapy Routes

	TA-EST (N:37)	TV-EST (N:32)	p
Age (mean, years)	31.135	30.688	0.733
Mean No of Cysts (range)	2.000	1.875	0.534
Mean Volume of Aspirated Fluid	198.333	174.400	0.587
Pre-op Cyst Size, cm (Right)	7.715	7.033	0.305
Post-op Cyst Size, cm (Right)	3.436	2.790	0.331
Pre-op Cyst Size, cm (Left)	6.231	6.400	0.798
Post-op Cyst Size, cm (Left)	3.255	3.256	0.998
Pre-op AMH Level (ng/mL)	3.203	1.895	0.023
Post-op AMH Level (ng/mL)	2.984	2.910	0.964
Difference of AMH Levels	0.529	0.505	0.110
Pre-op FSH Level (IU/L)	7.693	9.026	0.231
Post-op FSH Level (IU/L)	6.135	7.403	0.241
FSH level difference	1.916	2.129	0.888
Pre-op AFC	2.333	3.357	0.480
Post-op AFC	4.833	5.478	0.595
AFC difference	3.000	2.167	0.639
Complications (%)	0.105	0.000	0.063

Abbreviations: TA-EST; Transabdominal Ethanol Sclerotherapy, TV-EST; Transvaginal Ethanol Sclerotherapy, Pre-op; Pre-operative, Post-op; Post-operative, AMH; Anti-Müllerian Hormone, FSH; Follicle – Stimulating Hormone, AFC; Antral Follicle Count

SS-59

Incidental findings of patients with infertility and undergone whole exome sequencing

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Purpose Whole exome sequencing (WES) is a powerful tool for both molecular diagnosis and mutation carrier screening in infertility patients. Beyond the molecular diagnosis of the infertility, detection of incidental variants is critical to prevent any known diseases/syndromes in the next generations. Hence, in the present study, we aimed to report the incidental findings of patients with infertility in a large cohort. Methods We retrospectively analyzed 33 consecutive probands (25 women and 8 male partners) referred across the reproductive-failure spectrum who underwent whole-exome sequencing with copy-number analysis at a single tertiary center. Incidental variants associated with any OMIM diseases excepting infertility were prioritized using SOPHiA DDM v4 and classified using ACMG/AMP criteria. Results Incidental findings were identified in a meaningful subset of probands and fell into three groups. (i) Medically actionable adult-onset variants: TARDBP and SOD1 (amyotrophic lateral sclerosis spectrum), GBA1 (Gaucher disease, with downstream Parkinson-risk implications), FBN1 (Marfan syndrome, VUS), F11 (factor XI deficiency), TNFRSF13B (common variable immunodeficiency), ADAMTS13 (thrombotic thrombocytopenic purpura), and COL4A2. (ii) Pharmacogenomic alleles of immediate peri-procedural relevance: a pathogenic BCHE frameshift (prolonged apnea with succinylcholine), the G6PD Mediterranean allele (drug- and fava-induced hemolysis), and a CFTR ivacaftor drug-response allele. (iii) Heterozygous carrier states for severe recessive disorders, including CFTR (p.Phe508del), PAH, ASS1, MMUT, MMACHC, MCCC2, and ABCA4. Conclusion Because reproductive panels and expanded carrier screening overlap heavily in content, the same test routinely uncovers actionable adult-onset variants, pharmacogenomic alleles, and carrier states unrelated to fertility. The data reinforces professional recommendations that incidental findings be anticipated in pre-test counseling, restricted to medically actionable results at disclosure, and supported by post-test genetic counseling.

Keywords: Infertility, Whole exome sequencing, Incidental findings

SS-60

Factors associated with embryo arrest in IVF/ICSI cycles of patients with unexplained infertility: a retrospective cohort study

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AIM: Unexplained infertility, defined as the absence of an identifiable cause after a complete standard work-up, affects roughly 15–30% of infertile couples. In vitro fertilization/ intracytoplasmic sperm injection (IVF/ICSI) is the most effective treatment in this group, yet embryo arrest — the failure to obtain a transferable embryo despite fertilization — remains an important and poorly understood problem. It is still unclear which of these patients are at risk. We aimed to identify the clinical and laboratory factors associated with embryo arrest in women undergoing IVF/ICSI for unexplained infertility.

METHOD: We retrospectively reviewed 60 women who underwent their first IVF/ICSI cycle for unexplained infertility at Ankara Etlik City Hospital between January 2023 and March 2026. All were stimulated with a gonadotropin-releasing hormone (GnRH) antagonist protocol, and intracytoplasmic sperm injection was used in every cycle. Patients were grouped by embryo development outcome: the arrest group (n=25), in whom no transferable embryo (Grade A or B on day 3, or a good-quality blastocyst on day 5–6) was obtained despite fertilization, and the transfer group (n=35), in whom at least one embryo was transferred. The two groups were compared for demographic characteristics, ovarian reserve markers, and stimulation parameters. The ability of the normal fertilization count (number of two-pronuclear [2PN] zygotes) to predict arrest was assessed with receiver operating characteristic (ROC) curve analysis, and the optimal cut-off was determined by the Youden index. Analyses were performed in IBM SPSS Statistics 27.0, with $p<0.05$ considered significant.

RESULTS: Median age was 32 years and median anti-Müllerian hormone (AMH) was 3.8 ng/mL. Embryo arrest occurred in 25 patients (41.7%), and the clinical pregnancy rate in the transfer group was 31.4%. The groups did not differ in age, body mass index, AMH, basal follicle-stimulating hormone, antral follicle count, total gonadotropin dose, stimulation duration, or trigger-day estradiol (all $p>0.05$). The normal fertilization count was lower in the arrest group than in the transfer group (median 5 [interquartile range 3–6] vs. 6 [5–10]; $p=0.018$). On ROC analysis it showed moderate predictive value for arrest (area under the curve 0.680; 95% confidence interval 0.531–

0.816), with an optimal cut-off of 2PN ≤5 (sensitivity 64.0%, specificity 65.7%).

CONCLUSION: Embryo arrest was common in this unexplained-infertility cohort, and conventional ovarian reserve markers did not predict it. The normal fertilization count (2PN ≤5) was the only parameter associated with arrest and may serve as an early warning sign in clinical practice. Taken together, our results point to fertilization capacity and early embryo development — rather than ovarian reserve — as the more relevant problem in unexplained infertility.

Keywords: Embryo arrest, Fertilization rate, Intracytoplasmic sperm injection, Ovarian reserve, Two-pronuclear zygote, Unexplained infertility

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VS-01

Ultimate Pain Relief: Radical Management of Recurrent DIE Incorporating Dorsal Parametrectomy

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BACKGROUND: The surgical management of complex adnexal masses combined with severe adenomyosis requires meticulous planning, particularly in patients with a history of prior open pelvic surgery. Operating on a solitary ovary with a high-risk malignancy index demands both oncological safety and principles of minimally invasive surgery. This video demonstrates the challenging total laparoscopic hysterectomy (TLH) and left unilateral salpingo-oophorectomy (USO) in a patient suffering from chronic pelvic pain that severely impaired her social life, complicated by previous laparotomy and altered pelvic anatomy

METHODS: A 50-year-old nulliparous female (G0P0) presented with chronic pelvic pain significantly affecting her daily life. Her surgical history was notable for a laparotomy in 2007 for a right salpingo-oophorectomy and cyst excision. Preoperative laboratory tests revealed elevated tumor markers: CA-125 was 52.3 U/mL, HE4 was 129 pmol/L, and the ROMA index was calculated as 44.9. Pelvic MRI demonstrated an enlarged uterus with adenomyosis and multiple nodular lesions, including a 5 cm heterogeneous fundal mass with restricted diffusion. In the left adnexal lodge, a 64x45 mm complex mass—hyperintense on T1-weighted images and hypointense on T2, consistent with an endometrioma—was observed, accompanied by an adjacent 21 mm irregular, thick-walled cystic component. Transvaginal ultrasound confirmed the adenomyotic uterus and a 53x53 mm left adnexal mass. Preoperative endometrial sampling reported endometrial polyp fragments. Given her severe symptoms and imaging findings, a TLH and left USO were planned.

RESULTS: The laparoscopic procedure was completed in 128 minutes, with an estimated blood loss of 220mL. Despite the presence of pelvic adhesions from the prior laparotomy, optimal exposure and complete excision were achieved without any intraoperative complications. The patient had an uneventful recovery and was discharged on postoperative day 2. Final histopathological analysis confirmed Adenomyosis, and left ovarian endometrioma.

CONCLUSIONS: Total laparoscopic hysterectomy and adnexectomy can be safely and effectively performed in patients with complex adnexal masses, severe adenomyosis, and a history of previous open surgery. Thorough preoperative evaluation and meticulous laparoscopic technique are crucial for restoring the patient's quality of life while adhering to surgical safety principles.

Keywords: Deep Infiltrating Endometriosis, Dorsal parametrectomy, Chronic pelvic pain

VS-02

Single-suture vaginal cuff closure with concomitant uterosacral ligament plication during single-port total laparoscopic hysterectomy

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INTRODUCTION: Single-port total laparoscopic hysterectomy (SP-TLH) offers the potential advantages of fewer abdominal incisions and improved cosmetic outcomes while maintaining laparoscopic visualization. However, restricted triangulation, instrument crowding, and technically demanding intracorporeal suturing may limit its widespread use. We present a single-port hysterectomy in which vaginal cuff closure and bilateral uterosacral ligament plication were incorporated into a single continuous suturing sequence.

CASE PRESENTATION: A 48-year-old woman (G6P3 (SVD) A3) presented with abnormal uterine bleeding (AUB). Her medical history included well-controlled hypertension, diabetes mellitus, and treated hypothyroidism. She had no previous abdominal or pelvic surgery.

High-risk HPV screening was negative. Mammography was BI-RADS 1–2. Transvaginal ultrasonography demonstrated a diffusely myomatous uterus. Endometrial sampling revealed proliferative-phase endometrium without premalignant or malignant pathology.

Conservative treatment was initially preferred. A levonorgestrel-releasing intrauterine system (LNG-IUS) was inserted, but recurrent bleeding persisted. Additional hormonal therapy provided temporary control; however, treatment-resistant AUB recurred seven months after LNG-IUS insertion, and definitive surgical management was recommended.

The surgical route was selected through shared decision-making. vNOTES was discussed, including its advantages, technical limitations, and possible conversion to laparoscopy. The patient preferred a primary laparoscopic approach. Single-port surgery, when technically feasible, was also discussed preoperatively. Potential benefits of fewer abdominal incisions were balanced against instrument crowding, reduced triangulation, port-site hernia risk related to the larger umbilical fascial incision, and possible additional ports. The patient consented to a planned single-port approach conditional on intraoperative feasibility.

Intraoperative assessment demonstrated favorable anatomy and adequate exposure for single-port surgery. Single-port access was established through the umbilicus using an Alexis® wound retractor/protector combined with a GelPOINT® access platform. TLH was successfully completed without additional ports. Following hysterectomy, the ureters were identified bilaterally, and vaginal cuff closure with bilateral uterosacral ligament plication was integrated into a single continuous suturing sequence. Ureteral integrity and course were reassessed after plication, confirming a safe distance from the sutures. This provided simultaneous cuff closure and reinforcement of apical support.

Preoperative hemoglobin was 12.8 g/dL, decreasing to 12.2 g/dL at postoperative hour 6 and 10.8 g/dL on postoperative day 1. The early postoperative course was uneventful.

DISCUSSION AND CONCLUSION: Single-port laparoscopy reduces abdominal incisions but presents technical challenges, particularly during intracorporeal suturing. Integrating vaginal cuff closure and bilateral uterosacral ligament plication into a single continuous suturing sequence may simplify this step while providing concomitant apical support without additional suspension sutures or accessory ports.

This case also highlights the evolving role of single-port surgery in minimally invasive gynecology. Although SP-TLH gained popularity because of fewer abdominal incisions and favorable cosmetic outcomes, concerns regarding the larger umbilical fascial incision and port-site hernia risk limited its adoption. Instrument crowding, loss of triangulation, difficult fascial closure, and challenging intracorporeal suturing represent additional limitations. With the increasing popularity of vNOTES, offering a scarless approach without abdominal port-site complications, conventional laparoscopic single-port surgery declined in some practices.

However, robotic single-port platforms may renew interest in this approach. Wristed instruments, improved articulation, three-dimensional visualization, and enhanced suturing capabilities may overcome some technical limitations of conventional SP-TLH.

Keywords: Single-port laparoscopy, total laparoscopic hysterectomy, ureteral safety, uterosacral ligament plication, vaginal cuff closure

VS-03

Beyond cosmesis: prioritizing ureteral safety in single-port laparoscopic oophorectomy

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INTRODUCTION: Single-port laparoscopy reduces the number of abdominal incisions but has inherent technical limitations, including instrument crowding, reduced triangulation, and restricted traction-countertraction. These limitations become particularly relevant in patients with previous pelvic surgery, where adhesions may increase the complexity of adnexal surgery. We present a single-port bilateral oophorectomy following previous total laparoscopic hysterectomy, focusing on surgical feasibility and intraoperative safety.

CASE PRESENTATION: A 50-year-old woman (G4P4, four previous vaginal deliveries) presented for a second opinion after detection of an ovarian cyst during routine follow-up. She reported left groin pain. Her medical history included hypertension, and she had undergone total laparoscopic hysterectomy for uterine leiomyomas in 2020.

Transvaginal ultrasonography demonstrated a surgically absent uterus and an 80 × 52 mm unilocular, anechoic left adnexal cyst without solid components or papillary projections, consistent with a benign-appearing lesion according to IOTA terminology. Tumor markers were negative. Pelvic magnetic resonance imaging demonstrated a 68 × 60 mm left adnexal cystic lesion.

Considering the persistence and size of the lesion, surgical management was recommended. Following counseling regarding surgical options, the patient underwent single-port laparoscopic bilateral oophorectomy.

Intraoperatively, pelvic adhesions related to the previous hysterectomy required meticulous adhesiolysis and careful ovarian dissection. Both ureters were identified laparoscopically, and their courses were reassessed during dissection. Bilateral oophorectomy was completed through single-port access without additional ports. Cystoscopy performed at the end of the procedure demonstrated bilateral ureteral jets.

Preoperative hemoglobin was 13.3 g/dL, decreasing to 12.8 g/dL at postoperative hour 6 and 12.1 g/dL on postoperative day 1. The postoperative course was uneventful, and the patient was discharged on postoperative day 1.

DISCUSSION: Previous pelvic surgery may present a particular challenge for single-port laparoscopy because adhesions and altered anatomy amplify the inherent limitations of reduced triangulation and instrument mobility. During oophorectomy, this becomes especially relevant when safe control of the ovarian vascular pedicle requires clear awareness of its relationship with the ureter.

The present case demonstrates an important principle of reduced-port surgery: completion through a single incision should not be considered an endpoint in itself. The operative strategy should remain adaptable, with additional ports available whenever visualization, traction, or safe dissection becomes inadequate. In this case, satisfactory exposure permitted completion through single-port access despite adhesions.

Cystoscopy served as a complementary safety assessment rather than a substitute for meticulous laparoscopic dissection. Visualization of bilateral ureteral jets provided additional evidence of ureteral patency after completion of a technically challenging procedure. This layered approach—anatomical identification during surgery followed by functional assessment when indicated—may be particularly useful when operating in distorted pelvic anatomy.

CONCLUSION: Single-port bilateral oophorectomy can be feasible in selected patients with postoperative pelvic adhesions. Its successful application depends not merely on minimizing port number, but on maintaining adequate exposure, respecting ureteral anatomy, and prioritizing surgical safety throughout the procedure.

Keywords: Adhesions, cystoscopy, oophorectomy, single-port laparoscopy, ureteral safety

VS-04

Tips and Tricks for Complicated Hysterectomy

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INTRODUCTION: Hysterectomy in patients with previous pelvic surgery may be technically demanding because of dense adhesions, distorted pelvic anatomy, and increased vascularity within scar tissue. Safe surgery in these cases depends on identifying preserved anatomical planes rather than persistently dissecting through densely adherent central areas. We present a challenging hysterectomy and highlight practical surgical techniques that may facilitate safe dissection.

CASE PRESENTATION AND SURGICAL TECHNIQUE: A 46-year-old G2P2 woman with a history of two cesarean deliveries and two previous myomectomies presented with chronic pelvic pain. Imaging demonstrated multiple uterine leiomyomas, the largest measuring approximately 8 cm. Intraoperatively, extensive adhesions related to previous pelvic surgeries resulted in marked distortion of the normal pelvic anatomy and difficult dissection, particularly around the anterior uterine surface and bladder.

When the conventional midline approach was limited by dense adhesions, dissection was initiated laterally, where relatively preserved anatomical planes could be identified more clearly. This lateral-to-medial approach allowed safer progressive mobilization of the uterus and facilitated identification of the boundaries of the adherent tissues. Particular caution was exercised during adhesiolysis because previously operated and chronically adherent tissues may develop increased neovascularization and can bleed unexpectedly even during apparently minor dissection.

A second useful maneuver involved controlled filling of the urinary bladder with diluted methylene blue. Bladder distension improved visualization of its contours and helped define the vesicouterine interface in an area where the normal surgical plane had been obscured by previous cesarean sections. Dissection was then performed progressively along the identified bladder margin, avoiding blind separation of densely adherent tissues. Following careful adhesiolysis and restoration of the relevant anatomical planes, hysterectomy was completed while preserving both ovaries.

CONCLUSION: Complicated hysterectomy after multiple previous pelvic operations requires adaptation of the conventional surgical approach to the individual anatomy. Lateral entry into relatively preserved tissue planes can provide a safer route when central adhesions are dense, while controlled bladder filling with methylene blue may facilitate identification of bladder boundaries during difficult vesicouterine dissection. Awareness of increased vascularity within chronic adhesions and meticulous, stepwise dissection are essential for minimizing bleeding and urinary tract injury in these challenging cases.

Keywords: hysterectomy, hostile pelvis, pelvic adhesions, lateral approach, bladder dissection

VS-05

Primary Robotic-Assisted Davydov Neovaginoplasty in Type I Mayer–Rokitansky–Küster–Hauser Syndrome: A Video Case Report

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26-Year-Old Female, Diagnosis History: Diagnosed with primary amenorrhea at 15 years of age.

Prior Treatment: Unsuccessful conservative vaginal dilation therapy.

Physical Examination: Gynecological evaluation revealed a blind-ending vaginal pouch measuring approximately 1–2 cm in length.

Surgical Indication: Refractory to non-surgical vaginal elongation protocols, Indication for robotic-assisted neovaginoplasty using peritoneal flaps to restore functional vaginal depth,Full preoperative multidisciplinary assessment completed.

Surgical Approach Sequence: The pelvic peritoneum overlying the vaginal remnant was incised, the neovaginal space was developed, and the vaginal remnant was opened over a curette guide.The bilateral rudimentary Müllerian structures were dissected free while developing the lateral aspects of the neovaginal space.The anterior and posterior pelvic peritoneum were approximated to the corresponding vaginal edges with the sutures tied vaginally at the end of the procedure.The apex was reconstructed with two 2-0 barbed sutures using sequential circumferential plication, incorporating the peritoneum into the right lateral aspect of the neovaginal apex.

Keywords: Davydov, Neovaginoplasty, Robotic

VS-06

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-07

Sacrocolpopexy mesh complication presenting with persistent urge incontinence and chronic pelvic pain: Laparoscopic total mesh excision case report

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OBJECTIVE: Mesh-related complications following sacrocolpopexy may present with chronic pelvic pain, dysuria, dyspareunia, and lower urinary tract symptoms. This case report aimed to evaluate the surgical approach and early postoperative outcomes of laparoscopic total mesh excision performed in a patient who developed persistent urge incontinence and severe pelvic pain after sacrocolpopexy.

METHODS: A 31-year-old woman with a history of laparoscopic sacrocolpopexy performed approximately 1.5 years earlier was admitted to our clinic because of persistent urge incontinence and progressively worsening severe groin pain. Physical examination revealed a semi-mobile uterus and tenderness in the anterior Douglas pouch. Transvaginal ultrasonography demonstrated a normal endometrial appearance and a positive sliding sign. Surgical intervention was planned with a preliminary diagnosis of mesh-related complication.

During laparoscopic exploration, the mesh material was observed extending from the promontory to the posterior uterine torus at the S1 sacral level and to the superior border of the anterior bladder. The right ureter was identified through retroperitoneal dissection and lateralized. The mesh was dissected from the surrounding tissues using bipolar scissors while preserving the rectum and ureter. The bladder peritoneum was opened, the anterior mesh was released, and the mesh material was completely excised and sent for pathological examination. A drain was placed in the Douglas pouch.

RESULTS: No major vascular, bowel, or urinary tract injury occurred during the operation. Hemostasis was adequate, and no active bleeding was observed. Normal right ureteral peristalsis was confirmed intraoperatively. In the early postoperative period, the patient remained hemodynamically stable, with adequate and clear urine output. Intraoperative sponge, instrument, and compress counts were complete. No additional early postoperative complications developed.

CONCLUSION: Mesh-related complications should be considered in patients presenting with persistent urge incontinence and chronic pelvic pain after sacrocolpopexy. Laparoscopic total mesh excision performed with meticulous retroperitoneal dissection and careful ureteral preservation

may be a safe and effective treatment option in selected cases. In this patient, complete laparoscopic removal of the extensively distributed sacrocolpopexy mesh was associated with successful early postoperative outcomes.

Keywords: Chronic pelvic pain,Laparoscopic mesh excision, Mesh complication,Sacrocolpopexy,Urge urinary incontinence

VS-08

Laparoscopic Management of a Large Paraovarian Cyst in a Symptomatic Young Woman: A Case Report

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BACKGROUND: Paraovarian cysts are relatively uncommon adnexal lesions that develop within the broad ligament or adjacent to the ovary and fallopian tube. Although most paraovarian cysts are benign and asymptomatic, larger lesions may become clinically significant due to mass effect and compression of adjacent pelvic organs. Patients with large paraovarian cysts may present with nonspecific symptoms, including pelvic or groin pain, urinary frequency, abdominal discomfort, or a sensation of pelvic pressure. Accurate preoperative assessment and appropriate surgical management are important, particularly in young patients in whom preservation of ovarian function and reproductive potential should be considered.

CASE PRESENTATION: A 30-year-old P0, nonvirgo woman presented to our clinic with complaints of groin pain and increased urinary frequency. A transvaginal ultrasound examination was performed for further evaluation. Ultrasonography revealed an approximately 10-cm cystic lesion located in the left paraovarian region. The lesion was considered to be a large paraovarian cyst based on its location and sonographic appearance. Given the relatively large size of the cyst and the presence of symptoms, surgical treatment was planned.

The patient underwent laparoscopic surgery. During the procedure, the cystic lesion was identified in the left paraovarian region and was completely excised by laparoscopic cystectomy. The minimally invasive approach allowed removal of the lesion while avoiding unnecessary ovarian surgery. The postoperative course was uneventful, and the patient was discharged following routine postoperative care.

DISCUSSION: Paraovarian cysts should be considered in the differential diagnosis of adnexal cystic masses, particularly when a large cystic lesion is detected separately from the ovary. Although many of these lesions remain asymptomatic, increasing cyst size may result in pressure-related symptoms. In the present case, the patient's groin pain and urinary frequency were likely associated with the presence of a large paraovarian cyst. The 10-cm size of the lesion and the patient's symptomatic presentation were the main factors supporting surgical management.

Laparoscopy offers several advantages in the management of benign-appearing adnexal masses, including reduced postoperative pain, shorter hospital stay, faster recovery, and

improved cosmetic outcomes compared with conventional laparotomy. In young patients, careful surgical planning is particularly important to preserve normal ovarian tissue whenever possible. Laparoscopic cystectomy can therefore be an effective treatment option for selected patients with large and symptomatic paraovarian cysts.

CONCLUSION: Large paraovarian cysts may present with nonspecific pelvic and urinary symptoms and should be included in the differential diagnosis of adnexal masses. In symptomatic patients, laparoscopic cystectomy provides a minimally invasive approach for definitive surgical management while allowing preservation of the adjacent ovarian tissue. This case highlights the importance of considering paraovarian pathology in young women presenting with pelvic or urinary symptoms and a large adnexal cystic lesion.

Keywords: Paraovarian cyst, laparoscopic cystectomy, urinary frequency

VS-09

V-Notes Right Cyst Rupture and Paratubal Cyst Excision

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V-notes right ovarian cyst rupture and left paratubal cyst excision operation video

Keywords: Vnotes emergency surgery, operation video, cyst rupture

VS-10

Recurrent pelvic infection and tubo-ovarian abscess: From medical treatment to surgical management

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OBJECTIVE: Tubo-ovarian abscess (TOA) is a serious complication of pelvic inflammatory disease, with treatment options including broad-spectrum antibiotic therapy, image-guided drainage, and surgery. This video presentation aims to demonstrate the surgical management of a patient with a history of TOA and recurrent pelvic infections who underwent laparoscopic surgery following medical treatment and image-guided drainage.

METHODS: A 52-year-old woman, gravida 3, para 3, with two previous vaginal deliveries and one cesarean section, presented to the emergency department with left groin pain. Her medical history was notable for a previous TOA and multiple courses of antibiotic therapy for recurrent pelvic infections. On admission, she had a low-grade fever, a white blood cell count of 16,000/mm³, and a C-reactive protein (CRP) level of 282 mg/L. Computed tomography revealed a 5.5 × 4 cm contrast-enhancing, multiloculated collection with internal septations in the left adnexal region, accompanied by inflammatory changes in the adjacent mesenteric fat, consistent with a TOA. The patient was hospitalized and treated with ceftriaxone, doxycycline, and metronidazole. Image-guided drainage of the collection was performed by interventional radiology. Bacterial growth was detected in the drainage culture, whereas blood and urine cultures remained negative. After 12 days of antibiotic therapy, definitive surgical management was undertaken.

RESULTS: Laparoscopic exploration revealed dense adhesions involving the left tube and ovary, uterus, pelvic sidewall, and omentum. Following careful adhesiolysis and restoration of the anatomical planes, the left tubo-ovarian complex was dissected, and laparoscopic left salpingo-oophorectomy was performed. Contralateral opportunistic salpingectomy was performed during the same procedure. Final histopathological examination confirmed findings consistent with a tubo-ovarian abscess. By postoperative day 4, the CRP level had decreased to 82 mg/L, and the patient was discharged with oral antibiotic therapy.

CONCLUSION: Management of recurrent or complicated TOA should be individualized according to the patient's clinical condition, response to medical therapy, abscess characteristics, and history of recurrence. Although antibiotic therapy and image-guided drainage are effective for infection control, definitive surgical management may be appropriate in patients with recurrent disease and persistent tubo-ovarian pathology. In cases with dense pelvic adhesions, a laparoscopic approach can be successfully performed with careful dissection and identification of the anatomical planes.

Keywords: Laparoscopy, surgical management, tubo-ovarian abscess

VS-11

Vertical extension of the anterior colpotomy to facilitate vaginal extraction of a large myomatous uterus during total laparoscopic hysterectomy

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OBJECTIVE: To demonstrate a simple and reproducible technique for facilitating transvaginal extraction of a large myomatous uterus during total laparoscopic hysterectomy (TLH) by vertically extending the anterior colpotomy. This technique aims to preserve the minimally invasive approach while avoiding additional abdominal incisions or uncontained morcellation.

METHODS: A patient with a large symptomatic fibroid uterus underwent TLH. Following completion of the hysterectomy and circumferential colpotomy, transvaginal extraction of the enlarged uterus was not feasible because of its size. Under direct laparoscopic visualization, the anterior colpotomy was extended vertically to increase the vaginal extraction space while ensuring protection of the bladder and surrounding pelvic structures. The uterus was subsequently removed vaginally, and the vaginal cuff was closed laparoscopically.

RESULTS: Vertical extension of the anterior colpotomy provided sufficient enlargement of the vaginal outlet, allowing successful vaginal extraction of the large uterus without conversion to laparotomy or enlargement of the abdominal incisions. The procedure was completed laparoscopically without intraoperative complications, including bladder or ureteral injury. Vaginal cuff closure was completed laparoscopically, and the postoperative recovery was uneventful.

CONCLUSION: Specimen extraction remains a major technical challenge during TLH for large uteri. Vertical extension of the anterior colpotomy is a straightforward, safe, and effective technique that facilitates transvaginal removal of bulky specimens while maintaining the benefits of minimally invasive surgery. Performed under direct laparoscopic visualization, this approach may reduce the need for abdominal extraction or morcellation and represents a valuable option for gynecologic surgeons managing large myomatous uteri.

Keywords: Colpotomy extension, large uterus, total laparoscopic hysterectomy

VS-12

Hysteroscopy-Assisted Vaginal Repair of Isthmocele: A Combined Minimally Invasive Approach

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OBJECTIVE: To report a case of symptomatic cesarean scar defect (isthmocele) successfully managed via a combined surgical technique integrating surgical repair via the vaginal route with intraoperative hysteroscopic visualization.

CASE PRESENTATION: A 30-year-old patient (gravida 2, para 2) with a history of two prior cesarean deliveries presented with prolonged menstrual bleeding, severe dysmenorrhea, and intermenstrual bleeding. Clinical and imaging evaluation confirmed an isthmocele at the anterior lower uterine segment; transvaginal ultrasonography revealed a remaining residual myometrial thickness of 2 mm. Due to the residual myometrial thickness measuring 2 mm, resectoscopic repair was not considered suitable, and a combined vaginal approach was selected. The surgical procedure commenced with a circumferential incision at the anterior vaginal fornix. The vesicovaginal plane was dissected, pushing the bladder cephalad to safely expose the lower segment scar. Concurrently, hysteroscopy was performed to directly visualize and transilluminate the defect boundaries from within the uterine cavity. Under real-time continuous endoluminal guidance, the pathological scar tissue was precisely demarcated and excised using surgical scissors. The resulting myometrial defect was reconstructed in layers using absorbable sutures, and the vaginal mucosa was closed. The entire procedure was completed vaginally without entering the abdominal cavity. The patient had an uneventful postoperative recovery with complete resolution of symptoms.

CONCLUSION: Hysteroscopy-assisted vaginal repair ensures precise intraoperative localization and complete resection of pathological scar tissue while preserving the low-morbidity and rapid recovery benefits of a purely vaginal approach. This combined technique offers a safe, effective, and feasible minimally invasive alternative for selected patients with symptomatic isthmocele.

Keywords: Cesarean scar defect, Combined minimally invasive surgery, Isthmocele,Hysteroscopy,Vaginal repair

VS-13

Laparoscopic Management of Intraoperative Complications in Gynecologic Surgery: Two Surgical Cases

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Laparoscopic Management of Intraoperative Complications in Gynecologic Surgery: Two Surgical Cases

OBJECTIVE: To demonstrate the laparoscopic management of two distinct intraoperative complications during gynecologic surgery: bladder injury during sacrocolpopexy and partial obturator nerve injury during pelvic lymphadenectomy.

METHODS: Two surgical cases are presented. In the first, a full-thickness bladder injury occurred during laparoscopic sacrocolpopexy in a densely adhesive pelvis. In the second, the obturator nerve sustained a partial injury during LigaSure application while performing laparoscopic pelvic lymphadenectomy. Both injuries were recognized intraoperatively and repaired laparoscopically during the same procedure.

RESULTS: The bladder injury was repaired with a double-layer laparoscopic closure, and bladder integrity was confirmed intraoperatively. The obturator nerve injury, with preserved partial continuity, was repaired using interrupted sutures with careful approximation and without tension. Both procedures were completed laparoscopically. The patient with obturator nerve injury had mild transient difficulty with leg elevation for 48 hours, which resolved spontaneously.

CONCLUSION: Immediate recognition and laparoscopic repair of intraoperative bladder and obturator nerve injuries are feasible during complex gynecologic surgery. Prompt identification, precise tissue approximation, and tension-free repair are key to minimizing morbidity.

Keywords: bladder injury, bladder repair, obturator nerve injury, sacrocolpopexy, surgical complications

VS-14

Intraoperatively Tailored Surgery for a Positive Frozen-Section Pelvic Lymph Node in Cervical Squamous Cell Carcinoma: Ovarian Transposition and Bilateral Salpingectomy to Prepare for Definitive Radiotherapy — A Surgical Video

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OBJECTIVE: Young women with cervical cancer who require pelvic radiotherapy are at high risk of radiation-induced premature ovarian failure. We present the surgical management of a 36-year-old woman with cervical squamous cell carcinoma and no desire for fertility preservation, the case was discussed at the multidisciplinary oncology council of Muğla Sıtkı Koçman University, where surgery was selected as primary treatment with intraoperative pelvic lymph node assessment. Surgery would have proceeded had the node been negative; however, a malignant frozen-section result confirmed nodal involvement, and radical hysterectomy was not performed to avoid combining radical surgery with adjuvant radiotherapy, directing the patient toward definitive chemoradiotherapy. This video demonstrates how ovarian transposition with bilateral salpingectomy was performed to displace the ovaries out of the planned radiation field, preserving ovarian endocrine function before treatment.

METHODS: The entire procedure was performed through a purely laparoscopic, minimally invasive approach — the direction in which modern gynaecologic oncology has decisively evolved and which contemporary guidelines endorse for nodal staging and ovarian transposition. Laparoscopy offers an unrivalled, magnified view of the retroperitoneal anatomy, allowing meticulous, bloodless dissection along the avascular spaces. The benefits are considerable: minimal blood loss, less adhesion formation, reduced postoperative pain, a shorter hospital stay, and a swift recovery that lets the patient proceed to radiotherapy without delay. Preoperative imaging guided the plan: pelvic MRI showed a residual right-lateral cervical tumour without definite parametrial invasion, while 18F-FDG PET-CT highlighted an FDG-avid cervical lesion (SUVmax 11.9) alongside bilateral external iliac nodes suspicious for metastasis (SUVmax 9.0). The video follows each step: port

placement, exposure of the pelvic sidewall and retroperitoneal spaces, pelvic lymph node dissection, retrieval of nodes for frozen-section examination, and — once the pathology dictated a change of course — laparoscopic bilateral salpingectomy followed by high fixation of both mobilised ovaries above the pelvic brim, clip-marked to guide radiation-field planning.

RESULTS: Frozen-section pathology returned positive for metastatic squamous cell carcinoma, confirming node-positive disease and triggering the intraoperative change of plan. Recognising that radical surgery followed by radiotherapy would burden the patient with the compounded morbidity of two aggressive treatments, the team appropriately deferred definitive local therapy to chemoradiotherapy. The operation proceeded uneventfully, and final histopathology corroborated the intraoperative diagnosis. With both gonads lying outside the anticipated pelvic radiation field, the patient was referred promptly for concurrent chemoradiotherapy, while her ovarian endocrine function was given the best possible chance of being preserved.

CONCLUSION: This case illustrates that intraoperative frozen-section nodal assessment is a decisive checkpoint that can spare selected patients an unnecessary radical resection. When nodal metastasis redirects treatment towards radiotherapy, laparoscopic ovarian transposition combined with bilateral salpingectomy offers a swift, low-morbidity means of protecting gonadal function and lowering future adnexal risk. Building this reflex into surgical planning allows both oncological priorities and long-term quality of life to be honoured within a single minimally invasive operation.

Keywords: Cervical squamous cell carcinoma, Ovarian transposition, Laparoscopy, Intraoperative frozen-section lymph node

VS-15

vNOTES Surgical Staging of a Marker-Negative Adnexal Mass Revealing an Adult Granulosa Cell Tumor

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OBJECTIVE: To demonstrate, in a step-by-step video, the vaginal natural orifice transluminal endoscopic surgery (vNOTES) technique for the complete surgical management and staging of a clinically suspicious adnexal mass in a 36-year-old woman with normal serum tumor markers and no desire for fertility preservation. We highlight the diagnostic challenge of marker-negative ovarian malignancy and show how intraoperative frozen-section identification of an adult granulosa cell tumor shaped a minimally invasive staging strategy decided within a preoperative oncology-council pathway.

METHODS: We present a 36-year-old multiparous woman (body mass index 31.2) with no wish for fertility preservation, referred for a 6.5-cm complex left adnexal mass containing solid areas with increased Doppler flow on ultrasound and magnetic resonance imaging. Serum tumor markers were within normal limits, and thoraco-abdominal computed tomography showed no ascites, lymphadenopathy, or distant disease. After preoperative oncology-council assessment, vNOTES was undertaken. The video details each step: transvaginal posterior colpotomy and port placement, immediate peritoneal washing for cytology, left salpingo-oophorectomy with in-bag extraction to avoid spillage, and intraoperative frozen-section analysis. After frozen section reported a malignant stromal tumor, staging was completed with right salpingectomy, infracolic omentectomy, bilateral pelvic peritoneal biopsies, and endometrial curettage.

RESULTS: The procedure was completed entirely through the vaginal route, with an estimated blood loss of 90 mL and no conversion. The specimen was retrieved intact within an endobag, avoiding intra-abdominal rupture. Final histopathology confirmed an adult-type granulosa cell tumor of the left ovary (6.5 × 5 × 4 cm) with an uninvolved capsule and no surface involvement. Immunohistochemistry was characteristic: inhibin, calretinin, SF1, and CD56 positive, with estrogen (~50%) and progesterone (~40%) receptor expression; WT1 was weak and patchy and pankeratin patchy, whereas chromogranin, synaptophysin, CD10, CD99, SALL4, AFP, OCT3/4, EMA, PAX8, and p16 were negative. p53 showed a wild-type pattern and the Ki-67 index was 1–2% with rare mitoses, supporting the diagnosis and excluding epithelial and

germ-cell mimics. Peritoneal washing cytology was positive for tumor cells, whereas the omentum, bilateral pelvic peritoneal biopsies, and right tube were tumor-free; endometrial curettage was benign. The tumor was classified as FIGO stage IC3 (pT1c3). There were no intra- or postoperative complications, and the patient was discharged 36 hours after surgery, allowing prompt referral to adjuvant chemotherapy without delay.

CONCLUSION: This case highlights vNOTES as a feasible and safe approach for complete minimally invasive surgical staging of an early ovarian malignancy. Its principal oncologic advantage is extraction of the intact specimen through a natural orifice within an endobag, avoiding intra-abdominal rupture and iatrogenic peritoneal spillage when malignancy is unexpected. The low-morbidity, rapid recovery it affords can shorten the interval to adjuvant treatment. Equally important, a marker-negative adnexal mass may still be malignant; granulosa cell tumors, which typically do not raise conventional serum markers, should remain in the differential and prompt readiness for intraoperative frozen section and full staging.

Keywords: vNOTES, Ovarian cancer surgical staging, Minimally invasive surgery; Adnexal mass

VS-16

vNOTES Hysterectomy and Bilateral Salpingo-Oophorectomy for a Giant Uterine Leiomyoma

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OBJECTIVE: To demonstrate the feasibility, safety, and surgical steps of vaginal natural orifice transluminal endoscopic surgery (vNOTES) for a total hysterectomy and bilateral salpingo-oophorectomy (BSO) in a patient with a giant uterine leiomyoma.

CASE PRESENTATION: A 53-year-old multiparous woman (three vaginal deliveries) with no history of prior abdominal or pelvic surgeries presented to the outpatient clinic with a primary complaint of severe pelvic pain. Pelvic ultrasonography revealed a large solid mass measuring 155 x 140 mm. Subsequent magnetic resonance imaging (MRI) confirmed a giant uterine myoma measuring 17 x 16 x 6 cm, extending cranially up to the level of the umbilicus.

INTERVENTIONS: Given the patient's favorable vaginal parity and lack of prior surgeries, the vNOTES approach was selected. A vNOTES total hysterectomy and BSO were successfully performed. The video highlights the step-by-step surgical technique, including the anterior and posterior colpotomy, insertion of the vNOTES port, establishment of pneumovagina, division of the adnexal and uterine vessels, and the challenging vaginal extraction of the massive specimen using cold scalpel morcellation.

RESULTS AND CONCLUSION: The procedure was completed successfully without conversion to conventional laparoscopy or laparotomy, and without any intraoperative complications. The final histopathological examination reported a benign uterine leiomyoma. This case demonstrates that in experienced hands, vNOTES is a feasible, safe, and highly effective minimally invasive alternative for the surgical management of giant uterine myomas reaching the umbilicus, offering the benefits of no abdominal scars and potentially faster recovery.

Keywords: vnotes,Hysterectomy, myoma

VS-17

vNOTES Minimally Invasive Surgical Staging of Low-Grade Endometrioid Endometrial Carcinoma: Hysterectomy, Bilateral Salpingo-Oophorectomy, and Sentinel Lymph Node Biopsy

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OBJECTIVE. Endometrial carcinoma is the most frequently diagnosed gynaecological cancer in high-income countries, and contemporary international guidelines have reshaped its management around three principles: integration of molecular classification, a preference for minimally invasive surgery, and sentinel lymph node (SLN) mapping in place of routine lymphadenectomy. This video demonstrates the guideline-concordant, molecular-integrated surgical staging of a premenopausal woman with low-grade endometrioid endometrial carcinoma, performed entirely by vaginal natural orifice transluminal endoscopic surgery (vNOTES), and shows how sentinel lymph node biopsy provided accurate nodal staging that resolved preoperative imaging findings and directed adjuvant therapy.

METHODS. A 42-year-old premenopausal woman (gravida 1, para 1; body-mass index 29) presented with an endometrial biopsy showing endometrioid adenocarcinoma, grade 1. Molecular characterisation demonstrated retained mismatch-repair proteins (MLH1, MSH2, MSH6, PMS2), wild-type p53, and loss of PTEN, classifying the tumour as no specific molecular profile (NSMP). Pelvic MRI showed a uterus-confined lesion with multiple leiomyomas, whereas PET-CT revealed a hypermetabolic uterine mass and suspicious right pelvic lymph nodes (SUVmax 5.6). After multidisciplinary tumour-board review, the patient, who had no fertility wish, underwent complete minimally invasive staging by vaginal natural orifice transluminal endoscopic surgery (vNOTES). Through a single vaginal platform, bilateral pelvic sentinel lymph node mapping and biopsy were performed first using cervical indocyanine green (ICG) injection, followed by total hysterectomy with bilateral salpingo-oophorectomy and transvaginal specimen extraction.

RESULTS. The procedure was completed entirely by vNOTES, without conversion to conventional laparoscopy or laparotomy. Estimated blood loss was 110 mL, and no intraoperative or postoperative complications occurred; the patient was discharged 48 hours after surgery. Cervical ICG injection successfully mapped bilateral pelvic sentinel lymph nodes, which were removed for pathological assessment. Final histopathology showed endometrioid adenocarcinoma, grade 1, with a 4 cm exophytic polypoid tumour, superficial myometrial invasion (1 mm; less than 50%), and no lymphovascular space invasion; the cervix, parametria, serosa, and vaginal margins were free of tumour. The tumour retained mismatch-repair proteins and showed wild-type p53, confirming a no specific molecular profile (NSMP) subtype. A right pelvic sentinel lymph node was reported as metastatic, concordant with the hypermetabolic node seen on preoperative PET-CT. The disease was therefore upstaged to FIGO 2023 stage IIIC1 (pT1a N1), placing it in a high-risk category, and the multidisciplinary board recommended adjuvant chemotherapy combined with radiotherapy, after which the patient was enrolled in structured oncological surveillance.

CONCLUSION. This case illustrates that comprehensive minimally invasive staging of endometrial carcinoma can be achieved safely and reproducibly through vNOTES, offering scarless access, minimal blood loss, and early discharge without compromising oncological quality. Cervical ICG sentinel lymph node mapping identified a pelvic nodal metastasis that upstaged the disease and directed appropriate adjuvant therapy, underscoring the diagnostic value of sentinel node assessment. Integrating molecular classification, minimally invasive surgery, and sentinel lymph node biopsy enables precise, guideline-concordant, and individualised management of endometrial cancer while sparing patients the morbidity of systematic pelvic lymphadenectomy.

Keywords: vNOTES, minimally invasive surgery, endometrial cancer staging, sentinel lymphadenctomy

VS-18

Late Nodal Recurrence in Endometrial Cancer

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PURPOSE: The vast majority of recurrences in endometrial cancer (EC) occur within the first 3 years following primary treatment. While adjuvant radiation therapy (RT) reduces the risk of pelvic recurrence, it does not alter the risk of distant or nodal recurrence. "Ultra-late" isolated retroperitoneal nodal recurrences occurring more than 15 years after primary treatment are exceptionally rare. Surgical resection of retroperitoneal masses encasing the main vascular lumen of the inferior vena cava (IVC) carries a significant risk of life-threatening vascular injury. Here, we present a case of complete (R0) secondary cytoreduction for an IVC-encasing nodal recurrence occurring 16 years after primary surgery in a patient with a history of RT, managed using a vascular-preserving technique in a multidisciplinary setting with Cardiovascular Surgery (CVS). Therefore, the aim of this study is to present a case of complete (R0) secondary cytoreduction for an IVC-encasing nodal recurrence occurring 16 years after primary surgery in a patient with a history of RT, managed using a vascular-preserving technique in a multidisciplinary setting with Cardiovascular Surgery (CVS).

METHODS: A 64-year-old female patient underwent Total Abdominal Hysterectomy + Bilateral Salpingo-Oophorectomy (TAH+BSO) for EC in 2010 and received adjuvant RT. She also had a prior open partial nephrectomy in 2016. Surveillance PET-CT on June 15, 2026, demonstrated new FINDINGS: a 7 cm mass in the left kidney (SUVmax =6), a 5 cm para-retrocaval mass (SUVmax =27.1), and conglomerate retrocaval lymph nodes averaging 8 cm (SUVmax=27.1). A tru-cut biopsy of the para-retrocaval mass revealed "Papillary Adenocarcinoma with clear cell features (compatible with metastasis of endometrial origin)," and secondary cytoreductive surgery was planned.

RESULTS: Via a xiphoid-pubic incision, extensive adhesions were lysed and total omentectomy was performed. In the para-aortic region, renal vessels were dissected; the right ureter passing over the tumor was mobilized and preserved. The IVC was suspended using vessel loops below the right renal vein and at the bifurcation level. Due to severe IVC luminal narrowing, the CVS team was scrubbed in; intraoperative assessment determined that graft interposition would not be required. Through meticulous dissection, the lateral and medial boundaries of the IVC were delineated. The IVC was successfully preserved without vascular resection, achieving complete cytoreduction with no macroscopic residual tumor (R0). Management of the newly detected left renal mass was transferred to the Urology team. The Gynecologic Oncology Tumor Board recommended adjuvant systemic chemotherapy combined with immunotherapy. Surgical dissection steps and vascular-preserving techniques were intraoperatively video-documented and will be presented.

CONCLUSION: Retroperitoneal nodal recurrences can develop decades after initial therapy in EC patients who received adjuvant RT. In hypermetabolic recurrences encasing major vascular structures, vascular suspension using vessel loops and multidisciplinary intraoperative planning with CVS enhance surgical safety. Complete (R0) cytoreduction was safely achieved while preserving major vascular structures. Planned adjuvant chemotherapy and immunotherapy highlight the paramount importance of a multimodal therapeutic approach in late nodal recurrences.

Keywords: Endometrial cancer, late nodal recurrence, inferior vena cava, secondary cytoreduction, immunotherapy,

VS-19

Postmenopozal Kanama Nedeniyle Laparoskopik Histerektomi Planlanan Hastada Beklenmeyen Endometrioid Adenokarsinom

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INTRODUCTION: In patients presenting with postmenopausal bleeding, benign endometrial sampling results do not completely exclude the risk of malignancy. Furthermore, preoperative evaluation may not always predict advanced pelvic pathology encountered during surgery.

