TAJEV
TÜRK ALMAN JİNEKOLOJİ
EĞİTİM, ARAŞTIRMA ve HİZMET VAKFI

Deutsch-Türkische Gynäkologengesellschaft
1993

GÜNCEL YAKLAŞIMLAR SEMPOZYUMU

5-6 Haziran 2026, DoubleTree by Hilton Van

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BİLİMSEL PROGRAM ve BİLDİRİ ÖZETLERİ KİTABI

Değerli Meslektaşlarımız,

Sizleri **TAJEV Obstetrik ve Jinekolojide Güncel Yaklaşımlar Sempozyumu**'na davet etmekten büyük bir onur ve mutluluk duymaktayız. Bu sempozyumda temel amacımız kadın hastalıkları ve doğum alanında güncel bilgilerin işlenmesi, bütüncül değerlendirilmesi ve bilim insanlarının yeni çalışmalarını, bilgi birikimlerini paylaşmalarını sağlayacak etkileşimli bir ortam yaratmaktır.

Sempozyumda Obstetrik ve Jinekoloji alanlarında bilgilerimizi gözden geçirmeyi, yenilikleri ve deneyimlerimizi birbirimizle paylaşmayı, sahada karşılaştığımız problemleri dile getirmeyi ve çözüm önerileri oluşturmayı hedefleyerek, özlem gidermeyi amaçlıyoruz.

Ayrıca sempozyumun hemen öncesinde vNOTES cerrahisinin temel prensiplerinin gerçek organ modeli üzerinde uygulamalı olarak gösterileceği vNOTES kursu düzenlenecektir.

5-6 Haziran 2026 tarihlerinde, Van'da gerçekleşecek olan TAJEV Obstetrik ve Jinekolojide Güncel Yaklaşımlar Sempozyumu'nda sizleri aramızda görmeyi umuyor, değerli katılımlarınızı bekliyoruz.

Saygılarımızla,

Prof. Dr. Cihat Ünlü
Sempozyum ve TAJEV Başkanı

Prof. Dr. Yusuf Üstün
Sempozyum Başkanı

KONGRE DÜZENLEME KOMİTESİ

Sempozyum Başkanları

Cihat Ünlü	Yusuf Üstün

KONGRE DÜZENLEME KOMİTESİ

Mete Güngör

Erbil Karaman

Ali Kolusarı

M. Faruk Köse

U. Fırat Ortaç

Batuhan Özmen

Özlem Pata

Yaprak Üstün

*Soyadına göre alfabetik sıralamayla yazılmıştır.

4 Haziran 2026, Perşembe

vNOTES CERRAHİSİ 4 Saatlik Kompakt Uygulamalı Kurs Programı

Kurs Başkanları: ***Yaşam Kemal Akpak, Emrah Töz***

KONTENJAN 20 KİŞİ İLE SINIRLIDIR

Applied Medical

14:00-14:10	**Açılış ve Kursun Amacı**	
14:10-15:10	**Video Atölyesi I: vNOTES'e Güvenli Başlangıç**	
	vNOTES Cerrahisi Rasyoneli ve Kullanılan Aletler	***Emrah Töz***
	vNOTES Hasta Seçimi, Planlama ve Port Yerleşimi	***Emrah Töz***
	vNOTES Histerektomi – Kritik Cerrahi Adımlar	***Yaşam Kemal Akpak***
	vNOTES Adneksiyel Cerrahi	***Yaşam Kemal Akpak***
15:10-15:30	**Kahve Molası**	
15:30-16:20	**Video Atölyesi II: İleri Teknikler ve Komplikasyon Yönetimi**	
	vNOTES Yüksek Uterosakral Ligamanın Kısaltılması	***Yaşam Kemal Akpak***
	vNOTES Sakrospinöz Ligaman Fiksasyonu	***Emrah Töz***
	vNOTES Cerrahisi Komplikasyonları ve Korunma Stratejileri	***Yaşam Kemal Akpak***
16:20-18:00	**Dry Lab: Gerçek Organ Modeli Üzerinde Uygulamalı Eğitim**	
	Batına Giriş ve Port Yerleştirilmesi	
	Kamera Yönlendirme ve Koordinasyon Çalışmaları	
	vNOTES Adneksiyel Cerrahi Pratiği (Salpenjektomi, Ooferektomi)	
	vNOTES Histerektomi Temel Adımları	
	vNOTES Sakrouterin Ligaman Kısaltılması Pratiği	

Kurs Ücreti KDV dahil 9.000 TL'dir.