CASE: A 55-year-old woman with recurrent postmenopausal bleeding had undergone endometrial sampling twice, both of which revealed endometrial polyps. Due to persistent bleeding, laparoscopic hysterectomy was planned. Preoperative imaging at a secondary care center showed a uterus of normal size and approximately 2-cm simple cystic lesions in both adnexal regions. Bimanual examination revealed mild posterior fornix retraction; however, the patient was asymptomatic and denied pelvic pain. Tumor markers were within normal limits. Intraoperative frozen-section examination was not available at the center.

During surgical exploration, obliteration of the pouch of Douglas, bilateral hydrosalpinx, a “kissing ovaries” appearance, and dense pelvic adhesions were observed, consistent with advanced-stage endometriosis. Despite significant distortion of the pelvic anatomy, laparoscopic hysterectomy was successfully completed using systematic adhesiolysis and careful dissection. No intraoperative or postoperative complications occurred. Final histopathological examination revealed adenomyosis in the myometrium and endometrioid adenocarcinoma, FIGO grade 1.

CONCLUSION: In patients with postmenopausal bleeding, benign endometrial sampling, particularly the presence of an endometrial polyp, does not completely exclude malignancy. Advanced endometriosis may also cause unexpected and significant anatomical challenges during surgery, even in asymptomatic patients. In secondary care centers without access to intraoperative frozen-section examination, careful surgical planning, systematic dissection, and adequate laparoscopic expertise may allow safe management of complex cases. This case highlights the importance of maintaining clinical vigilance and adopting an appropriate surgical approach despite apparently benign preoperative findings in patients with postmenopausal bleeding.

Keywords: Adenomyosis, Endometriosis, Endometrioid adenocarcinoma, Laparoscopic hysterectomy, Secondary care center

VS-20

Sacrospinous ligament suspension via vNOTES for the management of POP

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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-21

vNotes Lateral Suspension and High Uterosacral Ligament Suspension for Treating Pelvic Organ Prolapse

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OBJECTIVE: To present the clinical evaluation and surgical management of a patient with advanced pelvic organ prolapse using a combined vNOTES lateral suspension and high uterosacral ligament suspension approach.

CASE PRESENTATION: A 56-year-old multiparous woman (gravida 3, parity 3, with a history of three normal vaginal deliveries) and a body mass index (BMI) of 34 kg/m² presented to our clinic complaining of pelvic pressure and vaginal bulging. Upon clinical evaluation, the patient was diagnosed with stage 3 apical vaginal prolapse. Ultrasonography confirmed that the uterus was of normal size and revealed no endometrial abnormalities.

INTERVENTIONS: A vaginal natural orifice transluminal endoscopic surgery (vNOTES) approach was utilized to perform a lateral suspension combined with a high uterosacral ligament suspension. The video demonstrates the key surgical steps for achieving robust apical support and anatomical restoration through this minimally invasive route.

RESULTS AND CONCLUSION: The combined vNOTES lateral and high uterosacral ligament suspension was completed successfully without intraoperative complications. This case highlights that the vNOTES approach is a feasible, safe, and highly effective minimally invasive surgical option for the correction of stage 3 apical pelvic organ prolapse, even in obese patients.

Keywords: vNOTES,Pelvic organ prolapse,Lateral suspension

VS-22

Extraperitoneal Approach for Sacrocolpopexy in Vaginal Natural Orifice Transluminal Endoscopic Surgery

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To present the clinical evaluation and surgical technique of an extraperitoneal sacrocolpopexy performed via Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) in a patient with severe pelvic organ prolapse.

A 62-year-old woman (para 4, following four vaginal deliveries) presented to our university hospital reporting significant pelvic pressure and the sensation of a vaginal bulge. Both her personal and family medical histories were unremarkable. Her body mass index (BMI) was 31 kg/m². Clinical evaluation confirmed a diagnosis of Stage 4 apical-vaginal prolapse according to the POP-Q system. A preoperative pelvic ultrasound demonstrated a uterus of normal size and revealed no abnormalities in the endometrium.

An extraperitoneal approach was utilized to perform a sacrocolpopexy via the vNOTES route

vNOTES extraperitoneal sacrocolpopexy was completed successfully without intraoperative complications, offering a minimally invasive, scarless alternative for restoring normal pelvic anatomy in patients with advanced apical prolapse

Keywords: vNOTES,Sacrocolpopexy,Pelvic organ prolapse

POSTER BİLDİRİLER



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PP-01

Severe obstetric disseminated intravascular coagulation following second-trimester pregnancy termination after feticide: A case report

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OBJECTIVE: Disseminated intravascular coagulation (DIC) is one of the most serious and life-threatening complications in obstetric practice. Although rare following second-trimester pregnancy termination, delayed diagnosis and treatment may result in massive hemorrhage, multiple organ failure, and maternal mortality. We report a case of obstetric DIC that developed after feticide, medical termination of pregnancy, and vacuum aspiration curettage, highlighting its diagnosis and multidisciplinary management.

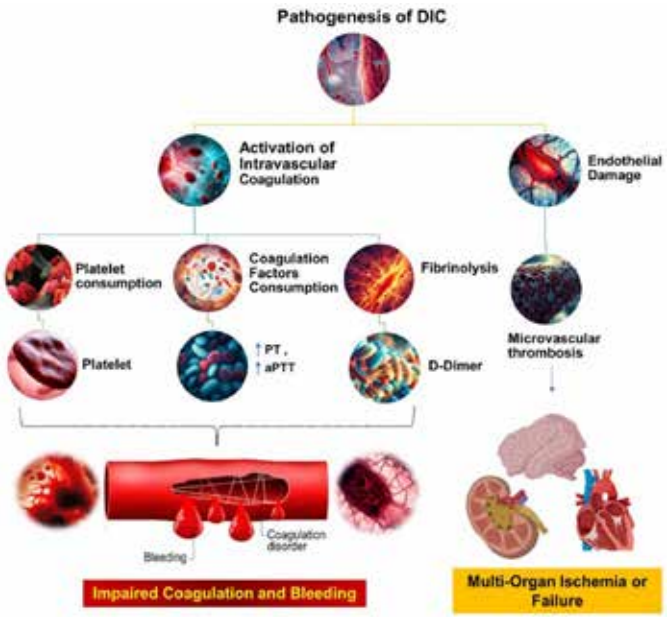
METHODS: A 22-week pregnant woman was admitted for pregnancy termination following feticide because of fetal hyperechogenic bowel, severe fetal growth restriction, and anhydramnios. Ultrasound confirmed the absence of fetal cardiac activity, and the estimated fetal weight was 207 g (<1st percentile). Medical termination was initiated using misoprostol. Approximately 10 hours after induction, a stillborn male fetus weighing 200 g was delivered vaginally. As the placenta failed to separate completely, vacuum aspiration curettage was performed using a Carmen cannula. Transvaginal ultrasonography confirmed an empty uterine cavity after the procedure.

RESULTS: Progressive vaginal bleeding developed in the early postoperative period. Repeated ultrasonographic examinations revealed neither retained products of conception nor intra-abdominal free fluid. Laboratory investigations demonstrated a decline in hemoglobin level, thrombocytopenia (59,000/mm³), prolonged prothrombin time (17 seconds), and severe hypofibrinogenemia (32 mg/dL), raising suspicion for obstetric DIC. Ongoing hemorrhage necessitated re-exploration under anesthesia, which revealed diffuse oozing from the upper cervical quadrant without evidence of retained placental tissue. Cervical suturing, intrauterine balloon tamponade, and vaginal packing were performed. Massive transfusion therapy included 4 units of packed red blood cells, 4 units of fresh frozen plasma, 7 g of fibrinogen concentrate, and 1 g of Hemocomplettan®. Coagulation parameters and liver function tests gradually normalized during follow-up. Vaginal bleeding resolved, and the patient was discharged in good clinical condition on postoperative day six.

CONCLUSION: Persistent vaginal bleeding following second-trimester pregnancy termination should not be attributed solely to uterine atony or retained placental tissue. Obstetric DIC should be considered in the differential diagnosis, particularly in the presence of severe hypofibrinogenemia. Prompt recognition, serial monitoring of coagulation parameters, timely surgical hemostasis, and goal-directed blood product replacement can achieve successful maternal outcomes while avoiding hysterectomy. This case underscores the importance of early multidisciplinary management in this rare but potentially life-threatening complication.

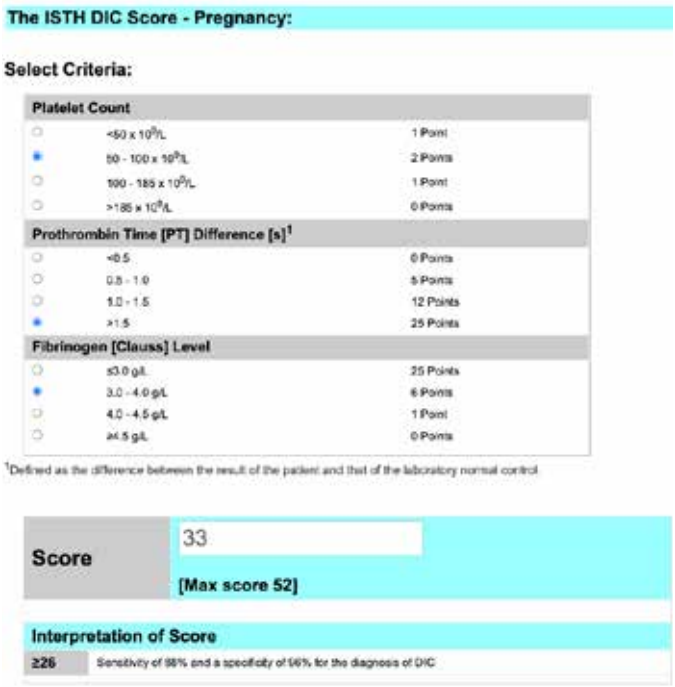
Keywords: Disseminated intravascular coagulation, feticide, hypofibrinogenemia, obstetric hemorrhage, second-trimester pregnancy termination.

DIK PATOGENEZİ



DIK PATOGENEZİ

ISTH DIC SCORE



ISTH DIC SCORE

PRE- AND POST-TREATMENT 'DIC' PARAMETERS

Parameter	Diagnosis	Treatment
Hb	8.3 g/dL	9.6 g/dL
Platelets	59.000/mm³	222.000/mm³
Prothrombin time	17.2	12.7
Fibrinogen	32 mg/dL	361 mg/dL
Aspartate Aminotransferase	924 U/L	62 U/L
Alanine Aminotransferase	735 U/L	175 U/L

PP-02

Massive Hemorrhagic Transformation of Ischemic Stroke Following Superimposed Preeclampsia: A Case Report

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Hypertensive disorders of pregnancy are among the leading causes of maternal morbidity and mortality. Superimposed preeclampsia in women with chronic hypertension significantly increases the risk of life-threatening complications, including cerebrovascular events. Postpartum ischemic stroke with hemorrhagic transformation is a rare but devastating obstetric emergency associated with high mortality and a substantial risk of permanent neurological sequelae. We aimed to present the clinical course of a young primigravid woman with chronic hypertension who underwent cesarean delivery for superimposed preeclampsia and subsequently developed a massive hemorrhagic transformation of an ischemic stroke requiring decompressive craniectomy.

A 22-year-old primigravid woman with a history of chronic hypertension had not received regular antihypertensive treatment during pregnancy and used methyldopa only when needed. At 33 weeks and 6 days of gestation, she was admitted to our clinic with a blood pressure of 154/96 mmHg. She reported headache and blurred vision on admission. She was hospitalized with a preliminary diagnosis of superimposed preeclampsia and received a loading dose of magnesium sulfate along with antenatal corticosteroid therapy. Due to persistent fetal tachycardia and ongoing maternal prodromal neurological symptoms, an emergency cesarean section was performed. Postoperatively, magnesium sulfate infusion was continued for 24 hours, venous thromboembolism prophylaxis was initiated, and cardiology and internal medicine consultations were obtained for the management of chronic hypertension.

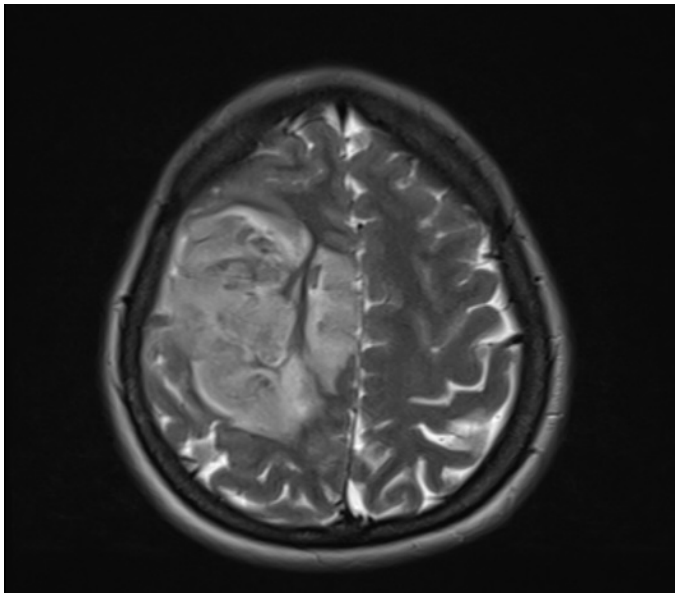
A live male infant weighing 2,210 g was delivered by cesarean section. During the postoperative period, the patient's blood pressure remained approximately 140/90 mmHg, and nifedipine therapy was initiated. As she remained clinically stable, she was discharged on postoperative day 3. The following day, she developed sudden loss of consciousness and weakness at home and was admitted to an outside hospital. Cranial imaging revealed intracranial hematomas. Follow-up imaging demonstrated an 84-mm space-occupying intracranial hematoma associated with a hemorrhagic transformation of an ischemic cerebral infarction. Further neurovascular evaluation excluded cerebral venous sinus thrombosis. After referral to a tertiary care center, decompressive craniectomy was performed by the neurosurgery team. Repeat imaging the following day demonstrated a large infarction measuring 105 × 65 mm with

secondary hemorrhagic transformation. During her stay in the neurological intensive care unit, acute deep vein thrombosis of the right lower extremity developed approximately three weeks later, and treatment with aspirin and low-molecular-weight heparin was initiated. Following approximately two months of intensive care and inpatient rehabilitation, the patient was discharged. At the four-month follow-up, she was able to ambulate with the assistance of a walker and subsequently underwent cranioplasty.

In patients with chronic hypertension and superimposed preeclampsia, the risk of postpartum cerebrovascular events persists even when blood pressure appears to be adequately controlled. This case illustrates a rare but life-threatening postpartum complication characterized by a large arterial ischemic infarction with hemorrhagic transformation after cerebral venous sinus thrombosis had been excluded. In pregnant and postpartum patients presenting with headache, visual disturbances, or other neurological symptoms, prompt neurological evaluation and a low threshold for urgent brain imaging are essential. Early diagnosis, a multidisciplinary approach, and timely neurosurgical intervention are critical for improving maternal survival and long-term functional outcomes.

Keywords: Ischemic Stroke, Massive Hemorrhagic Transformation, Superimposed Preeclampsia

MR



PP-03

Giant Borderline Mucinous Ovarian Tumor During Pregnancy: A Case Report

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INTRODUCTION: Adnexal masses are detected in approximately 1–5% of pregnancies, the majority of which are benign. Borderline ovarian tumors (BOTs) are rare ovarian neoplasms encountered during pregnancy and present significant diagnostic and therapeutic challenges. We report a case of a giant borderline mucinous ovarian tumor diagnosed during pregnancy, accompanied by intraoperative lesions that macroscopically suggested peritoneal implants but were ultimately found to be benign on histopathological examination.

CASE PRESENTATION: A 33-year-old woman at 22 weeks and 4 days of gestation was referred for evaluation of a persistent adnexal mass. A 10-cm ovarian cyst had been identified before pregnancy; however, the patient had declined the recommended pelvic magnetic resonance imaging. Transabdominal ultrasonography demonstrated a giant anechoic cystic mass extending from the pelvis to the xiphoid process. An 84 × 66 × 94 mm multiloculated mural lesion with a honeycomb appearance arising from the cyst wall was identified. Doppler ultrasonography showed no internal vascularization. At 32 weeks and 2 days of gestation, the patient underwent an emergency cesarean section because of transverse fetal presentation. A live male infant weighing 1,570 g was delivered. Surgical exploration revealed a 35-cm ovarian mass. Histopathological examination confirmed a borderline mucinous ovarian tumor containing an 11-cm multiloculated borderline component. Although a capsular defect was present, no tumor involvement of the ovarian surface was identified. Omental biopsy demonstrated congestion and reactive mesothelial proliferation. A suspicious right upper quadrant lesion revealed fibrohyalinized connective tissue with congestion, focal hemorrhage, and reactive mesothelial proliferation. No evidence of malignancy or peritoneal implants was detected in any specimen. The postoperative course was uneventful, and the patient was discharged in good condition.

DISCUSSION: Borderline mucinous ovarian tumors during pregnancy pose considerable diagnostic and surgical challenges. Borderline tumors should be considered in the differential diagnosis of large, multiloculated adnexal masses with mural components. Furthermore, intraoperative lesions suggestive of peritoneal implants do not necessarily indicate metastatic disease. Histopathological confirmation of suspicious lesions is essential before assigning tumor stage or planning additional oncologic treatment.

CONCLUSION: Persistent giant adnexal masses during pregnancy require multidisciplinary management. Borderline ovarian tumors should be included in the differential diagnosis of complex adnexal masses. Histopathological confirmation of lesions suspicious for peritoneal implants is crucial to avoid unnecessary upstaging and overtreatment.

Keywords: Adnexal mass, Borderline mucinous ovarian tumor; Giant ovarian mass, Pregnancy

Intraoverative view



Intraoverative view



PP-04

Prenatal ultrasound diagnosis of isolated fetal forearm agenesis: A case report

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OBJECTIVE: Fetal limb anomalies are among the most common major congenital structural anomalies after congenital heart defects. We aimed to present the prenatal diagnosis and obstetric management of fetal left forearm agenesis detected in a spontaneous dichorionic diamniotic twin pregnancy complicated by preterm prelabor rupture of membranes (PPROM).

METHODS: A 31-year-old pregnant woman with a spontaneous dichorionic diamniotic twin pregnancy, who had been followed at our clinic, was admitted at 18 weeks of gestation with a complaint of vaginal fluid leakage. Following a positive amnisure test, the diagnosis of preterm prelabor rupture of membranes (PPROM) was confirmed, and the patient was hospitalized for medical management and close maternal-fetal surveillance. During inpatient follow-up, a detailed obstetric ultrasonographic examination performed at 20 weeks of gestation revealed left forearm agenesis in the second fetus. It was noted that the patient had not undergone prenatal aneuploidy screening. After prenatal diagnosis, invasive diagnostic options were discussed in detail; however, the patient declined invasive testing, and written informed refusal was obtained.

RESULTS: The patient was managed conservatively because of PPROM, and fetal left forearm agenesis was successfully identified by prenatal ultrasonography. As no intrauterine infection or additional maternal or fetal complications requiring delivery developed during follow-up, expectant management of the pregnancy was continued. The pregnancy is currently ongoing at 32 weeks of gestation, with close maternal and fetal surveillance.

CONCLUSION: In twin pregnancies complicated by PPROM, detailed ultrasonographic evaluation facilitates the early detection of concomitant fetal structural anomalies. Prenatal diagnosis plays a crucial role in parental counseling and obstetric management. In cases where invasive diagnostic testing is declined, a multidisciplinary approach and close maternal-fetal surveillance are essential for optimizing pregnancy outcomes.

Keywords: isolated fetal forearm agenesis, preterm prelabor rupture of membranes,a spontaneous dichorionic diamniotic twin pregnancy

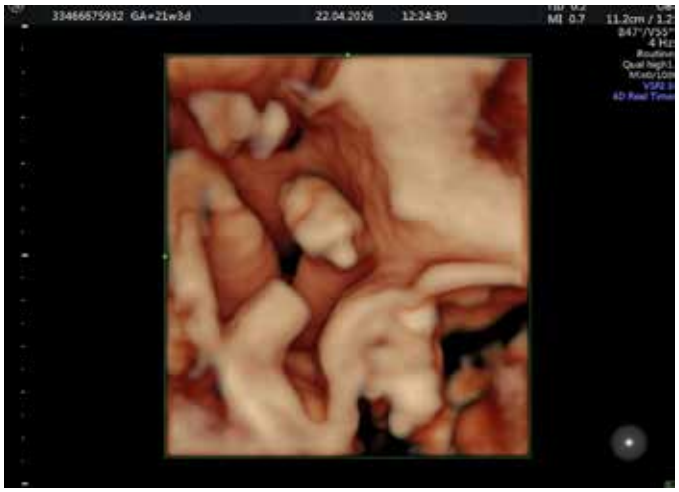
Doğum sonrası



Ultrason görüntüsü-1



Ultrason görüntüsü-2



PP-05

A Rare Combined Small Cell and Large Cell Neuroendocrine Carcinoma of the Cervix: A Case Report

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INTRODUCTION: Neuroendocrine carcinomas of the cervix are rare tumors accounting for approximately 1–2% of cervical malignancies and are characterized by high-grade, aggressive biological behavior. According to the 2020 World Health Organization (WHO) classification, small cell and large cell neuroendocrine carcinomas are classified as high-grade neuroendocrine neoplasms. Compared with other cervical cancers, they are associated with a poorer prognosis because of their tendency for early lymphovascular invasion, a high proliferative index, and distant metastasis. The coexistence of both small cell and large cell neuroendocrine components within the same tumor is an exceptionally rare histopathological pattern with important diagnostic and therapeutic implications. We present the clinical, surgical, and pathological features of a patient diagnosed with combined small cell and large cell neuroendocrine carcinoma of the cervix.

CASE PRESENTATION: A 51-year-old woman, gravida 7, para 6, abortus 1, who had been menopausal for two years and had a smoking history of more than 25 years, presented with postcoital bleeding. Gynecological examination revealed a protruding exophytic cervical lesion measuring approximately 15 mm without parametrial involvement. Transvaginal ultrasonography demonstrated an approximately 18-mm endophytic cervical lesion. Following an endocervical curettage and punch biopsy performed at another center, which was reported as a malignant epithelial tumor, pelvic magnetic resonance imaging supported the preliminary diagnosis of cervical malignancy. After multidisciplinary evaluation by the gynecologic oncology board, the patient underwent type III radical hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic and para-aortic lymph node dissection, and appendectomy.

Histopathological examination revealed a poorly differentiated neuroendocrine carcinoma measuring 2.2 × 1.7 cm involving both the ectocervix and endocervix. Focal lymphatic and perineural invasion were present, whereas vascular invasion, parametrial extension, vaginal involvement, and positive surgical margins were absent. All 31 pelvic and para-aortic lymph nodes were negative for metastasis. Immunohistochemical analysis demonstrated positivity for synaptophysin, chromogranin, CD56, and diffuse strong p16 expression,

while p40 and CK5/6 were negative. The Ki-67 proliferation index was 95%. Morphological evaluation identified extensive necrosis with areas of small cell carcinoma accompanied by a large cell neuroendocrine carcinoma component, leading to the diagnosis of combined small cell carcinoma and large cell neuroendocrine carcinoma.

CONCLUSION: Combined small cell and large cell neuroendocrine carcinoma of the cervix is an extremely rare malignancy with an aggressive clinical course due to its high proliferative activity. In addition to histomorphological evaluation, the use of neuroendocrine immunohistochemical markers is essential for accurate diagnosis. Even in early-stage disease, multidisciplinary treatment planning should be considered because of the high risk of systemic dissemination. The coexistence of small cell and large cell neuroendocrine components within the same tumor makes this case a valuable contribution to the literature and may help increase clinical awareness.

Because of its rarity, this case is presented to emphasize the importance of accurate histopathological classification and a multidisciplinary treatment approach.

Keywords: Case report.,Cervical cancer, large cell neuroendocrine carcinoma, neuroendocrine carcinoma, small cell carcinoma,

PP-06

Serial ultrasonographic follow-up and neonatal outcome of a persistent axillary-thoracic lymphatic malformation detected prenatally

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OBJECTIVE: Fetal lymphatic malformations are rare congenital anomalies with variable anatomical locations and clinical courses. We present the serial ultrasonographic follow-up, obstetric management, and neonatal outcome of a persistent fetal lymphatic malformation extending from the right axillary region to the thorax and anterior abdominal wall.

METHODS: Prenatal screening, serial ultrasonographic findings, diagnostic evaluation, pregnancy course, and postnatal clinical and imaging findings of a 32-year-old gravida 2, parity 1 patient were evaluated.

RESULTS: First-trimester screening at 12+2 weeks was normal, with a maternal age-related trisomy 21 risk of 1/415. At 19+5 weeks, ultrasonography demonstrated a hyperechoic focus in the fetal left ventricle and a subcutaneous edematous/cystic lesion extending from the right axillary region toward the anterior abdominal wall, suggesting a lymphatic malformation. Invasive prenatal diagnosis was recommended but declined. TORCH (toxoplasmosis, other infections, rubella, cytomegalovirus, and herpes simplex virus) screening showed no evidence of active infection.

Serial ultrasonography demonstrated appropriate fetal growth with persistence of the lesion. At 29+5 weeks, the right axillary lesion measured 98×23 mm. At 34+5 weeks, a septated 83×41 mm lesion was observed in the subcutaneous tissue of the right thorax. No fetal hydrops developed; amniotic fluid, fetal Doppler studies, and antenatal fetal well-being assessments remained normal. Fetal abdominal circumference reached the 95th percentile at 36+2 weeks and 97th percentile at 37+2 weeks.

At 38+3 weeks, cesarean delivery was performed for fetal disease and macrosomia. A 4660-g female infant was delivered with 1- and 5-minute Apgar scores of 9 and 10. Postnatal superficial soft-tissue ultrasonography demonstrated a well-circumscribed, avascular, multicystic 8×8 cm lesion involving the skin and subcutaneous tissues of the right thorax, consistent with a lymphatic malformation. Physical examination revealed an approximately 11×11×4 cm soft, lobulated subcutaneous mass in the right pectoral region. Chest radiography showed no compression or intrathoracic extension, and no extremity hemihypertrophy was observed. The clinically stable newborn

was scheduled for close follow-up by pediatric surgery and pediatric oncology.

CONCLUSION: Prognosis of prenatal axillary-thoracic lymphatic malformations should not be determined solely by lesion size. Anatomical extent, intrathoracic extension, fetal hydrops, and associated structural or chromosomal abnormalities should be considered in perinatal management. This case demonstrates that a large, persistent axillary-thoracic lymphatic malformation may reach term without hydrops or intrathoracic compression and may have a favorable early neonatal outcome.

Keywords: Axillary lymphatic malformation, Fetal anomaly, Lymphatic malformation, Prenatal diagnosis, Prenatal ultrasonography

Postnatal appearance of the right axillary-thoracic lymphatic malformation



PP-07

Evaluation of Vaccination Rates with Influenza Vaccines in Pregnant Women and Their Attitudes Towards These Vaccines

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AIM: The primary aim of this study was to determine the seasonal influenza vaccination rate among pregnant women and to identify the main reasons for non-vaccination. The secondary aim was to describe pregnant women's perceptions regarding the protective effect of influenza vaccination and the sources of vaccine recommendation.

MATERIAL-METHODS: The study was conducted as a cross-sectional survey study on pregnant women aged 18-45 in the first, second and third trimesterswho applied to theHealth Sciences Universityxxx Training and Research Hospital Gynecology and Obstetrics Clinic between November 2023 and April 2024. The researchers reviewed the relevant literature and prepared a survey consisting of 19 questions to be administered to the participants.

RESULTS: The mean age of the pregnant women included in the study was 25.66±5.2 (18–42) years, and the mean gestational age was 26.02±5.8 weeks (2–40 weeks). The influenza vaccination rate during the current pregnancy was 16.5% (66/400). Of the participants, 334 (83.5%) did not believe that the influenza vaccine was protective, whereas 66 (16.5%) believed that it was protective. The influenza vaccine had been recommended by a physician to 229 (57.3%) participants. Concern that the influenza vaccine might harm the baby was the most commonly reported reason for not receiving the vaccine.

CONCLUSION: The influenza vaccination rate among pregnant women in this study was low. A large proportion of participants did not believe that the influenza vaccine was protective, and concern that the vaccine might harm the baby was the most commonly reported reason for not being vaccinated. These findings highlight the need for healthcare professionals, particularly physicians providing antenatal care, to provide pregnant women with clear and evidence-based information regarding the benefits and safety of influenza vaccination.

Keywords: Influenza vaccine, pregnancy, questionnaire, perception

Table 1

Demographic data	Ort. ±SS (Min-Maks) or n (%)
Age	25,66±5,2 (18-42)
Pregnancyweek	26,02±5,8 (2-40)
Smoking	
No	300 (75)
Yes	100 (25)
Duration of smoking (years)	4,75±3 (1-10)
Additional disease	
No	393 (98,3)
Yes	7 (1,8)
Diabetes	7 (1,8)
Hypertension	0 (0)
Heart failure	0 (0)
Chronic renal failure	0 (0)
Immunosuppression	0 (0)
COPD	0 (0)
Chronic liver diseases	0 (0)
Other	0 (0)

Table 1. Demographic data and obstetric characteristics of the participants

Table 2

Do you believe that the influenza vaccine protects against influenza?	
No	334 (83,5)
Yes	66 (16,5)
Who recommended the influenza vaccine?	
Doctor	229 (57,3)
Other (friends, socialmedia, etc.)	171 (42,8)
Haveyou had an influenza vaccination this year?	
No	334 (83,5)
Yes	66 (16,5)
Did you receive an influenza vaccination last year?	
No	334 (83,5)
Yes	66 (16,5)
What is your reason for not receiving an influenza vaccination?	
I didn't know I needed to be vaccinated.	29 (7,3)
Because I think it will harm the baby.	121 (30,3)
Because I think the appropriate time has passed.	62 (15,5)
Because I'm afraid of the side effects.	81 (20,3)
Because I cannot obtain it.	11 (2,8)
Because I didn't know it was free.	66 (16,5)
Duetonegative news about the vaccine in the press	30 (7,5)

Table 2. Participants' responses to questions about influenza vaccination

Table 3

Variable	Vaccinated (n=66)	Unvaccinated (n=334)	p value
Age, years, median (Q1–Q3)	25.0 (22.25–29.75)	25.0 (21.0–30.0)	0.263
Gestational week, median (Q1–Q3)	27.0 (22.0–28.0)	27.0 (22.0–29.75)	0.796
Trimester, n (%)			**0.887**
First trimester	1 (1.5)	8 (2.4)	
Second trimester	39 (59.1)	191 (57.2)	
Third trimester	26 (39.4)	135 (40.4)	
Smoking, n (%)	17 (25.8)	83 (24.9)	0.877
Presence of additional disease, n (%)	0 (0.0)	7 (2.1)	0.606*
Belief that influenza vaccine is protective, n (%)	66 (100.0)	0 (0.0)	**<0.001†**
Vaccine recommended by a physician, n (%)	36 (54.5)	193 (57.8)	0.683
Influenza vaccination in the previous year, n (%)	66 (100.0)	0 (0.0)	**<0.001†**

PP-08

Interpretation of Postoperative Inflammatory Biomarkers in Gynecologic Surgery: Current Evidence and Clinical Approach

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OBJECTIVE: Postoperative inflammatory biomarkers are widely used for the early detection of infectious and non-infectious complications following gynecologic surgery. However, interpretation based solely on C-reactive protein (CRP) may be misleading because surgical trauma itself induces a physiological inflammatory response, potentially resulting in unnecessary investigations or interventions. In recent years, the diagnostic value of procalcitonin (PCT), neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), interleukin-6 (IL-6), serum amyloid A (SAA), presepsin, and lactate has been increasingly investigated. This review aimed to evaluate current evidence regarding postoperative inflammatory biomarkers after gynecologic surgery and to propose a practical, evidence-based clinical approach.

METHODS: A literature search was conducted in PubMed, Scopus, and Web of Science for systematic reviews, meta-analyses, prospective studies, and original articles published between 2020 and 2026. Studies evaluating the performance of CRP, PCT, NLR, PLR, IL-6, SAA, presepsin, and lactate in the early diagnosis of postoperative infection, surgical site infection, pelvic hematoma, sepsis, and other complications were reviewed. The available evidence was synthesized according to clinical applicability and level of evidence. Additionally, a patient with systemic lupus erythematosus (SLE) who underwent total abdominal hysterectomy was included to illustrate the clinical interpretation of inflammatory biomarkers in postoperative management.

RESULTS: Current evidence indicates that CRP remains the cornerstone biomarker for postoperative surveillance; however, its specificity for distinguishing infection from physiological postoperative inflammation is limited. PCT demonstrates higher specificity for bacterial infection and sepsis, whereas IL-6 rises rapidly during the immediate postoperative period, making it a promising early indicator. NLR and PLR are inexpensive, readily available inflammatory indices that provide supportive prognostic information regarding postoperative complications. Emerging evidence also suggests that presepsin and SAA may complement CRP, particularly in identifying postoperative infections. Furthermore, serial biomarker measurements consistently outperform isolated values, and multimarker assessment improves diagnostic accuracy.

In the presented case, persistent CRP elevation developed after total abdominal hysterectomy in a patient with SLE. Comprehensive clinical, microbiological, and radiological evaluation was performed to differentiate surgical complications, infection, and autoimmune disease activation. Imaging demonstrated a postoperative pelvic hematoma without definitive evidence of abscess formation. Following exclusion of infection, a marked decline in CRP levels after initiation of high-dose corticosteroid therapy was interpreted as supportive of lupus flare rather than postoperative infection. This case highlights that inflammatory biomarkers should always be interpreted within the overall clinical context rather than in isolation.

CONCLUSION: Postoperative inflammatory biomarker interpretation after gynecologic surgery should not rely on a single laboratory parameter. Although CRP remains the primary biomarker, its combined interpretation with PCT, IL-6, NLR, PLR, SAA, and presepsin may improve differentiation between postoperative infection, physiological surgical inflammation, and autoimmune disease activity. Based on current evidence, a stepwise biomarker interpretation algorithm incorporating CRP, PCT, NLR, PLR, IL-6, and presepsin is proposed. In patients with underlying rheumatologic diseases, serial biomarker trends should be interpreted together with imaging findings, microbiological investigations, and disease-specific immunological parameters to ensure accurate diagnosis and appropriate management.

Keywords: Gynecologic surgery, Postoperative inflammatory biomarkers, C-reactive protein (CRP),Systemic lupus erythematosus (SLE)

PP-09

A rare cause of acute abdomen: A case of torsed uterine leiomyoma

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Uterine leiomyomas are common benign gynecological tumors in women of reproductive age. Torsion of a pedunculated subserosal leiomyoma is a rare complication that may present as an acute abdomen and is difficult to diagnose preoperatively due to nonspecific clinical and radiological findings. Here we report a case of torsed uterine leiomyoma diagnosed intraoperatively in a young patient presenting with acute abdominal pain. A 38-year-old woman presented to the emergency department with sudden-onset lower abdominal pain of five hours' duration. Physical examination revealed guarding and rebound tenderness in the lower abdomen, with vital signs within normal limits. Ultrasonography demonstrated a 5×3 cm myoma in the right cornual region along with several smaller anterior uterine myomas, and contrast-enhanced MRI confirmed multiple uterine myomas. Because signs of acute abdomen persisted, diagnostic laparotomy was performed, revealing a 3×5 cm pedunculated subserosal myoma torsed approximately two full turns around its pedicle. The leiomyoma was detorsed and excised, and myomectomy was performed for the remaining myomas. The postoperative course was uneventful, and histopathological examination confirmed the diagnosis of leiomyoma. Although rare, torsion of a pedunculated subserosal leiomyoma should be considered in the differential diagnosis of acute abdominal pain, particularly in young patients with known uterine myomas. Early surgical evaluation is important to prevent complications such as ischemia and necrosis and to allow fertility-preserving management.

Keywords: acute abdomen, uterine leiomyoma, myoma torsion, pedunculated subserosal myoma

resim 1



resim 2



PP-10

Hemorrhagic ovarian cyst rupture and hemoperitoneum in women with von Willebrand disease: a three-patient, four-episode case series

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Kayseri City Hospital

OBJECTIVE: To describe the clinical spectrum and management of hemorrhagic ovarian cyst rupture-associated hemoperitoneum in women with von Willebrand disease (VWD), and to explore the observed relationship between per-episode hemostatic context, including prophylaxis adherence and access to factor concentrate, and clinical severity.

METHODS: This single-center, retrospective, descriptive case series included three women with established VWD who were managed for four episodes of ruptured hemorrhagic ovarian or corpus luteum cyst-associated hemoperitoneum. Demographic, hemodynamic, laboratory and imaging data; prescribed and actual factor use; hemostatic treatment; transfusion; surgical management; and outcomes were extracted from hospital records. Analyses were descriptive, with no hypothesis testing.

RESULTS: The patients were aged 20-22 years; VWD subtype was unavailable in the reviewed records. Two episodes occurred in patients with irregular or absent prophylaxis and delayed access to factor concentrate because of supply or administrative barriers. Both involved massive hemoperitoneum (approximately 2,000 and 3,000 mL) with hemoglobin nadirs of 6.5 and 5.8 g/dL. One patient presented with profound hemorrhagic shock, hypofibrinogenemia (95 mg/dL) and prolonged activated partial thromboplastin time. Both episodes required emergency laparotomy, transfusion support and intensive care; hospital stays were 9 and 5 days. Ovarian tissue was preserved in both operations. Two hemodynamically stable episodes in which factor replacement and tranexamic acid were administered at presentation were managed conservatively. One involved approximately 100 mL hemoperitoneum and a hemoglobin nadir of 11.4 g/dL and resolved without transfusion during 48 hours of observation. The other involved 800-1,000 mL hemoperitoneum and a hemoglobin nadir of 10.1 g/dL; von Willebrand factor/factor VIII (VWF/FVIII) concentrate (40 IU/kg) and intravenous tranexamic acid were administered, with no transfusion or surgery, and the patient was discharged on day 4. Notably, the same patient who was managed conservatively during an earlier episode required resuscitative laparotomy during a later episode after two years without prophylaxis, providing an intra-individual contrast under different hemostatic conditions. Hormonal ovulation suppression was initiated at discharge in two patients.

CONCLUSION: In this descriptive series, episode severity varied alongside differences in prophylaxis use and access to hemostatic treatment; these observations cannot establish causation. Prompt multidisciplinary assessment and hemostatic therapy were associated with successful conservative management in hemodynamically stable episodes, whereas instability and massive hemoperitoneum required resuscitation and emergency surgery. Ovarian preservation was achieved in both surgical episodes. Reliable factor access and individualized recurrence-prevention strategies, including consideration of ovulation suppression, warrant coordinated planning by gynecology and hematology.

Keywords: corpus luteum rupture, fertility preservation, hemoperitoneum, hemorrhagic ovarian cyst, von Willebrand disease

PP-11

Chronic Urinary Symptoms as a Presentation of Pelvic Endometriosis with Bladder Compression

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A female patient born on January 14, 1999, presented to the urology outpatient clinic on December 19, 2024, with a 3–4-year history of urinary frequency, a sensation of incomplete bladder emptying, and nocturia 5–6 times per night. She had previously undergone evaluation at multiple centers. She had no dysuria, hematuria, or costovertebral angle tenderness, and no history of concomitant medication use or previous urological surgery. Urinary tract ultrasonography revealed no significant abnormality.

On May31,2025, she presented to the emergency department with acute-onset, stabbing lower abdominal pain. Abdominalultrasonography revealed a large cystic mass posterior to the urinary bladder that could not be clearly distinguished from the bladder. Following urological consultation, the bladder was catheterized and filled with contrast, and contrast-enhanced computed tomography (CT) demonstrated a pelvic/adnexal lesion causing posterior compression of the urinary bladder.

Gynecological evaluation revealed an 11×10cm cystic lesion with thick septations. Contrast-enhanced pelvic magnetic resonance imaging (MRI) demonstrated a nodular lesion in the posterior aspect of the right ovary, consistent with an endometrioma, and a nodular lesion adjacent to the rectal serosa, consistent with deep endometriosis. Serum CEA, CA19-9, CA-125, and CA15-3 levels were within normal limits, and the ROMA index was low.

Given the long-standing unexplained urinary symptoms and radiological findings, surgical treatment was planned following consultation with M. Faruk Köse.

Laparoscopic bilateral ovarian cystectomy and excision of endometriotic nodules were performed. Intraoperatively, 3–4mm endometriotic nodules were identified on the vesicouterine fold, peritoneum, and uterus, with an additional nodule on the left uterosacral ligament. Two 5–6cm simple cysts with findings suggestive of previous torsion were observed in the left ovary. A 3–4cm cyst with a superficial endometriotic focus was identified in the right ovary. Multiple paratubal (Morgagni) cysts were also observed around the right fallopian tube, one of which had a thin adhesion to the omentum.

The left ovarian cysts were excised and the ovary was detorsed, followed by right ovarian cystectomy. The endometriotic nodules on the vesicouterine peritoneum and left uterosacral ligament were dissected and excised. Small endometriotic foci on the uterus and right uterosacral ligament were coagulated using bipolar cautery. After achieving hemostasis, a topical hemostatic agent and anti-adhesion barrier gel were applied. No intraoperative complications occurred, and no drain was placed.

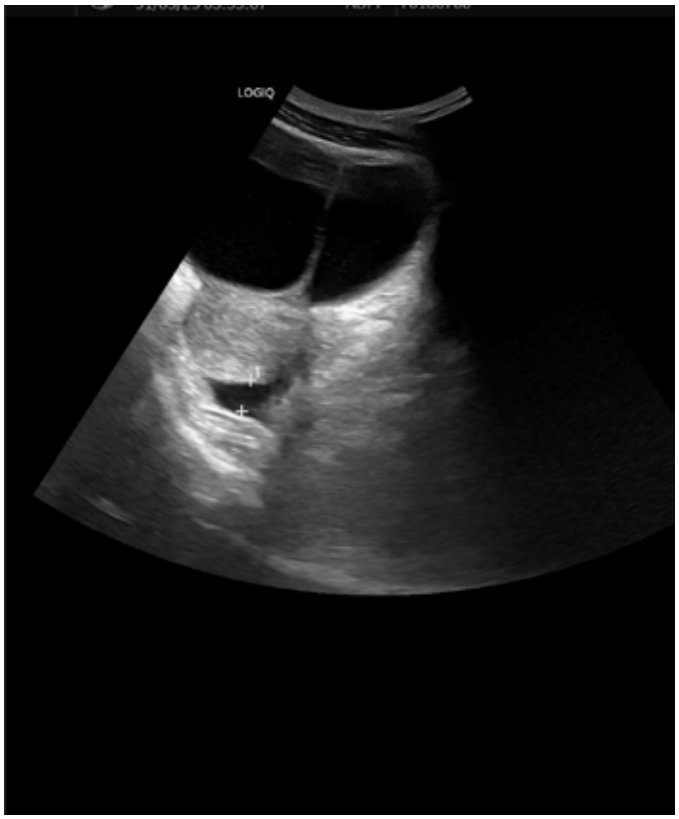
Histopathological examination demonstrated findings consistent with endometriosis in the bladder nodule, a simple serous cyst in the Morgagni cyst, a hemorrhagic corpus luteum, and serous cystadenomas in both ovaries. The left uterosacral ligament nodule consisted of congested and hyperemic fibroadipose tissue.Cytology was benign.

Postoperatively, combined oral contraceptive therapy with drospirenone/ethinylestradiol was initiated. During regular follow-up,no endometrioma recurrence was observed, and the patient's urinary symptoms markedly improved.

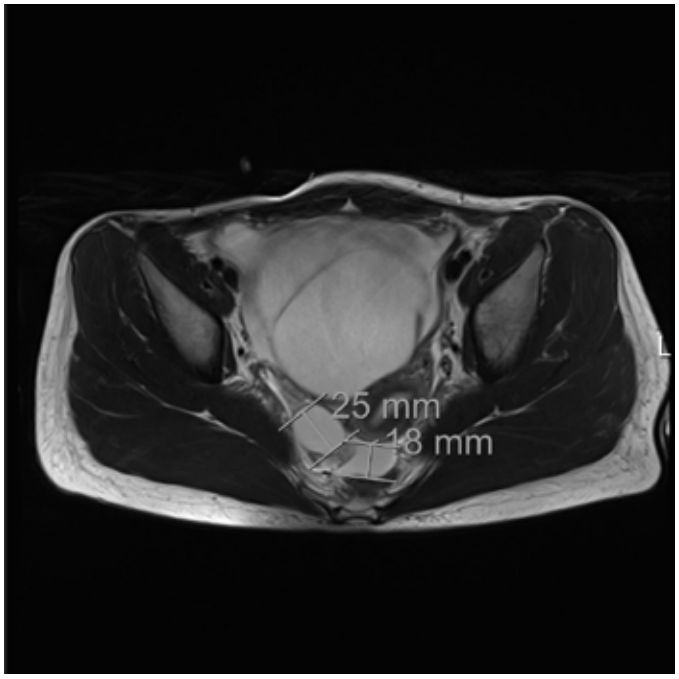
CONCLUSION: Pelvic endometriosis and other gynecological pathologies should be considered in young women presenting with chronic unexplained urinary symptoms, particularly when a pelvic mass is located adjacent to the urinary bladder. This case highlights the importance of comprehensive clinical evaluation and advanced imaging in identifying occult pelvic pathology and demonstrates that surgical treatment of the underlying pathology and associated bladder compression may result in significant symptomatic improvement.

Keywords: Bladder compression, Deep endometriosis, Endometrioma, Pelvic endometriosis, Urinary symptoms

Endometrioma



Endometrioma



PP-12

Enteric duplication cyst diagnosed during gynecologic surgery

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OBJECTIVE: Enteric duplication cysts are rare congenital anomalies of the gastrointestinal tract. Their pelvic location in adult women and their potential to mimic gynecologic pathologies may pose diagnostic challenges. We present a case of an enteric duplication cyst diagnosed intraoperatively in a patient who underwent surgery for a ruptured cyst initially considered to be of ovarian origin.

METHODS: A 48-year-old woman presented with acute-onset right lower quadrant abdominal pain. She had a history of laparoscopic surgery for endometriosis in 2013 and 2014 and was under follow-up for a known cyst, for which surgery had been planned two weeks later. On physical examination, rebound tenderness was present. Transvaginal ultrasonography revealed an endometrial thickness of 9 mm, a 65 × 48 mm fluid collection in the right paraovarian region, and a 6-cm ruptured right ovarian cyst. The left ovary was unremarkable, and approximately 4 cm of free fluid was observed in the pouch of Douglas. Laparoscopic cyst excision was planned.

RESULTS: On May 7, 2026, surgery was initiated laparoscopically under appropriate sterile conditions. Extensive mucinous fluid and severe intra-abdominal adhesions were observed, and conversion to laparotomy was performed. Following a Pfannenstiel incision, gelatinous white fluid was identified and sampled. The uterus and both ovaries appeared normal. An approximately 8-cm ruptured cystic lesion adherent to the right ovarian region and the lateral abdominal wall was observed, with mucinous white fluid draining from the cyst. As the cyst was noted to be adherent to the ileal mesentery, an on-call general surgeon was consulted. The lesion was clamped at its base and dissected without entering the intestinal lumen. The excised specimen was sent for histopathological examination. Pathological examination revealed a 9.5 × 6 cm enteric duplication cyst. At the two-week postoperative follow-up, the surgical wound was unremarkable, and the uterus and adnexa appeared normal. Evaluation by general surgery was recommended.

CONCLUSION: Pelvic enteric duplication cysts may clinically and radiologically mimic ovarian cystic lesions. Gastrointestinal tract–related pathologies should be considered in the differential diagnosis of cystic pelvic lesions presumed to be of ovarian origin, particularly when mucinous contents and extensive intra-abdominal adhesions are present. Careful assessment of anatomical relationships during surgery and a multidisciplinary approach when necessary are important for safe surgical management.

Keywords: enteric duplication cyst, laparoscopic cystectomy, laparotomy

PP-13

Düşük Vücut Kitle İndeksi ve Yeme Bozukluğu Öyküsü Olan Genç Kadında Hipoöstrojenizm: Prematür Over Yetmezliği ile Fonksiyonel Hipotalamik Amenore Arasında Tanısal Bir İkilem

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OBJECTIVE: Premature ovarian insufficiency (POI) and functional hypothalamic amenorrhea (FHA) are clinical conditions characterized by amenorrhea and hypoestrogenism in young women, but with distinct underlying pathophysiological mechanisms. Differentiating between these conditions can be challenging in patients with low body mass index (BMI) and a history of eating disorders. We present the diagnostic and therapeutic course of a patient with low BMI who was initially started on hormone replacement therapy (HRT) with a preliminary diagnosis of POI.

CASE: A 38-year-old G3P3 woman with a history of three spontaneous vaginal deliveries presented with amenorrhea, vaginal dryness, and bone pain. Her height was 180 cm, weight was 50 kg, and BMI was 15.4 kg/m². Her medical history included anorexia nervosa and hospitalization for bulimia nervosa at the age of 18. Before initiating HRT, laboratory evaluation after 3 months of amenorrhea revealed an FSH level of 24 IU/L, LH level of 4.79 IU/L, and estradiol level of 19 pg/mL. Prolactin, thyroid function tests, complete blood count, vitamin B12, and vitamin D levels were normal. Estradiol and micronized progesterone therapy was initiated for hypoestrogenic symptoms. Following treatment, her symptoms improved significantly, and menstrual bleeding was initially observed. As oral estradiol was not preferred, treatment was switched to transdermal estradiol and progesterone. Although symptomatic improvement persisted during follow-up, amenorrhea continued. Transvaginal ultrasonography demonstrated a 4-mm trilaminar endometrium.

DISCUSSION: An FSH level below 25 IU/L and an amenorrhea duration of less than 4 months did not fulfill the criteria for a definitive diagnosis of POI. In contrast, severely low BMI and a history of eating disorders were strong risk factors for FHA. Suppression of gonadotropins following HRT further complicated the assessment of endogenous ovarian function. Despite persistent amenorrhea, improvement in hypoestrogenic symptoms and the presence of a thin, trilaminar endometrium suggested that the absence of menstrual bleeding alone should not be considered evidence of treatment failure.

CONCLUSION: In women with low BMI and a history of eating disorders presenting with amenorrhea and hypoestrogenism, POI and FHA should both be considered in the differential diagnosis. The diagnostic value of FSH and LH levels is limited during HRT. Management should be individualized, focusing not solely on menstrual bleeding but also on symptom control, endometrial protection, nutritional rehabilitation, and long-term bone health.

Keywords: Eating disorders, Functional hypothalamic amenorrhea, Hormone replacement therapy, Hypoestrogenism, Premature ovarian insufficiency

PP-14

Adnexal Mass in a Patient With a History of Breast Cancer: From a Suspected Dermoid Cyst to Ischemic Fat Necrosis

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OBJECTIVE: Adnexal masses detected in patients with a history of breast cancer should primarily be evaluated for the possibility of metastatic disease. However, benign lesions may mimic malignancy on imaging and pose diagnostic challenges. We present a rare case of an adnexal mass that was radiologically considered to be a dermoid cyst but was ultimately diagnosed as ischemic fat necrosis on histopathological examination.

METHODS: The clinical, radiological, surgical, and histopathological findings of a 45-year-old gravida 2 patient with a history of two cesarean sections who was under follow-up for breast cancer were retrospectively evaluated. The patient had undergone surgery for breast cancer and was subsequently started on adjuvant tamoxifen therapy. The right adnexal mass was evaluated using ultrasonography (US), positron emission tomography/computed tomography (PET/CT), and magnetic resonance imaging (MRI).

RESULTS: Transvaginal ultrasonography performed on June 5, 2026, revealed a 50 × 40 mm hyperechoic, heterogeneous lesion with cystic components in the right adnexal region, which was primarily considered to be a dermoid cyst.

PET/CT performed on September 1, 2025, demonstrated a 43 × 60 mm heterogeneous-density lesion in the right adnexal region. Low-grade fluorodeoxyglucose (FDG) uptake was observed in a small portion of the lesion capsule, with a maximum standardized uptake value (SUVmax) of 4.64. On follow-up PET/CT performed on March 11, 2026, the lesion remained stable in size and metabolic characteristics, with no significant FDG uptake.

Pelvic MRI performed on April 30, 2026, demonstrated a 45 × 57 mm right adnexal mass containing a fat component and considered compatible with a dermoid cyst. The left ovary was normal.

Given the persistence of the mass and the patient's history of breast cancer, total hysterectomy and bilateral salpingo-oophorectomy were performed, accompanied by intraoperative frozen-section examination. The frozen-section evaluation indicated that paraffin-embedded sections were required for definitive diagnosis.

Final histopathological examination revealed ischemic fat necrosis within the adnexal mass. Additionally, corpus albicans and a follicular cyst were identified in the right ovary; bilateral fallopian tube papillomas and paratubal cysts were detected in the fallopian tubes; chronic cervicitis was present in the cervix; and disordered proliferative endometrial changes and an endometrial polyp were identified in the endometrium.

CONCLUSION: Adnexal masses in patients with a history of breast cancer should be carefully evaluated for metastatic disease. However, imaging findings may not always allow definitive differentiation between benign lesions and rare pathologies that mimic malignancy. In this case, an adnexal mass radiologically considered to be a dermoid cyst was ultimately diagnosed as ischemic fat necrosis on histopathological examination. This case highlights the importance of integrating clinical history, radiological findings, and histopathological evaluation in the assessment of adnexal masses, particularly in patients with a history of malignancy. A multidisciplinary approach is essential for accurate diagnosis and appropriate management.

Keywords: adnexal mass, benign mimic of malignancy, breast cancer, dermoid cyst, ischemic fat necrosis,

PP-15

A Nuck canal cyst with intra-abdominal extension: a case report

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OBJECTIVE: A Nuck canal cyst is a rare cause of presentation with a mass in the inguinal region in women, resulting from the failure of the processus vaginalis to close; it can be confused with various pathologies such as inguinal hernia, lymphadenopathy, and benign or malignant tumors. Although its association with inguinal hernia has been reported in the literature, cases showing intra-abdominal extension are quite rare. In this case, the aim was to describe the clinical, radiological, and intraoperative findings of this anatomical variation.

METHODS: A 25-year-old female patient presented with a palpable mass in the left inguinal region. The patient's physical examination, ultrasound (US), pelvic magnetic resonance imaging (MRI), intraoperative findings, and histopathological findings were evaluated.

RESULTS: Physical examination revealed a palpable, well-defined, soft, fixed mass measuring approximately 3 cm in the left inguinal region. No manual or spontaneous reduction was observed. There was no skin discoloration. Superficial ultrasound revealed a cystic lesion approximately 7 cm in length, extending from the level of the left inguinal region into the abdominal cavity; it had a lobulated contour, thin walls, contained fine septa in places, was anechoic, and showed no significant vascularity on color Doppler ultrasound. The lesion, which herniated from the level of the internal inguinal ring to the midportion of the canal, was observed to have a component measuring approximately 20×30 mm that continued into the intraperitoneal space at the level of the internal inguinal ring. (Figure 1.) Pelvic MRI revealed a cystic lesion extending from the left iliac fossa into the inguinal canal, showing minimal capsular enhancement; the findings were consistent with a Nuck canal cyst. The patient underwent left inguinal hernia repair and intra-abdominal cyst excision. During exploration, a cystic lesion extending toward the pubis was observed; part of it was intra-abdominal in location and had no relationship to the intra-abdominal organs. It was excised by blunt and sharp dissection. The excised specimen was a 6.5×3.5×2.5 cm piece of tissue with a cystic appearance and a cream-yellow color. (Figure 2.) On sectioning, serous fluid was discharged, and multilocular areas were observed within the cyst. The inguinal fascia defect was primarily repaired, and the posterior wall was reinforced with mesh. Histopathological examination revealed findings consistent with a benign cystic neoplasm lined with a single layer of columnar epithelium and showing widespread congestion and edema. When evaluated in conjunction with the clinical and radiological findings, the lesion was considered consistent with a Nuck canal cyst. During follow-up, the patient remained asymptomatic with no recurrence.

CONCLUSION: A Nuck canal cyst is a rare pathology that should be considered in the differential diagnosis of inguinal masses in women. While Ultrasound (US) and magnetic resonance imaging (MRI) provided significant contributions in assessing the lesion's anatomical extent and intraperitoneal continuity, the diagnosis was supported by histopathological examination. This case demonstrates that a Nuck canal cyst may exhibit intra-abdominal extension in conjunction with an inguinal hernia and highlights the importance of considering this anatomical feature in the diagnostic evaluation.

Keywords: A Nuck canal cyst, a mass in the inguinal region, intra-abdominal extension

Figure 1. Superficial ultrasound image of a Nuck canal cyst.



Figure 2. Post-excision appearance of a Nuck canal cyst.



PP-16

Ruptured Tubal Ectopic Pregnancy Despite a 98.6% Decline in β-hCG: When Is Methotrexate Follow-up Truly Safe to Stop?

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izmir şehir hastanesi

OBJECTIVE: A progressive decline in serum β-human chorionic gonadotropin (β-hCG) is widely used to monitor response to methotrexate (MTX) treatment in ectopic pregnancy. However, whether a declining β-hCG level reliably reflects resolution of the tubal ectopic pregnancy remains debatable. We present a case of tubal rupture with massive hemoperitoneum despite a continuous 98.6% decline in β-hCG, with rupture occurring at a level of only 85 mIU/mL. This case challenges the assumption that a favorable biochemical response indicates anatomical resolution.

METHODS: A 33-year-old gravida 1, para 0 woman presented at 7 weeks and 5 days of gestation. Transvaginal ultrasonography demonstrated an empty uterine cavity and a 25 × 30-mm right adnexal gestational sac containing a yolk sac, without free fluid. Initial serum β-hCG was 8256 mIU/mL. Dilatation and curettage was performed to exclude intrauterine pregnancy; pathology revealed decidual tissue without chorionic villi. The following day, with a β-hCG level of 6059 mIU/mL, a single intramuscular dose of MTX (50 mg/m²) was administered.

RESULTS: β-hCG decreased from 6059 mIU/mL to 4237 mIU/mL on day 4 and 2922 mIU/mL on day 7, representing a 31% decline. Subsequent measurements demonstrated an uninterrupted decline: 1180 mIU/mL on day 12, 353 mIU/mL on day 18, 218 mIU/mL on day 20, and 120 mIU/mL on day 21. Despite this apparently favorable biochemical response, right lower quadrant tenderness was noted on day 7. On day 22, the patient presented with an acute abdomen. Serum β-hCG was only 85 mIU/mL. Emergency laparoscopy revealed approximately 500 mL of hemoperitoneum and a ruptured 5-cm ectopic focus in the right fallopian tube. Notably, the adnexal lesion had enlarged from 25 × 30 mm to 5 cm despite the marked decline in β-hCG. Right salpingectomy and paratubal cyst excision were performed, and histopathology confirmed tubal pregnancy.

CONCLUSION: This case demonstrates a striking dissociation between biochemical response and anatomical progression following MTX treatment. A nearly complete (98.6%) decline in β-hCG did not prevent tubal enlargement or rupture, and massive hemoperitoneum occurred at a β-hCG level of only 85 mIU/mL. These findings challenge the concept that a steadily declining β-hCG level can be used as a surrogate for anatomical resolution. Therefore, a falling β-hCG should not be considered synonymous with treatment safety. Abdominal pain following MTX warrants renewed assessment for tubal rupture regardless of the absolute β-hCG level, and ultrasonographic reassessment may be essential when the clinical course is discordant with the biochemical response. In addition, the initial β-hCG level of 8256 mIU/mL exceeded commonly accepted thresholds for MTX treatment, emphasizing the importance of careful patient selection and informed decision-making when medical management is considered outside guideline-based criteria.

Keywords: Ectopic Pregnancy, Methotrexate, Human Chorionic Gonadotropin, Tubal Rupture, Hemoperitoneum, Medical Management

PP-17

Viable Unilateral Tubal Twin Ectopic Pregnancy with Two Embryos and Fetal Cardiac Activity in the Same Tubal Location: A Rare Case Report of Diagnostic Evaluation, Laparoscopic Management, and Postoperative β-hCG Follow-up

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Obstetrics and Gynecology, İzmir Şehir Hastanesi, İzmir, Türkiye

OBJECTIVE: Unilateral tubal twin ectopic pregnancy is a rare form of ectopic pregnancy with significant clinical implications for both diagnosis and management. We aimed to present a rare case of unilateral tubal twin ectopic pregnancy in which two viable embryos, both demonstrating fetal cardiac activity, were identified within the same tubal location, together with the diagnostic process, surgical management, and postoperative β-hCG course.

METHODS: A 35-year-old female patient, G4P2Y1Neoex1A1 (SVDx1), with an unknown gestational age and no previous ultrasonographic evaluation of the current pregnancy, presented to the emergency department with abdominal pain. Transvaginal ultrasonography revealed an anteverted and anteflexed uterus with an endometrial thickness of 11 mm. Two separate embryonic structures were identified in the right adnexal region within the tubal location. The first embryo had a crown-rump length (CRL) corresponding to 7+0 weeks of gestation, while the second had a CRL corresponding to 6+2 weeks; fetal cardiac activity was present in both embryos. The left ovary was unremarkable, and no free fluid was detected in the pouch of Douglas. Based on the ultrasonographic findings, a diagnosis of viable unilateral tubal twin ectopic pregnancy was established. The patient underwent emergency laparoscopic salpingectomy and revision curettage on August 8, 2026.

RESULTS: The preoperative hemoglobin level was 12.6 g/dL and remained stable at 12.3 g/dL 6 hours postoperatively, with no clinically significant decrease. The postoperative course was uneventful, and the patient was discharged on August 10, 2026. Serial serum β-hCG levels were 11,610 IU/L on August 9, 3,086 IU/L on August 10, 126 IU/L on August 17, and 7.26 IU/L on August 27, 2026, demonstrating a marked and progressive decline. The patient was followed up in the outpatient clinic on August 17 and August 27, 2026.

CONCLUSION: Unilateral tubal twin ectopic pregnancy is a rare clinical condition with distinctive diagnostic and therapeutic considerations. The simultaneous identification of two viable embryos within the same tubal location, both demonstrating fetal cardiac activity, highlights the rarity and clinical significance of this condition. This case emphasizes the importance of careful and systematic ultrasonographic evaluation in patients with suspected ectopic pregnancy. Early diagnosis and appropriate surgical management can result in favorable clinical outcomes, while serial postoperative β-hCG monitoring remains an important tool for assessing the resolution of residual trophoblastic activity.

Keywords: Ectopic pregnancy, Tubal viable pregnancy, Twin tubal ectopic pregnancy

PP-18

Acute fatty liver of pregnancy in a primigravid gestation: A rare case report

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OBJECTIVE: Acute Fatty Liver of Pregnancy (AFLP) is a rare but life-threatening clinical condition that typically presents in the third trimester of pregnancy, with an incidence of approximately 1 in 7,000 to 1 in 16,000. It carries high maternal and fetal mortality and morbidity risks. Overlapping features with preeclampsia and HELLP syndrome often cause diagnostic delays. The objective of this case report is to emphasize this rare pathology in a primigravid patient presenting with hypertension, coagulopathy, and severe abdominal pain, and to highlight key differential diagnostic markers.

CASE: A 26-year-old primigravid patient (Gravida 1, Para 0) at 35 weeks of gestation presented to our emergency department with a 3-day history of epigastric and right upper quadrant pain, severe headache, nausea, and diffuse edema. Physical examination revealed a blood pressure of 150/95 mmHg, pretibial 3+ edema, and right upper quadrant tenderness. Ultrasonography demonstrated a singleton live male fetus in cephalic presentation compatible with 35 weeks, with normal amniotic fluid index and Doppler parameters. Initial laboratory evaluation demonstrated marked transaminase elevation (aspartate aminotransferase [AST]: 840 U/L, alanine aminotransferase [ALT]: 920 U/L), persistent hypoglycemia (spot blood glucose: 54 mg/dL), hyperbilirubinemia (total bilirubin: 4.2 mg/dL, direct bilirubin: 2.8 mg/dL), elevated lactate dehydrogenase (LDH: 1,150 U/L), dipstick proteinuria (2+), and mild thrombocytopenia (platelet count: 110,000/µL). Coagulation studies revealed prolonged prothrombin time (PT: 18.2 sec, INR: 1.55) and hypofibrinogenemia (fibrinogen: 140 mg/dL). The patient was closely monitored for differential diagnosis between HELLP syndrome and AFLP, and intravenous magnesium sulfate was initiated. Due to worsening coagulopathy, persistent hypoglycemia, and an unfavorable cervix, an emergency cesarean section was performed, delivering a live 2,450 g male infant with APGAR scores of 7 and 9 at 1 and 5 minutes, respectively. Postoperatively, the patient was transferred to a tertiary intensive care unit (ICU) due to persistent hypoglycemia and coagulopathy. Management included intravenous dextrose infusions, fresh frozen plasma transfusions, and close monitoring. Hepatobiliary ultrasonography showed diffuse hyperechoic liver parenchyma consistent with fatty infiltration without vascular ischemia. Following three days of intensive supportive therapy, her clinical status and liver function tests improved, and she was successfully discharged on postoperative day six.

CONCLUSION: Overlapping clinical features of preeclampsia/HELLP syndrome and AFLP can lead to diagnostic confusion in the peripartum period. AFLP should be primarily considered in the presence of unexplained transaminase elevation accompanied by persistent hypoglycemia, coagulopathy, and normal or fatty-infiltrated hepatobiliary USG findings without ischemia. Primigravidity and a male fetus serve as established risk factors, as observed in our case. Prompt delivery, aggressive glucose and coagulation management, and a multidisciplinary intensive care approach are critical to optimizing maternal and fetal outcomes.

Keywords: Acute Fatty Liver of Pregnancy, Preeclampsia, HELLP Syndrome, Hypoglycemia, Coagulopathy

PP-19

Hypertension Management In Pregnancy: Current Approaches According To The 2025 Turkish Hypertension Consensus Report

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BACKGROUND AND AIM: Hypertensive disorders of pregnancy affect approximately 5–10% of pregnancies and are major causes of maternal and perinatal morbidity and mortality. Early diagnosis and appropriate management are essential to prevent severe maternal and fetal complications. This study aimed to summarize the current recommendations for the diagnosis and management of hypertension in pregnancy according to the 2025 Turkish Hypertension Consensus Report.

METHODS: A narrative review of the 2025 Turkish Hypertension Consensus Report was performed. Recommendations regarding the classification and diagnosis of hypertensive disorders of pregnancy, antihypertensive treatment, target blood pressure, contraindicated medications, magnesium sulfate use, and postpartum follow-up were evaluated.

RESULTS: Hypertension in pregnancy is defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg, whereas severe hypertension is defined as ≥160/110 mmHg and requires prompt treatment. Preeclampsia is characterized by hypertension accompanied by proteinuria and/or maternal organ dysfunction, including renal or hepatic impairment, thrombocytopenia, pulmonary edema, neurological or visual symptoms, or uteroplacental dysfunction. Antihypertensive treatment should be considered in persistent blood pressure ≥140/90 mmHg, while severe hypertension requires immediate treatment. Labetalol, long-acting nifedipine, and methyldopa are recommended treatment options. Intravenous labetalol, intravenous hydralazine, or oral immediate-release nifedipine may be used for severe hypertension. Angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, direct renin inhibitors, and mineralocorticoid receptor antagonists should be avoided during pregnancy. Magnesium sulfate is recommended for seizure prophylaxis in severe preeclampsia and for the treatment of eclampsia. Postpartum blood pressure monitoring during the first 72 hours, reassessment within 7–10 days, and long-term cardiovascular follow-up are recommended.

CONCLUSION: The 2025 Turkish Hypertension Consensus Report emphasizes early diagnosis, individualized antihypertensive therapy, maternal and fetal assessment, and multidisciplinary management. Adherence to evidence-based recommendations may reduce severe hypertensive complications and improve maternal and perinatal outcomes.

Keywords: Hypertension in pregnancy, preeclampsia, gestational hypertension,

PP-20

A Case of Severe HELLP Syndrome

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INTRODUCTION AND OBJECTIVE: HELLP syndrome is a pregnancy complication that usually occurs in the third trimester or postpartum period. Although associated with preeclampsia, it may develop without hypertension. The acronym HELLP refers to hemolysis, elevated liver enzymes, and low platelet count. Clinical manifestations may include right upper quadrant pain, headache, nausea, vomiting, and visual disturbances. Diagnosis is based on clinical and laboratory findings. Although medical management may be considered in selected cases with early gestational age, definitive treatment is delivery.

MATERIALS MATERYALIST METHODS: A 41-year-old woman, gravida 4, para 3, with three previous vaginal deliveries, presented to the obstetric emergency department with back pain. She had pregnancy-related hypertension and was receiving Alphamet. She had no history of smoking, allergies, or previous surgery and had regular antenatal follow-up.

RESULTS: On admission, her blood pressure was approximately 170/100 mmHg. She was hospitalized after a single 10-mg dose of Nidilat. Ultrasonography revealed a singleton, cephalic pregnancy with a gestational age of 26 weeks + 6 days according to biparietal diameter, positive fetal cardiac activity, and decreased amniotic fluid index. No contractions were observed on non-stress testing. She had no headache, nausea, or vomiting.

Initial laboratory findings were: WBC 8,640/mm³, hemoglobin 12.3 g/dL, platelet count 58,000/mm³, ALT 56.4 U/L, AST 90.7 U/L, and +4 proteinuria. The patient was followed with Alphamet 3 × 1. On the following day, she developed right upper quadrant and epigastric pain, and a proton pump inhibitor was added. As the pain persisted and blood pressure increased again, repeat laboratory tests were obtained and another 10-mg dose of Nidilat was administered. Laboratory findings showed WBC 8,660/mm³, hemoglobin 12.1 g/dL, platelet count 30,000/mm³, ALT 131 U/L, and AST 337 U/L. HELLP syndrome was suspected, and an emergency cesarean section was performed.

Postoperatively, the patient was admitted to the intensive care unit and magnesium sulfate therapy was initiated. Laboratory values showed ALT 131→137→116→98 U/L, AST 337→426→270→186 U/L, platelet count 30→25→16→34→51×10³/mm³, and LDH 1,132→725→639 U/L. Urea and creatinine remained normal. Two units of fresh frozen plasma were administered. Platelet apheresis was requested because the platelet count was <50,000/mm³ but could not be obtained. Prednisolone was administered every 12 hours. Peripheral blood smear showed no significant schistocytes, excluding thrombotic thrombocytopenic purpura. As laboratory values began to improve after 24 hours, the patient was transferred to the ward and discharged in good condition on postoperative day 3.

CONCLUSION: HELLP syndrome is a potentially life-threatening pregnancy complication requiring prompt diagnosis and management. Right upper quadrant pain may be a prominent symptom, while hypertension may not always be present.

Keywords: Cesarean delivery, HELLP syndrome, preeclampsia

PP-21

Suture-assisted transvaginal uterine artery occlusion for primary postpartum hemorrhage after vaginal delivery: a case report

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AIM: Postpartum hemorrhage (PPH) remains an obstetric emergency requiring rapid and effective hemorrhage control. We aimed to describe a suture-assisted transvaginal uterine artery occlusion technique used to control early primary PPH after vaginal delivery.

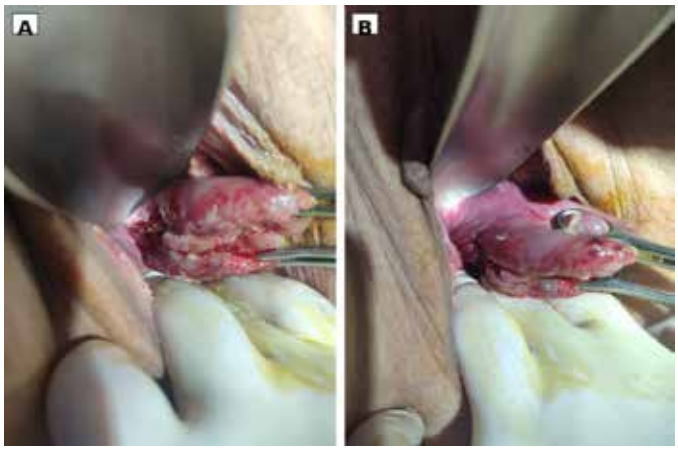
METHODS: A 27-year-old gravida 4, para 3, living 3 woman with a body mass index of 27.4 kg/m² was admitted at 37+3 weeks of gestation in active labor. She delivered a 3300-g, 49-cm live female neonate in cephalic presentation by normal spontaneous vaginal delivery. Apgar scores were 9 and 10 at 1 and 5 minutes, respectively. No episiotomy was performed, and a medial perineal tear was repaired. During the first postpartum hour, the patient developed active PPH. Initial PPH management, including intravenous fluid resuscitation, uterine massage, and uterotonic treatment, was promptly initiated. However, active bleeding persisted despite these measures. Therefore, under direct vaginal exposure, the cervix was visualized and traction was applied to optimize access to the lateral vaginal fornices. Hemostatic sutures were placed through the lateral paracervical tissues to compress the uterine vascular pedicles, based on the anatomical principle of transvaginal uterine artery occlusion (Figure 1A,B). Estimated blood loss, procedure time, hemoglobin (Hb) change, transfusion requirement, and early postpartum outcome were recorded. Approval was obtained from the hospital's local ethics committee, and written informed consent was obtained from the patient.

RESULTS: Estimated blood loss was 1500 mL. Admission Hb was 10.5 g/dL, active hemorrhage was controlled after placement of the transvaginal paracervical hemostatic sutures, and the total procedure time was 4 minutes. The patient received three units of packed red blood cells and two units of fresh frozen plasma. Following transfusion and clinical stabilization, Hb increased to 8.8 g/dL. No escalation to laparotomy, arterial embolization, or hysterectomy was required. The patient was discharged in stable condition at 48 hours postpartum.

CONCLUSION: Suture-assisted transvaginal uterine artery occlusion may provide a rapid, low-cost, and uterus-sparing option for selected cases of primary PPH after vaginal delivery when bleeding persists despite standard first-line measures. In this case, the technique achieved effective hemorrhage control within a short procedure time and avoided further invasive intervention. Careful vaginal exposure, appropriate cervical traction, and readiness to proceed to established second-line interventions remain essential.

Keywords: Postpartum hemorrhage, suture-assisted uterine artery occlusion, transvaginal uterine artery occlusion, paracervical hemostatic suture, uterine-sparing hemorrhage control.

Suture-assisted transvaginal uterine artery occlusion for primary postpartum hemorrhage.



PP-22

Four-turn adnexal torsion at 36+5 weeks of gestation associated with serous cystadenoma: a rare cause of acute abdomen in late pregnancy

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OBJECTIVE: Adnexal torsion is an uncommon surgical emergency in pregnancy and is particularly rare in the late third trimester. This case aimed to emphasize the diagnostic importance of combined clinical and Doppler ultrasonographic findings and the feasibility of ovarian preservation in near-term pregnancy complicated by extensive adnexal torsion.

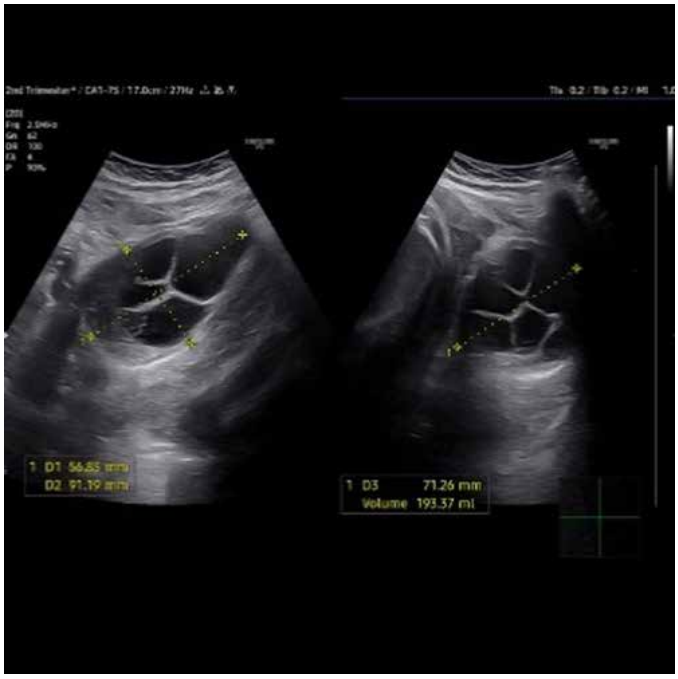
METHODS: Clinical, ultrasonographic, operative, histopathological, maternal, and neonatal findings of a 31-year-old gravida 4, para 3 woman at 36 weeks and 5 days of gestation were evaluated.

RESULTS: The patient reported intermittent left-sided abdominal pain for two days, which became severe and persistent during the final six hours before admission. Examination revealed marked left-sided tenderness with guarding and rebound tenderness. The white blood cell count was $8.88\times10^3/\mu L$, and C-reactive protein was elevated at 20.6 mg/L. Obstetric ultrasonography demonstrated a viable singleton fetus in breech presentation with reassuring fetal Doppler findings and a biophysical profile score of 10/10. The left ovary was markedly enlarged and edematous, measuring approximately 91×71×57 mm with an estimated volume of 193 mL. No vascular flow was detected within the affected ovary on Doppler ultrasonography. In the setting of an acute surgical abdomen and a strong suspicion of adnexal torsion, urgent surgical exploration was planned. Considering the gestational age and concurrent breech presentation, cesarean delivery was performed in the same operative session. A 2600-g female neonate was delivered with Apgar scores of 9 and 10. Intraoperative exploration demonstrated four complete turns of the left adnexa. Following detorsion, ovarian perfusion progressively recovered; however, the ipsilateral fallopian tube remained necrotic. Left salpingectomy and ovarian cystectomy were performed while preserving the ovary. Histopathological examination confirmed ischemic necrosis of the fallopian tube and benign serous cystadenoma of the ovary. The postoperative maternal course was uneventful, the neonate did not require neonatal intensive care, and the patient was discharged on postoperative day 3.

CONCLUSION: Adnexal torsion should be considered in pregnant patients with acute unilateral abdominal pain even near term. Intermittent pain followed by acute exacerbation, ovarian enlargement, stromal edema, and absent Doppler flow may substantially increase diagnostic suspicion. Even extensive torsion should not preclude detorsion and reassessment of ovarian perfusion when clinically appropriate, as organ-preserving surgery may remain feasible.

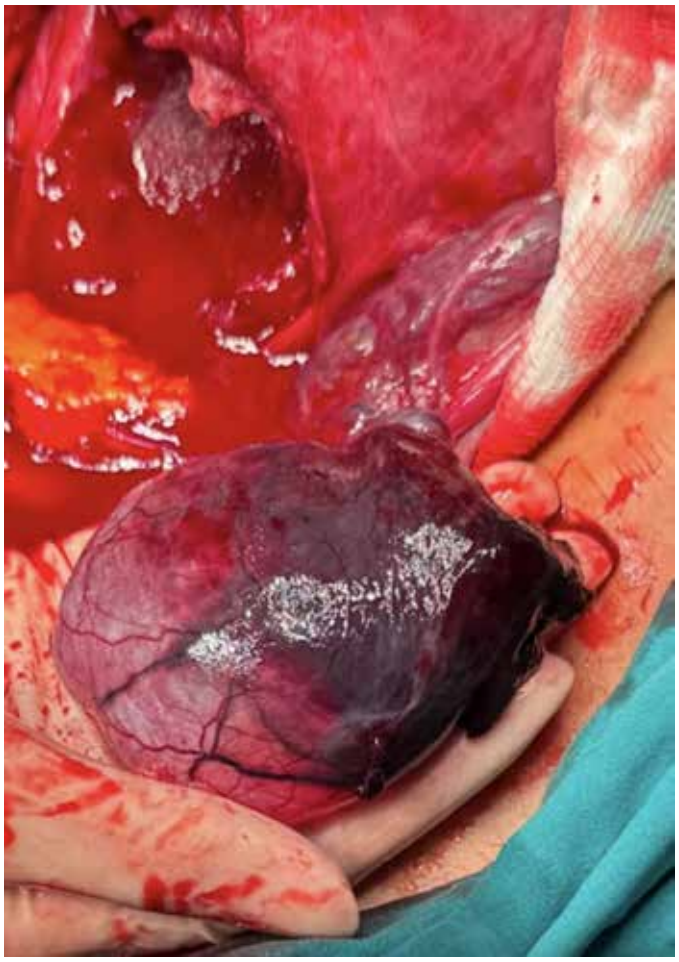
Keywords: adnexal torsion, Doppler ultrasonography, pregnancy, serous cystadenoma, third trimester

1. Ultrasonographic appearance of the enlarged left ovary in adnexal torsion



Transabdominal grayscale ultrasonography at 36+5 weeks of gestation demonstrates an enlarged and edematous left ovary measuring approximately 91 × 71 × 57 mm, with an estimated volume of 193 mL. No vascular flow was detected on complementary Doppler ultrasonography, supporting the clinical suspicion of adnexal torsion

2. Intraoperative Appearance of Ovarian Torsion in Late Pregnancy



Intraoperative appearance of the torsed ovary before detorsion at 36+5 weeks of gestation. Marked enlargement, hemorrhagic congestion, and dark violaceous discoloration indicating severe ovarian ischemia are evident.

PP-23

Diagnostic Dilemma in Postpartum Multiorgan Dysfunction: Sepsis-Induced Coagulopathy or Thrombotic Microangiopathy?

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INTRODUCTION AND OBJECTIVE: Sepsis-induced coagulopathy (SIC) is characterized by infection-driven thrombin generation, endothelial dysfunction, impairment of endogenous anticoagulant pathways, and suppression of fibrinolysis.[1] Severe cases may progress to overt disseminated intravascular coagulation (DIC).[1,2] During pregnancy and the postpartum period, thrombocytopenia, microangiopathic hemolysis, and end-organ dysfunction may overlap with HELLP syndrome and pregnancy-associated thrombotic microangiopathies (TMA), complicating the differential diagnosis.[3–6] We present a case of severe postpartum coagulopathy, Escherichia coli bacteremia, and dialysis-requiring acute kidney injury following preterm triplet delivery, highlighting the diagnostic challenge between sepsis-associated DIC and TMA.

CASE PRESENTATION: A 34-year-old G14P1A12 woman without systemic comorbidities was followed for an IVF-conceived trichorionic triamniotic triplet pregnancy achieved through oocyte donation. Her history included 12 pregnancy losses and a previous preterm cesarean delivery at 32+3 weeks. Cervical cerclage was performed at 14+6 weeks for cervical insufficiency. At 23 weeks, emergency cesarean delivery was performed for preterm labor without significant intraoperative hemorrhage.

Postoperatively, the platelet count rapidly decreased to 57,000/µL at the first hour, 37,000/µL at the second hour, and 29,000/µL at the third hour. At postoperative hour 3, laboratory evaluation revealed AST 107 U/L, LDH 1,118 U/L, INR 2.54, creatinine 1.1 mg/dL, aPTT 136 seconds, and fibrinogen 45 mg/dL. CRP was 31 mg/L and procalcitonin was 98 ng/mL. Blood product and fibrinogen replacement and broad-spectrum antibiotics were initiated.

By postoperative hour 10, creatinine had increased to 2.0 mg/dL, total bilirubin to 7.35 mg/dL, direct bilirubin to 5.43 mg/dL, AST to 151 U/L, LDH to 1,800 U/L, amylase to 3,672 U/L, CRP to 125 mg/L, and procalcitonin to >99 ng/mL; ALT was 32 U/L. Serum lactate was 10 mmol/L.

The patient was transferred to a tertiary center. On postpartum

day 1, imaging demonstrated extensive free fluid. In the context of severe endothelial injury and coagulopathy, the differential diagnosis included capillary leak–related free fluid and intra-abdominal hemorrhage. Because of suspected uterine arterial extravasation, uterine artery embolization was performed. Thoracic imaging demonstrated pleural effusion, alveolar hemorrhage, and atelectatic changes.

As renal function progressively deteriorated, continuous renal replacement therapy (CRRT) was initiated. Peripheral blood smear demonstrated 4% red blood cell fragmentation, raising concern for thrombotic microangiopathy (TMA). However, the concomitant presence of myeloid precursors and a left shift, together with Escherichia coli growth in blood cultures, suggested that the hematologic abnormalities could be attributable to sepsis. Subsequently, the patient developed anuria, with serum creatinine increasing to 4.2 mg/dL. Because of worsening respiratory findings and severe acute kidney injury, hemodialysis was performed. Multidisciplinary renal and systemic follow-up remains ongoing.

CONCLUSION: The rapid progression from normal coagulation parameters to severe thrombocytopenia, markedly prolonged coagulation times, and critical hypofibrinogenemia, together with E. coli bacteremia, hyperlactatemia, and marked inflammation, strongly supported sepsis-associated overt DIC.[1,2] However, erythrocyte fragmentation, elevated LDH and bilirubin, and persistent dialysis-requiring acute kidney injury made TMA an important differential diagnosis.[3–6] This case emphasizes the overlap between sepsis-associated DIC and pregnancy-associated TMA and the importance of integrating serial coagulation parameters, hemolysis markers, peripheral smear findings, infection markers, and renal course in multidisciplinary assessment.

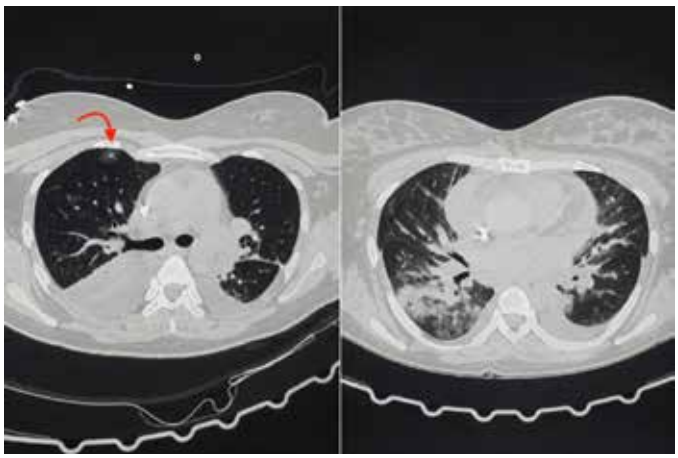
Keywords: sepsis-induced coagulopathy, disseminated intravascular coagulation, thrombotic microangiopathy, acute kidney injury, triplet pregnancy

Figure 1.



Bilateral pleural effusion with concomitant pericardial effusion

Figure 2.



Bilateral Ground-Glass Opacities and Focal Consolidations: Findings Consistent with Alveolar Hemorrhage in the Right Upper Lobe

Figure 3.



Minimal Fluid Density Adjacent to the Enlarged Postpartum Uterus

PP-25

Clinicopathological spectrum of cytomegalovirus associated placental disease: A case series

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BACKGROUND: Cytomegalovirus (CMV) infection during pregnancy has a heterogeneous clinical course, ranging from fetal loss to apparently favorable term delivery. Placental involvement may provide important diagnostic evidence, particularly when maternal serology, placental histopathological and immunohistochemical evaluation, and clinical presentation are discordant. We aimed to characterize recurring placental patterns in CMV associated pregnancies and identify findings that may facilitate recognition of similar cases.

CASE SERIES: Five pregnancies between 18 and 39 weeks of gestation were retrospectively evaluated. Maternal clinical and laboratory findings, pregnancy outcomes, placental histopathological and immunohistochemical features were reviewed together (Table 1). The series represented a broad spectrum of CMV associated pregnancy complications across different gestational periods and clinical outcomes. Despite this clinical heterogeneity, placental examination revealed a recognizable spectrum of chronic placental inflammation and vascular injury. Recurrent findings included various morphological patterns of chronic placental injury (chronic villitis, chronic histiocytic intervillositis, plasma cell deciduitis) and endovasculitis due to direct cellular injury of CMV infection (Figure 1). Maternal vascular malperfusion frequently accompanied these lesions, indicating concomitant involvement of the maternal and fetoplacental circulations (Table 1). The extent and combination of these abnormalities varied between cases, and placental CMV immunoreactivity was not uniformly detectable.

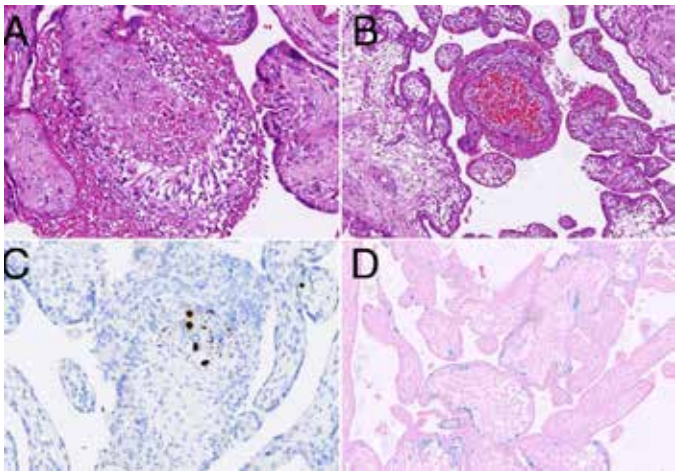
DISCUSSION: Placental CMV infection encompasses a heterogeneous spectrum of inflammatory and vascular lesions rather than a single pathognomonic histological pattern. Characteristic findings encompass various morphological patterns of chronic placental injury (chronic villitis, chronic histiocytic intervillositis, and plasma cell deciduitis) as well as endovasculitis driven by direct CMV induced cellular damage. However, these abnormalities are not individually specific for CMV. Importantly, negative CMV immunohistochemistry

should not be considered sufficient to exclude placental infection. Recent data demonstrate substantially higher CMV detection rates with placental polimerase chain reaction than with IHC, supporting a multimodal diagnostic approach when histopathological findings and clinical suspicion persist despite negative staining. Furthermore, CMV associated placental abnormalities have been reported across a wide range of gestational ages and may accompany both adverse fetal outcomes and clinically asymptomatic live births. Accordingly, integration of maternal serology, molecular testing, fetal assessment, and systematic placental histopathology is essential for establishing clinicopathological correlation and may also provide clinically relevant information for neonatal follow up and subsequent pregnancy counseling.

CONCLUSION: The findings of chronic placental inflammation and injury should prompt consideration of CMV in the appropriate clinical setting. Discordance between maternal serology, placental IHC, and pregnancy outcome highlights the importance of integrated clinicopathological assessment rather than reliance on a single diagnostic marker.

Keywords: Cytomegalovirus, Chronic placental injury, Endovasculitis, Maternal vascular malperfusion, Congenital infection

Figure 1. Histopathological and immunohistochemical features of CMV-associated placental disease.



(A) Granulomatous villitis characterized by granulomatous inflammation within the chorionic villous stroma, with associated villous stromal injury. (B) Endovasculitis involving a chorionic vessel, characterized by prominent inflammatory infiltration of the vascular wall and lumen, consistent with fetoplacental vascular involvement. (C) Focal CMV immunoreactivity within villous stromal cells demonstrated by CMV immunohistochemistry. (D) Chronic inflammatory and vascular lesions involving multiple chorionic villi, demonstrating the heterogeneous pattern of placental injury associated with CMV infection. A, B and D: H&E staining; C: CMV immunohistochemistry.

Table 1. Overview of clinical presentation, gestational age, maternal serological status, pregnancy outcomes, and placental histopathological and vascular alterations across five cases of CMV-associated pregnancy

Case	GA	Clinical Presentation	Maternal CMV Status and Serology	Fetal Outcome	Placental Weight	Placental Histopathology	Placental Vascular Pathology	IHC and Special Stains
Case 1	36W + 5D	Vaginal bleeding, suspected placental abruption; emergency C-Section	Not suspected	Live female infant (Apgar 9/9)	479 g (50–75th %tile)	• Chronic villitis & burnt-out villitis • Chronic histiocytic intervillositis • Villous endovasculitis • 25–30% perivillous fibrinoid	• MVM (+) • Severe villous congestion • Large villous infarcts • Increased syncytial knots	• CMV IHC (+) • CD8 (+) • CD68 (+) • Fe+ Prussian Blue (+)
Case 2	39W	Elective C-Section	Active infection, under treatment [CMV IgM (+), CMV IgG (+)]	Live female infant (Apgar 9/9)	417 g (<10th %tile)	• Low-grade chronic villitis • Chronic histiocytic intervillositis • Villous maturation arrest • 20–25% perivillous fibrinoid • Villous calcifications	• MVM (+) • Chorangiotic villi • Severe villous congestion • Distal villous hypoplasia	• CMV IHC (-) • Fe+ Prussian Blue (+)
Case 3	17–18W (Clin: 18W)	Missed abortion	Not suspected	Abortus	79.5 g (~50–75th %tile)	• Chronic low-grade CMV villitis • Chronic histiocytic intervillositis • Chronic plasma cell deciduitis • 30–40% perivillous fibrinoid • Stromal karyorrhexis	• MVM (+) (mild) • Retroplacental hematoma • Postmortem vascular obliteration	• CMV IHC (+) • CD8 (+) • CD68 (+)
Case 4	25W + 3D	Placental pathology referral	CMV positive pregnancy	—	435 g (>90th %tile)	• Chronic lymphoplasmacytic villitis • Burnt-out villitis • Accelerated villous maturation • 20–25% fibrinoid deposition • Stromal karyorrhexis	• MVM (+) (mild) • Maternal vascular thrombosis • Chorangiosis / chorangiotic villi • Retroplacental hemorrhage	• Fe+ Prussian Blue (+)
Case 5	19W	Anhydramnios; termination of pregnancy	Not suspected	Abortus	75 g (25–75th %tile)	• Chronic granulomatous villitis • Chronic histiocytic intervillositis • Accelerated villous maturation • Villous endovasculitis • 20–25% perivillous fibrinoid • Secondary intravillous hemorrhage	• MVM (+) (mild, global/partial) • Chorangiotic villi • Increased syncytial knots • Marginal cord insertion	• CMV IHC (+) • Fe+ Prussian Blue (+)

GA, gestational age; IHC, immunohistochemistry; MVM, maternal vascular malperfusion; CMV, cytomegalovirus; W, weeks; D, days.

8. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi
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PP-26

Placenta Accreata Spectrum in the Absence of Classical Uterine Surgical Risk Factors: A Case in a Primigravid Patient

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INTRODUCTION AND OBJECTIVE: Placenta accreta spectrum (PAS) is a serious pregnancy complication characterized by abnormal placental adherence to and invasion into the myometrium and is associated with massive obstetric hemorrhage, the need for blood transfusion, and peripartum hysterectomy.[1] Although previous cesarean delivery and other uterine surgeries are the major risk factors, PAS may also occur in patients with placenta previa without a history of uterine surgery.[1] This report aims to present the diagnosis and management of a histopathologically confirmed case of PAS associated with complete placenta previa in a primigravid patient without classical uterine surgical risk factors.