Vnotes Kursuna kayıt olabilmek için öncelikle kongre kaydının yapılmış olması gerekmektedir.

5 Haziran 2026, Cuma

08:30-08:50	**Açılış**	
08:50-10:30	**Oturum 1: Obstetrik Ultrasonografi**	
	Oturum Başkanları: *Mansur Kamacı, Güler Şahin*	
08:50-09:10	İlk Üç Ayda Kaçırılmaması Gereken Anomaliler? NIPT İlk Üç Ay Ultrasonografisinin Yerini Alabilir mi?	***Recep Has***
09:10-09:30	Erken Fetal Ekokardiyografi: 11-13 Haftada Kalp Anomalilerini Nasıl Tespit Edelim?	***Hakan Timur***
09:30-09:50	İkinci Trimester Temel Ultrasonografik Değerlendirme, Bilmemiz Gereken Her Şey	***Özgür Deren***
09:50-10:10	Üçüncü Trimester Obstetrik Ultrasonografinin İşlevselliği, ISUOG Klavuzu	***Özlem Pata***
10:10-10:30	Tartışma	
10:30-10:50	**Kahve Molası**	
10:50-11:30	**Uydu Sempozyumu** **PMOS Yönetiminde Yardımcı Stratejiler: Metabolik ve Hormonal Dengenin Yönetimi** **Konuşmacı:** *Yaprak Üstün*	ORZAX SAĞLIĞA HEDİYE
11:30-12:45	**Oturum 2: Onkoloji**	
	Oturum Başkanları: *Ali Kolusarı, İhsan Bağlı*	
11:30-11:50	Adneksiyal Kitlelerde Hasta Yönetiminin Bireyselleştirilmesi	***Nejat Özgül***
11:50-12:10	Olgular Bazında Servikal Premalign Lezyonlarda Anormal Sitoloji ve Histolojinin Değerlendirilmesi	***U. Fırat Ortaç***
12:10-12:30	HPV İlişkili Hastalıklar ve Kanserlerin Önlenmesinde HPV Aşısı	***M. Faruk Köse***
12:30 12:45	Tartışma	
12:45-13:45	**Öğle Yemeği**	

5 Haziran 2026, Cuma

13:45-15:00	**Oturum 3: Reproduktif Endokrinoloji**
	Oturum Başkanları: *Yaprak Üstün, Emsal Pınar Topdağı Yılmaz*

13:45-14:05	Kişiye Özel Oral Kontraseptif Seçimi	***Gürkan Uncu***
14:05-14:25	Endometriozis Cerrahisinde Güncel Yaklaşımlar	***M. Murat Naki***
14:25-14:45	Uterin Anomalilerde Kime, Ne Zaman Cerrahi?	***Nuray Bozkurt***
14:45-15:00	Tartışma	

15:00-15:20	**Kahve Molası**
15:20-16:00	**Uydu Sempozyumu** **Moderatörler:** *Cihat Ünlü, Özlem Pata* **Konuşmacı:** *Fatih Durmuşoğlu* NBL PREGNA OMEGA
16:00-17:00	**Panel 1: Gebelikte Mikrobesin Gereksinimleri, Demir, D Vitamini, Folat, Kalsiyum, İyot ve Omega-3** **Moderatör:** *Özlem Pata* **Panelistler:** *Berrin Göktuğ Kadıoğlu, Cemil Oğlak*

5 Haziran 2026, Cuma — Salon B

09:30-10:30	**Sözlü Bildiri Oturumu**
	Oturum Başkanları: *Ramazan Erda Pay, Alp Tokalıoğlu*

Detaylar için QR okutunuz!

11:30-12:30	**Sözlü Bildiri Oturumu**
	Oturum Başkanları: *Mehmet Ceyhan, Uygar Tanyeri*

Detaylar için QR okutunuz!

16:00-17:00	**Sözlü Bildiri Oturumu**
	Oturum Başkanları: *Murat Gözüküçük, Erdal Özmen*

Detaylar için QR okutunuz!

6 Haziran 2026, Cumartesi

08:30-09:30	**Panel 2: Olgularla İnfertilite, Ovulasyon İndüksiyonu**
	Moderatör: *L. Cem Demirel* **Panelistler:** *Aziz Gül, Gürkan Bozdağ, Batuhan Özmen, Şahin Zeteroğlu*
09:30-10:40	**Oturum 4: Maternal Mortalite**
	Oturum Başkanları: *Mete Güngör, Erbil Karaman*

09:30-10:00	Postpartum Kanamaya Yaklaşımda Temel Prensipler	***Yaprak Üstün***
10:00-10:30	Maternal Mortaliteyi Azaltmaya Yönelik Yaklaşımlar	***Yusuf Üstün***
10:30-10:40	Tartışma	

10:40-11:00	**Kahve Molası**
11:00-11:40	**Uydu Sempozyumu** **Moderatör:** *Cihat Ünlü* **Menopozda Non-Hormonal Tedavi: VEOZA™ (Fezolinetant)** **Konuşmacı:** *Yaprak Üstün*
11:40-12:40	**Oturum 5: Ürojinekoloji**
	Oturum Başkanları: *Onur Karaaslan, Latif Hacıoğlu*

11:40-11:55	Üriner İnkontinansta Kime Hangi Cerrahi?	***Akın Sivaslıoğlu***
11:55-12:10	Pelvik Organ Prolapsusunda Cerrahi Yöntemler	***Yaşam Kemal Akpak***
12:10-12:25	Ürojinekolojik Cerrahi Komplikasyonlarının Yönetimi	***Emrah Töz***
12:25-12:40	Tartışma	

12:40-13:40	**Öğle Yemeği**

6 Haziran 2026, Cumartesi

13:40-14:55	**Oturum 6: Menopoz**	
	Oturum Başkanları: *Cihat Ünlü, Metin Aygar*	
13:40-14:00	Menopozda Hormon Replasman Tedavisi: 2026 Güncellemesi	***Yaprak Üstün***
14:00-14:20	Menopozda Hormon Dışı Tedavilerde Güncel Gelişmeler	***Fatih Durmuşoğlu***
14:20-14:40	Postmenopozal Kanamaya Yaklaşım ve Yönetim Nasıl Olmalı?	***Salih Taşkın***
14:40-14:55	Tartışma	
14:55-15:15	**Kahve Molası**	
15:15-16:30	**Oturum 7: Kozmetik Jinekoloji**	
	Oturum Başkanları: *Yusuf Üstün, Ersin Onat*	
15:15-15:35	Videolar Eşliğinde Labioplasti ve Hudoplasti Teknikleri	***Süleyman Eserdağ***
15:35-15:55	Kozmetik Jinekolojide Durulması Gereken Sınır Nedir?	***Ozan Doğan***
15:55-16:15	Videolar Eşliğinde Genital Bölge Hyaluronik Asit, PRP, Kök Hücre, Ekzozom, Mezoterapi, Peeling Uygulamaları	***Akın Sivaslıoğlu***
16:15-16:30	Tartışma	
16:30	**Kapanış**	

6 Haziran 2026, Cumartesi — Salon B

08:30-09:30	**Sözlü Bildiri Oturumu**	
	Oturum Başkanları: *Doğukan Özkan, Okan Oktar*	

Detaylar için QR okutunuz!

SÖZEL BİLDİRİLER

SS-01

A case of primary ovarian high-grade endometrial stromal sarcoma, youngest reported to date, and a brief review of the literature

Helin Elçi, Onur Karaaslan, Erbil Karaman
Department of Obstetrics and Gynecology, Van Yuzuncu Yıl University, Van, Turkey

BACKGROUND: Endometrial stromal sarcoma (ESS) is a rare mesenchymal tumor, typically arising in the uterus and accounting for a small proportion of gynecologic malignancies. Extrauterine ESS, particularly primary ovarian high-grade ESS (HG-ESS), is extremely uncommon and associated with an aggressive clinical course and poor prognosis. Reported cases predominantly occur in peri- or postmenopausal women.

CASE PRESENTATION: We present a 17-year-old nulligravid patient, representing the youngest reported case of primary ovarian HG-ESS to date. The patient initially presented with abdominal pain and distension. Imaging revealed a large adnexal mass, and tumor markers (CA-125 and CA 19-9) were markedly elevated. Despite a prior benign diagnosis of mucinous cystadenoma and regular follow-up, the disease progressed rapidly.