CASE PRESENTATION: A 34-year-old primigravid patient (G1P0) at 33 weeks of gestation presented with painful uterine contractions. Uterine contractions were documented on tocodynamometry. Her medical history was unremarkable, with no history of previous uterine surgery, and antenatal screening tests were normal. Ultrasonography revealed complete placenta previa. Focal loss of the retroplacental hypoechoic zone and increased vascularity on color Doppler imaging were observed, particularly in the posterior cervical region of the placenta; therefore, the diagnosis of PAS could not be definitively excluded. The retroplacental hypoechoic zone was preserved in the anterior portion of the placenta. The fetus was in breech presentation, amniotic fluid volume was adequate, and cervical length was 36 mm. Fetal biometry was consistent with gestational age, with an estimated fetal weight of 2229 g.

The patient was hospitalized and received two doses of betamethasone for antenatal corticosteroid therapy, magnesium sulfate, and nifedipine for tocolysis. Following evaluation by the perinatology team, magnetic resonance imaging (MRI) was performed for further assessment of placental invasion. MRI demonstrated findings consistent with myometrial invasion involving the left posterolateral portion of the placenta. Expectant management with prolongation of pregnancy was planned as long as maternal and fetal conditions remained stable. However, at 34 weeks and 3 days of gestation, persistent vaginal bleeding occurred, and an emergency cesarean delivery was performed for antepartum hemorrhage in the setting of placenta previa.

Intraoperative evaluation revealed areas of placental invasion consistent with the prenatal imaging findings. Uterine compression sutures were applied to achieve hemostasis while preserving the uterus, and packed red blood cell transfusion was administered. The procedure was completed without the need for hysterectomy. Histopathological examination confirmed the diagnosis of PAS.

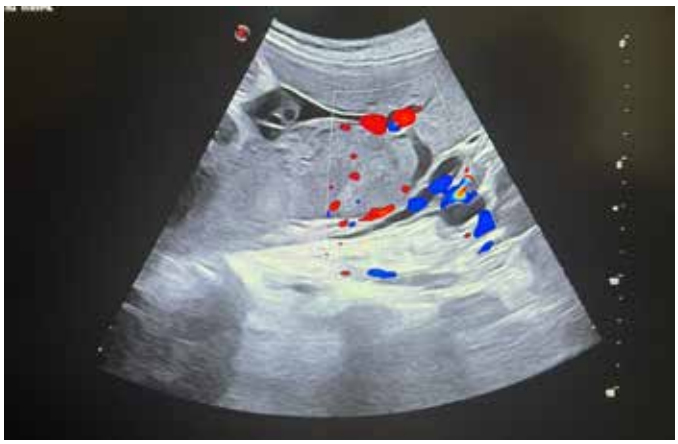
CONCLUSION: Although previous cesarean delivery and uterine surgery are important risk factors for PAS, their absence does not exclude the diagnosis.[1] In the presence of placenta previa, suspicious ultrasonographic findings should be carefully evaluated for PAS even in primigravid patients. MRI may provide complementary diagnostic information, particularly in cases with posterior placental location or when ultrasonographic assessment is limited.[2–4] This case highlights the importance of prenatal suspicion, multidisciplinary management, and individualized uterus-preserving surgical management in selected patients with PAS despite the absence of classical risk factors.

Keywords: Complete placenta previa, magnetic resonance imaging, placenta accreta spectrum, primigravida, uterus-preserving surgery

Figure 1. Loss of the retroplacental hypoechoic zone



Figure 2. Focal increased vascularity on color Doppler imaging



PP-27

Silent Alarm: Complete Placental Abruption and Fetal Death Without Bleeding or Pain: A Case Report

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OBJECTIVE: Placental abruption occurs in approximately 0.4-1% of pregnancies and remains a leading cause of perinatal mortality (1).It typically presents with vaginal bleeding, abdominal pain, and uterine tenderness; however, a substantial proportion of cases lack these classic findings, and ultrasound has limited sensitivity for detecting retroplacental hematoma (2).We report a case of complete placental abruption with intrauterine fetal death,discovered at cesarean section in a normotensive pregnancy without bleeding,pain,or sonographic hematoma,but with isolated fetal growth restriction and intermittent umbilical artery doppler abnormality.

METHODS: A 31-year-old primigravida with a BMI of 24 and hepatitis B carrier status presented to our clinic at 18 weeks of gestation.Ultrasound revealed a 3-cm myoma on the anterior uterine wall, adjacent to the placenta.Blood pressure remained normal throughout pregnancy;an isolated elevation in AST at 24-26 weeks resolved after discontinuation of dietary supplements.Antenatal follow-up,the growth restriction that emerged after 35 weeks,two emergency presentations,and delivery management were retrospectively reviewed.

RESULTS: At 35+0 weeks, abdominal circumference (AC) had declined to the 13th-15th percentile from the 40th percentile three weeks earlier; the patient was placed under close surveillance for growth restriction and preeclampsia, with normal blood pressure and laboratory findings. At 35+1 weeks, she presented with spotting; the nonstress test was reactive,the AmniSure test was negative, and the uterus was non-tender on palpation.At 35+3 weeks, evaluation revealed cervical dilation of 3-4 cm with 50% effacement, oligohydramnios, an AC at the 3rd-5th percentile, and intermittent absent end-diastolic flow on umbilical artery Doppler, without vaginal bleeding, uterine tenderness, or hematoma on ultrasound. Given the mother's report of decreased fetal movement, the Doppler abnormality, and the growth restriction, she was admitted and taken to cesarean section within 40-45 minutes, without awaiting laboratory results.No fetal heart rate was detected intraoperatively, and the placenta was found to be completely abrupted; resuscitation attempts after delivery were unsuccessful, and fetal demise was confirmed.A 3-4 cm subserosal myoma was noted on the anterior uterine surface. The mother remained hemodynamically stable perioperatively, laboratory values were normal, and she was discharged on postoperative day 2.

CONCLUSION: This case demonstrates that placental abruption can occur without the classic findings of bleeding, pain, and sonographic retroplacental hematoma.In the meta-analysis by Chen et al.(3),comprising over seven million pregnancies,small-for-gestational-age status and preeclampsia were independently associated with abruption, suggesting that the growth restriction observed here may, in retrospect, represent a meaningful warning sign; intermittent Doppler abnormality may likewise reflect underlying placental insufficiency.Growth restriction and doppler abnormality, even without classic alarm findings, warrant a high index of suspicion and prompt delivery. Families should be counseled,clearly and empathetically,that abruption can remain largely unpredictable despite thorough surveillance.

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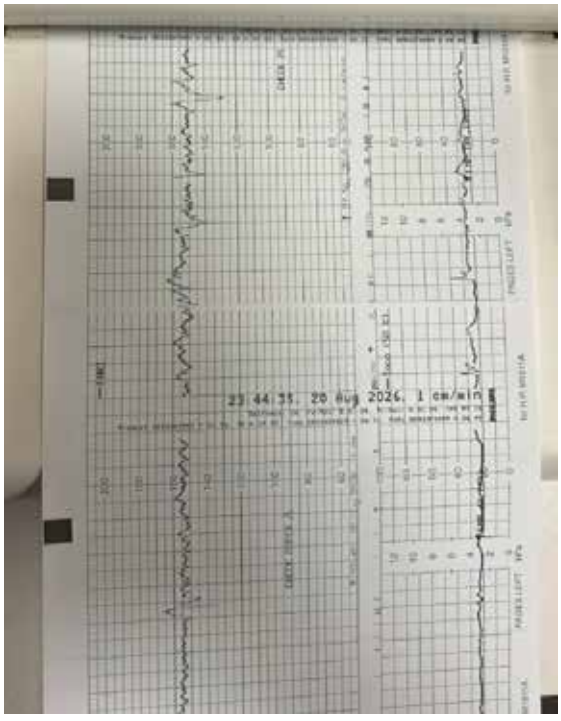
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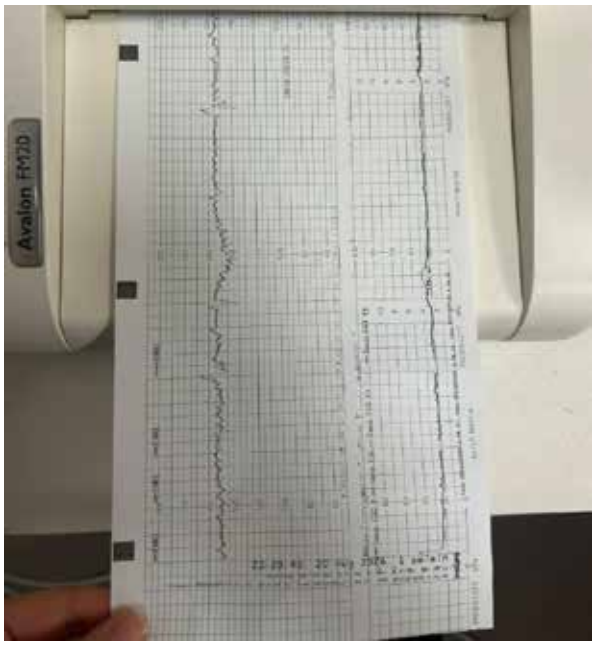
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Keywords: Placental abruptiom, fetal death, ıntrauterin growth restriction

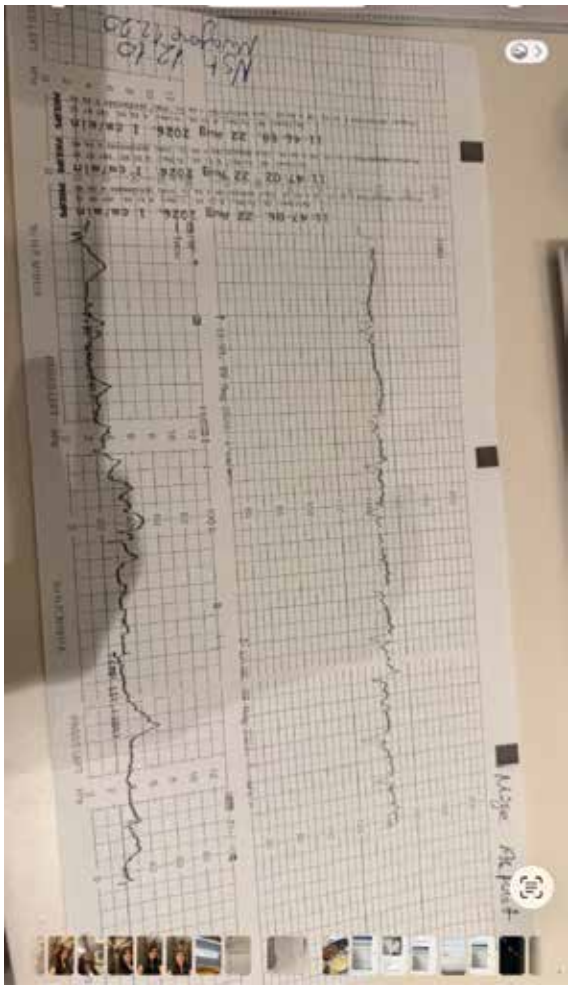
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Gece nöbetindeki NST-1



Sezaryen öncesi NST-3



PP-28

Successful Pregnancy Following Fertility-Sparing Treatment in a Young Patient with Endometrial Cancer: A Case Report

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INTRODUCTION: Endometrial cancer is a malignancy that predominantly affects women who have completed childbearing. Approximately 8% of cases are diagnosed in young women of reproductive age. Accordingly, in patients who wish to preserve their fertility and in whom the tumor is detected at an early stage, a number of hormonal treatments may be administered to preserve fertility. However, these treatments are recommended only for a limited subset of patients with appropriate clinical and pathological characteristics. Pregnancy rates following hormonal therapy are reported in the literature to be approximately 20–27%, with live birth rates of approximately 20%.

CASE REPORT: A 27-year-old gravida 0, para 0 woman was referred to our clinic following an outside-institution pathology report of endometrioid-type adenocarcinoma. Endometrial curettage material obtained during her follow-up revealed FIGO Grade 1 endometrioid adenocarcinoma arising on a background of an endometrial polyp. As the tumor was progesterone receptor positive, megestrol acetate therapy (160 mg/day) was initiated and maintained for three months.

Endometrial curettage sampling obtained after treatment demonstrated a response to therapy, with no evidence of malignancy; atypical hyperplasia was present in only a few specimens, and the foci were reduced compared with the previous pathology. In view of this treatment response, a levonorgestrel-releasing intrauterine device (LNG-IUD) was inserted, and megestrol acetate therapy was continued to complete a total of 12 months. The endometrial curettage specimen obtained at the conclusion of treatment revealed neither atypical hyperplasia nor malignancy.

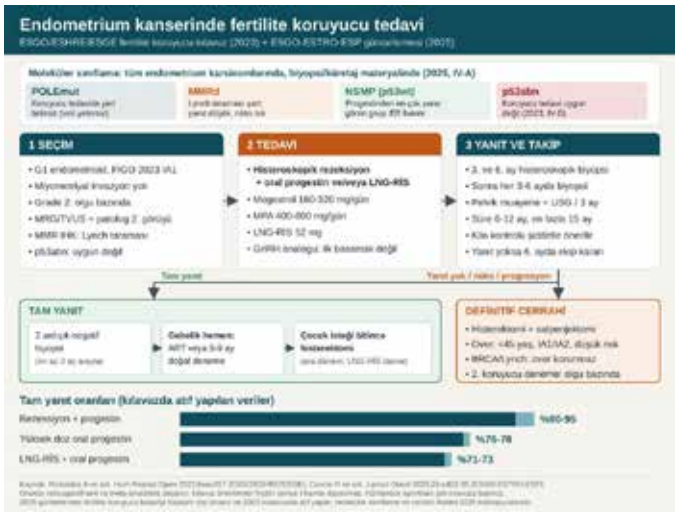
The patient, who desired pregnancy, conceived by in vitro fertilization (IVF) approximately one year after completion of treatment, and the pregnancy was followed with routine obstetric surveillance and concurrent oncologic follow-up. From an oncologic standpoint, elective surgery was planned, and it was decided that hysterectomy would be performed in the same session at the time of delivery. At 36 weeks and 1 day of gestation, spontaneous labor ensued and cervical effacement was detected; the patient therefore underwent cesarean section together with total hysterectomy and bilateral salpingectomy.

DISCUSSION: Fertility-sparing treatment can be applied as a safe and effective option in appropriately selected young patients with early-stage endometrial cancer. However, this approach requires close histopathologic surveillance; in the present case, follow-up was carried out with repeated endometrial curettage sampling at approximately three-month intervals.

CONCLUSION: Conservative treatment may be considered a safe and effective option for selected young patients diagnosed with early-stage endometrial cancer who desire fertility preservation. Important selection criteria for this approach include disease confined to FIGO Stage IA, endometrioid histology of FIGO Grade 1–2, absence of lymphovascular invasion, and progesterone receptor positivity. Megestrol acetate, medroxyprogesterone acetate, and the levonorgestrel-releasing intrauterine device may be used for fertility-sparing treatment. In the case presented, a complete response was achieved with progesterone-based therapy, a successful pregnancy was subsequently obtained through IVF, and oncologic treatment was completed with the hysterectomy performed at the time of delivery.

Keywords: Endometrioid adenocarcinoma, fertility-sparing treatment,megestrol acetate

ENDOMETRİYUM KANSERİNDE FERTİLİTE KORUYUCU TEDAVİ YAKLAŞIMI



PP-29

Laparoscopic Surgical Management of Endometrioid Endometrial Carcinoma in a Patient with Total Situs Inversus: A Rare Case Report

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Konya Şehir Hastanesi

BACKGROUND: Total situs inversus is a rare congenital condition characterized by complete mirror-image transposition of the thoracic and abdominal organs. The coexistence of endometrial carcinoma and total situs inversus is exceptionally uncommon and presents unique anatomical challenges during minimally invasive gynecologic oncologic surgery.

CASE PRESENTATION: A 51-year-old gravida 2, para 2 woman presented with abnormal uterine bleeding. Endometrial biopsy revealed FIGO grade 1 endometrioid endometrial carcinoma. Preoperative magnetic resonance imaging demonstrated total situs inversus and a heterogeneous endometrial mass measuring approximately 45 × 29 × 30 mm located at the uterine fundus. The lesion showed deep myometrial invasion without serosal extension, restricted diffusion, and heterogeneous contrast enhancement, raising suspicion for malignancy. A second 15-mm heterogeneous lesion extending from the uterine isthmus toward the cervix was also identified. This lesion was absent on MRI performed in August 2024, whereas the fundal lesion had increased in size compared with the previous examination. In addition, multiple uterine leiomyomas were detected, the largest measuring 91 × 55 × 72 mm. The patient underwent total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, pelvic lymphadenectomy, and infracolic omentectomy. Despite the mirrored anatomy caused by total situs inversus, the procedure was completed laparoscopically without intraoperative complications.

PATHOLOGICAL FINDINGS: Final histopathological examination demonstrated a 3.5-cm FIGO grade 1 endometrioid endometrial carcinoma with <50% myometrial invasion (7 mm). There was no lymphovascular space invasion, no cervical stromal involvement, no parametrial involvement, and no adnexal metastasis. The cervix showed only chronic cervicitis and Nabothian cysts. Immunohistochemistry revealed positivity for PanCK, Vimentin, and estrogen receptor, while p16, p53, and CEA were negative. Mismatch repair protein analysis demonstrated loss of MLH1 and PMS2 expression with preserved MSH2 and MSH6, consistent with MMR deficiency due to MLH1 loss.

CONCLUSION: This case highlights the feasibility and safety of laparoscopic surgical staging for endometrial cancer in patients with total situs inversus when meticulous preoperative anatomical assessment is performed. The coexistence of mirror-image anatomy, multiple large leiomyomas, and

mismatch repair-deficient endometrial carcinoma makes this an exceptionally rare presentation. Awareness of altered anatomy and careful surgical planning are essential to achieve optimal oncologic outcomes.

Keywords: Total situs inversus, Endometrioid Endometrial Carcinoma, anormal uterin bleeding

PP-30

Recurrent Complete Cervical Stenosis with Hematometra Following Repeat Cervical Conization for CIN 3: A Case Report

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INTRODUCTION: Cervical conization is a fertility-preserving standard excisional procedure for the treatment of high-grade cervical intraepithelial neoplasia (CIN). Cervical stenosis is an uncommon but clinically significant complication, particularly following repeat excisional procedures. It may result in secondary amenorrhea, hematometra, infertility, and impaired reproductive outcomes. Early diagnosis, appropriate treatment, and long-term follow-up are especially important in young women who desire future fertility.

CASE PRESENTATION: A 28-year-old woman (gravida 1, para 1) with a history of one vaginal delivery was diagnosed with high-risk human papillomavirus (HPV) type 16 infection in September 2022. Cervical conization was performed in April 2023, and histopathological examination revealed CIN 3 with positive surgical margins. Therefore, a repeat conization was performed in February 2024. The final pathology demonstrated chronic cervicitis with negative surgical margins. Three months after the second conization, the patient presented with secondary amenorrhea. Gynecological examination revealed complete obliteration of the external cervical os with marked cervical fibrosis. Cervical recanalization was successfully performed in May 2024, and a feeding catheter was placed within the cervical canal to maintain cervical patency. During follow-up, cervical cytology and HPV DNA test results remained negative. In July 2026, the patient was readmitted with a three-month history of amenorrhea and severe pelvic pain. Recurrent complete cervical stenosis was diagnosed, and repeat cervical recanalization was performed on July 10, 2026. Retained menstrual blood was evacuated from the uterine cavity, and a single-lumen triangle-headed catheter was placed within the cervical canal to reduce the risk of restenosis. The catheter was removed 10 days later. At the most recent follow-up, the patient remained asymptomatic, with no active complaints.

DISCUSSION: Cervical stenosis is a rare but important late complication of cervical excisional procedures, with an increased incidence following repeat conization. Although cervical recanalization remains the standard treatment, restenosis continues to represent a significant clinical challenge. Therefore, long-term follow-up should include not only oncologic surveillance but also assessment of cervical patency, menstrual function, and future reproductive potential.

CONCLUSION: This case demonstrates that recurrent complete cervical stenosis may develop despite successful oncologic management after repeat cervical conization for CIN 3. Long-term follow-up should extend beyond cytology and HPV testing to include evaluation of menstrual function, cervical patency, and fertility plans. Early recognition, timely cervical recanalization, and individualized fertility counseling are essential for optimal patient management.

Keywords: Cervical Stenosis,CIN 3, Hematometra, Repeat Cervical Conization, Cervikal Recanalization;

PP-31

Vulvar epithelioid sarcoma: A case report

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OBJECTIVE: The incidence of primary vulvar sarcoma is estimated to be between 1.5% and 5% of all vulvar malignancies. This report aims to present a 28-year-old patient diagnosed with vulvar epithelioid sarcoma who underwent radical surgery followed by planned multidisciplinary adjuvant treatment.

METHOD: The clinical, imaging, histopathological, surgical, and postoperative oncological treatment data of a 28-year-old patient diagnosed with vulvar epithelioid sarcoma were obtained from the hospital information management system and evaluated.

RESULTS: A 28-year-old G1P1 patient who was breastfeeding during the postpartum period presented to another institution with a rapidly growing vulvar lesion first noticed in May 2026. An excisional biopsy performed in June 2026 was reported as a small round cell tumor. Re-evaluation of the pathological material at our institution revealed a neoplasm of the left labium majus with loss of INI1 (SMARCB1) expression, consistent with epithelioid sarcoma. Staging PET/CT performed on June 16, 2026, demonstrated two FDG-avid nodular lesions in the left labium majus and low-level FDG uptake in a left inguinal lymph node. On June 24, 2026, the patient underwent left radical hemivulvectomy and left inguinal lymph node dissection. Final histopathology revealed a 50-mm epithelioid sarcoma with a depth of invasion of 18 mm. The tumor was 5 mm from the nearest lateral margin and 6 mm from the deep margin, with all surgical margins free of tumor. The excised left inguinal lymph node was reactive. Following multidisciplinary evaluation, four cycles of ifosfamide, mesna, and doxorubicin were planned, with radiotherapy to follow chemotherapy.

CONCLUSION: Vulvar epithelioid sarcoma is a rare malignant mesenchymal neoplasm, and the diagnosis based solely on morphological features can be challenging. Integrated evaluation of clinical and histomorphological findings, together with the demonstration of loss of nuclear INI1 (SMARCB1) expression, is valuable for accurate diagnosis. Wide surgical resection remains the primary treatment for localized disease; however, the efficacy of adjuvant chemotherapy and radiotherapy remains unclear because of the limited number of reported cases.

Keywords: Vulvar Neoplasms, Epithelioid Sarcoma, Vulvectomy

Figure 1



Preoperative macroscopic appearance of the epithelioid sarcoma located on the left labium majus.

Figure 2



Postoperative appearance of the surgical defect after left radical hemivulvectomy and left inguinal lymph node dissection

Figure 3



Surgical specimen

PP-32

Peritoneal tuberculosis mimicking advanced ovarian cancer: A diagnostic dilemma

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OBJECTIVE: Peritoneal tuberculosis may closely mimic advanced ovarian malignancy through ascites, elevated serum cancer antigen 125 (CA-125) levels, and diffuse peritoneal involvement. We present a diagnostically challenging case initially evaluated for advanced ovarian/peritoneal malignancy, in which diagnostic laparoscopy and histopathological examination redirected the diagnosis toward peritoneal tuberculosis.

METHODS: A 64-year-old postmenopausal woman was referred to our gynecologic oncology department because of diffuse ascites and markedly elevated serum CA-125. Clinical, radiological, cytological, laparoscopic, and histopathological findings were evaluated.

RESULTS: The serum CA-125 level was 839 U/mL. Transvaginal ultrasonography demonstrated diffuse ascites without an identifiable adnexal mass. Thoracic computed tomography showed no pulmonary mass, nodule, pathological lymphadenopathy, or findings suggestive of active pulmonary infection. Abdominopelvic imaging demonstrated inflammatory changes involving the sigmoid and descending colon and fat stranding at the mesenteric root. Cytological examination of ascitic fluid revealed a single cell with prominent cytological atypia among acute inflammatory cells; however, the cell block was hypocellular and malignancy could not be confirmed. A previous percutaneous tru-cut biopsy had demonstrated granulomatous inflammation. Because ovarian/peritoneal malignancy could not be excluded despite inconclusive preoperative sampling, diagnostic laparoscopy was performed. Intraoperatively, abundant ascites and innumerable whitish nodules diffusely involving the peritoneal surfaces were observed, closely resembling peritoneal carcinomatosis. Multiple biopsies were obtained. Histopathological examination showed no neoplasia and revealed necrotizing granulomatous inflammation. An interferon-gamma release assay was positive. Following infectious diseases consultation, the clinicopathological findings were considered highly suggestive of peritoneal tuberculosis, and treatment with isoniazid, rifampicin, pyrazinamide, and ethambutol was planned.

CONCLUSION: Peritoneal tuberculosis should be considered in the differential diagnosis of patients presenting with ascites, markedly elevated CA-125, and a peritoneal carcinomatosis-like appearance, even when the clinical presentation strongly suggests advanced ovarian cancer. Histopathological confirmation before initiating oncologic treatment is crucial, as infectious and granulomatous diseases may closely mimic advanced ovarian malignancy and lead to unnecessary chemotherapy or radical surgery.

Keywords: Ascites, CA-125, Diagnostic laparoscopy, Ovarian cancer, Peritoneal carcinomatosis, Peritoneal tuberculosis

Laparoscopic appearance of peritoneal tuberculosis mimicking peritoneal carcinomatosis

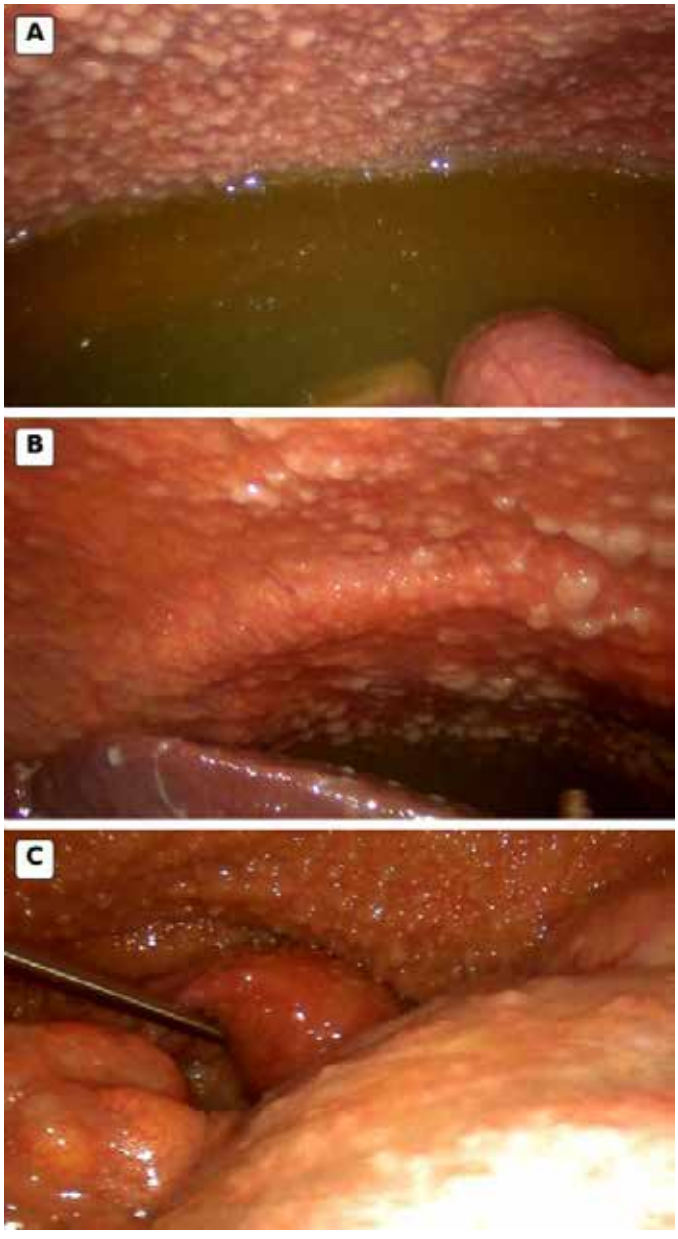


Figure 1. Laparoscopic appearance of diffuse peritoneal involvement. (A) Abundant ascites with widespread whitish peritoneal nodules. (B) Close-up view of multiple nodular lesions mimicking peritoneal carcinomatosis. (C) Diffuse distribution of peritoneal lesions within the abdominal cavity.

PP-33

Metachronous Appendiceal Neuroendocrine Tumor Following Cervical Large Cell Neuroendocrine Carcinoma: Second Primary Tumor or Metastatic Disease?

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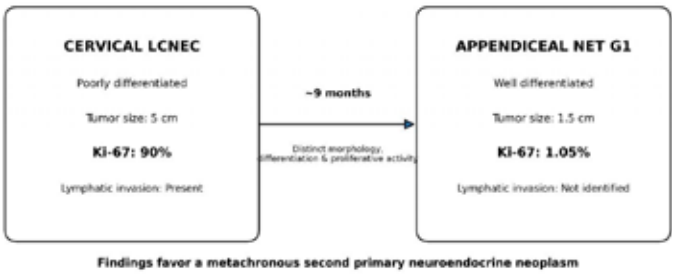
INTRODUCTION: Large cell neuroendocrine carcinoma (LCNEC) of the cervix is an extremely aggressive and rare malignancy, accounting for less than 1% of cervical cancers. In contrast, appendiceal neuroendocrine tumors (NETs) are generally well-differentiated, indolent neoplasms. The co-occurrence of metachronous neuroendocrine neoplasms exhibiting strikingly distinct biological behaviors in separate organs is exceptionally rare. Here, we aim to present the clinical and pathological evaluation of a patient with high-grade cervical LCNEC who developed a metachronous appendiceal Grade 1 NET during surveillance.

CASE PRESENTATION: A 46-year-old woman presented with a cervical mass. Staging FDG PET/CT demonstrated a hypermetabolic cervical lesion extending into the vagina (SUVmax 21) and a hypermetabolic right pelvic lymph node (SUVmax 13.8), with no distant metastasis. Biopsy confirmed cervical LCNEC with diffuse synaptophysin, CD56, and p16 positivity, and a Ki-67 proliferation index of 90%. Following three cycles of neoadjuvant etoposide-based chemotherapy, the patient underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy, pelvic lymphadenectomy, and adjuvant pelvic radiotherapy (50.4 Gy). Final pathology revealed a 5-cm tumor with lymphatic invasion, negative surgical margins, no parametrial involvement, and nineteen negative pelvic lymph nodes. Nine months post-diagnosis, surveillance imaging detected an appendiceal lesion, for which the patient underwent appendectomy. Histopathological examination confirmed a 1.5-cm well-differentiated NET Grade 1. Immunohistochemistry demonstrated diffuse strong positivity for synaptophysin and chromogranin, INSM1 positivity, absence of lymphatic invasion (D2-40), and a Ki-67 index of 1.05%.

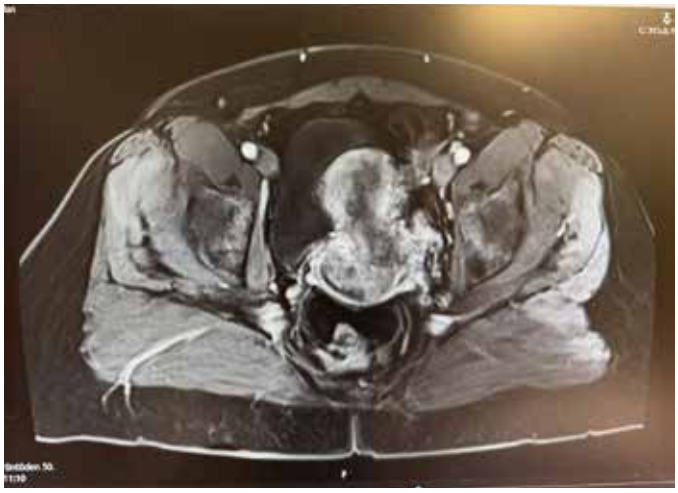
DISCUSSION & CONCLUSION: Differentiating a second primary neuroendocrine neoplasm from metastatic disease is crucial when a new lesion arises in a patient with a history of high-grade neuroendocrine carcinoma. The profound disparity in Ki-67 proliferation indices (90% vs. 1.05%), discordant histological differentiation, and immunophenotypic variations (chromogranin expression) strongly establish the appendiceal lesion as a metachronous second primary NET rather than metastatic cervical LCNEC. Thorough pathological assessment is essential for accurate diagnosis, prognostic evaluation, and tailoring appropriate management strategies.

Keywords: Cervical neuroendocrine carcinoma, Large cell neuroendocrine carcinoma, Appendix, Neuroendocrine tumor, Second primary tumor, Ki-67.

Clinicopathological Comparison of Cervical LCNEC and Appendical NET G1



Pelvik MRI showing the cervical mass



Clinicopathological Comparison of Cervical LCNEC and Appendical NET G1

Comparison of Tumor Characteristics
Cervical large cell neuroendocrine carcinoma vs appendiceal neuroendocrine tumor Grade 1

Feature	Cervical LCNEC	Appendiceal NET G1
Differentiation	Poorly differentiated	Well differentiated
Tumor size	5 cm	1.5 cm
Ki-67 index	90%	1.05%
Synaptophysin	Diffuse positive	Diffuse strong positive
Chromogranin	Focal positive	Diffuse strong positive
CD56	Diffuse positive	Not reported
INSM1	Not reported	Positive
Lymphatic invasion	Present	Not identified (D2-40)
Vascular invasion	Absent	Not reported
Parametrial involvement	Absent	—
Surgical margins	Negative	Cecal margin 2.2 cm away
Pelvic lymph nodes	0/19	—

The marked difference in differentiation and proliferative activity supports two biologically distinct neuroendocrine neoplasms.

PP-34

Gynecologic Tract Involvement by Lymphoid Neoplasms: A Five-Case Series

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OBJECTIVE: Involvement of the female genital tract by lymphoid neoplasms is rare and may clinically and radiologically mimic primary gynecologic malignancies. This study aimed to present the clinical, histopathological, treatment, and follow-up characteristics of five patients with gynecologic involvement by lymphoid neoplasms.

CASE SERIES: Five patients with histopathologically confirmed involvement of the female genital tract were retrospectively evaluated. The median age was 61 years (range, 36–71), and four patients were postmenopausal. The involved sites were the ovaries in two patients, the endometrium in one, the cervix in one, and the vaginal cuff in one. Bilateral fallopian tube involvement was also present in one patient with ovarian disease. Histopathological diagnoses were diffuse large B-cell lymphoma in two patients, high-grade B-cell lymphoma in one, and chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) infiltration in two. Clinical presentations included an incidentally detected ovarian cyst, abdominal pain associated with a complex adnexal mass, and postmenopausal bleeding. Cervical and vaginal cuff involvement by CLL/SLL was asymptomatic and detected incidentally during gynecologic evaluation. Diagnosis was established surgically in the two ovarian cases and by endometrial, cervical, or vaginal cuff sampling in the remaining cases. Immunohistochemical examination was essential for diagnosis and classification. The three patients with aggressive B-cell lymphoma received rituximab-based systemic therapy, with additional radiotherapy administered to the patient with endometrial involvement. Active surveillance was continued in the two asymptomatic patients with CLL/SLL infiltration. No gynecologic recurrence or progression was documented during follow-up periods ranging from approximately two months to six years.

CONCLUSION: Lymphoid neoplasms may involve various sites of the female genital tract and may present as a symptomatic mass, abnormal bleeding, or incidental microscopic infiltration. Histopathological evaluation supported by immunohistochemistry is crucial for establishing an accurate diagnosis, preventing unnecessary radical surgery, and selecting appropriate treatment for the underlying hematologic disease. A multidisciplinary approach is essential when evaluating atypical gynecologic lesions.

Keywords: lymphoma, chronic lymphocytic leukemia, extranodal involvement

PP-35

Clinical management challenges in uterine inflammatory myofibroblastic tumor: A fertility-sparing approach

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OBJECTIVE: Inflammatory myofibroblastic tumors (IMTs) of the uterus are extremely rare, predominantly benign mesenchymal neoplasms that carry a reported 25% risk of local recurrence or distant metastasis. Due to their clinical and radiological resemblance to common uterine leiomyomas or endometrial polyps, preoperative diagnosis is highly challenging. We present a rare case of a uterine IMT in a young female patient, highlighting the diagnostic dilemma, molecular characteristics, and the clinical application of a recently proposed, integrated risk stratification model.

CASE PRESENTATION: A 26-year-old nulligravid female presented with a one-year history of irregular, heavy menstrual bleeding, with an acute one-month exacerbation of persistent abnormal uterine bleeding prompting admission. Pelvic magnetic resonance imaging (MRI) revealed a 64x31 mm uterus containing a 2x3 cm T2-hyperintense lesion attached to the myometrium. The mass exhibited greater hyperintensity than a typical leiomyoma and appeared to prolapse into the endometrial cavity, raising suspicion for a large polypoid lesion. The patient initially underwent an operative hysteroscopy for the resection of the approximately 3 cm tumor.

Immunohistochemical evaluation of the hysteroscopic biopsy revealed that the neoplastic cells were positive for Anaplastic Lymphoma Kinase (ALK) and 90% positive for Estrogen (ER) and Progesterone (PR) receptors, but completely negative for Desmin, H-caldesmon, and CD10. The mitotic rate was 1/10 high-power fields (HPF), confirming the diagnosis of uterine IMT. Following evaluation by the Gynecologic Oncology Multidisciplinary Board, a fertility-sparing laparotomic myomectomy and right paratubal cyst excision were performed as definitive surgical management. An initial ALK break-apart FISH study performed on the hysteroscopic specimen was non-informative. Pathological examination of the 3x2.5x2 cm myomectomy specimen confirmed the IMT diagnosis with diffuse ALK positivity. A repeat FISH study, despite again yielding suboptimal signal quality, ultimately demonstrated a few cells with breaks favoring ALK translocation, further corroborating the immunohistochemical findings.

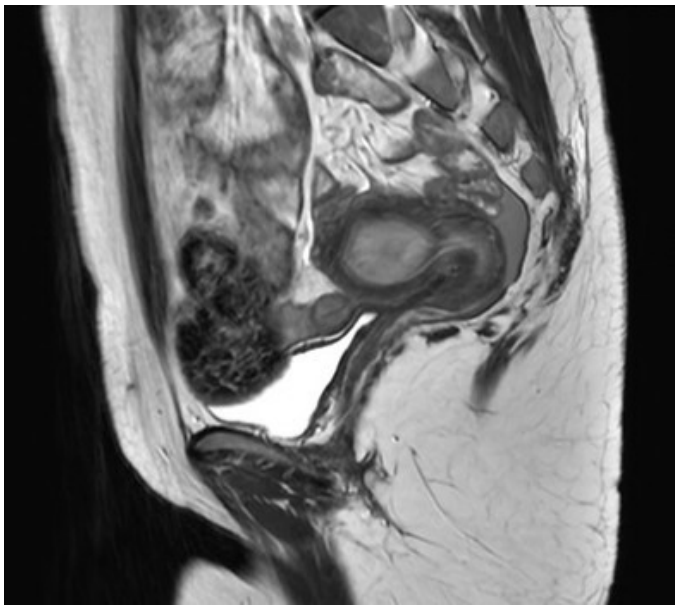
To predict the biological behavior of the tumor, the recent risk stratification model proposed by Ladwig et al. (2023)

was applied. Based on this integrated algorithm, the neoplasm was distinctly categorized as “low risk,” since the patient was younger than 45 years, the tumor size was less than 5 cm, the mitotic rate was below 4/10 HPF, and the resected tissue exhibited well-demarcated, non-infiltrative borders. At the three-month postoperative follow-up, lower abdomen MRI and thorax computed tomography (CT) showed no evidence of local recurrence or metastasis. Consequently, the Medical Oncology department recommended a drug-free observation period, with routine clinical and radiological follow-up visits scheduled every six months.

CONCLUSION: Uterine IMTs should be carefully considered in the differential diagnosis of submucosal uterine masses, particularly when MRI reveals atypical T2-hyperintensity relative to a typical leiomyoma. Definitive diagnosis relies primarily on immunohistochemical profiling, notably ALK positivity together with the absence of myogenic markers, since ALK FISH may remain technically inconclusive despite repeated testing on separate specimens. For young patients wishing to preserve fertility, this surgical approach combined with close multidisciplinary follow-up provides effective, individualized management. Incorporating the Ladwig risk stratification algorithm—evaluating patient age, tumor size, mitotic index, and tumor borders—is crucial for predicting biological behavior and individualizing adjuvant follow-up strategies.

Keywords: Anaplastic Lymphoma Kinase, Inflammatory Myofibroblastic Tumor, Uterine Neoplasms

Figure 1



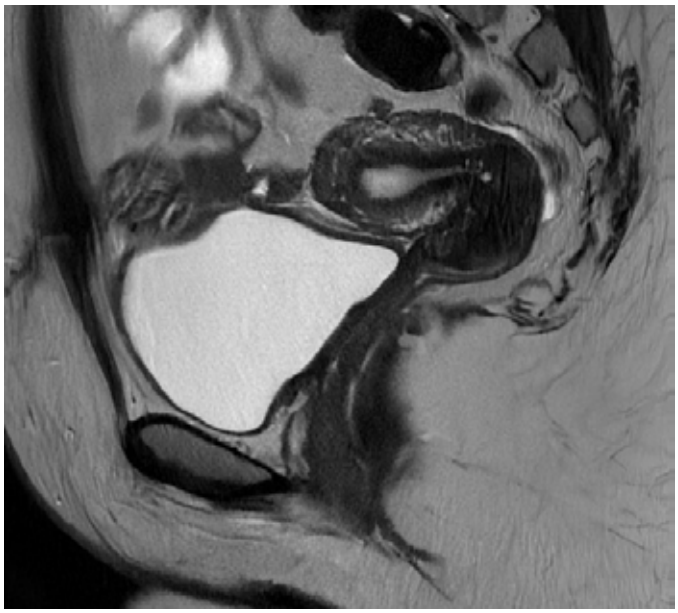
Preoperative MRI

Figure 2



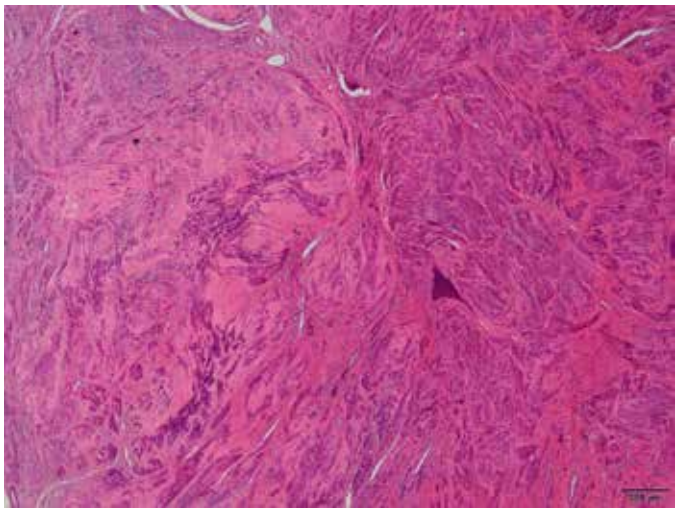
Preoperative MRI 2

Figure 3



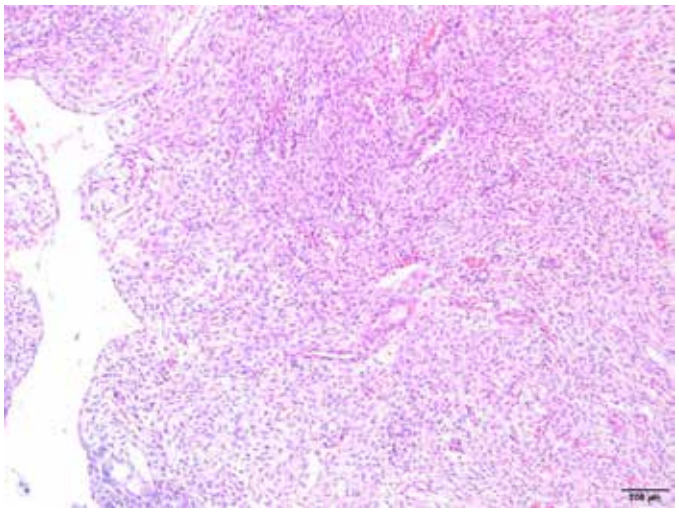
Postoperative MRI

Figure 4A



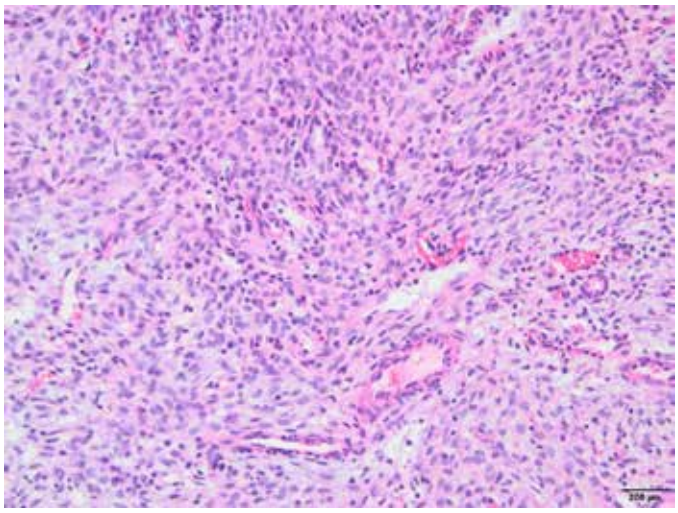
Classic leiomyoma: Compact, intersecting fascicles of smooth muscle cells with eosinophilic cytoplasm.

Figure 4B



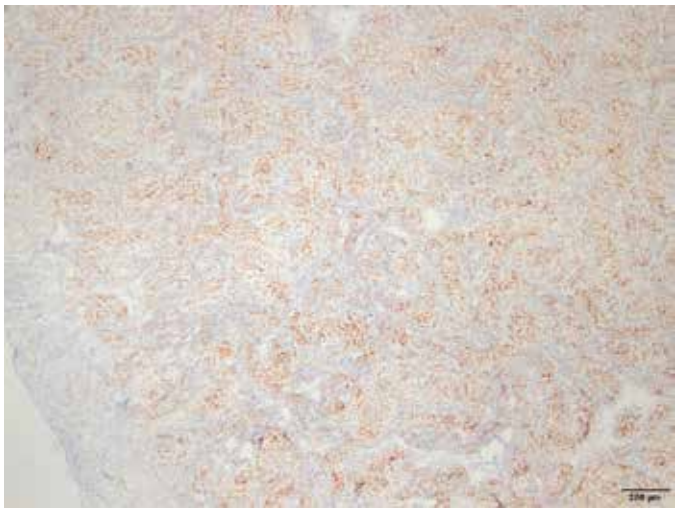
Uterine IMT: Loosely arranged plump spindle cells in an edematous/myxoid stroma.

Figure 5



High-power view demonstrating a prominent lymphoplasmacytic inflammatory infiltrate mixed with neoplastic myofibroblasts.

Figure 6



Immunohistochemistry revealing strong, diffuse cytoplasmic positivity for ALK in the neoplastic cells, confirming the diagnosis of IMT.