The patient underwent emergency exploratory laparotomy due to acute clinical deterioration. Intraoperative findings included massive ascites and a large malignant-appearing ovarian mass. Optimal cytoreductive surgery was achieved. However, the postoperative course was complicated by rapid clinical decline, refractory ascites, and multi-organ involvement. Despite intensive care management, the patient died within one month of initial presentation. Final histopathology confirmed primary ovarian high-grade endometrial stromal sarcoma.

DISCUSSION: Primary ovarian ESS is exceedingly rare, with fewer than 100 cases reported, most of which are low-grade. High-grade variants are particularly aggressive and often diagnosed at advanced stages. Clinical presentation is nonspecific, frequently mimicking other ovarian neoplasms, which contributes to diagnostic challenges—especially in young patients.

There is no standardized treatment due to the rarity of the disease. While complete cytoreductive surgery remains the cornerstone of management, HG-ESS typically requires systemic chemotherapy, as hormonal therapies are generally ineffective. Prognosis is poor, with high recurrence rates and limited survival, particularly in high-grade cases.

CONCLUSION: This case highlights the aggressive nature and diagnostic challenges of primary ovarian HG-ESS in adolescents. It underscores the importance of maintaining a high index of suspicion for rare malignancies, even in young patients with previously benign pathology. Early recognition and a multidisciplinary approach are essential, although outcomes remain poor. Further studies are needed to establish optimal management strategies for this rare entity.

Keywords: extrauterine, high grade, ovarian endometrial stromal sarcoma

SS-02

Early postoperative bowel incarceration through a non-incisional fascial defect following total abdominal hysterectomy: A case report

Vefa Şakar
Department of Obstetrics and Gynecology, S.B.U. Gulhane Training and Research Hospital, Ankara, Turkey

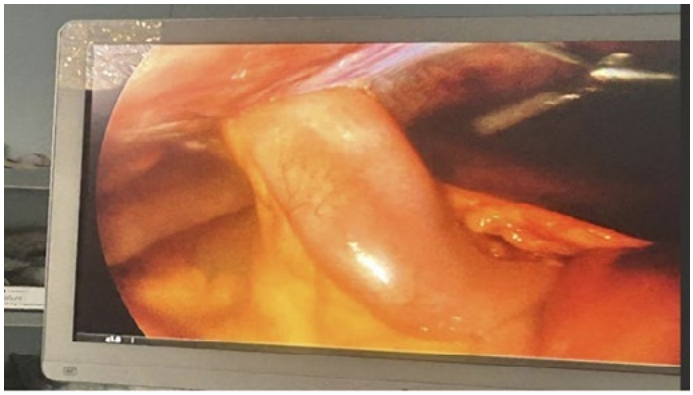
Postoperative bowel incarceration is a rare but serious complication and is usually associated with the surgical incision site. Herniation arising from abdominal wall defects outside the incision site, however, is extremely rare and may lead to a delay in diagnosis.

A 46-year-old patient who had undergone a total abdominal hysterectomy developed acute abdominal symptoms on the third postoperative day. The patient had a history of myomectomy and caesarean section. Imaging studies revealed bowel incarceration arising from an abdominal wall defect located in a region distinct from the surgical incision line. The patient underwent emergency laparoscopic surgery, and the incarcerated bowel was reduced. Following reduction of the bowel loops, bowel motility and viability were assessed, and the fascial defect was closed laparoscopically using 2/0 Vicryl sutures in accordance with the LeBlanc suture technique. The postoperative period proceeded uneventfully. During follow-up, a marked improvement in the patient's complaints of nausea and vomiting was observed. As gastrointestinal function improved, oral intake was gradually increased, and the patient became able to tolerate oral feeding. No adverse findings were observed in clinical or laboratory results. The patient was discharged with recommendations following a stable course. No postoperative complications were identified during outpatient follow-up.

This case demonstrates that abdominal pain developing in the postoperative period should not always be interpreted as ileus. In particular, in patients who have previously undergone abdominal surgery, herniations developing in non-incisional areas should also be considered. Early diagnosis is of critical importance in preventing serious complications such as strangulation and necrosis.