PP-36

A Broad Ligament Leiomyoma Mimicking Ovarian Germ Cell Malignancy

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BACKGROUND: Broad ligament leiomyomas are rare extrauterine smooth muscle tumors that may closely simulate malignant adnexal pathology on preoperative imaging, leading to unnecessary surgical radicality if the correct diagnosis is not established. We report a case in which a large broad ligament myoma generated MRI features strongly suggestive of a germ cell malignancy, yet was resolved with straightforward fertility-preserving surgery upon direct intraoperative inspection.

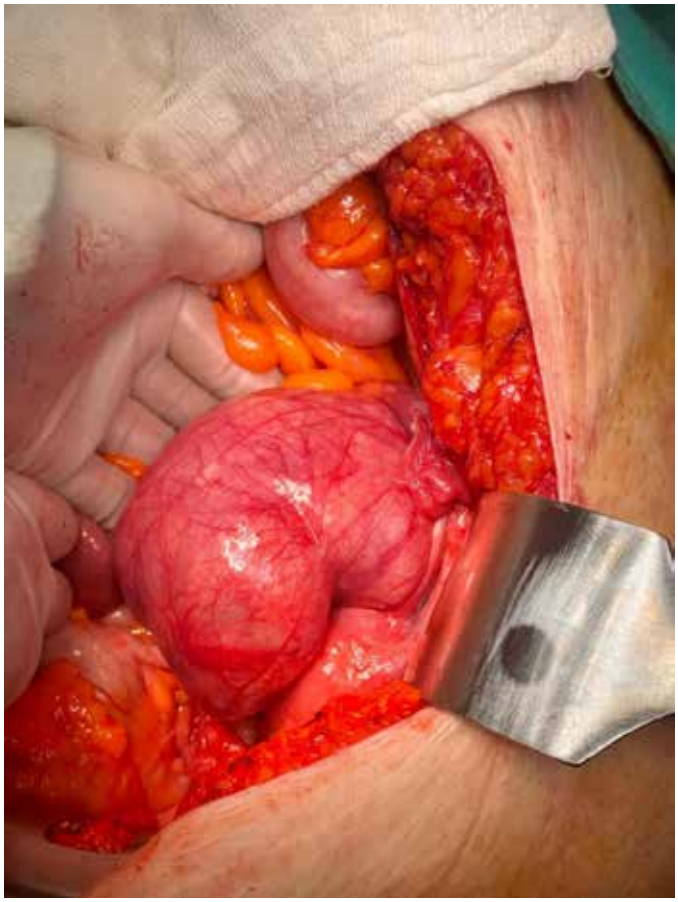
METHODS: A 32-year-old woman with type 2 diabetes mellitus presented with a complex pelvic mass detected on transvaginal ultrasonography, which demonstrated a 26 mm heterogeneous irregular lesion in the posterior uterine isthmus and a 3 cm cervical lesion with poorly defined margins. Pelvic MRI revealed a 63 mm complicated cystic lesion in the left adnexal region (T2 hyperintense, T1 hypointense, with peripheral contrast enhancement), and, posterior to this, a 101×56 mm solid-cystic mass in the Douglas pouch exhibiting heterogeneous enhancement and mild diffusion restriction — a constellation of findings reported as highly suspicious for dysgerminoma. Serum tumor markers were negative; inhibin B was mildly elevated (12 pg/mL) and AMH was markedly suppressed (0.04 ng/mL). To exclude synchronous gastrointestinal malignancy, endoscopic workup was performed: initial colonoscopy identified a low-grade dysplastic tubular adenoma at 80 cm, while repeat colonoscopy and upper gastrointestinal endoscopy three months later were entirely normal. Cervical cytology and HPV testing were both negative.

RESULT: Given the persistent imaging concern for malignancy, the patient underwent exploratory laparotomy via a midline incision. Intraoperatively, both ovaries and the uterus were grossly normal; a 15×9 cm mobile, pedunculated mass arising from the left lateral uterine corpus and extending into the broad ligament was identified. The left ureter was meticulously dissected and preserved throughout. The mass was excised without adnexal sacrifice, peritoneal cytology was obtained, and no additional pathology was identified on systematic abdominal survey. Final histopathology confirmed leiomyoma without atypia or malignant change.

CONCLUSION: This case demonstrates the well-recognized but persistently challenging capacity of broad ligament leiomyomas to mimic ovarian germ cell malignancies — including dysgerminoma — across multiple preoperative imaging modalities. Normal intraoperative adnexal appearance permitted immediate fertility-sparing resection without diagnostic uncertainty. In reproductive-aged women with markedly diminished ovarian reserve, the risk of unnecessary oophorectomy based on misleading preoperative imaging carries profound reproductive consequences. This case reinforces that direct surgical inspection remains the definitive arbiter in complex pelvic mass management, and that a multidisciplinary, stepwise diagnostic approach can prevent overtreatment even when imaging findings are highly suspicious for malignancy.

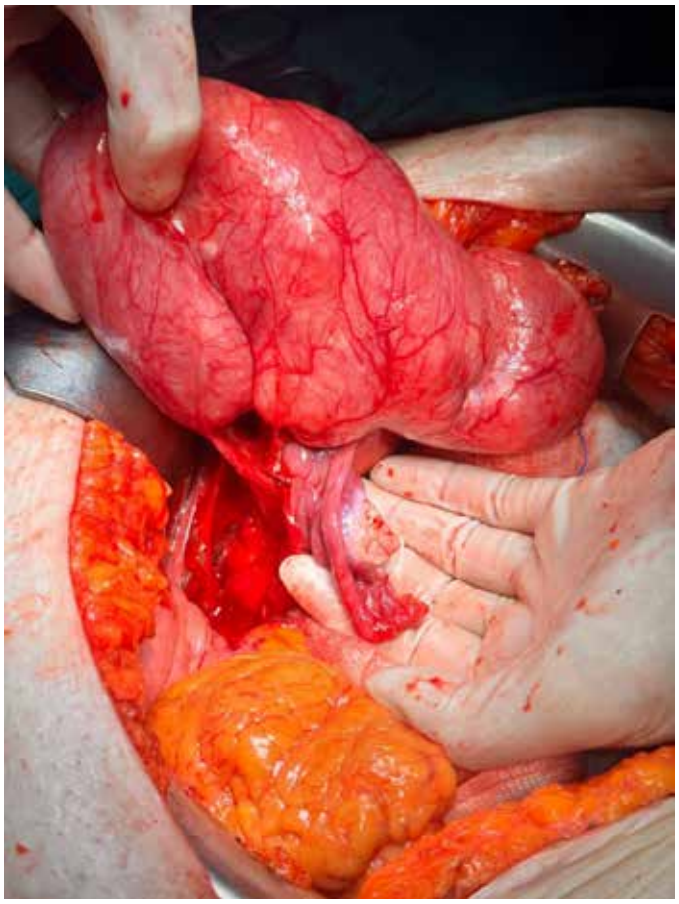
Keywords: adnexal mass, Broad ligament leiomyoma, dysgerminoma, fertility-sparing surgery, germ cell tumor, pelvic MRI

Figure 1



a 15×9 cm mobile, pedunculated mass arising from the left lateral uterine corpus and extending into the broad ligament was identified.

Figure 2



a 15×9 cm mobile, pedunculated mass arising from the left lateral uterine corpus and extending into the broad ligament was identified.

PP-37

Persistent postpartum cholestasis revealing chronic active hepatitis after severe early-onset cholestasis in pregnancy: a case report

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OBJECTIVE: To describe the diagnostic course and maternal–neonatal outcomes of severe early-onset cholestasis in pregnancy with progressive postpartum hypercholanemia and subsequent histopathologic evidence of chronic active hepatitis.

METHODS: Deidentified maternal, obstetric, radiologic, histopathologic, and neonatal records were retrospectively reviewed. Serial total serum bile acid concentrations, liver biochemical tests, coagulation indices, hematologic findings, autoimmune and infectious investigations, hepatobiliary imaging, delivery data, and the early neonatal course were evaluated.

RESULTS: A 32-year-old gravida 4, para 2 patient was transferred at 22+3 weeks after a 16-day hospitalization for pruritus and suspected intrahepatic cholestasis of pregnancy. Ursodeoxycholic acid therapy, initiated before transfer, was continued. Total serum bile acid concentrations at approximately 22+4, 24+1, 25+2, 27+4, and 29+3 weeks were 104, 94.1, 197, 164, and 300 µmol/L, respectively. At approximately 32 weeks, aspartate aminotransferase was 506 U/L, alanine aminotransferase 265 U/L, total bilirubin 9.48 mg/dL, and direct bilirubin 9.02 mg/dL. The international normalized ratio and platelet count remained preserved, with no documented hemolysis or proteinuria. Autoimmune serology and the available infectious screening were unrevealing, while serial ultrasonography, portal Doppler imaging, and magnetic resonance cholangiopancreatography showed no biliary obstruction. Progressive maternal liver dysfunction raised concern for an additional pregnancy-associated or underlying liver disorder. Following multidisciplinary assessment, cesarean delivery was performed at 32+2 weeks. A female infant weighing 1,840 g had Apgar scores of 8, 9, and 10; brief noninvasive respiratory support was required before stabilization and advancement of enteral feeding. Maternal biochemical abnormalities persisted after delivery, and the total serum bile acid concentration reached 397 µmol/L on postpartum day 35. Subsequent magnetic resonance cholangiography again showed a normal biliary tree but coarse, granular liver parenchyma. A liver biopsy approximately five months postpartum was reported as chronic active hepatitis.

CONCLUSION: Severe cholestasis presenting early in pregnancy and persisting or worsening postpartum should not

be attributed to pregnancy-specific cholestasis alone. Normal biliary imaging and negative initial serologies do not exclude chronic hepatic pathology. Close postpartum hepatology follow-up and multidisciplinary management are essential.

Keywords: case report, chronic active hepatitis, early-onset cholestasis, intrahepatic cholestasis of pregnancy, postpartum cholestasis, preterm delivery

PP-38

Prenatal diagnosis of Walker-Warburg syndrome: A case report with a compound heterozygous variant in the POMT1 gene

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INTRODUCTION: Walker-Warburg Syndrome (WWS) is a rare, genetically heterogeneous autosomal recessive alpha-dystroglycanopathy characterized by congenital muscular dystrophy, hydrocephalus, type II lissencephaly, and complex cerebellar and ocular malformations. Mutations in POMT1, POMT2, POMGNT1, FKTN, LARGE1, and FKRP disrupt alpha-dystroglycan O-mannosylation, critical for muscle, brain, and ocular development. Transvaginal neuroimaging can detect pathognomonic lissencephaly, making detailed fetal neurosonography vital for early prenatal diagnosis. Here, we present a WWS case diagnosed prenatally with severe central nervous system (CNS) anomalies and novel compound heterozygous POMT1 variants in trans-configuration.

Case Presentation: A 29-year-old pregnant woman (G3P2) was referred at 21 weeks of gestation with a preliminary diagnosis of ventriculomegaly. Detailed transvaginal neurosonography revealed a dysmorphic skull with preserved bone integrity, an open posterior fossa, absent sulcation/gyration, bilateral ventriculomegaly, a dilated third ventricle, a Z-shaped brainstem, and an unvisualized vermis—findings highly suggestive of lissencephaly. Facial evaluation demonstrated microphthalmia and hypertelorism (interocular: 12 mm, binocular: 31 mm, ocular: 8.4 mm), a depressed nasal bridge, and a flat profile. Echocardiography identified a 2.5 mm inlet ventricular septal defect (VSD). Fetal biometry and amniotic fluid volume were normal for the gestational age. Amniocentesis was performed due to multiple structural anomalies. Initial whole exome sequencing (WES) yielded no pathogenic variants directly explaining the phenotype. Consequently, a targeted genetic investigation focused on the phenotype was conducted, identifying two heterozygous variants in the POMT1 gene: a pathogenic c.162C>A p.(Tyr54Ter) variant and a likely pathogenic c.1826-2A>G (IVS18 -2A>G) variant. Parental testing confirmed both parents as heterozygous carriers, establishing that the fetus carried compound heterozygous variants in trans-position, consistent with an autosomal recessive inheritance pattern. The antenatal course was otherwise uneventful. At 37 weeks, following the detection of contractions on non-stress testing, a female infant weighing 2770 g (length: 46 cm) was delivered via cesarean section, with Apgar scores of 9 and 10 at 1 and 5 minutes, respectively. Postnatally, the infant required supportive

care in the neonatal intensive care unit for 60 days. The clinical prognosis was poor due to severe neurological impairment linked to microphthalmia and lissencephaly. Integrating the prenatal neuroimaging, molecular results, and postnatal findings, the diagnosis of WWS was confirmed.

DISCUSSION / CONCLUSION: Fetal lissencephaly accompanied by complex CNS, ocular, and facial anomalies warrants the consideration of WWS and related alpha-dystroglycanopathies in the prenatal differential diagnosis. Both POMT1 variants detected in this case are exceptionally rare in the general population. Distinguishing lissencephaly from isolated ventriculomegaly is crucial, as accurate prenatal diagnosis fundamentally guides perinatal management and parental counseling.

Keywords: Walker-Warburg Syndrome, POMT1, lissencephaly

Axial view showing a smooth brain appearance, lacking sulcal and gyral structures.



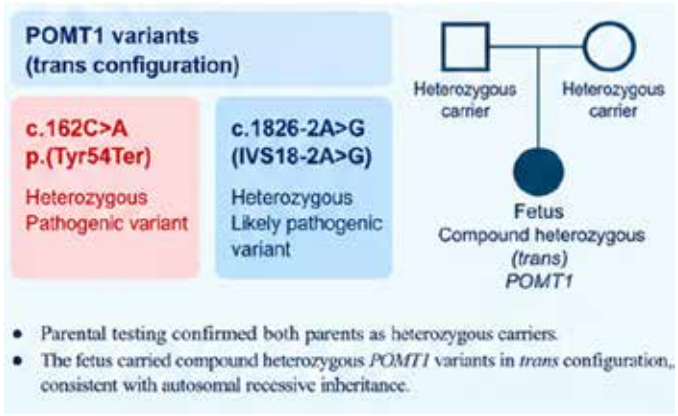
Malalignment VSD associated with WWS



Z-shaped brainstem, a pathognomonic abnormality for WWs



GENETIC FINDINGS



PP-39

Prenatal diagnosis of a de novo FGFR3 mutation by whole exome sequencing in late-detected fetal long bone shortening: a case report

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OBJECTIVE: We aimed to present the perinatal management of a case with long bone shortening detected late during routine prenatal follow-up, in whom a de novo pathogenic mutation in the FGFR3 gene was identified by whole exome sequencing (WES) performed on amniocentesis material.

METHOD: A 30-year-old primigravid woman (gravida 1, para 0) with a height of 178 cm, whose partner was 192 cm tall, was referred to our perinatology unit at 27 weeks of gestation after routine obstetric ultrasonography revealed shortening of the fetal long bones, despite normal first-trimester screening, second-trimester detailed ultrasonography, and low-risk non-invasive prenatal testing (NIPT). Detailed fetal biometry was performed, and amniocentesis was carried out for quantitative fluorescence polymerase chain reaction (QF-PCR), conventional karyotype analysis, SNP-array (chromosomal microarray), and WES.

RESULTS: Biparietal diameter (BPD), head circumference (HC), and abdominal circumference (AC) were consistent with gestational age, whereas marked shortening was observed in all long bones (right femur length [FL]: 24 weeks + 5 days, <1st percentile; left FL: 24 weeks + 6 days, <1st percentile; right humerus length [HL]: 28 weeks + 0 days, <1st percentile; left HL: 27 weeks + 5 days, <1st percentile). Foot length (55 mm) exceeded femur length (foot/femur ratio >1), and the thoracic circumference-to-abdominal circumference (TC/AC) ratio was 0.70. QF-PCR and conventional karyotype analysis were normal (46,XY), and SNP-array revealed no pathogenic copy number variants, while WES identified a de novo pathogenic point mutation in the FGFR3 gene, consistent with thanatophoric dysplasia. Following genetic counseling and parental consent, the pregnancy was terminated at 31 weeks of gestation. Postnatal examination showed macrocephaly, marked rhizomelia, and a narrow thorax (Figure 1), and postmortem skeletal radiography demonstrated short, bowed long bones, a small thoracic cage, and a relatively large skull, supporting the clinical and genetic diagnosis (Figure 2).

CONCLUSION: Disproportionate long bone shortening developing in the late trimester despite normal findings on standard prenatal ultrasonography is an important indicator of skeletal dysplasia. In this case, a foot length/femur length ratio >1 and a TC/AC ratio of 0.70 ultrasonographically supported the characteristic features of thanatophoric dysplasia. In cases where conventional cytogenetic and chromosomal microarray analyses are uninformative, WES is a critical diagnostic tool for identifying sporadic skeletal dysplasias caused by de novo mutations, such as those involving FGFR3. This case highlights that skeletal dysplasia may become apparent in advanced gestation despite normal NIPT and detailed anomaly screening results and emphasizes the importance of integrating WES into prenatal diagnostic algorithms.

Keywords: Thanatophoric dysplasia, FGFR3, whole exome sequencing, prenatal diagnosis, skeletal dysplasia, long bone shortening

Figure 1. Postnatal appearance of the fetus diagnosed with thanatophoric dysplasia following termination of pregnancy at 31 weeks of gestation.



(A) General appearance of the fetus after termination: marked macrocephaly, disproportionate shortening of the proximal extremities (rhizomelia), and a narrow trunk are noted. (B) Image obtained during cesarean delivery: the umbilical cord is clamped, and short, dysmorphic extremities are clearly visible.

Figure 2. Postmortem whole-body skeletal radiograph (babygram) of the fetus diagnosed with thanatophoric dysplasia, at 31 weeks of gestation.



The radiograph shows macrocephaly, a narrow, bell-shaped thoracic cage, telephone-receiver-shaped short and bowed femurs, and marked rhizomelia. These findings are consistent with Thanatophoric Dysplasia Type 1 due to a de novo FGFR3 mutation.

PP-40

Fetal adrenal enlargement mimicking congenital adrenal hyperplasia: a case of spontaneous resolution

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OBJECTIVE: We aimed to present a case of prenatal bilateral fetal adrenal enlargement with clitoromegaly, initially raising suspicion for congenital adrenal hyperplasia (CAH), which showed spontaneous antenatal regression and no postnatal pathology, and to highlight the importance of postnatal follow-up before establishing a definitive diagnosis.

METHOD: A 33-year-old woman (gravida 3, para 2) with parental consanguinity presented at 20 weeks of gestation for evaluation of a fetal adrenal finding. Fetal ultrasonography, fetal magnetic resonance imaging (MRI), amniocentesis with karyotype analysis, and a next-generation sequencing (NGS) panel for disorders of sex development were performed. Results Fetal ultrasonography revealed bilateral adrenal enlargement (left: 17.9x11 mm; right: 10x14 mm) (Figure 1), and adrenal cortex and medulla dimensions were measured (Figure 2). Together with clitoromegaly (Figure 3), these findings raised suspicion for CAH. Fetal MRI demonstrated nodular adrenal enlargement without T1 hyperintensity, with neuroblastoma, adrenal hemorrhage, and nodular hyperplasia included in the differential diagnosis. On follow-up ultrasonography, adrenal dimensions regressed and fetal genitalia appeared normal. Amniocentesis revealed a normal 46,XX karyotype, and the NGS panel for disorders of sex development showed no pathogenic variants, although a heterozygous TOE1 variant of uncertain significance was noted. The infant was born with fetal growth restriction; postnatal evaluation revealed no adrenal pathology, and subsequent follow-up remained normal.

CONCLUSION: Fetal adrenal enlargement with clitoromegaly may mimic CAH prenatally but can resolve spontaneously without postnatal sequelae. A multidisciplinary approach including perinatology, pediatric endocrinology, and medical genetics is essential. This case highlights the importance of postnatal follow-up before drawing definitive conclusions from prenatal imaging findings.

Keywords: Fetal adrenal enlargement, congenital adrenal hyperplasia, clitoromegaly, prenatal diagnosis, disorders of sex development, spontaneous resolution

Figure 1. Prenatal ultrasonographic images demonstrating bilateral adrenal gland enlargement. (A) Axial view showing the enlarged adrenal glands. (B) Coronal-plane evaluation of the adrenal glands with caliper measurements.



Figure 2. Ultrasonographic measurement of the adrenal cortex and medulla.



Figure 3. Ultrasonographic image demonstrating fetal clitoromegaly.



PP-41

Multiple Fetal Anomalies and an Unbalanced Chromosomal Abnormality Detected Prenatally

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OBJECTIVE: The presence of multiple fetal structural anomalies significantly increases the likelihood of an underlying chromosomal abnormality. Early recognition of characteristic anomaly patterns may facilitate timely genetic evaluation and appropriate counseling. We present a case of multiple fetal anomalies diagnosed in the first trimester, in which an unbalanced chromosomal abnormality involving chromosome 18 was identified.

METHODS: A 24-year-old gravida 3, para 1, with one living child and a history of ectopic pregnancy, was referred to the perinatology council at 14 weeks of gestation because of suspected multiple fetal anomalies. There was no parental consanguinity, known maternal disease, regular medication use, previous surgery, or relevant family history. TORCH serology was negative.

RESULTS: Ultrasonographic examination demonstrated a live singleton fetus with a CRL of 68.9 mm, corresponding to 13 weeks and 1 day of gestation. A left-sided unilateral cleft lip and palate was identified. An anterior abdominal wall defect measuring 14×8 mm was observed, with an omphalocele sac containing the liver and bowel. A septated cystic structure surrounding the fetal neck was consistent with cystic hygroma. The fetal bowel was also hyperechoic.

Given the combination of multiple structural anomalies, Medical Genetics consultation was obtained. After detailed counseling regarding invasive fetal sampling, procedural risks, and the planned genetic investigations, the patient consented to invasive testing. Karyotype analysis, QF-PCR, maternal contamination testing, and trio microarray analysis were planned, together with paired CFTR gene sequencing.

Invasive fetal sampling was performed without complications. QF-PCR showed no numerical abnormalities involving chromosomes 13, 21, X, or Y. However, a possible 2:1 ratio was detected in one marker of chromosome 18, prompting further cytogenetic evaluation. Karyotype analysis demonstrated 46,XY,der(18)t(18;?)(p11.2;?), indicating an increase involving the short arm of chromosome 18 and consistent with an unbalanced chromosomal abnormality. Parental chromosome analysis was recommended to investigate a possible balanced parental rearrangement. CFTR sequencing revealed no pathogenic or likely pathogenic variant.

Considering the severity and combination of the fetal anomalies and the anticipated poor prognosis, termination of pregnancy was recommended by the perinatology council. The patient accepted the recommendation. Genetic counseling was provided, and parental testing was planned following termination. Medical abortion was subsequently performed, and histopathological examination of the pregnancy material was consistent with hydropic abortion.

CONCLUSION: This case emphasizes that the coexistence of omphalocele, cleft lip and palate, and cystic hygroma in the first trimester should prompt comprehensive genetic evaluation, even when initial rapid aneuploidy testing is negative. The identification of an unbalanced chromosomal abnormality highlights the diagnostic value of conventional cytogenetic analysis in fetuses with multiple structural anomalies. Parental chromosome analysis is essential for detecting a possible balanced translocation and determining recurrence risk, thereby enabling accurate genetic counseling in subsequent pregnancies.

Keywords: Cystic hygroma, multiple fetal anomalies, omphalocele, prenatal diagnosis, unbalanced chromosomal abnormality

First-trimester ultrasonographic



First-trimester ultrasonographic appearance of a cystic structure surrounding the fetal neck, consistent with cystic hygroma.

First-trimester ultrasonographic



First-trimester ultrasonographic appearance of multiple fetal structural anomalies.

Macroscopic appearance of the fetus following termination of pregnancy



Prenatal ultrasonography demonstrated multiple fetal structural anomalies, including left-sided unilateral cleft lip and palate, omphalocele, and cystic hygroma.

PP-42

Unusual cardiac involvement of the donor fetus in twin-to-twin transfusion syndrome: A case report

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OBJECTIVE: Twin-to-twin transfusion syndrome (TTTS) is a serious complication of monochorionic diamniotic (MCDA) twin pregnancies resulting from unbalanced intertwin blood flow through placental vascular anastomoses. Cardiovascular involvement predominantly affects the recipient twin, whereas significant cardiac abnormalities in the donor twin are less commonly encountered. This report presents a case of Quintero stage I TTTS associated with cardiac abnormalities in the donor fetus and highlights the importance of detailed cardiac assessment of both fetuses.

METHODS: A 26-year-old primigravida with an MCDA twin pregnancy was evaluated at 19 weeks of gestation following ultrasonographic detection of an oligohydramnios–polyhydramnios sequence. Detailed obstetric ultrasonography, Doppler assessment, and fetal echocardiography were performed, followed by close fetal surveillance throughout the pregnancy.

RESULTS: At 19 weeks of gestation, the maximum vertical pocket measured 18 mm in the donor sac and 98 mm in the recipient sac. Both fetal bladders were visualized, consistent with Quintero stage I TTTS. Detailed fetal echocardiography of the donor fetus demonstrated pulmonary stenosis, tricuspid regurgitation, and right ventricular hypertrophy, as well as a hyperechogenic intracardiac focus in the left ventricle. Umbilical artery Doppler assessment showed a systolic/diastolic ratio of 3.21 and a pulsatility index of 1.16 in the donor fetus, compared with 4.32 and 1.42, respectively, in the recipient fetus. Management options, including fetoscopic laser therapy and selective feticide, were discussed with the family; however, invasive interventions were declined. During follow-up, antenatal betamethasone was administered because of threatened preterm delivery, and magnesium sulfate was given for fetal neuroprotection. At 26 weeks of gestation, deterioration in the biophysical profile and fetal well-being necessitated emergency cesarean delivery. The first neonate weighed 610 g and had 1- and 5-minute Apgar scores of 5 and 7, respectively. The second neonate weighed 640 g and had corresponding Apgar scores of 6 and 8. Postnatal cardiac evaluation confirmed the prenatally detected cardiac abnormalities in the donor twin, and both neonates were admitted to the neonatal intensive care unit.

CONCLUSION: Although cardiovascular involvement in TTTS predominantly affects the recipient twin, clinically significant cardiac abnormalities may also be detected in the donor fetus. This case underscores that cardiac abnormalities in TTTS are not restricted to the recipient twin and highlights the importance of systematic fetal echocardiographic evaluation of both fetuses, even in early-stage disease. Close fetal surveillance and multidisciplinary management remain essential, particularly when invasive fetal therapy is not performed.

Keywords: donor fetus, fetal cardiac abnormality, monochorionic diamniotic twins, pulmonary stenosis, twin-to-twin transfusion syndrome

PP-43

A Case of Trisomy 13 (Patau Syndrome) with Multiple Congenital Anomalies Diagnosed Prenatally

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Trisomy 13 (Patau syndrome) is a common autosomal aneuploidy with a severe prognosis. In a 24-year-old consanguineous pregnant woman whose first-trimester combined screening was high-risk, diagnosis was delayed to an advanced gestational age because the recommended invasive test was initially declined. Detailed ultrasonography and fetal echocardiography at approximately 24 weeks revealed an increased nuchal fold, vermian and cerebellar hypoplasia, micrognathia, bilateral hand and foot polydactyly, clinodactyly, rocker-bottom feet, a single umbilical artery, mesocardia, a hyperechogenic intracardiac focus, a persistent left superior vena cava, and a dilated coronary sinus. Karyotyping/QF-PCR from amniocentesis and cordocentesis confirmed trisomy 13; feticide followed by termination of pregnancy was performed after a council decision and parental consent. The case underscores the diagnostic value of multi-marker ultrasound findings, that young age and consanguinity do not exclude aneuploidy, and the importance of timely invasive confirmation.

INTRODUCTION: Trisomy 13 (Patau syndrome) is the third most common autosomal aneuploidy after trisomies 21 and 18, occurring in approximately 1 in 10,000–20,000 live births and most often resulting from meiotic non-disjunction, with translocation and mosaic forms being less common. Holoprosencephaly, midline facial defects, postaxial polydactyly, congenital heart disease, and severe neurodevelopmental impairment are characteristic, and postnatal survival is severely limited [1]. We present, alongside current literature, a case diagnosed at an advanced gestational age despite a high-risk first-trimester screening result, in the setting of consanguinity.

CASE REPORT: A 24-year-old woman in her second pregnancy (G2P0A1; one previous miscarriage and no living children), with consanguineous parents (the grandfathers were siblings), was evaluated. First-trimester combined (dual) screening in this pregnancy was high-risk; the recommended amniocentesis was declined by the patient. Detailed ultrasonography at approximately 24 weeks of gestation (24 weeks 4 days) revealed an increased nuchal fold (7.9 mm), vermian hypoplasia (12×7 mm), a small cerebellum (transverse cerebellar diameter below the 5th percentile, corresponding to ~22 weeks), micrognathia, bilateral hand polydactyly and clinodactyly, bilateral foot polydactyly with rocker-bottom feet, a single umbilical artery, and an incidental Phrygian cap gallbladder (a normal anatomic variant). Biometry indicated low percentiles for head circumference and biparietal diameter (2nd–8th percentile). Fetal echocardiography showed mesocardia, an abnormal cardiac axis, a hyperechogenic intracardiac focus in the left ventricle, a persistent left superior vena cava (PLSVC) with a dilated coronary sinus, and minimal pericardial effusion. Following these findings, amniocentesis and cordocentesis were performed, and karyotyping with QF-PCR was consistent with trisomy 13; the report did not specify fetal sex. Feticide followed by termination of pregnancy was performed after a multidisciplinary council decision and parental consent.

Keywords: Patau syndrome, polydacty,persistent left superior vena cava;.

figure 1



figure 2



Figure 1. Prenatal ultrasound findings at 24 weeks of gestation. (A) Cerebellar hypoplasia (transverse cerebellar diameter 2.39 cm, <5th percentile). (B) Mid-sagittal view of the posterior fossa showing vermian hypoplasia (12.3 × 7.0 mm). (C) Facial profile demonstrating micrognathia. (D) Hand with postaxial polydactyly and clinodactyly. (E) Foot with polydactyly. (F) Rocker-bottom foot. (G) Color Doppler at the level of the fetal bladder showing a single umbilical artery. (H) Gallbladder with a Phrygian cap configuration (an incidental normal variant). Figure 2. Postnatal (post-termination) gross appearance. (A) Overall view; the identifying band has been masked. (B) Hand with postaxial polydactyly. (C) Foot with polydactyly. The findings confirmed the prenatal ultrasound phenotype

PP-44

Bardet-Biedl syndrome 10 (BBS10): a prenatally diagnosed case with renal dysplasia and postaxial polydactyly

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To report a prenatal case of Bardet-Biedl syndrome 10 (BBS10) presenting with bilateral hyperechogenic enlarged kidneys and postaxial polydactyly, confirmed by a homozygous pathogenic BBS10 variant, and to discuss its diagnostic and genetic counseling implications in light of current literature.

METHOD: We describe a 22-year-old woman (gravida 3, para 2, living 2), non-consanguineous, whose previous child had a documented atrioventricular septal defect (AVSD) and postaxial polydactyly, who underwent detailed obstetric ultrasonography, amniocentesis with quantitative fluorescent polymerase chain reaction (QF-PCR), karyotyping, trio chromosomal microarray, trio ciliopathy gene panel testing, parental spinal muscular atrophy (SMA) multiplex ligation-dependent probe amplification (MLPA) testing, and multidisciplinary perinatology-genetics counseling.

FINDINGS: At 23 weeks of gestation, ultrasonography revealed bilateral hyperechogenic enlarged kidneys and bilateral hand-foot postaxial polydactyly; findings persisted on follow-up ultrasonography at 28 weeks. A ciliopathy gene panel performed on maternal peripheral blood identified a heterozygous BBS10 variant (c.931T>G; p.Ser311Ala), classified as pathogenic per American College of Medical Genetics and Genomics/ Association for Molecular Pathology (ACMG/AMP) criteria and registered as pathogenic in ClinVar. Amniocentesis karyotype and QF-PCR were normal, with no marker chromosome. The amniocentesis-derived ciliopathy panel confirmed the same variant in homozygous state, establishing a diagnosis of Bardet-Biedl syndrome 10 (MIM #615987). Parental karyotype, QF-PCR and SMA MLPA were normal, and both parents were confirmed heterozygous carriers; paternal ciliopathy panel testing was delayed due to administrative coding restrictions. Cell-free DNA screening had additionally identified an incidental, unrelated 606-kb variant of uncertain significance at Xq13.3. Following two sequential multidisciplinary counseling sessions, the family was informed of the likely poor fetal prognosis and elected termination of pregnancy, performed at 33 weeks 1 day of gestation.

CONCLUSION: This case illustrates the diagnostic value of trio ciliopathy gene panel testing in confirming a prenatal diagnosis of BBS10 when classic postnatal clinical criteria cannot yet be applied. The co-occurrence of a prior sibling's cardiac and polydactyly findings with the current pregnancy's renal and limb anomalies underscores the importance of considering recessive ciliopathy spectrum disorders, including phenotypic overlap with McKusick-Kaufman syndrome, in families with recurrent multisystem congenital anomalies. Since renal involvement in BBS may escape prenatal ultrasound detection in a substantial proportion of cases, molecular confirmation remains essential for accurate prognostication, recurrence-risk counseling (25% for future pregnancies) and multidisciplinary family counseling.

Keywords: Bardet-Biedl syndrome, BBS10, postaxial polydactyly

figure 1

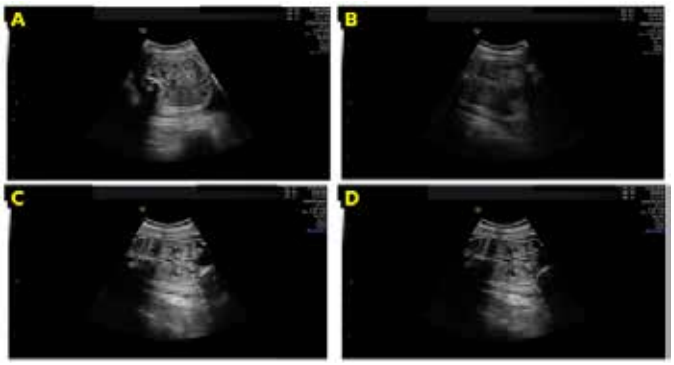


Figure 1. Prenatal ultrasonographic images (A-D) obtained on the day of pregnancy termination (33 weeks 1 day of gestation), showing bilaterally enlarged, diffusely hyperechogenic kidneys with loss of corticomedullary differentiation and multiple punctate cystic foci, consistent with the cystic-dysplastic renal phenotype reported in BBS10.

figure 2



Figure 2. Postmortem fetal examination photographs demonstrating postaxial polydactyly. (A) Bilateral hexadactyly of the feet. (B) Right hand held at the wrist, showing a rudimentary postaxial accessory digit on the ulnar border, consistent with the previously documented right-hand postaxial polydactyly.

PP-45

Progression from unilateral mild ventriculomegaly to bilateral severe fetal hydrocephalus: a prenatal diagnosis case

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Abstract To report a prenatal case in which mild ventriculomegaly, unilateral at presentation, progressed within four weeks to bilateral severe fetal hydrocephalus, accompanied by a persistent right umbilical vein (PRUV), an increased nuchal fold, nasal bone hypoplasia and mild cardiovascular findings, and to discuss the diagnostic and counseling implications when invasive testing is declined, in light of current literature.

METHOD: We describe a 21-year-old woman (first pregnancy), with no relevant medical history and no consanguinity, who underwent serial obstetric ultrasonography, fetal echocardiography, fetal magnetic resonance imaging (MRI) and multidisciplinary perinatology-pediatric neurology counseling. Combined first-trimester screening had shown a low-risk result (1/10000). Lateral ventricular atrial diameter was measured in the transventricular axial plane and nasal bone length in the mid-sagittal facial profile.

FINDINGS: At 23 weeks of gestation, ultrasonography showed mild ventriculomegaly of the right lateral ventricle (atrial diameter 10.58 mm), whereas the left atrial diameter was 9.65 mm, below the 10 mm threshold; the finding was therefore unilateral at presentation. The corpus callosum was intact in the mid-sagittal plane, excluding callosal agenesis. The same examination demonstrated a PRUV, a nuchal fold of 6.10 mm and a hypoplastic nasal bone of 5.05 mm (<1st percentile), while the cisterna magna (7.49 mm) and transverse cerebellar diameter (24.68 mm) were normal and fetal echocardiography was normal. Follow-up at 27 weeks showed progression to severe ventriculomegaly (right atrial diameter 16 mm, then 23 mm bilaterally within the same gestational week), dilation of the third ventricle and frontal horns, mild aortic root dilation and flow aliasing at the ductus arteriosus on the three-vessel-trachea view. Fetal MRI at 28 weeks confirmed dilated lateral ventricles (right posterior horn 21 mm, left 18 mm), posteriorly compressed brain parenchyma, a mega cisterna magna variant and mildly delayed sulcation. A second pediatric neurology consultation raised suspicion of aqueductal stenosis. The patient declined amniocentesis, precluding cytogenetic or molecular confirmation. Following multidisciplinary counseling, the family elected to terminate the pregnancy.

CONCLUSION: This case illustrates that apparently isolated, unilateral mild ventriculomegaly can be a dynamic finding that becomes bilateral and progresses to severe hydrocephalus within a few weeks; unilateral presentation did not predict a benign course, and close serial follow-up is therefore essential. Documenting an intact corpus callosum favored an obstructive mechanism. The co-occurrence of a PRUV, an increased nuchal fold, nasal bone hypoplasia and evolving cardiovascular findings underlines the importance of integrated interpretation of soft markers and structural findings rather than assessment of ventricular size alone. When invasive diagnostic testing is declined, the etiological classification of ventriculomegaly (chromosomal, monogenic/syndromic or isolated structural) remains uncertain, and this uncertainty should be communicated transparently to the family.

Keywords: ventriculomegaly,fetal hydrocephalus, PRUV

figure 1

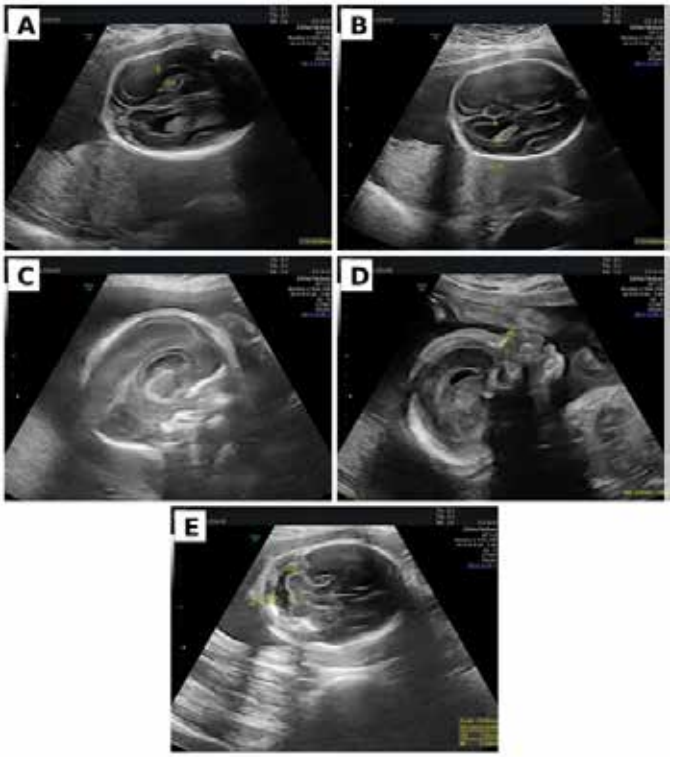


Figure 1. Ultrasonographic findings at 23 weeks 1 day of gestation. (A) Transventricular axial plane: right lateral ventricular atrial diameter 10.58 mm, above the 10 mm threshold and consistent with mild ventriculomegaly. (B) Same session, contralateral measurement: left atrial diameter 9.65 mm, below the 10 mm threshold, so the finding was unilateral at presentation. (C) Midsagittal plane: the corpus callosum is intact, arching over the cavum septi pellucidi; callosal agenesis was excluded. (D) Mid-sagittal facial profile: nasal bone 5.05 mm (<1st percentile), assessed as hypoplastic. (E) Transcerebellar axial plane: nuchal fold 6.10 mm; transverse cerebellar diameter 24.68 mm and cisterna magna 7.49 mm were within normal limits.

figure 2



Figure 2. Color Doppler studies at 23 weeks. (A) Axial abdominal plane showing the umbilical venous system, consistent with a persistent right umbilical vein; the stomach and portal sinus are seen in the same plane. (B) Fetal heart (B-mode left, color Doppler of the same plane right): the great vessels and outflow tracts were assessed, with high-velocity flow reaching the upper limit of the color scale in the central vessel. The cardiac findings of the case were mild aortic root dilation and flow aliasing at the ductus arteriosus on the three-vessel-trachea view.

PP-46

Mosaic trisomy 20 with progressive cerebellar growth restriction, talipes equinovarus and single umbilical artery: a prenatal diagnosis case

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Abstract To report a rare prenatal case of Level III mosaic trisomy 20 associated with progressive cerebellar growth restriction, corpus callosum involvement, talipes equinovarus and single umbilical artery (SUA), and to discuss its diagnostic and counseling implications in light of current literature.

METHOD: We describe a 42-year-old woman (gravida 2, para 1, living 1), with a non-consanguineous marriage, who underwent detailed obstetric ultrasonography, amniocentesis with conventional karyotyping and quantitative fluorescent polymerase chain reaction (QF-PCR), fetal magnetic resonance imaging (MRI), multidisciplinary perinatology-genetics counseling, and placental histopathological examination after termination of pregnancy.

FINDINGS: At 22 weeks of gestation, ultrasonography revealed SUA, right-sided talipes equinovarus and a transverse cerebellar diameter (TCD) of 21.4 mm, above the 1st percentile threshold of the reference chart in use (19.47 mm at this gestational age) and therefore interpreted as borderline rather than hypoplastic; fetal echocardiography was normal. Amniocentesis performed at the same gestational age showed a karyotype of 47,+20[5]/46,[84]: trisomy 20 was detected in 5 of 89 metaphase cells, confirmed in 2 of 3 independent culture flasks, consistent with Level III mosaicism. QF-PCR was normal and no additional marker chromosome was found, as chromosome 20 falls outside standard rapid-screening panels. Serial biometry then documented progressive cerebellar growth restriction: TCD was 25.08 mm at 27 weeks, falling below the 1st percentile for the first time, and 29.6 mm at 29 weeks 3 days, corresponding to a gestational-age equivalent of 25 weeks 6 days, with a normal cisterna magna (6.81 mm). Between 22 and 27 weeks the TCD increased by approximately 0.74 mm per week, well below the reported normal rate of about 1.3 mm per week, and the gestational-age equivalent lag widened from roughly one to four weeks. Talipes equinovarus and SUA persisted throughout. Fetal MRI corroborated the cerebellar findings, a corpus callosum length near the lower limit of normal, right talipes equinovarus and SUA. After multidisciplinary counseling, the pregnancy was terminated; placental histopathology confirmed a two-vessel umbilical cord consistent with SUA.

CONCLUSION: Level III mosaic trisomy 20, confirmed in independent cell cultures, indicates a high probability of true fetal mosaicism rather than a culture artefact and, in this case, was associated with a distinct multisystem phenotype rarely reported in combination. The cerebellar abnormality would have been missed on a single second-trimester measurement: it was established by serial biometry, as a normal-range diameter at 22 weeks crossed below the 1st percentile by 27 weeks with a widening gestational-age lag. The co-occurrence of central nervous system, musculoskeletal and vascular anomalies should prompt comprehensive cytogenetic evaluation beyond rapid aneuploidy screening, since standard QF-PCR panels do not cover chromosome 20. Multidisciplinary counseling and multimodal confirmation, including serial ultrasound, MRI and histopathology, are essential for accurate prognostication and family counseling.

Keywords: Mosaic trisomy 20,talipes equinovarus,

figure 1

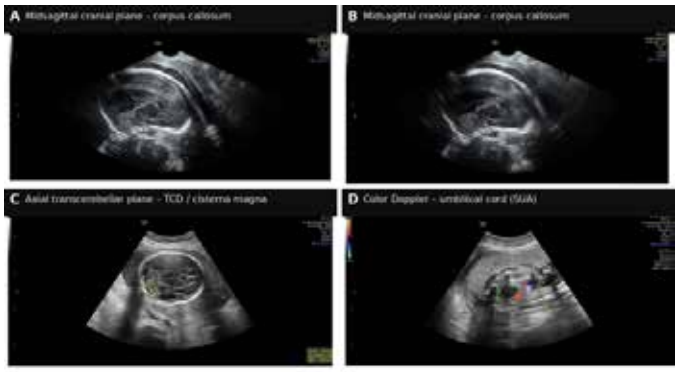


Figure 1. Prenatal sonographic findings - mosaic trisomy 20 (GA 29w3d; anonymized)

Figure 1. Prenatal sonographic findings at 29 weeks 3 days of gestation (patient identifiers removed). (A, B) Midsagittal transcranial planes demonstrating a continuous, intact corpus callosum of relatively reduced length, with no evidence of complete or partial agenesis. (C) Axial transcerebellar plane: transverse cerebellar diameter 29.6 mm, corresponding to a gestational-age equivalent of 25 weeks 6 days (<1st percentile for actual gestational age); cisterna magna 6.81 mm, within normal limits, arguing against a Dandy-Walker-spectrum malformation. (D) Color Doppler of the umbilical cord demonstrating a two-vessel cord, consistent with single umbilical artery, later corroborated by placental histopathology.

PP-47

Unexpected cause of postpartum urinary retention: A bladder stone

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OBJECTIVE: Postpartum urinary retention (PPUR) is a condition frequently encountered in the early postpartum period, with an incidence ranging from 0.05% to 37%. It typically develops due to functional causes such as transient detrusor muscle damage, regional anesthesia, or birth trauma. In this case, we present a rare instance of a bladder stone that led to postpartum persistent PPUR, which was masked among pregnancy-related non-specific lower urinary tract symptoms. By presenting this case, we aim to emphasize the crucial importance of early imaging to exclude mechanical pathologies in cases of prolonged urinary retention.

CASE REPORT: A 30-year-old primiparous patient was recatheterized at the postoperative 5th hour due to the inability to void spontaneously after an elective cesarean delivery under epidural anesthesia. Because of recurrent failed de-catheterization attempts during the following days, the patient refused intermittent catheterization (ICC) and was followed up with an indwelling Foley catheter for 1 month. Although spontaneous micturition was achieved after the removal of the catheter, the patient applied to our outpatient clinic with persistent complaints of straining, frequency, and a feeling of incomplete emptying.

The patient's medical history revealed mild voiding dysfunction prior to pregnancy that did not affect her quality of life, and a single Staphylococcus hominis urinary tract infection treated with nitrofurantoin during the first trimester. In the outpatient evaluation, the urine culture was negative. Urinary ultrasonography (USG) revealed a 26 mm calculus inside the bladder and 160 ml of post-void residual urine (PVR).

Cystoscopy was performed under general anesthesia, and the stone was completely fragmented and cleared using a holmium laser lithotriptor. Stone analysis confirmed a mixed structure of calcium oxalate monohydrate and struvite. The catheter was removed at the postoperative 2nd hour, and the patient voided spontaneously without difficulty. At the postoperative 2nd week and 3rd month follow-ups, the clinical symptoms resolved completely, and PVR values decreased to 35 ml and 15 ml, respectively.