Keywords: hysterectomy, bowel incarceration, laparoscopy

Şekil 3



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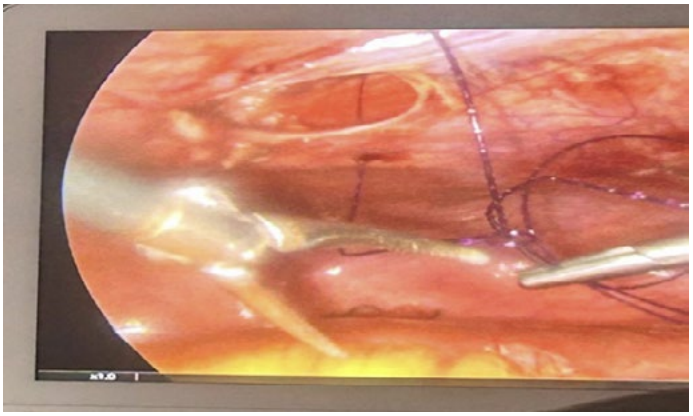
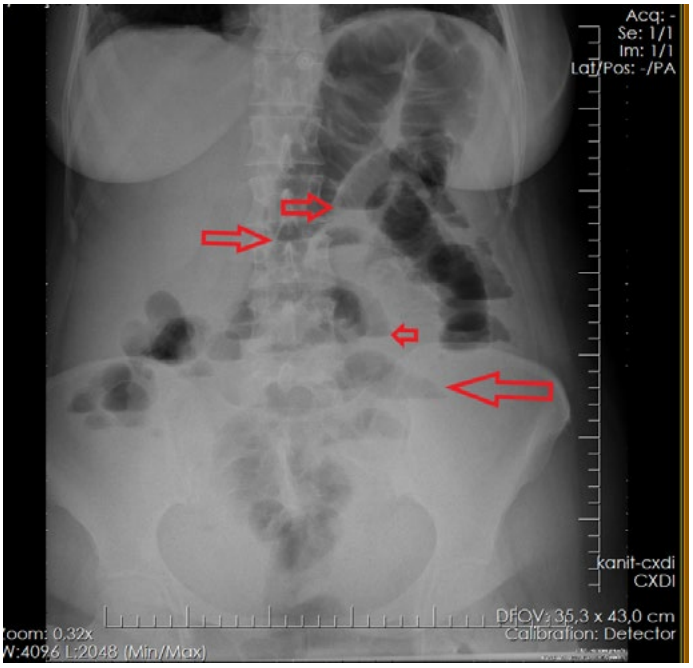


Şekil1



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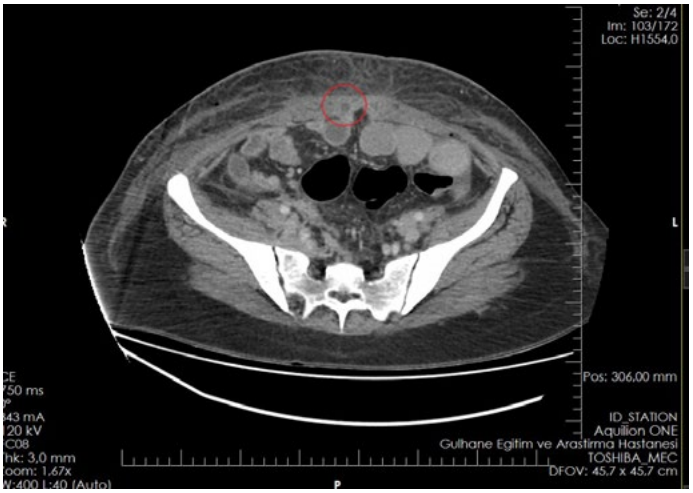


SS-03

Giant adnexal mass in pregnancy: A case report of cystectomy performed concomitantly with cesarean section at term

Buse Kara[1], Saygın Çolak[1], Orhan Nural[2], Bahar Konuralp[2], Atalay Ekin[2], Yaşam Kemal Akpak[1], Yaprak Üstün[1]
[1]Department of Obstetrics and Gynecology, İzmir City Hospital, İzmir, Turkey
[2]Department of Perinatology, İzmir City Hospital, İzmir, Turkey

OBJECTIVE: Adnexal masses detected during pregnancy are mostly benign and may be managed conservatively with close follow-up in selected cases. However, large adnexal masses require careful evaluation because of the risks of adnexal torsion, rupture, hemorrhage, obstruction during labor, and, rarely, malignancy. In this case report, we present the follow-up of a giant adnexal mass detected in early pregnancy and its surgical management concomitantly with cesarean section at term.