CONCLUSION: Current guidelines for managing PPUR do not prioritize routine early imaging, considering the accuracy of USG measurements controversial due to the enlarged uterine size in the early postpartum period. However, urolithiasis during pregnancy can be overlooked in up to 30% of cases as it mimics non-specific pregnancy symptoms. In this

case, it is considered that recurrent infection and prolonged catheterization contributed to the growth of the stone. In PPUR cases that do not show spontaneous resolution within the first 72 hours or are resistant to recurrent catheterization, excluding mechanical obstruction causes such as bladder stones with a non-invasive USG is critical to prevent prolonged bladder damage and maternal-infant bonding issues.

Keywords: Pregnancy, Bladder stone, Postpartum urinary retention

PP-48

Cervicovaginal Agenesis Presenting with Hematometra and Hematosalpinx in an Adolescent with Down Syndrome: A Rare Case Report

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Cervicovaginal agenesis is an extremely rare Müllerian duct anomaly characterized by congenital absence of the cervix and/or vagina despite the presence of a functional uterus. Patients typically present during adolescence with cyclic pelvic pain and obstructive menstrual symptoms resulting from retained menstrual blood. Delayed diagnosis may lead to hematometra, hematosalpinx, endometriosis, pelvic inflammation, and impaired reproductive outcomes. The coexistence of cervicovaginal agenesis with Down syndrome is exceptionally uncommon, making diagnosis and management particularly challenging. We present the surgical management of a 12-year-old girl with Down syndrome who presented with obstructive genital tract anomaly complicated by hematometra and hematosalpinx. A 12-year-old girl with Down syndrome presented with persistent lower abdominal pain. Her medical history was significant for aortic valve insufficiency and a spontaneously closed ventricular septal defect. Based on the initial physical examination, imperforate hymen was considered the leading diagnosis, and an examination under general anesthesia was planned. Preoperative magnetic resonance imaging demonstrated a 7-cm cavity containing dense fluid at the level of the lower uterine segment. The findings initially suggested vaginal agenesis with associated hematosalpinx. In addition, inflammatory changes were observed in the fatty planes surrounding the uterus and fallopian tubes, raising concern for ongoing pelvic inflammation secondary to long-standing obstruction. Intraoperatively, transabdominal ultrasonography and detailed perineal examination revealed a blind-ending vagina. The lower uterine segment and cervical canal were markedly distended with retained blood, consistent with hematometra. The fibrous tissue separating the perineum from the cervix measured approximately 38 mm, confirming complete cervicovaginal obstruction. Considering the anatomical findings, the extensive distance between the perineum and the cervix, and the presence of inflammatory changes, reconstructive surgery was considered technically unsuitable with a high risk of failure and postoperative complications. Following multidisciplinary discussion and intraoperative assessment, supracervical hysterectomy with bilateral salpingectomy was performed. The procedure was completed without intraoperative complications. Because of her underlying congenital cardiac disease, the patient was admitted to the pediatric intensive care unit for

overnight postoperative monitoring. She resumed oral intake and mobilization without difficulty and was discharged home on postoperative day four in good clinical condition. Cervicovaginal agenesis represents one of the rarest obstructive Müllerian anomalies and often requires individualized surgical management. While uterovaginal reconstructive procedures may be considered in selected patients, successful reconstruction depends on favorable anatomy, adequate cervical development, and the possibility of establishing a functional outflow tract. In cases with complete obstruction, a long fibrous segment between the cervix and perineum, and evidence of chronic inflammation, definitive surgical treatment may provide the safest therapeutic option. This case also emphasizes the importance of comprehensive intraoperative evaluation. Although preoperative imaging suggested vaginal agenesis, the definitive diagnosis and optimal surgical strategy were established only after combining transabdominal ultrasonography with detailed examination under anesthesia. In selected patients with unfavorable anatomy and advanced obstructive complications, supracervical hysterectomy with bilateral salpingectomy may represent a safe and effective treatment. This rare case highlights the complexity of managing obstructive Müllerian anomalies in patients with Down syndrome and associated congenital cardiac abnormalities, emphasizing the importance of a multidisciplinary approach.

Keywords: Cervicovaginal agenesis, Down syndrome, Supracervical hysterectomy

Perop



PP-49

Multidisciplinary managment of a pregnancy complicated by concomitant Guillian-Barre Syndrome and superimposed preeclampsia: A rare case report

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OBJECTIVE: Pregnancies complicated by Guillain–Barré syndrome (GBS) are rare, and their coexistence with superimposed preeclampsia presents significant diagnostic and therapeutic challenges. We aimed to present the multidisciplinary management of a pregnant woman with GBS, type 2 diabetes mellitus, and hypothyroidism who developed superimposed preeclampsia, with particular emphasis on magnesium sulfate-associated respiratory depression.

METHODS: A 36-year-old pregnant woman with a history of Guillain–Barré syndrome (GBS), hypothyroidism, and type 2 diabetes mellitus was hospitalized on multiple occasions throughout her pregnancy for close maternal and fetal monitoring because of superimposed preeclampsia. At 27 weeks of gestation, a complete course of antenatal corticosteroids was administered, and 24-hour urinary protein excretion was measured at 7723 miligram(mg). Following cardiology consultation, antihypertensive therapy was initiated and adjusted, and the patient was managed through a multidisciplinary approach. Because of severe hypertension refractory to medical treatment, an emergency cesarean delivery was performed at 35 weeks and 6 days of gestation.

RESULTS: Magnesium sulfate was administered as a loading dose followed by a maintenance infusion of 2 gram/hour. A live female infant weighing 2.915 gram(g) was delivered by cesarean section, with Apgar scores of 6 and 9 at 1 and 5 minutes, respectively. The patient was transferred to the intensive care unit for close postoperative monitoring. Respiratory depression developed during the eighth hour of magnesium sulfate infusion, necessitating immediate discontinuation of treatment. After stabilization of blood pressure and blood glucose levels, the patient was discharged on postoperative day 4 with scheduled outpatient follow-up in the cardiology, neurology, and endocrinology clinics.

Keywords: Guillain–Barré syndrome, superimposed preeclampsia,pregnancy

PP-50

Incarceration of a pedunculated uterine fibroid in an umbilical hernia

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Uterine fibroids are common benign tumors that may cause an umbilical hernia in patients with increased intra-abdominal pressure due to pregnancy, obesity, ascites, and intra-abdominal tumors. However, the simultaneous occurrence of uterine fibroids and umbilical hernias, or fibroids and an associated umbilical hernia, during pregnancy has rarely been reported. Here, we present the case of a fibroid presenting as an incarcerated umbilical hernia in a pregnant patient.The herniation can cause rupture, strangulation, and, in rare cases, incarceration. Incarceration requires surgical repair of the hernia, and accounts for 10% to 20% of all operative cases.

A 33-year-old 20 week pregnant woman presented with a palpable, painful mass in the umbilical region that had been present for 3 days. She had no symptoms suggestive of intestinal obstruction, such as nausea, vomiting, or abdominal distension. She had not undergone any abdominal surgical treatment, which ruled out the possibility of umbilical herniation as a postoperative complication. Although her body mass index was 28 kg/cm2, her general condition was good. Physical examination revealed a goose egg-sized firm, movable, and nontender mass in an umbilical lesion, without any surrounding inflammation. The initial laboratory results showed normal values. Abdominal ultrasound showed an 27,7x35,9x36 mm oval, hypoechogenic mass within the umbilical sac, connected to an intra-abdominal mass with a 30 mm umbilical fascial defect.Intraoperative findings showed an umbilical hernia sac containing an approximately 3 cm × 3 cm pedunculated fibroid, with the short stalk measuring 1 cm×1 cm, which was the umbilical defect.Umblical defect operation done by general surgeon.After operation pregnancy follow up.

Incarceration of uterine fibroids in an umbilical hernia is a rare complication that has mostly been reported in pregnant women. In 1999, the first case of pedunculated fibroid incarceration in an umbilical hernia in a pregnant woman was reported [. A fibroid uterus is typically too small to reach the level of the umbilicus, and the intra-abdominal pressure is too low to cause herniation. Consequently, all reported cases of incarceration of an umbilical hernia occurred during pregnancy, especially in the third trimester, after 28 weeks of gestation.

In conclusion, increased intra-abdominal pressure in pregnancy due to a huge fibroid may contribute to the herniation of the fibroid through the umbilicus.

Keywords: Hernia, Incarceration, Pregnancy

PP-51

When an Incidental Adnexal Mass Is Not What It Seems: A Non-Functioning Ovarian Steroid Cell Tumor in a Postmenopausal Woman

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INTRODUCTION: Ovarian steroid cell tumors (SCTs) are exceptionally rare sex cord–stromal neoplasms, accounting for less than 0.1% of all ovarian tumors. The majority are classified as steroid cell tumors, not otherwise specified (SCT-NOS), and are typically associated with steroid hormone production, particularly hyperandrogenism. However, up to one-quarter of reported cases may lack overt endocrine manifestations, especially in postmenopausal women, making preoperative diagnosis particularly challenging. In these patients, imaging findings and serum tumor markers are frequently nonspecific, and definitive diagnosis largely depends on histopathological and immunohistochemical evaluation. We report an incidentally detected ovarian steroid cell tumor in a postmenopausal woman and discuss the diagnostic challenges associated with this uncommon clinical presentation.

CASE PRESENTATION: A 59-year-old postmenopausal woman presented with complaints of urge urinary incontinence and pelvic organ prolapse. Gynecological examination demonstrated a stage II cystorectocele. Transvaginal ultrasonography incidentally revealed a 2-cm cystic lesion in the right ovary. Her medical history was notable for hypertension, diabetes mellitus, and hyperlipidemia. She denied symptoms suggestive of androgen excess, including hirsutism or virilization, and no clinical evidence of hyperandrogenism was observed on physical examination. Preoperative serum tumor markers, including CA-125, CA 15-3, and CA 19-9, were within normal limits.

The patient underwent total laparoscopic hysterectomy with bilateral salpingo-oophorectomy in combination with anterior and posterior colporrhaphy. Histopathological examination demonstrated a well-circumscribed 1.7-cm sex cord–stromal tumor confined to the right ovary with an intact capsule. No mitotic activity, nuclear atypia, or necrosis was identified. Immunohistochemical analysis revealed positivity for SF-1, inhibin-α, calretinin, and Melan-A, whereas EMA, PAX8, and cytokeratin were negative, confirming the diagnosis of an ovarian steroid cell tumor. The patient was subsequently scheduled for close clinical follow-up.

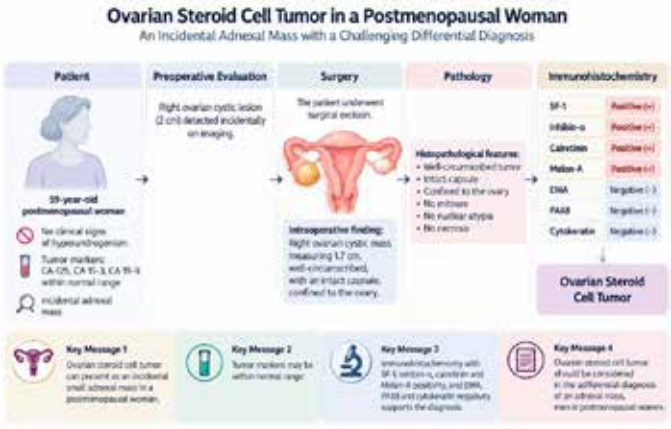
DISCUSSION: Steroid cell tumors classically present with manifestations of androgen excess, whereas hormonally silent lesions remain uncommon and constitute an important

diagnostic pitfall. The absence of endocrine symptoms, together with normal serum tumor markers and nonspecific imaging findings, may obscure the diagnosis until definitive pathological evaluation is performed. In postmenopausal women, the differential diagnosis includes epithelial ovarian neoplasms, particularly clear cell carcinoma, as well as other sex cord–stromal tumors such as Sertoli–Leydig cell tumors and adult granulosa cell tumors. In this setting, the integration of characteristic histomorphological findings with an appropriate immunohistochemical panel is essential for establishing the correct diagnosis. Furthermore, tumor size and histopathological characteristics are considered major determinants of biological behavior. Features associated with malignant potential include tumor size greater than 7 cm, increased mitotic activity, nuclear atypia, necrosis, and hemorrhage. In contrast, the present case demonstrated none of these adverse pathological features, suggesting a favorable prognosis; nevertheless, continued surveillance remains appropriate because the biological behavior of ovarian steroid cell tumors is not always predictable.

CONCLUSION: Although exceedingly rare, ovarian steroid cell tumors should be considered in the differential diagnosis of incidentally detected adnexal masses in postmenopausal women, even in the absence of endocrine manifestations or abnormal tumor markers. Careful histopathological assessment supported by an appropriate immunohistochemical panel is essential for establishing an accurate diagnosis and guiding appropriate postoperative management.

Keywords: Adnexal Mass, Differential Diagnosis, Immunohistochemistry, Ovarian Steroid Cell Tumor, Postmenopausal Woman

Graphical Abstract of an Ovarian Steroid Cell Tumor Case



PP-52

Cold agglutinin disease presenting with fetal tachycardia and resistant fever: A case report

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OBJECTIVE: Cold agglutinin disease (CAD) is a rare form of autoimmune hemolytic anemia (AIHA) caused by IgM antibodies that bind to red blood cells at low temperatures. Physiological immune alterations during pregnancy can mask or exacerbate autoimmune conditions, complicating the diagnostic process. In this report, we present a rare case of CAD diagnosed in the early postoperative period following an emergency cesarean section performed for fetal distress.

METHOD: A 19-year-old primigravida at 35+3 weeks of gestation was admitted with high fever (41°C) and fetal tachycardia (205 bpm). Despite aggressive intravenous hydration and antipyretic therapy, the fever remained refractory. Obstetric ultrasonography and non-stress test (NST) revealed persistent signs of fetal distress. Due to the lack of response to medical treatment and ongoing fetal compromise, an emergency cesarean section was performed. No significant intra-abdominal or uterine bleeding was observed intraoperatively. At the 6th postoperative hour, the patient's fever spiked again to 40.5–41°C. Hemoglobin (Hb) levels were repeatedly measured at 5.8 g/dL across three consecutive samples. Although clinically stable, the patient was transfused with 3 units of packed red blood cells (pRBC) and fresh frozen plasma (FFP). However, the expected post-transfusion increment in hemoglobin levels was not achieved. A hematology consultation was requested.

RESULTS: Upon notification by nursing staff that blood samples clotted immediately after venipuncture, the hematologist advised transferring the samples directly into hemogram tubes pre-warmed and maintained at 37°C. The complete blood count (CBC) performed using this warm-sample protocol revealed a true Hb level of 13.3 g/dL. Suspecting CAD, further diagnostic workup was initiated. The patient was transferred to a tertiary university hospital, where comprehensive hematological evaluation confirmed the diagnosis of cold agglutinin disease. With appropriate targeted management and thermal protection protocols, the patient's clinical status normalized, and she was safely discharged.

CONCLUSION: This case highlights the diagnostic challenge of rare autoimmune hematological disorders in obstetric emergencies. Cold-induced erythrocyte agglutination can lead to artifactual lab results, falsely low hemoglobin values, and inappropriate transfusion management. Clinicians facing refractory fever, unexplained anemia, or lack of response to

transfusion should consider pre-analytical sample handling errors caused by cold agglutinins. Early multidisciplinary collaboration between obstetricians and hematologists is critical for accurate diagnosis and optimal maternal-fetal outcomes.

Keywords: Autoimmune hemolytic anemia, Cesarean section, Cold agglutinin disease, Fetal distress, Pregnancy

PP-53

Pregnancy in the contralateral uterine cavity despite intrauterine device use in previously unrecognized uterus didelphys: A case report

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OBJECTIVE: Uterus didelphys is a congenital Müllerian anomaly resulting from complete failure of Müllerian duct fusion and is characterized by two separate uterine cavities, usually accompanied by duplication of the cervix. Although it may remain clinically silent, failure to recognize duplicated uterine anatomy may have important implications for both obstetric and contraceptive management. We present an unusual case of a viable pregnancy developing in one uterine cavity while an intrauterine device (IUD) remained appropriately positioned in the contralateral cavity, ultimately leading to the diagnosis of previously unrecognized uterus didelphys.

METHODS: A 27-year-old gravida 2, para 1 woman presented with persistent vaginal spotting and concern regarding possible IUD displacement. Her previous pregnancy had been routinely followed, including detailed fetal ultrasonographic examination, without recognition of a maternal uterine anomaly. At 39 weeks of gestation, cesarean delivery was performed for breech presentation with fetal head hyperextension, resulting in the birth of a healthy infant. No Müllerian anomaly had previously been documented. Four months postpartum, an IUD was inserted at an outside institution without recognition of duplicated uterine or cervical anatomy. Five months after insertion, persistent spotting prompted transvaginal ultrasonography to evaluate IUD localization, followed by speculum examination.

RESULTS: Transvaginal ultrasonography demonstrated two separate uterine cavities. One cavity contained a viable intrauterine pregnancy at 6 weeks and 2 days of gestation with positive fetal cardiac activity, whereas the IUD was visualized in an appropriate intracavitary position within the contralateral uterus. Speculum examination subsequently demonstrated two distinct cervices, and the combined findings were consistent with uterus didelphys. Thus, the presentation initially suspected to represent IUD displacement revealed an unintended pregnancy in the non-IUD-containing uterine cavity despite appropriate positioning of the device in the opposite cavity. The Müllerian anomaly had remained unrecognized throughout a previous term pregnancy, cesarean delivery, postpartum care, and subsequent IUD insertion. Following counseling regarding the diagnosis and available pregnancy options, the patient elected termination of the pregnancy based on her reproductive preferences, considering the short interpregnancy interval and having a nine-month-old infant.

CONCLUSION: This case illustrates an uncommon but clinically important mechanism of apparent contraceptive failure caused by previously unrecognized duplicated uterine anatomy. Correct positioning of an IUD in one uterine cavity cannot be assumed to provide contraceptive protection to a completely separate contralateral cavity. Furthermore, a previous uncomplicated term pregnancy or cesarean delivery does not exclude an undiagnosed Müllerian anomaly. Recognition of duplicated cervical or uterine anatomy should prompt systematic assessment of the reproductive tract before intrauterine contraception is selected. When a Müllerian anomaly is identified, contraceptive counseling should be individualized according to uterine anatomy rather than assuming that conventional single-cavity IUD placement provides adequate protection. Persistent abnormal bleeding after IUD insertion should also prompt reassessment of both device location and uterine anatomy. This case highlights the importance of anatomical awareness during reproductive care and demonstrates how an unrecognized congenital anomaly may result in unintended pregnancy despite apparently appropriate IUD placement.

Keywords: uterus didelphys, Müllerian anomaly, intrauterine device, unintended pregnancy, contraceptive failure

CERVIKS PHOTO



USG FKA (+) CRL PHOTO



USG RIA PHOTO



PP-54

Progressive fetal hydrops associated with critical aortic stenosis and trisomy 21: a case report

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BACKGROUND: Trisomy 21 is strongly associated with congenital heart disease, with atrioventricular septal defect and ventricular septal defect among the most frequently reported cardiac abnormalities in affected fetuses. (1,2) Critical aortic stenosis is a rare but potentially severe congenital cardiac lesion that may progress during gestation and lead to left ventricular dysfunction and fetal heart failure. (3,4) Severe fetal aortic stenosis may result in hydrops fetalis, particularly when significant cardiac dysfunction develops. (4,5) We present a fetus with trisomy 21 who developed progressive cardiac abnormalities, critical aortic stenosis, severe hydrops fetalis, and ultimately intrauterine fetal demise.

CASE: A 24-year-old gravida 3, para 2 woman with two previous cesarean deliveries and a first-degree consanguineous marriage presented for routine ultrasonographic examination at 17 weeks of gestation. Ultrasound examination revealed increased nuchal fold thickness, a dextroposed aorta, a large ventricular septal defect, abnormal cardiac offset at the level of the crux, and pericardial effusion. The patient was counseled regarding the possibility of an underlying genetic disorder, and amniocentesis was recommended; however, she initially declined invasive genetic testing. At 24 weeks of gestation, follow-up ultrasonography demonstrated critical aortic stenosis, bilateral pleural effusions (Figure 1), generalized subcutaneous edema, and ascites, consistent with fetal hydrops. The option of pregnancy termination was discussed, but the patient declined. Amniocentesis was subsequently performed for genetic evaluation, and polymerase chain reaction analysis was compatible with trisomy 21. Fetal thoracentesis was performed to drain the pleural effusions (Figure 2). At 27 weeks of gestation, the patient presented with absent fetal movements. Ultrasound examination confirmed absent fetal cardiac activity and severe hydrops fetalis, consistent with intrauterine fetal demise. Delivery following intrauterine fetal demise was performed by repeat cesarean section under spinal anesthesia because of her history of two previous cesarean deliveries. A 1470-g stillborn female fetus was delivered (Figure 3). The postoperative course was uneventful, and the patient was discharged in good condition. Written informed consent was obtained from the patient for publication of the clinical information and photographs.

CONCLUSION: This case demonstrates the rapid progression of severe fetal cardiac disease to hydrops fetalis and intrauterine fetal demise in a fetus with trisomy 21. Serial fetal echocardiographic assessment is important when complex cardiac abnormalities are detected early in gestation, as the severity of aortic stenosis and cardiac dysfunction may progress during pregnancy. (3,4) Early genetic evaluation may provide important information for parental counseling and pregnancy management. In selected fetuses with critical aortic stenosis and hydrops, fetal aortic valvuloplasty may be considered in experienced fetal cardiac centers. (5,6)

Keywords: Trisomy 21, Critical aortic stenosis, Fetal hydrops, Congenital heart disease, Intrauterine fetal demise

Figure 1



Bilateral pleural effusions in the fetus at 24 weeks of gestation.

Figure 2



Fetal thoracic appearance after thoracentesis.

Figure 3



Postmortem appearance of the hydropic fetus, demonstrating generalized subcutaneous edema.

PP-55

Advanced-stage ovarian anaplastic carcinomatous mural nodule arising in an intact ovarian mucinous neoplasm: A case report

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INTRODUCTION: Primary anaplastic carcinomatous mural nodules in ovarian mucinous tumors represent an ultra-rare histotype, accounting for less than 1% of all mucinous ovarian neoplasms, with fewer than 50 well-documented cases reported in global literature. Differentiating true anaplastic carcinoma from non-neoplastic Sarcoma-Like Mural Nodules (SLMNs) is critical, as their prognoses are completely different. We report an advanced-stage case which has a pleomorphic anaplastic carcinomatous mural nodule with microscopic capsular invasion and occult omental metastasis despite an intact primary ovarian capsule.

CASE PRESENTATION: A 68-year-old postmenopausal woman (G3P3 all c-section) with medical history of cardiac arrhytmia and hypertension presented with a three-month history of progressive abdominal distension and pelvic pain. Preoperative biomarkers revealed normal CA125 (33 U/mL), CEA (0.69 ng/mL), CA15-3 (12.2 U/mL), and mildly elevated CA19-9 (43 U/mL) levels. Magnetic resonance imaging demonstrated an 11 cm heterogeneous adnexal mass, radiologically interpreted as serous cystadenocarcinoma. Midline laparotomy revealed an intact left adnexal mass comprising a 10 cm cystic structure and an adjacent 6 cm solid mural nodule. Complete cytoreductive staging surgery was achieved. Histopathology confirmed a background mucinous cystadenoma containing a pleomorphic anaplastic carcinomatous mural nodule with focal sarcomatoid features. Microscopic examination demonstrated direct capsular invasion to the inked outer margin, lymphovascular space invasion (LVI), atypical peritoneal cytology, and microscopic omental metastasis. IHC panel confirmed epithelial origin (Pancytokeratin+, LMWCK+, patchy EMA+)(Figure 1,2,3) with focal sarcomatoid transition (Vimentin+, patchy CD10+, patchy p53+), while ruling out primary sarcomas, high-grade serous, clear cell, mesothelial, and germ cell malignancies.

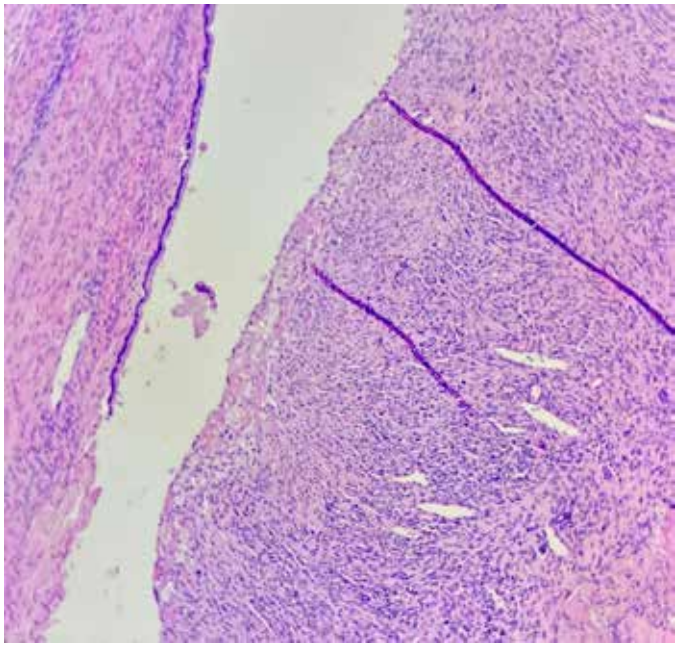
DISCUSSION: We present this case to contribute crucial diagnostic and prognostic notion into an exceptionally rare malignancy that is frequently misdiagnosed due to misleading imaging and non-specific biomarkers. Our case expands current understanding by proving that anaplastic carcinomatous mural

nodules can cause occult transcoelomic dissemination through LVI and microscopic capsular invasion despite a grossly intact outer mesothelium. In the literature, these tumors occur in a broad age range (17 to 87 years; median ~44–52 years), placing our 68-year-old patient in the older demographic interval. Clinically, while published cases present with large abdominal-pelvic masses, non-specific abdominal distension, and variable biomarker elevations, our patient demonstrated normal CA125 and elevated CA19-9, indicating a dangerous diagnostic pitfall. Prognostically, stage is the key factor: stage Ia unruptured cases achieve excellent long-term survival, whereas advanced-stage cases (FIGO III/IV) indicate rapid recurrence and poor overall survival, with median survival ranging from 6 to 28 months despite aggressive surgery and platinum-based chemotherapy. Following complete macroscopic cytoreduction (R0), our patient has initiated adjuvant platinum-based chemotherapy and remains under close clinical and radiological follow-up to evaluate treatment response.

CONCLUSION: A grossly intact ovarian capsule does not rule out advanced peritoneal disease in anaplastic carcinomatous mural nodules. Identifying any solid mural nodule on frozen section requires immediate, full cytoreductive staging—including systematic omentectomy, lymphadenectomy, and peritoneal cytology—to ensure accurate FIGO staging and prompt administration of adjuvant platinum-based chemotherapy.

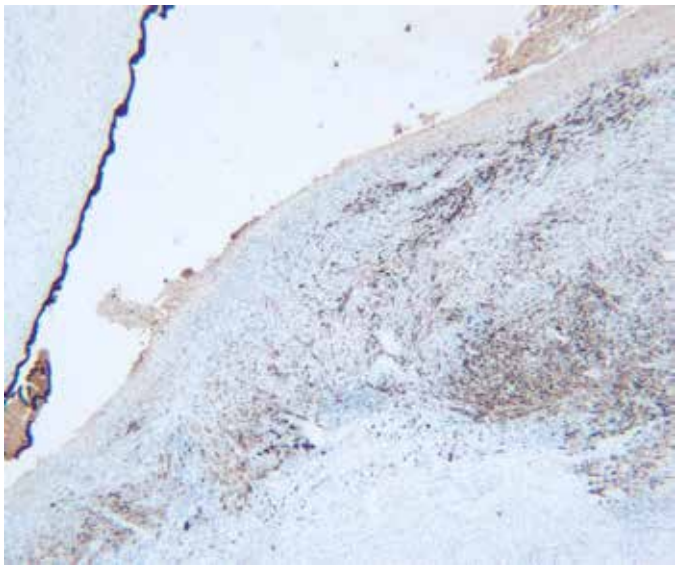
Keywords: Anaplastic carcinoma, ovarian mucinous tumor, mural nodule

Figure 1



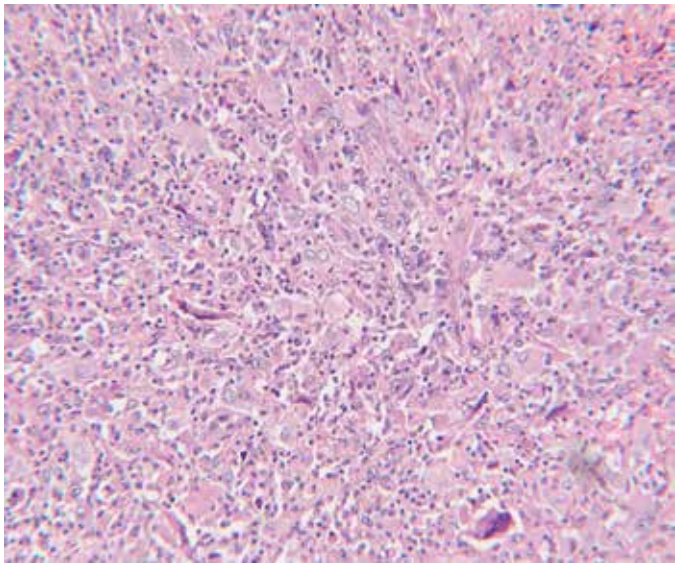
Mural nodule (right) adjacent to the cyst epithelium (left) (100x)

Figure 2



Pancytokeratin expression in tumor cells and cyst epithelium

Figure 3



Atypical cells with bizarre nuclei (100x), H&E stain

PP-56

Squamous Cell Carcinoma Arising from a Mature Cystic Teratoma with Direct Invasion of the Cecum: A Case Report

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INTRODUCTION: Malignant transformation of a mature cystic teratoma (dermoid cyst) is uncommon, occurring in 1-2% of cases, and most frequently manifests as squamous cell carcinoma (SCC). It predominantly affects postmenopausal women and is often diagnosed at an advanced stage, with adjacent organ invasion worsening prognosis. We report a case of SCC arising from a dermoid cyst with direct invasion of the cecum and ileum in a patient with no gynecological follow-up for three decades.

CASE: A 64-year-old woman presented with severe abdominal pain, 30 years after intrauterine device placement and no subsequent gynecological follow-up. Examination revealed pelvic tenderness without guarding or rebound. Non-contrast CT showed a 14.5-cm complex pelvic collection, a pericecal soft tissue lesion, and bilateral calcified adnexal lesions suggestive of dermoid cysts. The patient declined gynecological examination and received empirical antibiotics. On presentation to our institution, the device was removed and cervical and endometrial sampling were performed. Contrast-enhanced pelvic MRI revealed a 150x100-mm complex cystic left ovarian mass with a solid, enhancing mural nodule, raising concern for mucinous carcinoma, and a smaller complex cystic right ovarian lesion. Laboratory evaluation showed anemia, elevated CRP, and markedly elevated tumor markers (CA 125, CA 15-3, CA 19-9, CEA). Follow-up CT showed a 7-cm centrally necrotic right lower quadrant mass and a 13-cm multiseptated left adnexal cystic lesion, without distant metastasis.

Given suspicion of a cecal mass, gastroenterological surgery was consulted. Preoperative colonoscopy identified an ulcerovegetative mass at the cecal base near the appendiceal orifice; biopsy showed squamous differentiation, suggesting invasion from an adjacent primary. Following multidisciplinary evaluation, the patient underwent cytoreductive surgery: total abdominal hysterectomy with bilateral salpingo-oophorectomy, complete bilateral pelvic and para-aortic lymphadenectomy, total omentectomy, and cecal/distal ileal resection, with right hemicolectomy and ileotransverse anastomosis performed jointly with gastroenterological surgery. Frozen section confirmed SCC at the base of the left dermoid cyst; the right ovarian mass was benign.

The postoperative course was uneventful, and the patient was discharged on postoperative day 7. Final histopathology confirmed a moderately differentiated SCC, 22 cm in diameter, with capsular involvement and tumor invasion into the bowel specimen; 5 of 44 lymph nodes showed metastasis. The right ovary showed a mature cystic teratoma. Pathological stage was pT2b pN0, and the patient was referred for adjuvant chemotherapy. DISCUSSION: SCC arising from a dermoid cyst is diagnostically challenging, often asymptomatic or presenting with nonspecific symptoms. Advanced age, tumor diameter over 10 cm, and a solid component are reported risk factors for malignant transformation. Markedly elevated tumor markers supported the malignancy suspicion but lack specificity to distinguish an ovarian from a gastrointestinal primary.

This case is distinguished by direct tumor invasion into the cecum and ileum, mimicking a primary gastrointestinal malignancy and requiring a multidisciplinary approach.

CONCLUSION: Prolonged absence of gynecological follow-up may allow adnexal masses to progress undiagnosed to an advanced stage with adjacent organ invasion. Malignant transformation should be considered in large adnexal masses with a solid component and elevated tumor markers, and early multidisciplinary evaluation is essential for surgical planning and optimal oncologic outcomes.

Keywords: Cecal invasion, Dermoid cyst, Malignant transformation, Mature cystic teratoma, Squamous cell carcinoma

Figure 1



Figure 2



Figure 3



Figure 4



Figure 5



PP-57

Five Episodes of Recurrent Ovarian Torsion Despite Fixation Approaches: A Case Report

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INTRODUCTION: Adnexal torsion is a gynecological emergency that develops as a result of rotation of the ovary and/or fallopian tube around its vascular pedicle and requires early diagnosis and surgical intervention to preserve ovarian function. Recurrent torsion represents an important clinical management problem, particularly in young, nulligravid patients with fertility potential. Although ovarian fixation may be performed in addition to detorsion in recurrent cases, recurrence may not be completely prevented. In this report, a case in which right ovarian/adnexal torsion developed a total of five times despite repeated fixation procedures is presented.

CASE PRESENTATION: A 30-year-old G0P0 woman was found to have a history of hypothyroidism, subtotal thyroidectomy, and polycystic ovarian morphology. The patient first presented with groin pain on 12 May 2025. Laparoscopy revealed that the right ovary was larger than normal and twisted approximately four times, and atraumatic detorsion was performed. The patient underwent surgery again on 30 June 2025 because of recurrent groin pain, and right ovarian detorsion was performed for the second time. During the third torsion episode, laparoscopy performed on 4 September 2025 revealed that the right ovary was enlarged and hemorrhagic in appearance and that the right fallopian tube was also involved in the torsion. The right adnexa was found to be twisted 7–8 times. Following detorsion, the right ovary and tubal tissues were fixed to the pelvic sidewall with 2/0 Vicryl. Despite this intervention, the patient presented again on 4 May 2026 with right-sided pain similar to her previous torsion episodes. During the fourth laparoscopy, the right adnexa was found to be twisted 3–4 times. Following detorsion, the right ovary was this time fixed to the right uterosacral ligament. The patient presented again on 11 August 2026 with right groin pain. Pelvic magnetic resonance imaging demonstrated marked edema of the right ovary, loss of contrast enhancement, twisting of the ovarian pedicle, and minimal pelvic free fluid; the findings were considered consistent with torsion. During the fifth laparoscopy performed on 12 August 2026, the right ovary was found to be torsed again, and atraumatic detorsion was performed. In order to prevent recurrence, the right ovary was re-fixed to the uterosacral ligament at three different points.

DISCUSSION: The remarkable feature of this case is the development of five separate episodes of right ovarian/adnexal torsion within approximately 15 months and the persistence of recurrence despite repeated fixation procedures. During the third operation, the right ovary and tubal tissues were fixed to the pelvic sidewall, while during the fourth operation, the right ovary was fixed to the right uterosacral ligament. Despite this, a fifth torsion developed, and during the final operation, in addition to detorsion, the right ovary was re-fixed to the uterosacral ligament at three different points. This has demonstrated that although ovarian fixation aims to reduce the risk of recurrence, it may not completely prevent recurrent torsion. In young and nulligravid patients, early recognition of recurrent torsion, ovarian-conserving detorsion, and determination of a patient-specific fixation technique are important for preserving fertility potential.

Keywords: reccurent ovarian torsion, detorsion, ovarian fixation

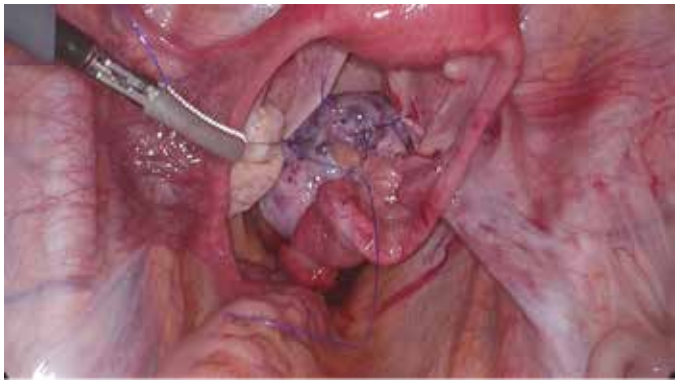
Intraoperative view of the torsed right ovary at the beginning of surgery.



Intraoperative appearance of the right ovary immediately after detorsion.



Final intraoperative view following fixation of the right ovary to the uterosacral ligaments.



PP-58

Diffuse foreign-body granulomatous peritonitis after cesarean delivery mimicking peritoneal malignancy: a case report

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AIM: To describe a rare case of diffuse foreign-body granulomatous peritonitis developing shortly after cesarean delivery and mimicking peritoneal malignancy and infectious granulomatous disease.

METHODS: Clinical records, imaging findings, intraoperative observations, microbiological investigations, histopathology, and follow-up data were reviewed.

RESULTS: A 39-year-old gravida 6, para 4 woman with four previous vaginal deliveries underwent cesarean delivery for suspected fetal macrosomia with concomitant bilateral tubal ligation. Fifteen days later, she presented with abdominal pain, fatigue, and dysuria. Ultrasonography showed extensive intraperitoneal fluid, and emergency laparotomy was performed because of suspected intra-abdominal hemorrhage. Exploration revealed abundant serous fluid without active bleeding, multiple millimetric calcified-appearing lesions diffusely involving the peritoneal surfaces and small-bowel mesentery, and an omental cake-like appearance. Partial omentectomy and peritoneal sampling were performed, together with appendectomy because the appendix appeared inflamed. Serum cancer antigen 125 (CA-125) was elevated to 170 U/mL. An extensive work-up for infectious and malignant causes of granulomatous peritonitis was undertaken. Bacterial cultures, acid-fast bacilli testing, mycobacterial polymerase chain reaction, QuantiFERON testing, and Brucella serology were negative, and histopathological examination showed no evidence of malignancy. Histopathology demonstrated chronic inflammation, extensive fibrosis, and granulomatous reactions in specimens from the omentum, appendix, Douglas pouch implant, right fallopian tube, and adipose tissue. Blue-gray translucent inert material was identified within the granulomatous foci and was surrounded by foreign body-type multinucleated giant cells. In view of the recent cesarean delivery and histopathological findings, a postoperative foreign-body reaction, most likely related to surgical suture material, was considered. However, a reaction to other intraoperative materials could not be excluded. During follow-up, reactive axillary and inguinal lymphadenopathy was detected. Excisional biopsy of the left inguinal lymph node was recommended, but the patient declined. Serial ultrasonography showed progressive regression of the lymphadenopathy, and the patient remained clinically well and asymptomatic.

CONCLUSION: Diffuse foreign-body granulomatous peritonitis is a rare postoperative condition that can closely mimic peritoneal malignancy, tuberculosis, or intra-abdominal infection. Surgical suture material may be a trigger after cesarean delivery, although other intraoperative materials should remain in the differential diagnosis when the offending material cannot be definitively identified. Careful correlation of histopathological, microbiological, and clinical findings is essential to avoid diagnostic misinterpretation and unnecessary further intervention.

Keywords: cesarean delivery, foreign-body granulomatous peritonitis,peritoneal malignancy

PP-59

Unexpected placenta accreta in a primigravida without conventional risk factors: uterus-preserving management and 80-day follow-up

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OBJECTIVE: Placenta accreta spectrum (PAS) is strongly associated with previous cesarean delivery and uterine surgery or instrumentation, and is rare in an unscarred, previously uninstrumented uterus. We report antenatally unsuspected placenta accreta in a primigravida managed with a uterus-preserving approach and followed for 80 days.

METHODS: A 27-year-old G1P0 woman at 39+0 weeks underwent cesarean delivery for breech presentation in labor. Antenatal ultrasonography showed an anterior placenta, normal amniotic fluid volume and normal Doppler findings, without features suggestive of PAS. She had no history of cesarean delivery, curettage, hysteroscopy, myomectomy, or other uterine procedure. Preoperative hemoglobin was 12.3 g/dL. Intraoperative findings, serial hemoglobin measurements, histopathology, and postoperative ultrasonographic follow-up were evaluated.

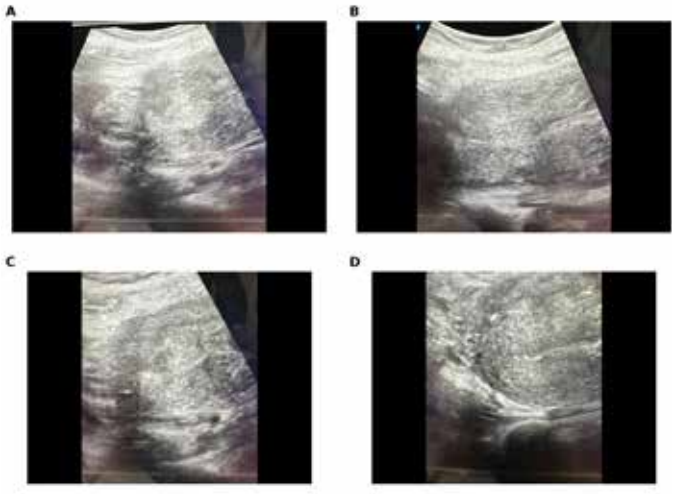
RESULTS: A 3650-g neonate was delivered with Apgar scores of 8/9. The placenta was manually removed, and no macroscopic residual placental tissue was identified. The fundal extension of the anterior placenta was markedly adherent. After separation, severe focal loss of fundal myometrium was observed, with only intact serosa remaining. Initially, no active bleeding was present. During intraoperative observation, a fundal hematoma developed; uterine compression sutures were applied, after which the hematoma remained stable without active bleeding. Oxytocin, methylergometrine, and tranexamic acid were administered, and a Douglas drain was placed. Hemoglobin decreased from 12.3 g/dL preoperatively to 10.8 g/dL at 6 hours and 10.1 g/dL at 24 hours. The patient remained hemodynamically stable, required no transfusion, and was discharged on postoperative day 3. Histopathology demonstrated chorionic villi adjacent to smooth-muscle bundles without intervening decidua, supporting placenta accreta. On day 35, ultrasonography demonstrated an intrauterine hematoma; because the patient remained stable despite ongoing vaginal bleeding, expectant follow-up was continued. On day 60, the hematoma had regressed to approximately 2.64 × 2.72 cm, but persistent vaginal discharge prompted dilatation and curettage for suspected hematometra; the specimen was reported as compatible with hematoma. By

day 80, bleeding and discharge had completely resolved, with marked ultrasonographic resolution.

CONCLUSION: PAS may occur in primigravid patients without conventional risk factors or a uterine scar, and absence of characteristic antenatal ultrasonographic findings does not exclude the diagnosis. In selected hemodynamically stable focal cases recognized unexpectedly intraoperatively, individualized uterus-preserving hemostatic management may be feasible. Prolonged postpartum surveillance remains important because delayed complications such as hematoma and hematometra may require secondary intervention.

Keywords: Placenta accreta spectrum, primigravida, unscarred uterus, uterus-preserving surgery

Early postoperative ultrasonography



Early postoperative ultrasonography. Postoperative day 2 ultrasonographic assessment during conservative clinical surveillance.

Intraoperative findings and uterus-preserving management



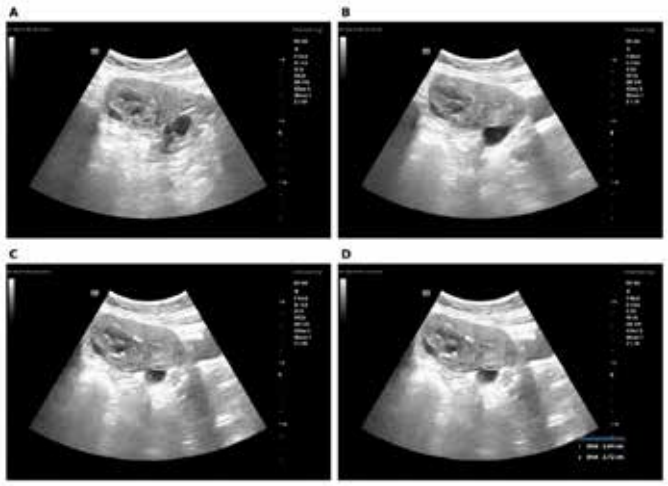
Intraoperative findings and uterus-preserving management. (A) Fundal region following placental removal, demonstrating near-complete focal loss of the myometrial layer with preservation of the serosal surface. (B) Development of a fundal hematoma during intraoperative observation. (C) Uterine compression sutures applied to limit hematoma expansion and provide mechanical hemostasis.

Postoperative day 35 ultrasonography



Postoperative day 35 ultrasonography. Heterogeneous intrauterine collection considered compatible with hematoma during expectant outpatient follow-up.

Postoperative day 60 ultrasonography



Postoperative day 60 ultrasonography. Marked regression of the intrauterine collection with residual heterogeneous material measuring approximately 2.64 × 2.72 cm. Persistent vaginal discharge prompted dilatation and curettage for hematometra.

Postoperative day 80 ultrasonography



Postoperative day 80 ultrasonography. Marked resolution of the previous intrauterine collection, accompanied by complete cessation of vaginal bleeding and discharge.

PP-60

Acute bilateral isolated tubal torsion in a patient scheduled for elective hysterectomy associated with uterine leiomyoma

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OBJECTIVE: Isolated fallopian tube torsion (IFTT) is a rare gynecological emergency, and bilateral involvement is exceptionally uncommon. Preoperative diagnosis remains challenging as symptoms mimic other acute pelvic pathologies. While uterine leiomyomas are common, their potential role in pelvic vascular congestion or altered anatomical forces predisposing heavy tubes to axial rotation is underrecognized. The aim of this presentation is to report an extraordinary case of acute asymmetric bilateral IFTT in a patient with a known uterine fibroid scheduled for elective hysterectomy, highlighting the diagnostic dilemmas and clinical management.

METHODS: A 45-year-old multiparous female awaiting an elective total abdominal hysterectomy (TAH) for a symptomatic leiomyoma presented to the emergency department on the morning of her planned admission with severe right lower quadrant pain, nausea, and vomiting. Physical examination revealed lower abdominal distension, severe tenderness, guarding, and rebound tenderness. Transvaginal ultrasonography demonstrated an anteverted uterus with a 70x82 mm fundal intramural leiomyoma, normal bilateral ovaries with preserved follicular architecture, a 10–12 cm complex cystic structure with dense echoes adjacent to the right ovary, and a 5–6 cm cystic structure adjacent to the left ovary. Laboratory tests revealed mild leukocytosis. Given the acute abdomen presentation, an emergency exploratory laparotomy was performed.

RESULTS: Intraoperative examination confirmed normal bilateral ovaries. The right fallopian tube was necrotic with a 6-turn complete axial torsion, while the left fallopian tube was congested with a 1-turn partial torsion. Total abdominal hysterectomy with bilateral salpingectomy was successfully performed while preserving both ovaries. Histopathology confirmed extensive ischemic hemorrhagic necrosis of both fallopian tubes and a benign 8 cm fundal intramural leiomyoma. The patient had an uneventful postoperative recovery, bowel function returned on day 1, and she was discharged on postoperative day 3. At her 4-week follow-up, she remained completely asymptomatic.

CONCLUSION: This case demonstrates that clinicians must maintain a high index of suspicion for isolated tubal torsion when adnexal cystic structures are visualized alongside normal-appearing ovaries in patients presenting with acute abdominal symptoms. Acute pain in patients awaiting elective hysterectomy for leiomyomas should not automatically be attributed to simple fibroid degeneration. Furthermore, tubal torsion can occur bilaterally and asymmetrically; a prominent unilateral lesion should not preclude thorough evaluation of the contralateral adnexa.

Keywords: tubal torsion, isolated fallopian tube torsion, bilateral adnexal torsion, uterine leiomyoma, acute abdomen

figure 1

Intraoperative view of the right adnexal area demonstrating the right fallopian tube rotated 6.5 turns.

figure 2

"Intraoperative view of the left adnexal area demonstrating the right fallopian tube rotated 1.5 turns, and 6.5 cm uterine fibroid.

PP-61

Sclerosing Stromal Tumor in an Adolescent: Is Ovarian-Sparing Surgery Always Feasible?

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OBJECTIVE: Sclerosing stromal tumor (SST) is a rare, benign sex cord-stromal tumor of the ovary, accounting for approximately 2–6% of ovarian sex cord-stromal tumors. Unlike most other ovarian stromal tumors, SST predominantly affects young women, typically in the second and third decades of life, although it remains uncommon in the pediatric and adolescent population. Clinical presentation is often nonspecific and may include menstrual irregularities, pelvic pain, or abdominal distension. Its heterogeneous appearance, with both solid and cystic components, may mimic other ovarian neoplasms and complicate surgical decision-making in young patients. Given its benign behavior, preservation of ovarian tissue should be considered whenever feasible. However, tumor size and the amount of remaining functional ovarian tissue may ultimately determine the extent of surgery. We present an adolescent patient with an SST suspected on preoperative imaging, with particular emphasis on the choice between ovarian-sparing surgery and oophorectomy.

CASE: A 17-year-old patient presented with menstrual irregularity. Pelvic ultrasonography revealed an 82×71 mm well-circumscribed, heterogeneous cystic mass with solid components in the right adnexa, without abnormal vascularity. Serum ovarian tumor markers and testosterone levels were within normal limits. Magnetic resonance imaging demonstrated a 7.5×6 cm predominantly cystic, complex right adnexal mass. On T2-weighted images, hypointense foci were observed within the hyperintense components, with marked enhancement of these areas following contrast administration. Based on these findings, a sclerosing stromal tumor was considered the leading diagnosis. Computed tomography showed a 7.4×5.6 cm cystic right adnexal lesion containing enhancing solid components, with no pathological lymphadenopathy or intra-abdominal free fluid. The patient underwent laparotomy through a Pfannenstiel incision. The uterus, left ovary, and fallopian tubes appeared normal. A well-circumscribed, solid-cystic mass measuring approximately 7.5 cm originated from the right ovary. Given the patient's young age and the presumed benign nature of the lesion, ovarian-sparing surgery was initially considered. However, the mass occupied most of the ovary, and it was judged that cystectomy would leave insufficient healthy ovarian tissue. Therefore, a right unilateral salpingo-oophorectomy was performed. Intraoperative frozen-section examination was reported as a benign stromal tumor, and no additional surgery was undertaken. Final histopathological examination confirmed the diagnosis of a sclerosing stromal tumor. At the six-month postoperative follow-up, the patient remained well, with no evidence of recurrence or other abnormalities.

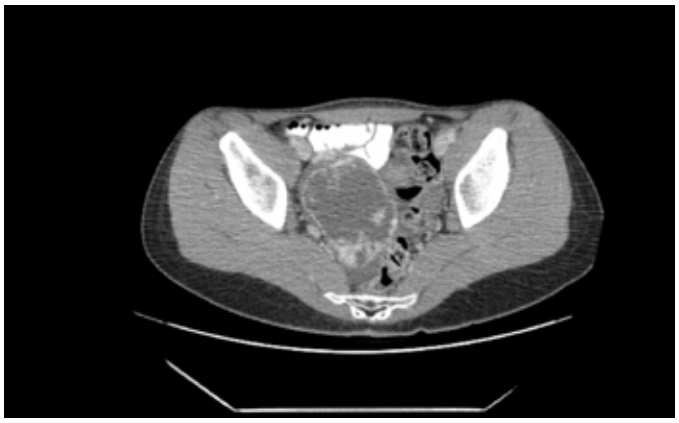
CONCLUSION: Although rare in adolescents, sclerosing stromal tumor should be considered in the differential diagnosis of complex adnexal masses in young patients. Recognition of its characteristic imaging features may facilitate preoperative diagnosis and help avoid unnecessarily extensive surgery. Because SST is benign and commonly occurs in young women, ovarian-sparing surgery should be considered whenever technically feasible. However, benign histology alone does not necessarily make ovarian preservation possible. The extent of ovarian involvement and the amount of viable ovarian tissue expected to remain after cystectomy should also guide surgical management. This case highlights that cystectomy may not always be feasible in large SSTs and that unilateral oophorectomy may be an appropriate option when adequate healthy ovarian tissue cannot be preserved.

Keywords: Sclerosing stromal tumor, ovary, adolescent, adnexal mass, oophorectomy.

Coronal CT image



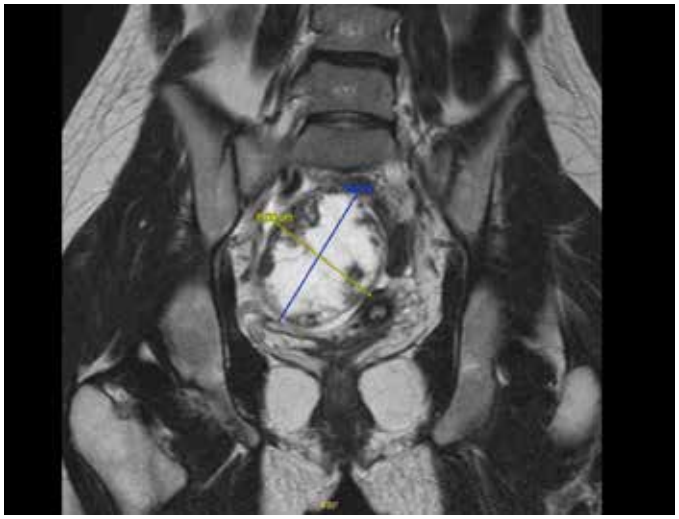
Axial CT image



Sagittal MR image



Coronal MR image



Gross Appearance of the Ovarian Mass



PP-62

Multidisciplinary Management and En-Bloc Bowel Resection of a Complicated Gossypiboma After Cesarean Section: A Case Report

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INTRODUCTION: Gossypiboma, a mass formed around a retained surgical sponge, is a rare, preventable, and potentially life-threatening complication of surgery. We present a case of gossypiboma secondary to a cesarean delivery, where the retained foreign body elicited massive fibrosis and dense adhesions, necessitating an extensive multidisciplinary surgical approach. This case underscores the clinico-pathological consequences of retained surgical items (RSIs), emphasizing the critical need for rigorous intraoperative counting procedures in abdominopelvic surgery.

CASE PRESENTATION: A 31-year-old multiparous woman (gravida 4, para 3) underwent a cesarean delivery at another institution on February 21, 2026, for suspected fetal macrosomia. She was readmitted five days later with nausea and vomiting. Transvaginal ultrasonography revealed a cervical echogenicity suspicious for retained placenta. Subsequent dilation and curettage (D&C) was performed, histopathologically confirmed the retained fragments.

On May 7, 2026, the patient re-presented to the outside center complaining of left upper quadrant pain and swelling. No foreign body was detected on the initial plain abdominal radiograph. However, subsequent abdominal ultrasonography and computed tomography (CT) revealed a 121 x 105 x 91 mm encapsulated, spongiform mass with internal air locules. Presenting to our center with these findings, clinical and radiological re-evaluation confirmed the high suspicion of a retained intra-abdominal foreign body. On May 14, 2026, the patient was admitted for a planned diagnostic laparoscopy, followed by bowel preparation and comprehensive informed consent.

Intraoperatively, diagnostic laparoscopy was converted to laparotomy due to dense adhesions. Dissection of a massive conglomerate mass involving the omentum and bowel loops revealed an abscess cavity containing a retained surgical sponge. Following intraoperative general surgery consultation, the severe fibroinflammatory reaction necessitated en-bloc excision. Segmental resections of the descending colon and small bowel (70 and 150 cm distal to the ligament of Treitz) were performed with stapled side-to-side anastomoses. The patient had an uncomplicated postoperative course with broad-spectrum antibiotics and fully recovered.

DISCUSSION: The pathogenesis of gossypiboma involves exudative and aseptic fibrotic phases, which in this case resulted in massive fibrosis, abscess formation, and severe bowel involvement. Furthermore, the failure to detect the foreign body on the initial plain radiograph highlights the diagnostic challenge posed by surgical sponges lacking radiopaque markers. This scenario dictates that managing the resulting severe anatomical distortion requires complex, multidisciplinary surgical interventions rather than simple foreign body extraction.

CONCLUSION: Gossypiboma is a devastating but highly preventable iatrogenic complication. Strict adherence to comprehensive surgical safety protocols is essential, and early recognition alongside a multidisciplinary surgical approach is crucial for its effective management.

Keywords: Gossypiboma, Cesarean Section, Iatrogenic Complication

Figure 1



Abdominal CT scan showing a gossypiboma exhibiting a spongiform appearance

Figure 2



Palpable Abdominal Mass on Physical Examination

Figure 3



Intraoperative view of a gossypiboma

Figure 4



Gossypiboma

PP-63

Unexpected unilateral adnexal absence during risk-reducing surgery in a BRCA1 mutation carrier: A diagnostic and management dilemma

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AIM: To report an unexpected unilateral absence of the ovary and fallopian tube identified during risk-reducing gynecologic surgery in a BRCA1 mutation carrier and to highlight the diagnostic and management challenges associated with this rare finding and equivocal postoperative imaging.

METHOD: A 40-year-old woman with a history of breast cancer, who achieved a pathological complete response following neoadjuvant chemotherapy, and a confirmed germline BRCA1 mutation underwent laparoscopic total hysterectomy with planned bilateral salpingo-oophorectomy for risk reduction. Her previous surgical history was limited to cesarean delivery, with no history of ovarian or tubal surgery. Preoperative ultrasonography demonstrated no gross adnexal pathology; however, the left ovary was not unequivocally visualized as a separate structure.

RESULTS: During careful laparoscopic exploration, neither the left ovary nor the fallopian tube could be identified. At the left uterine cornu, no tubal structure or identifiable tubal insertion was observed, while the left round ligament was clearly visualized. The right ovary and fallopian tube were identified and removed together with the uterus. Histopathological examination of the surgical specimen confirmed the presence of the right ovary and fallopian tube, with no left adnexal tissue identified.

Considering the complete non-visualization of both the left ovary and fallopian tube, the absence of an identifiable tubal insertion at the left uterine cornu, and the lack of previous ovarian or tubal surgery, congenital unilateral adnexal absence was considered the leading diagnosis. However, a remote asymptomatic torsion with subsequent autoamputation could not be completely excluded.

Given the clinical importance of excluding residual tubo-ovarian tissue in a BRCA1 mutation carrier, postoperative imaging was performed with particular attention to the left adnexal region. Transvaginal ultrasonography demonstrated a 20 × 14 mm hypoechoic nodular area. Although it lacked suspicious features, the possibility of atrophic ovarian tissue was conservatively included in the report to avoid overlooking potential residual tissue. Subsequent pelvic magnetic resonance imaging demonstrated no soft-tissue structure suggestive of ovarian tissue in the left adnexal region. Follow-up transvaginal ultrasonography after 6–8 weeks was recommended to distinguish postoperative changes from possible residual tissue, and the patient remains under imaging surveillance.

CONCLUSION: Unexpected unilateral adnexal absence during risk-reducing surgery represents a rare and clinically relevant diagnostic challenge, particularly in BRCA1 mutation carriers, in whom exclusion of residual tubo-ovarian tissue is essential. In this case, the intraoperative anatomical findings and absence of previous adnexal surgery favored congenital unilateral adnexal absence, although an acquired etiology could not be definitively excluded. Equivocal postoperative ultrasonographic findings should be interpreted in conjunction with operative findings and complementary imaging. Multimodal assessment and interval follow-up may help prevent both overlooked residual tissue and overinterpretation of benign postoperative changes.

Keywords: BRCA1 mutation, risk reducing salpingo-ooferectomy, adnexal agenesis, ovarian torsion/autoamputation, diagnostic imaging discordance

Figure 1



Surgical specimen demonstrating the uterus with the right ovary and fallopian tube. No left adnexal tissue was identified in the specimen.

PP-64

Bilateral giant theca lutein cysts associated with twin pregnancy, TTTS, and maternal virilization: A case report

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BACKGROUND: Hyperreactio luteinalis (HL) is a rare, benign, and usually self-limiting condition characterized by bilateral ovarian enlargement during pregnancy. It is associated with elevated β-human chorionic gonadotropin levels and is more frequently observed in multiple pregnancies. Maternal hyperandrogenism and virilization may occur but can lead to diagnostic uncertainty and concern for an androgen-secreting ovarian or adrenal tumor.

CASE PRESENTATION: A 29-year-old woman with a monochorionic diamniotic twin pregnancy developed progressive maternal virilization during the second trimester, characterized by severe nodular acne, increased terminal hair growth, and a modified Ferriman–Gallwey score of 10. At 33 weeks of gestation, stage I twin-to-twin transfusion syndrome (TTTS) and fetal growth restriction were diagnosed. No ovarian abnormalities had been detected on previous antenatal ultrasonographic examinations. At 34 weeks, cesarean delivery was performed because of absent end-diastolic flow in the umbilical artery of one twin. Approximately 3 cm of clitoromegaly was noted immediately before surgery. Intraoperatively, both ovaries were markedly enlarged, measuring up to 10 × 6 × 4 cm, with multiple cystic areas on their surfaces. Bilateral ovarian wedge resections were performed because of concern regarding possible malignancy. Histopathological examination revealed theca lutein cysts. Six hours postoperatively, total testosterone was >34.61 ng/mL, while DHEA-S was 123.9 µg/dL. At the 40-day follow-up, both ovaries had returned to normal size, total testosterone had decreased to 0.46 ng/mL, and the patient's clitoromegaly had resolved. Her acne had improved by approximately 80%.

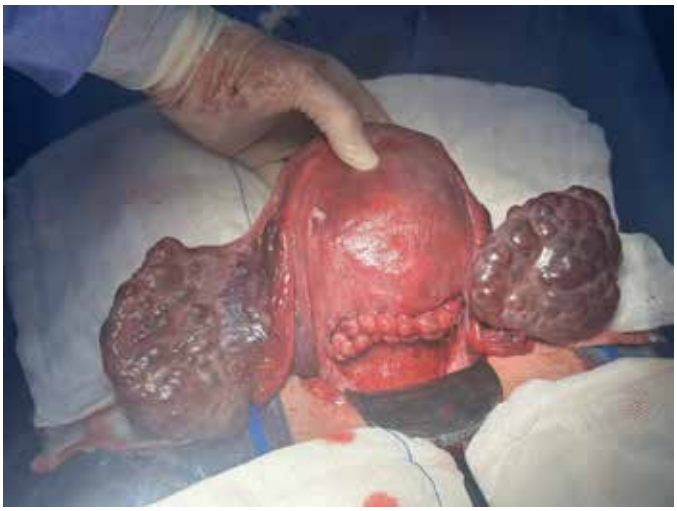
CONCLUSION: HL should be considered in the differential diagnosis of pregnant women presenting with maternal virilization and bilateral ovarian enlargement, particularly in multiple pregnancies and those complicated by TTTS. Recognition of this benign and self-limiting condition is crucial because it can mimic ovarian malignancy. Increased awareness may facilitate conservative management and prevent unnecessary ovarian surgery and iatrogenic loss of ovarian tissue.

Keywords: Hyperandrogenism, Luteomas, Pregnancy

Appearance of nodular acne on the back



Image of bilateral hyperreactio luteinalis obtained during a Cesarean section



PP-65

Silent total uterine rupture during misoprostol induction in the second trimester

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OBJECTIVE: Uterine rupture during second-trimester medical induction is rare but potentially life-threatening, particularly in women with a previously scarred uterus. Diagnosis may be challenging when classical manifestations such as hemodynamic instability, vaginal bleeding, or persistent severe abdominal pain are absent. We report a complete lower uterine segment rupture during misoprostol induction in a woman with two previous cesarean deliveries, in whom the clinically distinctive manifestation was the abrupt disappearance, rather than escalation, of severe induction-associated abdominal pain.

METHODS: The clinical course, misoprostol exposure, ultrasonographic findings, surgical management, and postoperative outcome of a patient undergoing second-trimester medical induction for intrauterine fetal demise were evaluated.

RESULTS: A 28-year-old gravida 4, parity 2 woman at 18 weeks and 5 days of gestation was referred for management of intrauterine fetal demise. Her obstetric history included two previous cesarean deliveries, performed in 2019 and 2021 through low-transverse uterine incisions. Medical induction had already been initiated with misoprostol at an outside facility; however, the individual doses, route, dosing intervals, and cumulative pre-referral exposure could not be reliably verified. Following admission, induction was continued with 400 µg of vaginal misoprostol at approximately 3-hour intervals, consistent with the International Federation of Gynecology and Obstetrics (FIGO) recommendation for fetal demise at 18–24 weeks of gestation. During the night, the patient experienced recurrent severe abdominal pain temporally associated with the induction process. By the following morning, the pain had abruptly disappeared without fetal expulsion. Despite this unexpected clinical change, she remained hemodynamically stable, without major vaginal bleeding, peritoneal irritation, or evidence of acute circulatory deterioration. In the context of two previous cesarean scars, the unexplained cessation of pain was not interpreted as symptomatic improvement and prompted immediate ultrasonographic reassessment. Ultrasonography demonstrated discontinuity of the anterior lower uterine segment at the previous cesarean-scar site, with the entire intact gestational sac protruding through the uterine wall defect and lying outside the uterine cavity. No free intraperitoneal fluid was observed. Emergency laparotomy confirmed a 3–4-cm complete rupture along the previous cesarean-scar line. The intact gestational sac and pregnancy tissue had protruded entirely through the rupture site, without intra-abdominal hemorrhage. The pregnancy tissue was removed, and the uterine defect was repaired with preservation of the uterus. No major intraoperative blood loss or hemodynamic deterioration occurred, postoperative transfusion was not required, and recovery was uncomplicated.

CONCLUSION: Uterine rupture during second-trimester misoprostol induction may occur before hemodynamic deterioration and without major hemorrhage or persistent abdominal pain. In a scarred uterus, abrupt disappearance of previously severe induction-associated pain without fetal expulsion should not automatically be interpreted as clinical improvement. Such an unexpected change should prompt immediate reassessment for uterine rupture. In hemodynamically stable patients, targeted ultrasonography may demonstrate uterine wall disruption and extrauterine displacement of gestational tissue, enabling diagnosis before catastrophic maternal deterioration. Because the pre-referral misoprostol exposure could not be quantified, a direct causal relationship with a specific dosing regimen cannot be established; the event should instead be interpreted in the context of multiple previous cesarean scars, repeated pharmacological uterine stimulation, and uncertain cumulative misoprostol exposure.

Keywords: induction, laparotomy, misoprostol, rupture, ultrasonography

Figure 1.

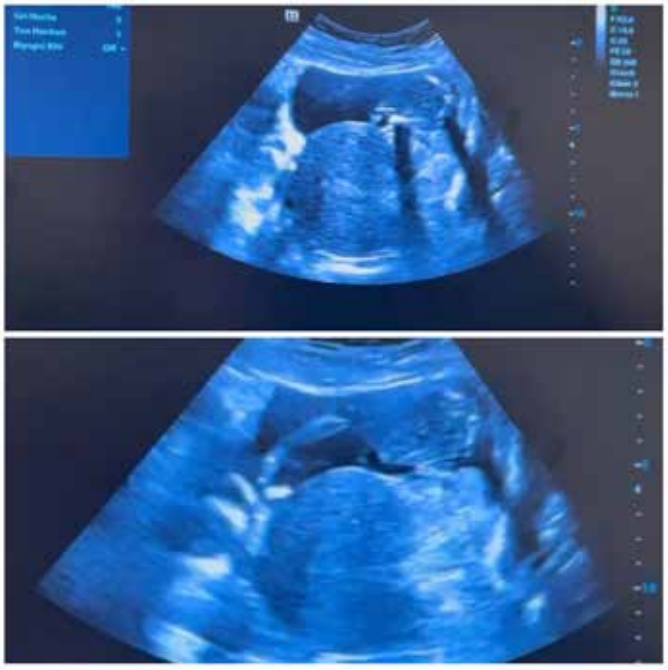


Figure 2.



PP-66

Uterine Perforation During Manipulator Placement in Total Laparoscopic Hysterectomy: Intraoperative Recognition and Management

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46,Gravida 2,Parity 1 –cesarean section

A patient with symptomatic uterine leiomyomas, presenting with abnormal uterine bleeding and pressure-related symptoms. A total laparoscopic hysterectomy was planned for the patient. During total laparoscopic hysterectomy, uterine perforation occurred during insertion of the uterine manipulator, resulting in an incidental injury to the intestinal serosa. The serosal injury was identified intraoperatively, and the procedure was completed laparoscopically without further complications. The patient had an uneventful postoperative course and was monitored appropriately following surgery. No additional complications were observed, and the patient was discharged in good clinical condition after an adequate period of postoperative observation.

Keywords: Abnormal uterine bleeding,Total Laparoscopic Hysterectomy,Uterine Perforation

PP-67

Robotic-assisted excision of eroded sacrocolpopexy mesh from the rectovaginal space: A step-by-step surgical video combined with total laparoscopic hysterectomy and bilateral salpingo-oophorectomy

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AIM: Mesh-related complications following sacrocolpopexy may require complex revision surgery because dense fibrosis and distortion of normal pelvic anatomy can increase the risk of visceral injury. This video demonstrates a structured, step-by-step robotic approach for complete excision of an eroded, retroperitoneally incorporated sacrocolpopexy mesh from the posterior uterine wall and rectovaginal space, combined with total laparoscopic hysterectomy and bilateral salpingo-oophorectomy.

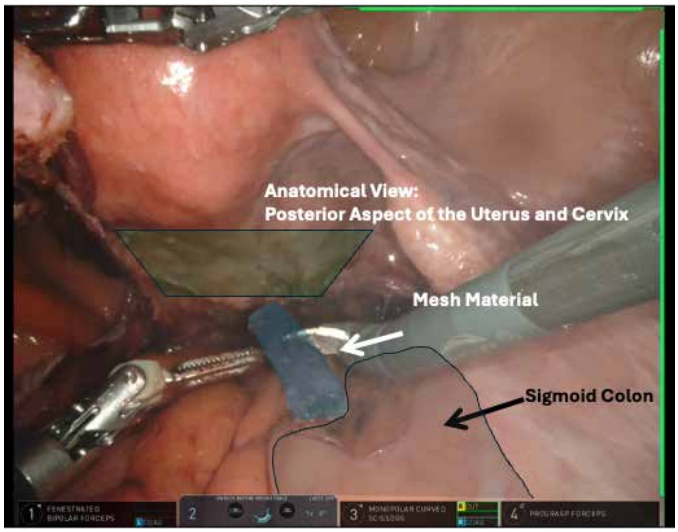
METHODS: A 53-year-old gravida 4, para 3 woman was referred with a one-year history of progressive vaginal bulging, severe deep dyspareunia, chronic constipation, obstructive voiding requiring manual reduction of the anterior vaginal wall to initiate micturition, and abnormal uterine bleeding. She had undergone abdominal sacrocolpopexy with synthetic mesh one year previously at another center, and conservative treatment had failed. Examination revealed recurrent apical prolapse, mesh erosion through the posterior vaginal wall near the vault with chronic granulation tissue, and marked tenderness along the retroperitoneal course of the mesh. Robotic-assisted mesh excision with concurrent total laparoscopic hysterectomy and bilateral salpingo-oophorectomy (TLH-BSO) was planned; hysterectomy was indicated for abnormal uterine bleeding. The procedure consisted of staged pelvic adhesiolysis, progressive isolation of the mesh from the posterior uterine wall and anterior rectal surface, development of the rectovaginal space, TLH-BSO, complete mesh excision, and robotic repair of the resulting posterior vaginal wall defect followed by vaginal cuff closure.

RESULTS: The mesh was completely dissected from the surrounding fibrotic tissue and removed transvaginally without rectal, urinary tract, or vascular injury. The approximately 1-cm full-thickness posterior vaginal wall defect created after excision of the eroded segment was repaired robotically. Total operative time was 90 minutes and estimated blood loss was 100 mL. No intraoperative or postoperative complications occurred, and the patient was discharged on postoperative day 2. Final uterine pathology was benign and demonstrated multiple intramural and submucosal leiomyomas with proliferative endometrium, while the excised tissue showed a foreign-body giant cell reaction consistent with chronic mesh-related inflammation. At three-month follow-up, the patient remained free of prolapse recurrence, mesh-related symptoms, and other complications.

CONCLUSION: In this case, a staged and anatomically oriented robotic approach enabled complete excision of a retroperitoneally incorporated sacrocolpopexy mesh while preserving adjacent visceral structures. Enhanced visualization and precise dissection may be particularly useful when operating within severely fibrotic and distorted rectovaginal tissue planes. This structured approach may provide a useful surgical framework for selected patients requiring complex mesh revision surgery.

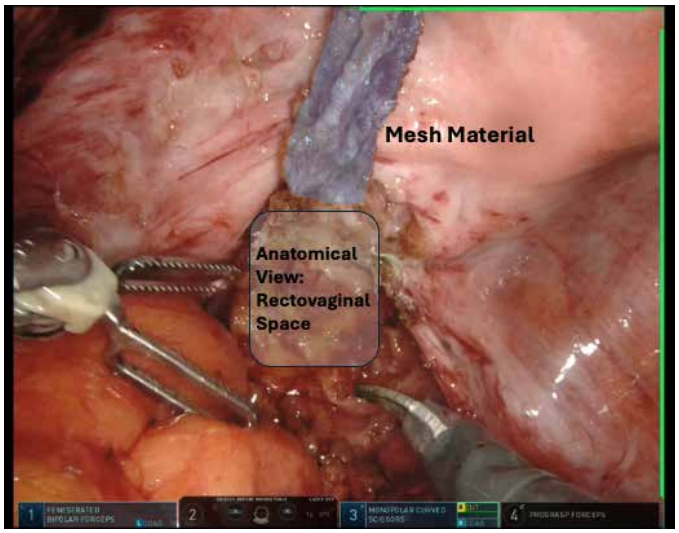
Keywords: Mesh erosion, Robotic surgery, Sacrocolpopexy

Anatomical Relationship of the Mesh to the Posterior Uterus and Sigmoid Colon



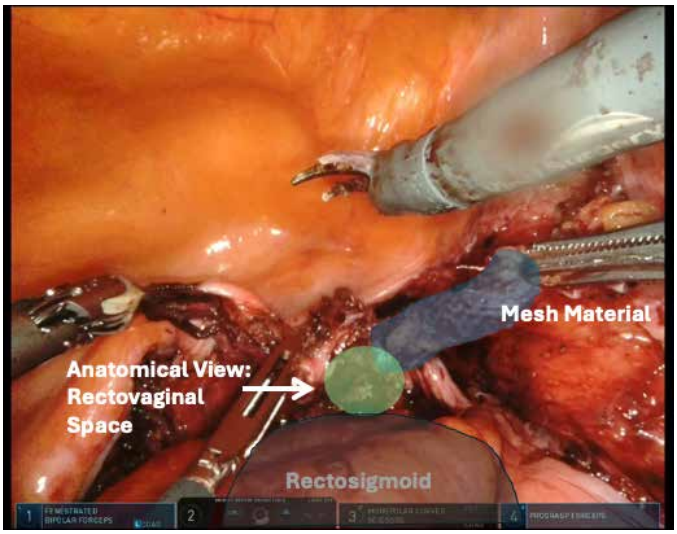
Intraoperative robotic view demonstrating the retroperitoneally incorporated mesh in relation to the posterior aspect of the uterus and cervix and the adjacent sigmoid colon before further mobilization.

Isolation of the Mesh in the Rectovaginal Space



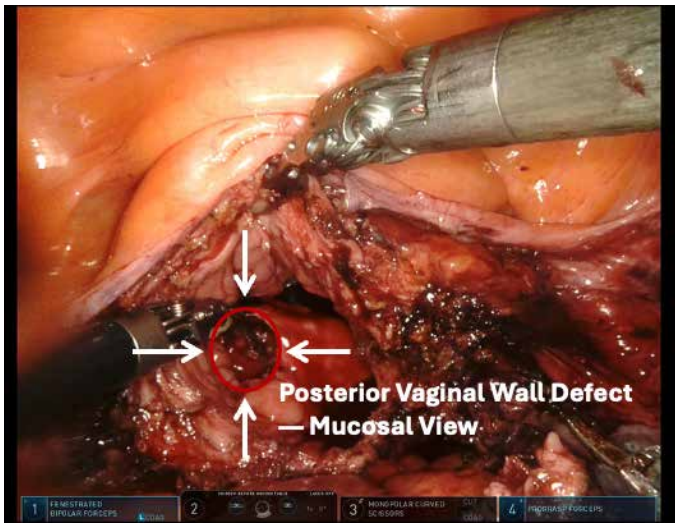
Robotic dissection of the retroperitoneally incorporated mesh from the anterior rectal wall and surrounding fibrotic tissue during development of the rectovaginal space.

Residual Mesh After Total Laparoscopic Hysterectomy



Intraoperative view after total laparoscopic hysterectomy showing the residual mesh segment remaining attached within the rectovaginal region prior to complete excision.

Mucosal View of the Posterior Vaginal Wall Defect



Mucosal view of the approximately 1-cm full-thickness posterior vaginal wall defect identified after complete excision of the eroded mesh.

PP-68

Placental Mesenchymal Dysplasia Initially Misdiagnosed as Molar Pregnancy: The Critical Role of p57 and CD31 Immunohistochemistry

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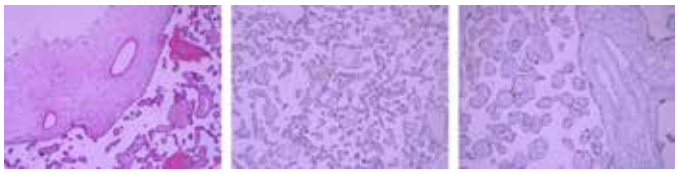
Placental mesenchymal dysplasia (PMD) is a rare developmental placental disorder defined by stem villous enlargement, placentomegaly, and abnormal villous vascularization. Its multicystic sonographic appearance closely mimics molar pregnancy, and failure to recognize it as a distinct entity may lead to unnecessary termination of an otherwise viable pregnancy.

CASE: A 33-year-old woman in her fourth pregnancy was referred to our tertiary center at 17–18 weeks of gestation with a preliminary diagnosis of partial hydatidiform mole. Maternal serum AFP was markedly elevated at 169 ng/mL. Fetal anatomy was structurally intact; maternal serum β-hCG was 16,066 mIU/mL, within the expected range for gestational age and well below levels typically associated with complete hydatidiform mole. Thyroid function tests (TSH, free T3, free T4) were within normal limits. Expectant management was adopted. Third-trimester surveillance revealed intrauterine growth restriction (IUGR) and increased resistance in the umbilical artery. Elective cesarean section was performed at 37 weeks; a live female infant weighing 2600 g (below the 10th percentile for gestational age, consistent with IUGR) was delivered. Following an initial pathological assessment that interpreted the findings as consistent with a placental chorionic cyst, p57 and CD31 immunohistochemical staining was added and the diagnosis was revised to PMD.

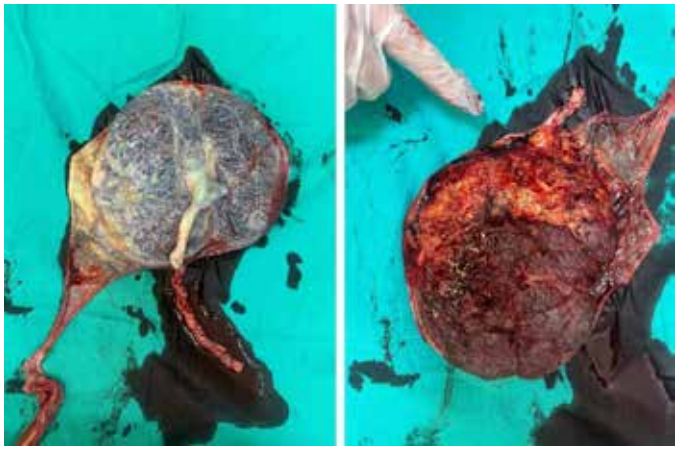
CONCLUSION: PMD must be considered in any multicystic placental lesion accompanied by a structurally normal fetus and β-hCG not markedly elevated for gestational age. H&E staining alone can be misleading; p57 and CD31 immunohistochemistry should be part of the standard workup, not reserved as a last resort. Diagnostic errors in this condition carry real clinical consequences, and awareness among obstetricians and pathologists is the most effective safeguard against them.

Keywords: Placental mesenchymal dysplasia, molar pregnancy, intrauterine growth restriction, p57, CD31

Microscopic panel. (A) Hematoxylin-eosin staining (low power; scale bar: 200 µm). Enlarged stem villus containing fibrotic stroma and thick-walled vascular structures at its periphery. Normal-sized distal villi are visible at the periphery. No trop



Macroscopic appearance of the placenta. (A) Fetal surface: prominently dilated and tortuous (“cirsoid”) chorionic vessels radiating from the umbilical cord insertion site and focal cystic dilatations are observed. (B) Maternal surface: wide



Reported frequencies of adverse perinatal outcomes associated with placental mesenchymal dysplasia [2,11,17,20–22,24].

Clinical Finding	Reported Frequency
Intrauterine growth restriction	30–72%
Intrauterine fetal demise	10–40%
Preterm birth	20–30% ~40%
Beckwith–Wiedemann syndrome	20–25%
Live birth without major complication	~40%

Differential diagnostic features of placental mesenchymal dysplasia, partial hydatidiform mole, and complete hydatidiform mole.

Feature	PMD	Partial Mole	Complete Mole
Fetus	Usually present	Often abnormal	Absent
B-HCG	Mildly ↑ / normal	Moderately ↑	Markedly ↑↑
Trophoblastic proliferation	Absent	Present	Diffuse / prominent
Villous architecture	Cystic + vascular	Scalloping	Hydropic
Serum AFP	Often elevated	Normal / low	Normal / low
p57 expression	Cytotrophoblast (+) Stroma (−)	(+)	(−)
Genetic Profile	ABM / diploid	Triploid	Androgenetic

PP-69

Thoracopagus Conjoined Twins in the First Trimester: A Case Report

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OBJECTIVE: Conjoined twins represent an uncommon developmental anomaly arising in monozygotic twin pregnancies and are associated with substantial perinatal morbidity and mortality. Their anatomical classification is determined by the predominant site at which the two fetuses are united.In thoracopagus twins, the fetuses are joined anteriorly at the thorax, with the fusion potentially extending into the upper abdomen. The presence of shared cardiac structures is particularly important in determining prognosis. This report aims to present a case of thoracopagus conjoined twin pregnancy in a patient undergoing follow-up for infertility, which resulted in medical evacuation due to loss of fetal cardiac activity at the end of the first trimester and demonstrated thoracic fusion on post-termination macroscopic and histopathological examination.

METHODS: A 31-year-old woman who had been followed in the Department of Obstetrics and Gynecology for infertility achieved pregnancy, and a twin pregnancy was subsequently identified during routine follow-up. At 12 weeks and 6 days of gestation, fetal cardiac activity was absent, and the patient was hospitalized for medical evacuation of the pregnancy. For medical termination and cervical preparation, two doses of buccal and two doses of intravaginal misoprostol were administered. Subsequently, evacuation of the uterine cavity was completed using 4- and 6-mm Karman cannulas. Following termination, the anatomically intact conjoined twin fetuses and placental tissue were obtained and submitted for macroscopic and histopathological examination. A fetal skin biopsy specimen was also obtained for genetic analysis.

RESULTS: Macroscopic examination revealed two fetuses conjoined at the thoracic and abdominal regions. The combined fetal weight was 18.5 g. The crown-to-heel lengths of the first and second fetuses were 6.6 and 6.7 cm, respectively, while the crown-to-rump lengths were 4.5 and 5 cm, respectively. The chest circumference was 7.4 cm and the abdominal circumference was 7 cm in both fetuses. The upper and lower extremities appeared macroscopically normal, with complete digits of the hands and feet. During dissection, lung, kidney-adrenal, and testicular tissues from each fetus were sampled separately, whereas a shared heart, stomach, small intestine, and large intestine were identified. The placenta weighed 88.8 g and measured 15.5 × 6 × 0.5 cm. Histopathological examination revealed no significant additional structural abnormalities in the examined organs and no major additional congenital malformations of the soft tissues or extremities. Chromosomal microarray analysis performed on the fetal skin biopsy specimen yielded arr(X,Y)x1,(1-22)x2,

with no clinically significant copy number alterations detected. The macroscopic and histopathological findings were considered consistent with thoracopagus conjoined twins.

CONCLUSION: Thoracopagus conjoined twinning is a rare congenital anomaly associated with high fetal mortality. In the present case, a conjoined twin pregnancy resulted in loss of fetal cardiac activity at the end of the first trimester, and post-termination macroscopic and histopathological examinations demonstrated fusion at the thoracic region with shared cardiac structures. The combined evaluation of prenatal findings and post-termination pathological examination is important for defining the anatomical characteristics and accurate classification of conjoined twins.

Keywords: Thoracopagus,conjoined twins, prenatal diagnosis

Ultrasonographic appearance of thoracopagus conjoined twins.



Post-termination macroscopic appearance of thoracopagus conjoined twins.



PP-70

Complex ovarian cyst and extensive pelvic adhesions mimicking ovarian torsion: a case report

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OBJECTIVE: Ovarian torsion is a gynecological emergency requiring early diagnosis and surgical evaluation. However, complex adnexal masses and extensive pelvic adhesions may produce overlapping clinical and radiological findings and create diagnostic uncertainty. We aimed to present a patient who underwent diagnostic laparoscopy for suspected ovarian torsion and was found to have a complex left ovarian cyst, extensive pelvic adhesions, and concomitant small endometriomas.

METHODS: A 42-year-old woman was evaluated for recurrent left lower-quadrant pain persisting for approximately one month and temporarily relieved by analgesics. She had no fever, abnormal vaginal discharge, or vaginal bleeding. The patient was living with human immunodeficiency virus infection and receiving antiretroviral therapy, with a viral load of <20 copies/mL in June 2026. Transvaginal ultrasonography demonstrated an enlarged left ovary measuring approximately 46×39 mm, containing a septated hemorrhagic/complex cystic lesion and an additional anechoic cystic structure. Doppler examination demonstrated limited vascular signals, and ovarian torsion could not be reliably excluded. Because of persistent pain and ongoing suspicion of torsion, diagnostic laparoscopy was performed.

RESULTS: Laparoscopic exploration revealed extensive intra-abdominal and pelvic adhesions. The bowel was densely adherent to the pelvis and surrounding the left adnexal region. Following adhesiolysis, the right ovary appeared macroscopically normal. The left ovary was enlarged to approximately 5–6 cm and contained a complex cystic lesion. During adhesiolysis and ovarian dissection, two approximately 1-cm cystic foci macroscopically compatible with endometriomas ruptured. The extensive pelvic and periovarian adhesions were considered potentially related to the accompanying endometriotic lesions. Left oophorectomy was performed. Considering the patient's known human immunodeficiency virus infection, the surgical approach was planned to avoid an additional abdominal wall incision and minimize unnecessary tissue exposure. The surgical specimens were placed in a 10-mm endobag introduced through the camera port and retrieved through the same trocar site without creating an additional incision. The specimens were sent for histopathological examination. No early postoperative complication occurred.

CONCLUSION: Complex ovarian cysts and extensive pelvic

adhesions may mimic ovarian torsion clinically and radiologically and complicate preoperative diagnosis. Diagnostic laparoscopy remains important for definitive evaluation and treatment when torsion cannot be reliably excluded in a symptomatic patient. Small concomitant endometriotic lesions may represent a possible explanation for extensive pelvic adhesions. In patients with relevant infectious comorbidities, surgical planning aimed at minimizing additional incisions and unnecessary tissue exposure may also be considered.

Keywords: Endometriosis, Human immunodeficiency virus, Laparoscopy, Ovarian cyst, Ovarian torsion, Pelvic adhesions

PP-71

Restoration of tubal patency after laparoscopic partial salpingectomy for torsion caused necrotic distal segment resection: a case report

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AIM: Isolated fallopian tube torsion (IFTT) is a rare gynecological emergency responsible for approximately 9% of all adnexal torsions. Delayed diagnosis may result in permanent effects on fertility. The clinical presentation mimicking ovarian torsion, the non-specific nature of imaging findings, and the apparent preservation of ovarian vascularity are among the primary factors complicating diagnosis. When the distal tube undergoes necrosis, the optimal surgical approach remains doubtful: total salpingectomy versus fertility-sparing partial resection. Preservation of fertility potential is a critical determinant of surgical decision-making, particularly in nulliparous women of reproductive age. This case shows in which laparoscopic partial salpingectomy for resection of a necrotic distal segment was followed by successful restoration of tubal patency, confirmed by postoperative hysterosalpingography.

METHODS: A 28-year-old nulliparous woman (gravida 0, para 0) presented with a two-week history of mild groin pain and was admitted with suspicion of torsion. Contrast-enhanced pelvic computed tomography (CT) revealed a 67×59×72 mm cystic lesion in the anterior uterine region and free pelvic fluid. Doppler ultrasonography (USG) identified a 79×73 mm dense-content lesion originating from the right fallopian tube, consistent with hydrosalpinx; preserved ovarian vascularity did not definitively exclude torsion. Whole-abdomen contrast-enhanced magnetic resonance imaging (MRI) demonstrated a 7×6 cm cystic formation adjacent to the right ovary communicating with a dilated tube, consistent with tubal torsion. Due to lack of response to medical therapy and also developing an acute pain after being relieved for 3 days, laparoscopic exploration was performed on the forth day of hospitalization.

RESULTS: Laparoscopic exploration under general anesthesia revealed a 3-turn torsion of the right fallopian tube with an approximately 5 cm necrotic distal segment. The left tube was adherent to the left ovary, left infundibulopelvic ligament, and pelvic sidewall, with approximately 4 cm of distal hydrops. Initial chromopertubation via the uterine manipulator demonstrated tubal passage. Following right tube detorsion, the hydrosalpinx was aspirated and the necrotic distal segment was excised by partial salpingectomy; methylene blue passage through the right tube was subsequently confirmed. On the

left side, adhesiolysis and drainage of the distal hydrops resolved the obstruction, and methylene blue passage was achieved. Bilateral intraoperative tubal patency was confirmed by chromopertubation. The patient had an uneventful postoperative period and was discharged on postoperative day 2. Postoperative hysterosalpingography confirmed bilateral tubal patency with normal passage after 3 months.

CONCLUSION: This case demonstrates that fertility-sparing partial salpingectomy can restore tubal patency even in the presence of a necrotic distal segment when performed with appropriate surgical technique. Although salpingectomy remains the most performed procedure for IFTT, other options might be considered for women of reproductive age. This case highlights the value of combining intraoperative chromopertubation to confirm surgical success and suggests that partial resection with intraoperative patency assessment may be a superior fertility-preserving strategy over immediate total salpingectomy in nulliparous patients with distal tubal necrosis.

Keywords: Isolated fallopian tube torsion, hydrosalpinx, partial salpingectomy, fertility sparing surgery

PP-72

Parvovirus B19 associated severe fetal anemia progressing to non-immune hydrops and fetal death

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BACKGROUND: Parvovirus B19 is an important infectious cause of fetal anemia, non-immune hydrops fetalis, and fetal death. Viral tropism for erythroid progenitor cells can cause profound impairment of fetal erythropoiesis, followed by tissue hypoxia, compensatory erythropoiesis, high output cardiac failure, and hydrops. This case highlights the importance of recognizing the fetal hematologic phenotype early, particularly when maternal serology is not indicative of recent infection.

CASE PRESENTATION: A 38-year-old primigravida was referred for evaluation of suspected fetal anemia at approximately 29 weeks of gestation. Maternal and paternal blood groups were A Rh positive, and the indirect Coombs test was negative, making alloimmune fetal anemia unlikely. At 29+2 weeks, ultrasonography demonstrated a structurally normal fetus with an estimated fetal weight of 1658 gr, mild polyhydramnios, and ascites. Middle cerebral artery peak systolic velocity (MCA-PSV) was markedly elevated at approximately 73–82 cm/s, raising suspicion of significant fetal anemia. Maternal Parvovirus B19 serology showed positive IgG but negative IgM. Despite the negative IgM, fetal disease progressed. At 30+4 weeks, ultrasonography demonstrated marked ascites, skin edema, and pericardial effusion, consistent with non-immune hydrops fetalis. MCA-PSV had increased to 95–100 cm/s. Fetal blood sampling confirmed profound anemia with hemoglobin of 6 g/dL, and amniotic fluid PCR was positive for Parvovirus B19. Intrauterine red cell transfusion was performed. However, subsequent fetal monitoring showed deterioration and loss of fetal heart rate variability, followed by intrauterine fetal death. Vaginal delivery was subsequently performed. Postmortem examination revealed a 1985 gr male fetus with stage II maceration and no major congenital anomaly. Generalized edema, ascites, cardiomegaly, hepatomegaly, and splenomegaly confirmed severe systemic involvement. Histologically, striking erythroblastosis involved

the heart, lungs, liver, spleen, kidneys, and thymus. Diffuse endocardial fibroelastosis suggested prolonged cardiovascular stress. The lungs showed edema, intra-alveolar fibrin exudation, and interstitial capillary fibrin thrombi. The liver demonstrated diffuse necrosis, extensive erythroblastosis, and hemosiderosis confirmed by Prussian blue staining. Placental examination demonstrated diffuse villous edema and prominent erythroblastosis within fetal vessels. Importantly, overt villitis, perivillitis, and characteristic erythroblastic nuclear inclusions were absent despite PCR confirmed fetal infection.

DISCUSSION: The clinical course underscores the importance of early recognition and longitudinal assessment of fetal anemia in pregnancies affected by Parvovirus B19. At 29–31 weeks of gestation, an MCA-PSV exceeding approximately 60–65 cm/s may indicate clinically significant fetal anemia before advanced hydrops becomes apparent, supporting prompt investigation and close serial surveillance. Importantly, negative maternal Parvovirus B19 IgM does not exclude fetal infection when otherwise unexplained fetal anemia or hydrops is present. In this case, progression to hydrops with cardiovascular and multiorgan involvement was followed by fetal deterioration despite intrauterine transfusion, suggesting that established end organ injury may limit the effectiveness of fetal therapy. The absence of placental inflammation or characteristic viral inclusions should likewise not be interpreted as evidence against Parvovirus B19 infection. These findings support an integrated approach combining MCA Doppler surveillance, direct assessment of fetal hemoglobin, molecular testing, and timely fetal intervention before advanced hydrops and potentially irreversible organ injury develop.

Keywords: Parvovirus B19, non-immune hydrops fetalis, fetal anemia

PP-73

Severe bilateral fetal pleural effusion associated with placental fetal vascular malperfusion: A unique fetal autopsy case

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BACKGROUND: Fetal pleural effusion is a rare prenatal finding that may occur as an isolated condition or in association with chromosomal abnormalities, congenital anomalies, infection, cardiac dysfunction, or hydrops fetalis. Progressive pleural fluid accumulation may impair venous return and cardiac function and cause compression of the developing lungs, potentially resulting in pulmonary hypoplasia and fetal deterioration. Establishing the underlying etiology is therefore important for prenatal counseling and management. We present a case of severe bilateral fetal pleural effusion in a pregnancy with an otherwise unremarkable maternal course and no significant maternal abnormalities identified during antenatal follow up.

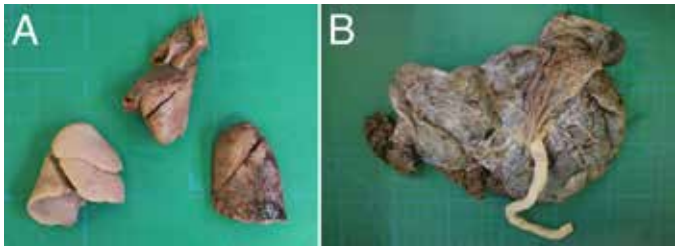
CASE PRESENTATION: A 28-year-old pregnant woman at 30 weeks and 6 days of gestation was found to have severe fetal pleural effusion on prenatal evaluation. Because of the severity of the fetal and maternal condition and anticipated poor outcome, pregnancy termination was performed. Following the procedure, the mother remained clinically stable. A female fetus weighing 1621 g was underwent detailed fetal and placental examination. Fetal anthropometric measurements and maturation parameters were consistent with a gestational age. No major craniofacial, skeletal, gastrointestinal, genitourinary, central nervous system, or cardiovascular malformation was identified. Cardiac situs and the origins of the great vessels were normal, and no major venous return anomaly was detected. Thoracic examination demonstrated abundant bilateral serohemorrhagic pleural effusions and mild serohemorrhagic pericardial effusion. Both lungs were macroscopically smaller than expected. Histologically, the lungs showed appropriate saccular stage maturation with prominent atelectatic changes. Fresh hemorrhagic foci were present within the pulmonary interstitium and visceral pleura, particularly in the left lung. Petechial hemorrhages were also observed on the cardiac and pericardial surfaces, suggesting terminal hypoxic injury. No histopathological evidence of fetal infection was identified.

The placenta weighed 346 g, corresponding to the expected range for gestational age. Despite appropriate placental weight and villous maturation, histopathological examination revealed prominent fetal vascular malperfusion characterized by avascular and hypovascular villi, groups of fibrotic villi, segmental severe villous congestion, and extensive villous aggregation. Mild maternal vascular malperfusion was also present. The umbilical cord contained two arteries and one vein, with no significant structural abnormality. No placental inflammatory lesion supporting ascending or hematogenous intrauterine infection was detected.

DISCUSSION: The absence of major fetal structural abnormalities or histological evidence of infection narrowed the differential diagnosis of severe pleural effusion. The coexistence of prominent fetal vascular malperfusion and extensive perivillous fibrinoid deposition indicates substantial disturbance of fetoplacental circulation. Placental dysfunction may contribute to chronic fetal hypoxemia and hemodynamic compromise, potentially aggravating the development or progression of fetal serous cavity effusions. In addition, the small lungs and atelectatic changes suggest that prolonged intrathoracic fluid accumulation may have adversely affected pulmonary development. Although a direct causal relationship between the placental lesions and pleural effusion cannot be established, their coexistence supports the potential contribution of impaired fetoplacental circulation to fetal deterioration. Comprehensive placental examination should therefore be considered an important component of the etiologic assessment of otherwise unexplained fetal pleural effusion and may also provide relevant information for counseling and management of subsequent pregnancies.

Keywords: Fetal pleural effusion, pulmonary atelectasis, fetal vascular malperfusion

Figure 1. Gross pathological examination



(A) Contracted, hypoplastic fetal lungs demonstrating prominent atelectasis alongside the heart. (B) Fetal surface of the placenta and umbilical cord showing gross correlates of fetal vascular malperfusion.

PP-74

vNOTES hysterectomy in advanced uterine prolapse: does it provide additional clinical benefit?

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OBJECTIVE: Vaginal natural orifice transluminal endoscopic surgery (vNOTES) is a minimally invasive approach that combines vaginal access with endoscopic visualization. However, the additional clinical benefit of vNOTES remains debatable in patients with uterine prolapse who are suitable candidates for conventional vaginal hysterectomy and have no concomitant adnexal pathology. This case report aimed to present our experience with vNOTES hysterectomy in a patient with advanced uterine prolapse and to discuss the potential benefits and necessity of this approach in such patients.

METHODS: A 59-year-old woman, gravida 2, para 2, presented with a vaginal bulge. Her medical history included previous inguinal hernia surgery. Gynecological examination revealed grade 3 uterine prolapse, with no additional uterine or adnexal pathology. The patient underwent vNOTES hysterectomy with bilateral salpingo-oophorectomy. Anterior and posterior colpotomies were performed to access the peritoneal cavity. A wound retractor was inserted transvaginally, followed by placement of a gel-seal access platform containing one camera port and two working ports, and pneumoperitoneum was established. Under endoscopic visualization, the uterine and adnexal pedicles were dissected, and hysterectomy with bilateral salpingo-oophorectomy was completed. The specimens were removed transvaginally. After removal of the access platform, the vaginal cuff was closed transvaginally.

RESULTS: vNOTES hysterectomy with bilateral salpingo-oophorectomy was completed in approximately 120 minutes. No abdominal incision or additional laparoscopic port was required. No intraoperative or postoperative complications occurred. The patient was discharged on postoperative day 2. Final histopathological examination revealed benign findings.

CONCLUSION: vNOTES hysterectomy was successfully performed without abdominal incisions or perioperative complications in this patient with advanced uterine prolapse. However, technical feasibility does not necessarily imply that

the approach is required in every suitable patient. In patients who are appropriate candidates for conventional vaginal hysterectomy and have no concomitant adnexal pathology, the benefits of enhanced endoscopic visualization offered by vNOTES should be weighed against the need for additional equipment, cost, and the associated learning curve. The surgical approach should therefore be individualized according to the additional clinical benefit expected for each patient.

Keywords: Hysterectomy, vNOTES, uterine prolapse

PP-75

Primary Laparoscopic Davydov Neovaginoplasty in Type II Mayer–Rokitansky–Küster–Hauser Syndrome With a Pelvic Kidney: A Video Case Report

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AIM: Mayer–Rokitansky–Küster–Hauser (MRKH) syndrome is characterized by congenital uterovaginal agenesis and may be accompanied by extragenital anomalies in type II disease, including urinary system anomalies. The presence of a pelvic ectopic kidney may complicate neovaginal reconstruction because of altered pelvic anatomy and the close relationship of the kidney, ureter, and potentially anomalous vasculature to the operative field. This video aims to demonstrate the technical feasibility of primary laparoscopic Davydov neovaginoplasty in a patient with type II MRKH syndrome and a pelvic ectopic kidney, with particular emphasis on adaptation of the apical reconstruction to the altered anatomy and incorporation of the peritoneum overlying the kidney into the neovaginal apex.

METHODS: A 42-year-old woman with primary amenorrhea and a previous diagnosis of MRKH syndrome presented requesting surgical treatment after unsuccessful progressive vaginal dilation. Examination revealed normal external genitalia and a distal one-third vaginal segment ending blindly. Preoperative pelvic magnetic resonance imaging was obtained for anatomic mapping and demonstrated uterine agenesis with a 12-mm fibrotic Müllerian remnant, both ovaries were normal, marked hypoplasia of the upper vagina, and a pelvic ectopic kidney with preserved parenchymal appearance and no hydronephrosis. Following counseling regarding available reconstructive options and the implications of the renal anomaly, laparoscopic Davydov neovaginoplasty was planned. The pelvic ectopic kidney, which was adherent to the anterior abdominal wall, was carefully dissected free. The peritoneum overlying the vaginal remnant was incised, and the potential neovaginal space was developed using blunt dissection and an advanced bipolar vessel-sealing device. A curette placed within the distal vaginal remnant was used as a guide, and the proximal end of the remnant was opened over the curette tip. Bilateral rudimentary Müllerian structures were dissected while developing the lateral aspects of the neovaginal space. The anterior and posterior pelvic peritoneum were approximated to the corresponding vaginal edges. The neovaginal apex was then reconstructed using two barbed sutures with sequential circumferential plication of the surrounding peritoneal surfaces. The bladder peritoneum anteriorly, rectal serosa posteriorly,

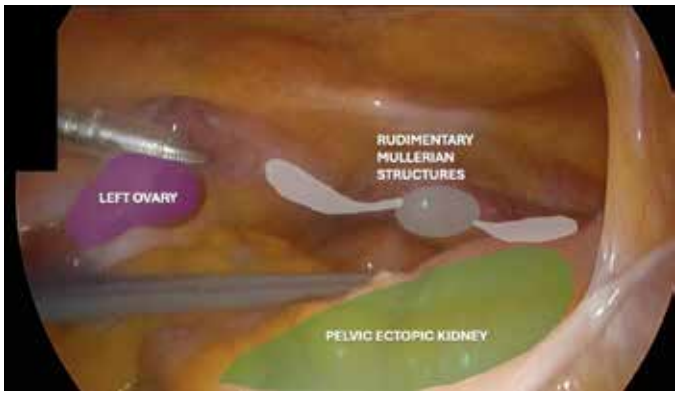
peritoneum overlying the left Müllerian remnant laterally, and peritoneum overlying the pelvic ectopic kidney together with the right Müllerian remnant were incorporated into the reconstruction.

RESULTS: The procedure was completed without concomitant urologic intervention or perioperative complications. The intraoperative neovaginal length was approximately 8 cm under active dilation. The patient was discharged on postoperative day 2 after vaginal dilator training. At 3-month follow-up, speculum examination demonstrated a healthy neovagina. Pelvic magnetic resonance imaging showed a neovaginal canal measuring 6.5 cm, with no mass or fluid collection in the surgical bed. The pelvic ectopic kidney remained unchanged in appearance.

CONCLUSION: Primary laparoscopic Davydov neovaginoplasty may be feasible in selected patients with type II MRKH syndrome and a pelvic ectopic kidney when preoperative anatomy is carefully assessed and the reconstructive technique is individualized. In this case, the core principles of Davydov neovaginoplasty were preserved despite altered pelvic anatomy. The principal technical distinction was incorporation of the peritoneum overlying the pelvic ectopic kidney into the neovaginal apex reconstruction, which may represent a useful reconstructive option in anatomically similar cases.

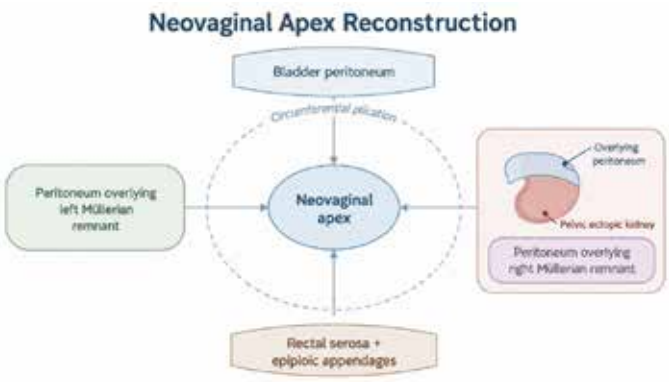
Keywords: Davydov neovaginoplasty, laparoscopic surgery, Mayer–Rokitansky–Küster–Hauser syndrome, neovaginal reconstruction, pelvic ectopic kidney, vaginal agenesis

Initial Laparoscopic Anatomy



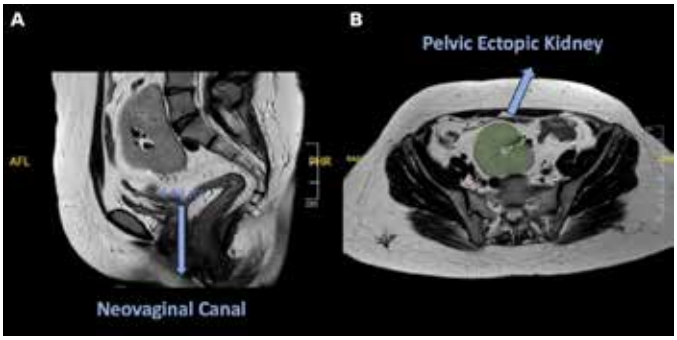
Initial laparoscopic view demonstrating bilateral rudimentary Müllerian structures and the right-sided pelvic ectopic kidney.

Neovaginal Apex Reconstruction



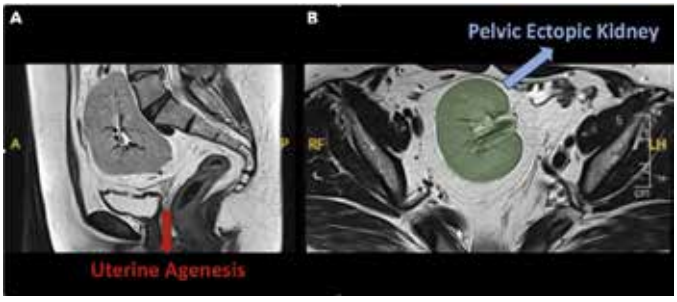
Schematic representation of circumferential neovaginal apex reconstruction. The bladder peritoneum was incorporated anteriorly, the rectal serosa and epiploic appendages posteriorly, the peritoneum overlying the left Müllerian remnant laterally, and the peritoneum overlying the pelvic ectopic kidney together with the right Müllerian remnant on the right.

Postoperative Pelvic MRI at 3 Months



Three-month postoperative pelvic MRI. (A) Sagittal T2-weighted image demonstrating the newly formed neovaginal canal measuring 6.5 cm. (B) Axial T2-weighted image showing the pelvic ectopic kidney, unchanged in appearance from the preoperative study.

Preoperative Pelvic MRI



Preoperative pelvic MRI. (A) Midsagittal T2-weighted image demonstrating uterine agenesis. (B) Axial T2-weighted image demonstrating the pelvic ectopic kidney.

PP-76

When should the rudimentary horn be excised? Staged surgical management and fertility preservation after second-trimester rupture

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OBJECTIVE: Non-communicating rudimentary horn pregnancy is a rare and life-threatening condition, reported in 1/76,000–150,000 pregnancies. Preoperative ultrasonography (USG) diagnoses only 29% of cases; the remainder are detected intraoperatively. Rupture occurs in 44% of cases, most commonly between 16 and 20 weeks of gestation. The optimal timing of definitive surgery in ruptured cases remains uncertain, particularly when severe hemodynamic instability and anatomical uncertainty coexist. Additionally, the timing of prophylactic excision in incidentally detected functional non-communicating rudimentary horns is not well established. We present the staged surgical management, elective laparoscopic resection, and fertility-preserving approach following second-trimester rudimentary horn rupture.

METHODS: A 28-year-old G1P0 patient with no comorbidities or surgical history was retrospectively evaluated. Informed consent was obtained.

RESULTS: The patient had a history of dysmenorrhea on previous gynecological evaluations; no uterine anomaly had been identified. She presented to an external center at 17 weeks of gestation with acute abdominal pain. Ultrasonography revealed a single fetus of approximately 17 weeks with no cardiac activity and widespread free fluid. Emergency laparotomy was performed following magnetic resonance imaging (MRI) findings suspicious for tubal pregnancy and rupture. Preoperative blood gas analysis revealed a hemoglobin (Hb) level of 5.6 g/dL. Approximately 2 liters of hemoperitoneum were evacuated; given hemodynamic instability and the inability to classify the uterine anomaly intraoperatively, priority was given to rapid hemorrhage control and maternal stabilization. The rupture site was sutured, and the patient was transferred to a tertiary center following blood product support. After stabilization, comprehensive anatomical evaluation was performed using hysterosalpingography (HSG), office hysteroscopy, and contrast-enhanced MRI. HSG demonstrated a single right-deviated uterine cavity with intraperitoneal contrast passage from the right tube; hysteroscopy revealed no passage into a left rudimentary horn cavity. MRI showed a left lateral structure in continuity with the uterus containing a 45 × 35 mm organized hematoma, consistent with a non-communicating rudimentary horn. Approximately four months after rupture, elective laparoscopy revealed a 7 cm rudimentary horn with dense adhesions to the descending colon, left salpinx, and left ovary. Following adhesiolysis, chromopertubation confirmed fimbrial patency of the right tube; no dye passage was observed from the left salpinx. Rudimentary horn excision and ipsilateral salpingectomy were then performed, preserving the left ovary. No macroscopic communication was identified between the main uterine cavity and the rudimentary horn. Repeat chromopertubation at the completion of the procedure confirmed no methylene blue leakage from the excision line.

CONCLUSION: Undiagnosed non-communicating rudimentary horn pregnancy may present with massive hemoperitoneum and hemorrhagic shock in the second trimester. Although horn excision is the definitive treatment for ruptured rudimentary horn pregnancy, in selected patients with acute hemorrhagic shock and anatomical uncertainty, rapid hemorrhage control and maternal stabilization followed by definitive surgery after detailed anatomical delineation may be an individualized management option. In incidentally detected functional non-communicating rudimentary horns, prophylactic resection should be individualized according to patient characteristics and future fertility plans. Multimodal anatomical assessment and multidisciplinary planning enabled preservation of the functional uterine cavity and patent contralateral tube in this case.

Keywords: Rudimentary horn pregnancy, Non-communicating uterine horn, Uterine rupture, Staged surgical management, Fertility preservation

HSG



Figure 2. Hysterosalpingography (HSG) demonstrating a right-deviated, spindle-shaped uterine cavity communicating with a single right fallopian tube of normal caliber. Free intraperitoneal contrast spill is noted on the right. No intracavitary filling defects are identified. Findings are consistent with a right unicornuate uterus.

MRI

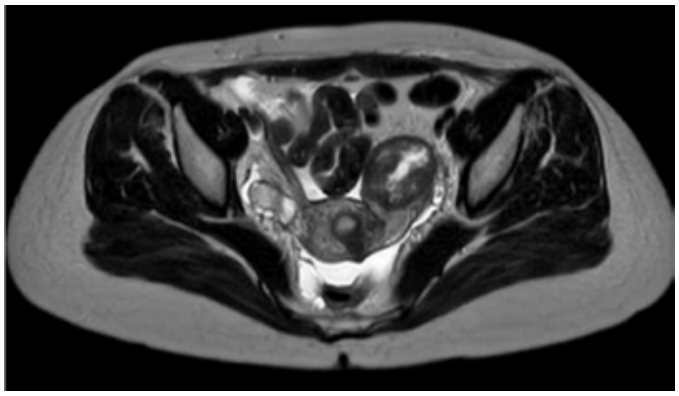


Figure 1. Transverse contrast-enhanced MRI demonstrating a left lateral structure in continuity with the uterine corpus, containing a 45 × 35 mm organized hematoma with peripheral enhancement — consistent with a non-communicating rudimentary horn (unicornuate uterus).

Non-communicating rudimentary horn — pre-resection

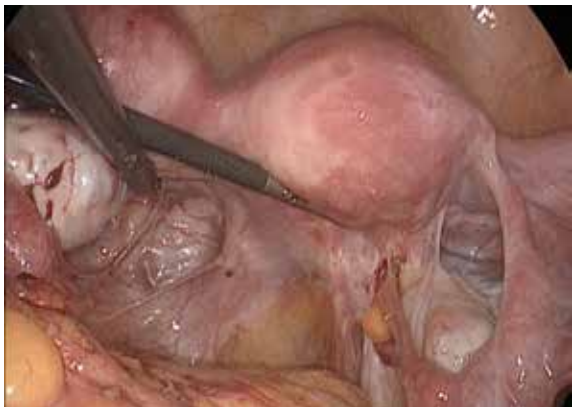


Figure 3A. Laparoscopic view prior to resection demonstrating the left non-communicating rudimentary horn (approximately 7 cm) with dense adhesions to the descending colon, left salpinx, and left ovary. The unicornuate uterine corpus is visible to the right.

Unicornuate uterus — post-resection



Figure 3B. Laparoscopic view following rudimentary horn excision and ipsilateral salpingectomy.

PP-77

Splenectomy Following Traumatic Splenic Rupture in the Second Trimester of Pregnancy and Successful Vaginal Delivery: A Case Report

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OBJECTIVE: Abdominal trauma during pregnancy is an important clinical condition that may result in significant maternal and fetal morbidity and mortality. Although splenic injury is rare during pregnancy, splenic rupture may require rapid diagnosis and surgical intervention. Continuation of pregnancy following splenectomy requires multidisciplinary management because of the increased risks of thromboembolism and infection. In this case report, we present the course of pregnancy and delivery in a pregnant woman who developed traumatic splenic rupture following a motor vehicle accident at 17 weeks of gestation and underwent emergency splenectomy.

CASE: A 27-year-old gravida 2 patient presented to the emergency department following a motor vehicle accident at 17 weeks of gestation. Clinical evaluation and imaging revealed traumatic splenic rupture and intra-abdominal hemorrhage. The patient underwent emergency surgery by the general surgery team, and splenectomy was performed. Postoperatively, obstetric follow-up was continued through a multidisciplinary approach. Considering the increased risk of venous thromboembolism associated with both splenectomy and pregnancy, thromboprophylaxis with low-molecular-weight heparin was administered. Appropriate vaccination was planned to reduce the risk of severe infections associated with asplenia, and [pneumococcal, meningococcal, and Haemophilus influenzae type b (Hib) vaccines were administered]. Maternal and fetal conditions were closely monitored throughout pregnancy. The pregnancy progressed without complications, and the patient had a spontaneous vaginal delivery at 39 weeks of gestation. A healthy live neonate weighing 3220 g was delivered, with Apgar scores of 7 and 9 at the first and fifth minutes, respectively.

CONCLUSION: Traumatic splenic rupture during the second

trimester of pregnancy is a rare but life-threatening condition. Successful continuation of pregnancy to term is possible with prompt surgical intervention when necessary for maternal stabilization and hemorrhage control, followed by close obstetric surveillance, thromboprophylaxis, and infection-prevention strategies appropriate for asplenia. This case demonstrates that pregnancy can be successfully continued and vaginal delivery can be safely achieved following traumatic splenectomy.

Keywords: Pregnancy, trauma, splenic rupture, splenectomy, asplenia, venous thromboembolism

PP-78

Pelvic-peritoneal granulomatous inflammation mimicking advanced ovarian cancer: A case with omental cake

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OBJECTIVE: An adnexal mass accompanied by ascites, elevated cancer antigen 125 (CA-125), peritoneal implants, and omental cake in a postmenopausal woman is highly suggestive of advanced ovarian malignancy. However, granulomatous diseases may produce similar clinical, radiological, and intraoperative findings. We present a case of extensive pelvic-peritoneal granulomatous inflammation mimicking advanced ovarian cancer.

METHODS: The clinical, laboratory, imaging, surgical, histopathological, and microbiological findings of a 70-year-old postmenopausal woman with one previous vaginal delivery who presented with pelvic pain and an adnexal mass were reviewed.

RESULTS: Transvaginal ultrasonography revealed a 30×16 mm irregular hyperechoic right adnexal mass and pelvic free fluid. Serum CA-125 was 483 U/mL and CA 15-3 was 46.4 U/mL, while carcinoembryonic antigen (CEA) and carbohydrate antigen 19-9 (CA 19-9) were within normal limits.

Abdominopelvic computed tomography (CT) demonstrated a 27×20 mm irregular solid mass thought to arise from the right ovary together with lesions suspicious for peritoneal implants in the left adnexal region and Douglas pouch. Nodular peritoneal thickening, diffuse heterogeneous omental involvement with an omental cake appearance, and pelvic and interloop ascites were also present. No pathological intra-abdominal lymphadenopathy was detected. Thoracic CT showed several right pulmonary nodules measuring up to 5 mm and a minimal left pleural effusion.

Given the strong suspicion of advanced ovarian malignancy, laparotomy was performed. Intraoperative exploration revealed both adnexa adherent to the posterior uterine surface, an obliterated Douglas pouch, and 1–2 cm implant-like lesions on the adnexal surfaces and posterior uterus. Hysterectomy and bilateral salpingo-oophorectomy, including the Douglas peritoneum, were performed, and the specimen was sent for frozen-section examination. Frozen section revealed granulomatous inflammation. Bilateral pelvic and para-aortic lymphadenectomy, total omentectomy, and falciform ligament excision were subsequently performed.

Final histopathology revealed extensive granulomatous

inflammation involving both ovaries and fallopian tubes, broad ligament, Douglas peritoneum, omentum, and falciform ligament. Granulomatous lymphadenitis was identified in one left pelvic lymph node, while the remaining 15 lymph nodes showed reactive lymphoid hyperplasia. No caseating necrosis was identified, and intra-abdominal cytology was negative for malignancy.

Histomorphological findings raised suspicion of an atypical mycobacterial infection, particularly Mycobacterium bovis, and the patient was evaluated by the Infectious Diseases department. She reported a history of animal husbandry approximately 30 years earlier but no history of brucellosis or consumption of unpasteurized dairy products. Brucellosis and syphilis serologies were negative. Ehrlich-Ziehl-Neelsen (EZN) staining showed no acid-fast bacilli, and tissue GeneXpert MTB/RIF testing was negative for Mycobacterium tuberculosis complex. Mycobacterial cultures were pending at the time of submission.

CONCLUSION: Granulomatous disease can closely mimic advanced ovarian cancer clinically, radiologically, and even intraoperatively. The combination of an adnexal mass, ascites, elevated CA-125, peritoneal lesions, and omental cake is highly suspicious for malignancy but is not specific. In this case, even the operative findings favored malignancy, whereas final histopathology revealed extensive granulomatous inflammation. Histopathological confirmation is crucial in such cases, and a specific mycobacterial etiology should not be assigned without microbiological confirmation.

Keywords: ovarian cancer, granulomatous inflammation, omental cake, CA-125, mycobacterial infection

PP-79

Mesenteric Ischemia Mimicking Pelvic Inflammatory Disease: A Case Report of a Diagnostic Challenge

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Pelvic inflammatory disease (PID) is a clinical condition frequently encountered in gynecological practice, typically characterized by lower abdominal pain, cervical motion tenderness, and signs of genital tract infection. However, the diagnosis of PID relies primarily on clinical findings; due to low specificity, it can be confused with other abdominal pathologies. Acute abdominal conditions—such as appendicitis, inflammatory bowel disease, and, more rarely, mesenteric ischemia—can mimic gynecological disorders. Mesenteric ischemia is a clinical condition that is difficult to diagnose due to its presentation with nonspecific early symptoms and limited physical examination findings, yet it can lead to serious consequences if diagnosis is delayed. This case report highlights the importance of differential diagnosis by presenting a patient who was initially evaluated for pelvic inflammatory disease but was subsequently diagnosed with mesenteric ischemia during follow-up.

Keywords: Abdominal pain, mesenteric ischemia, pelvic inflammatory disease

iskemik barsak



Mezenter iskemiye bağlı ödemli ince barsak anslarının intraoperatif görünümü



PP-80

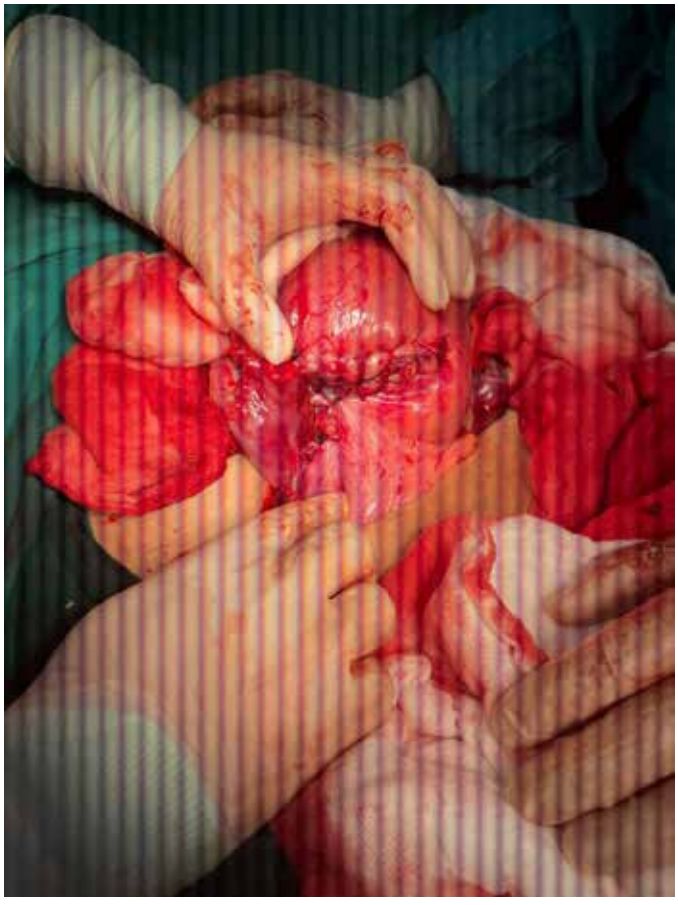
Case Report of Uterine Subrupture

Serhan Kütük
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A patient at 37 weeks of gestation (G3P2, with two prior Cesarean sections) underwent a Cesarean delivery due to persistent abdominal pain, despite irregular contractions on the initial non-stress test (NST) and the absence of pain activity on the follow-up NST. Intraoperative assessment revealed a subrupture in the lower uterine segment, which was repaired with a double-layer suture. It should be borne in mind that patients with a history of surgeries such as Cesarean sections, myomectomy, or uterine septum resection may not always exhibit pain on the NST; therefore, the patient's clinical presentation of pain should be the primary consideration.

Keywords: cesarean section, subrupture, NST

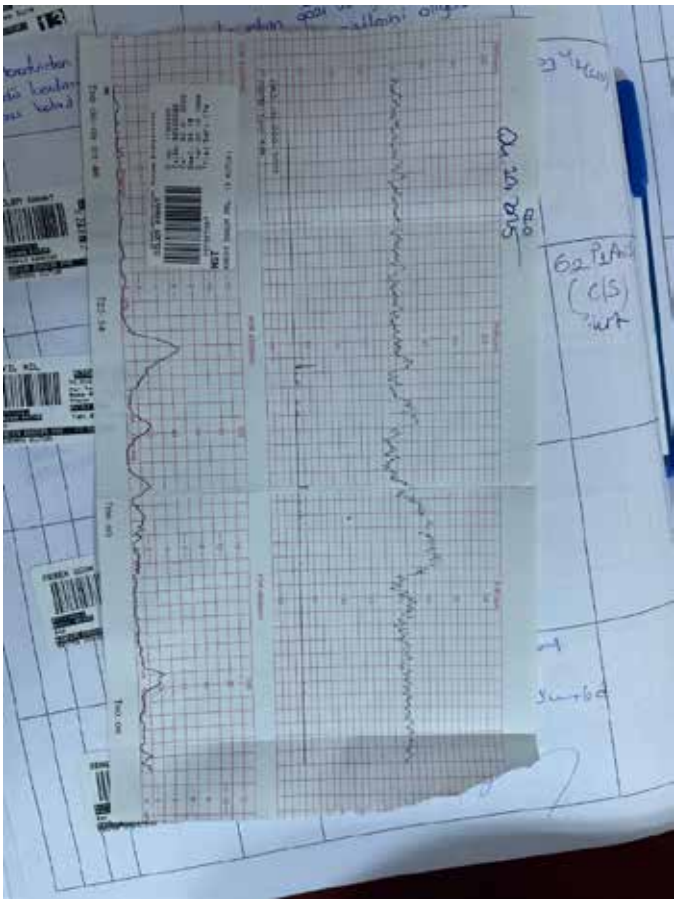
Uterin subrüptür hastanın intraoperatif onarım sonrası resmi



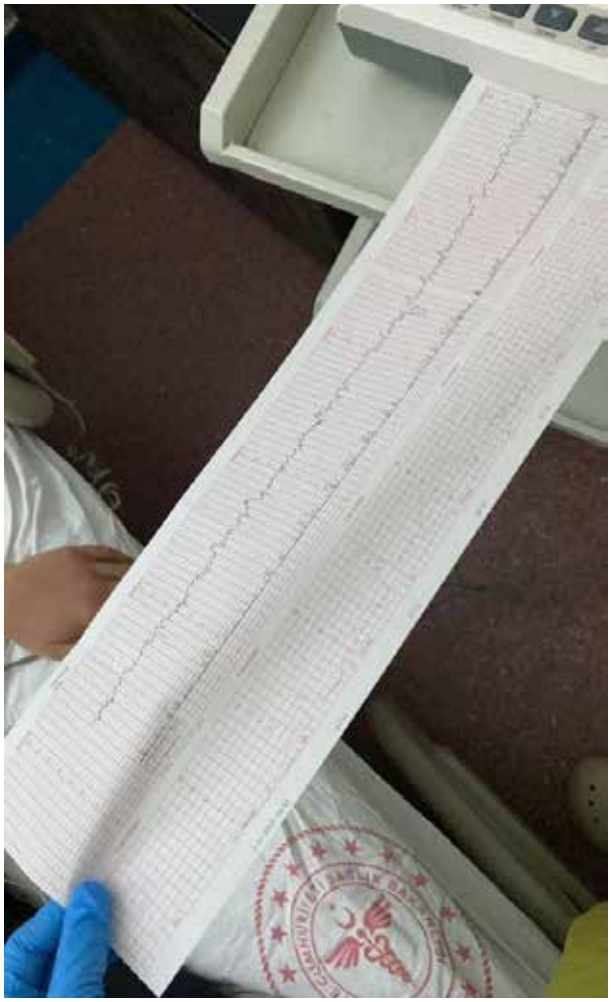
Uterin subrüptür hastanın intraoperatif resmi



Uterin subrüptür hastanın nst resimleri



Uterin subrüptür hastanın nst resimleri



8. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi
30 Eylül - 4 Ekim 2026
NG Phaselis Bay Kemer, Antalya

PP-81

Beyond nuchal translucency: first-trimester detection of holoprosencephaly leading to the diagnosis of trisomy 13

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OBJECTIVE: Trisomy 13 is associated with severe multisystem congenital anomalies involving the central nervous system, face, heart, and extremities. Congenital heart defects are among the most frequently reported abnormalities, while holoprosencephaly is one of the characteristic central nervous system findings. We present a case highlighting the importance of systematic fetal anatomical assessment during first-trimester screening, even when nuchal translucency is within the normal range.

METHODS: A 39-year-old gravida 4, para 2 woman with a spontaneous pregnancy underwent first-trimester combined screening at 12 weeks of gestation. Nuchal translucency was 1.4 mm (0.98 multiples of the median [MoM]), pregnancy-associated plasma protein-A was markedly decreased at 0.03 MoM, and free β-human chorionic gonadotropin was 0.81 MoM. The calculated risks for trisomy 21 and trisomy 18 were 1:75 and 1:1260, respectively. No calculated risk for trisomy 13 was reported. The patient was subsequently referred for detailed fetal ultrasonography.

RESULTS: At 13 weeks and 5 days, ultrasonography demonstrated holoprosencephaly, with suspected cyclopia and proboscis (Figure 1). An atrioventricular septal defect and bilateral rocker-bottom feet were also identified. Based on these multiple structural abnormalities, chorionic villus sampling was performed on the same day. At 16 weeks and 4 days, cytogenetic analysis confirmed trisomy 13. Follow-up ultrasonography demonstrated definite cyclopia and proboscis, while holoprosencephaly, the atrioventricular septal defect, and bilateral rocker-bottom feet persisted. Following genetic counseling, termination of pregnancy was offered because of the confirmed chromosomal abnormality and severe associated fetal anomalies. The family accepted, and the pregnancy was terminated at 16 weeks and 4 days. Post-termination external examination demonstrated cyclopia, a supraorbital proboscis, and hand polydactyly (Figure 2).

CONCLUSION: This case highlights that normal nuchal translucency does not exclude severe fetal structural or chromosomal abnormalities. Systematic first-trimester anatomical assessment enabled early recognition of holoprosencephaly and associated multisystem abnormalities, prompting invasive diagnostic testing and confirmation of trisomy 13. The coexistence of central nervous system, facial, cardiac, and limb abnormalities is highly suggestive of trisomy 13. Early integration of detailed ultrasonography and cytogenetic diagnosis facilitates accurate counseling and timely pregnancy management.

Keywords: cyclopia, first-trimester ultrasound, holoprosencephaly, polydactyly, proboscis, trisomy 13

Figure 1



Prenatal ultrasonographic image demonstrating holoprosencephaly with suspected cyclopia and proboscis at 13 weeks and 5 days of gestation.

Figure 2



Post-termination external appearance demonstrating cyclopia, a supraorbital proboscis, and hand polydactyly.

PP-82

Incidental isolated tubal torsion detected during laparoscopic hysterectomy case

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AIM: Isolated tubal torsion (ITT) is a rare gynecological condition in which the fallopian tube twists around its own vascular pedicle without concomitant ovarian torsion. Paraovarian cysts are recognized predisposing factors; however, ITT may remain clinically unsuspected because of its nonspecific symptoms and rarity. We present a case of isolated fallopian tube torsion secondary to a paraovarian cyst, unexpectedly diagnosed during laparoscopic hysterectomy.

METHODS: A 45-year-old woman was admitted for laparoscopic hysterectomy due to abnormal uterine bleeding. Preoperative transvaginal ultrasonography demonstrated a left paraovarian cyst measuring approximately 4 cm, without definitive evidence of adnexal torsion. During laparoscopic exploration, the uterus and both ovaries were assessed. A paraovarian cyst was identified adjacent to the left fallopian tube, which appeared markedly enlarged, congested, and twisted around its vascular pedicle. The ipsilateral ovary was normal in size and appearance, confirming the diagnosis of isolated tubal torsion. The torsed tube and paraovarian cyst were carefully isolated and removed laparoscopically. The surgical specimen was subsequently examined histopathologically.

FINDINGS: Intraoperative inspection revealed approximately 3 times of torsion of the left fallopian tube associated with a 4-cm paraovarian cyst. The twisted tube showed significant venous congestion and a ischemic appearance, whereas the ipsilateral ovary remained completely normal. Detorsion was considered unlikely to restore tubal viability; therefore, laparoscopic salpingectomy with excision of the paraovarian cyst was performed. Histopathological examination demonstrated hemorrhagic congestion and ischemic changes of the fallopian tube consistent with torsion, while the cyst was compatible with a benign paraovarian cyst. The postoperative course was uneventful, and the patient was discharged in good clinical condition.

CONCLUSION: Isolated tubal torsion is an uncommon but important adnexal pathology that can be overlooked preoperatively because its clinical and radiological findings are nonspecific. Paraovarian cysts may act as a mechanical trigger for tubal torsion. Careful inspection of the adnexa during laparoscopic hysterectomy can facilitate incidental diagnosis and appropriate treatment. When a paraovarian cyst is identified, particularly in association with an abnormal or congested fallopian tube, isolated tubal torsion should be considered in the differential diagnosis. Early recognition and laparoscopic management may prevent further ischemic complications and unnecessary morbidity.

Keywords: Cyst, torsion, tuba, paraovarian

Isolated tubal torsion



Isolated tubal torsion 2



PP-83

First-trimester diagnosis of sirenomelia with megacystis: diagnostic challenges beyond standard genetic testing

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OBJECTIVE: To present the first-trimester diagnosis of sirenomelia associated with megacystis and to highlight the diagnostic and genetic counseling challenges posed by a severe fetal structural anomaly despite normal conventional cytogenetic and chromosomal microarray findings.

METHODS: A 30-year-old gravida 3, para 1 woman with a spontaneous pregnancy and no history of maternal diabetes was evaluated at 12 weeks and 2 days of gestation. Nuchal translucency was within the normal range. Detailed ultrasonography demonstrated fused lower extremities consistent with sirenomelia and fetal megacystis, with a longitudinal bladder diameter of 9 mm. Amniotic fluid volume was normal, and no additional major structural anomaly was identified. Chorionic villus sampling (CVS) was performed. Whole-exome sequencing (WES) was discussed as an additional diagnostic option but was declined by the family.

RESULTS: Following counseling regarding the severe fetal phenotype and prognosis, the family elected termination of pregnancy on the same day as CVS without awaiting the genetic results. Post-termination external examination confirmed fused lower extremities consistent with sirenomelia (Figure 1). Quantitative fluorescence polymerase chain reaction (QF-PCR), conventional karyotyping, and chromosomal microarray analysis subsequently yielded normal results.

CONCLUSION: Sirenomelia can be diagnosed in the first trimester by systematic evaluation of the fetal lower extremities, even when nuchal translucency and amniotic fluid volume are normal. Associated megacystis may provide an additional clue to abnormal caudal development. Normal karyotype and chromosomal microarray findings do not exclude an underlying monogenic etiology. Emerging evidence implicating genes involved in caudal developmental pathways, including CDX2, supports consideration of extended genomic testing in selected cases with severe structural abnormalities after nondiagnostic standard testing. Establishing a molecular diagnosis may improve etiologic clarification and permit more individualized recurrence-risk counseling in future pregnancies.

Keywords: chromosomal microarray, first-trimester ultrasound, megacystis, prenatal diagnosis, sirenomelia, whole-exome sequencing

Figure 1



Post-termination external appearance demonstrating fused lower extremities consistent with sirenomelia. The exposed abdominal contents result from an anterior abdominal wall disruption sustained during the termination procedure and do not represent a congenital abdominal wall defect.

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A Case of an Adolescent Presenting with Concurrent Ovarian Torsion and Acute Appendicitis: A Coincidental Association or a Causal Relationship?

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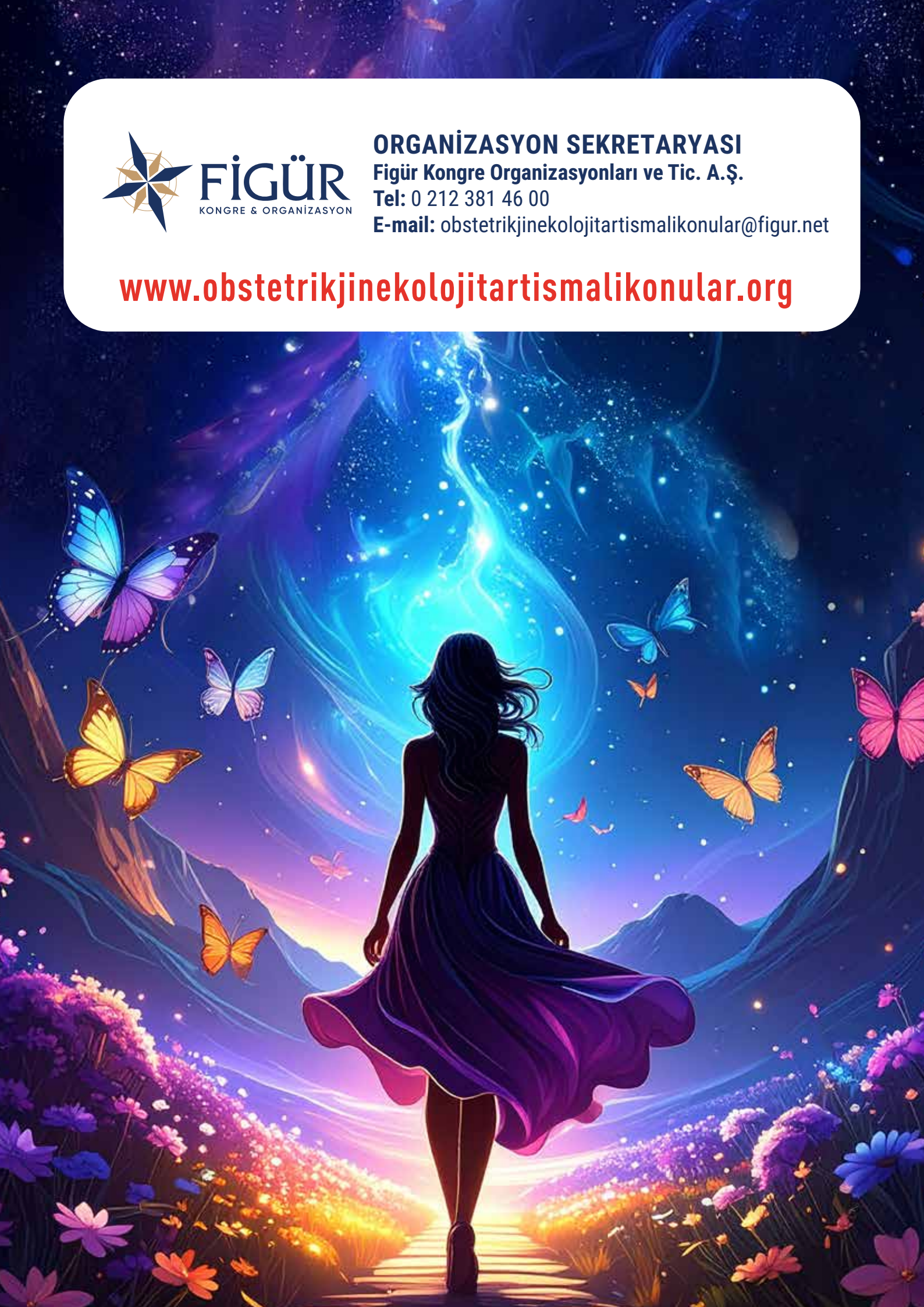
OBJECTIVE: Ovarian torsion, one of the significant gynaecological causes of acute abdominal pain in adolescents, can frequently mimic acute appendicitis clinically. Less commonly, inflammation of the appendix accompanying ovarian torsion has been reported. It has been suggested in the literature that this association, particularly in cases of delayed and necrotic torsion, may be related to the twisted ovary causing inflammation in the adjacent appendix. In this case report, the potential causal relationship and the importance of surgical exploration are discussed based on the identification of findings of acute appendicitis concurrent with ovarian torsion.

CASE: A 17-year-old female patient was assessed for pain in the right lower quadrant. Physical examination findings suggested ovarian torsion, and the patient was taken to emergency surgery with a provisional diagnosis of adnexal torsion. During exploration, the right ovary was found to be twisted three full turns (1080°). The twisted ovary was detorsioned and the operation continued whilst preserving the ovary. During further abdominal exploration, the appendix was observed to be consistent with acute appendicitis. Consequently, an appendectomy was performed. Both surgical procedures were completed without complications.

DISCUSSION: It is quite rare for ovarian torsion and appendiceal pathologies to co-occur in the same patient. In previously reported case series in the literature, it has been suggested that periappendicitis may accompany ovarian torsion and that a twisted ovary may cause inflammation in the adjacent appendix. However, in the present case, it could not be definitively established whether the inflammation of the appendix developed prior to ovarian torsion, thereby creating a predisposing condition for torsion via an intra-abdominal inflammatory response and increased peritoneal fluid, or whether the local inflammation caused by the twisted ovary triggered acute inflammation in the appendix. Consequently, rather than a causal relationship between the two pathologies, the possibility that they developed simultaneously and independently should also be considered. Furthermore, failure to recognise the second pathology identified intraoperatively could result in the patient's treatment being incomplete.

CONCLUSION: In patients suspected of having ovarian torsion, diagnostic and therapeutic surgical exploration should not be limited to the assessment of the adnexa alone; other abdominal organs should also be systematically examined. The possible causal relationship between ovarian torsion and appendicitis remains a matter of debate. Further studies, particularly those involving histopathological correlation, are required to elucidate the mechanism underlying this rare association.

Keywords: Acute abdomen, Acute appendicitis, adolescent, Over Torsion



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