METHODS: A 19-year-old primigravid patient was referred to our clinic at 15 weeks of gestation due to a cystic adnexal lesion thought to originate from the right ovary. The patient had no complaints at admission. In addition to serial ultrasonographic evaluations, non-contrast pelvic magnetic resonance imaging (MRI) was performed for more detailed characterization of the mass. MRI revealed a well-circumscribed, purely cystic lesion measuring approximately 190 × 149 × 93 mm, thought to originate from the right ovary and extending toward the upper abdomen (Figures 1 and 2). Tumor markers were within normal limits, and no radiological finding suggestive of malignancy was observed. The option of surgical management during pregnancy was discussed with the patient in detail; however, the patient did not accept antenatal surgery. Therefore, close antenatal follow-up with serial ultrasonography was planned.

RESULTS: During pregnancy, the patient did not develop adnexal torsion, rupture, acute abdomen, or signs of obstetric deterioration. When the pregnancy reached 39 weeks of gestation, cesarean section was planned because of breech presentation of the fetus and the accompanying giant adnexal mass. During the operation, a cystic adnexal mass measuring approximately 19 × 15 cm was excised (Figure 3). Intraoperative frozen section examination was evaluated as benign. No postoperative complication was observed, and no adverse maternal or neonatal outcome occurred. The final histopathological examination result was reported as serous cystadenoma.

CONCLUSION: This case demonstrates that large adnexal masses without clinical, laboratory, or radiological suspicion of malignancy may be followed until term in selected pregnant patients under close surveillance. In cases without acute complications and with an obstetric indication for cesarean delivery, cystectomy performed concomitantly with cesarean section at term may be a safe and effective management option. Individualized decision-making, multidisciplinary evaluation, and close antenatal follow-up should be the main approaches in the management of giant adnexal masses during pregnancy.

Keywords: Adnexal mass, pregnancy, ovarian cyst, cesarean section, cystectomy, serous cystadenoma

Figure 1. Coronal non-contrast pelvic magnetic resonance imaging obtained at 15 weeks of gestation showing a giant, well-circumscribed, thin-walled, purely cystic adnexal lesion presumed to originate from the right ovary. The lesion measured approxim

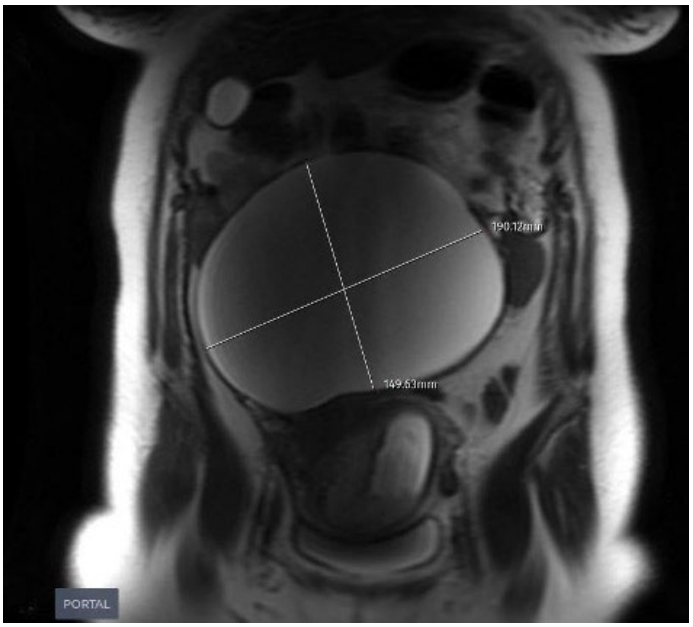


Figure 2. Sagittal non-contrast pelvic magnetic resonance imaging demonstrating the giant cystic adnexal mass extending toward the upper abdomen, with an anteroposterior diameter of approximately 93 mm. No solid component, septation, or radiological

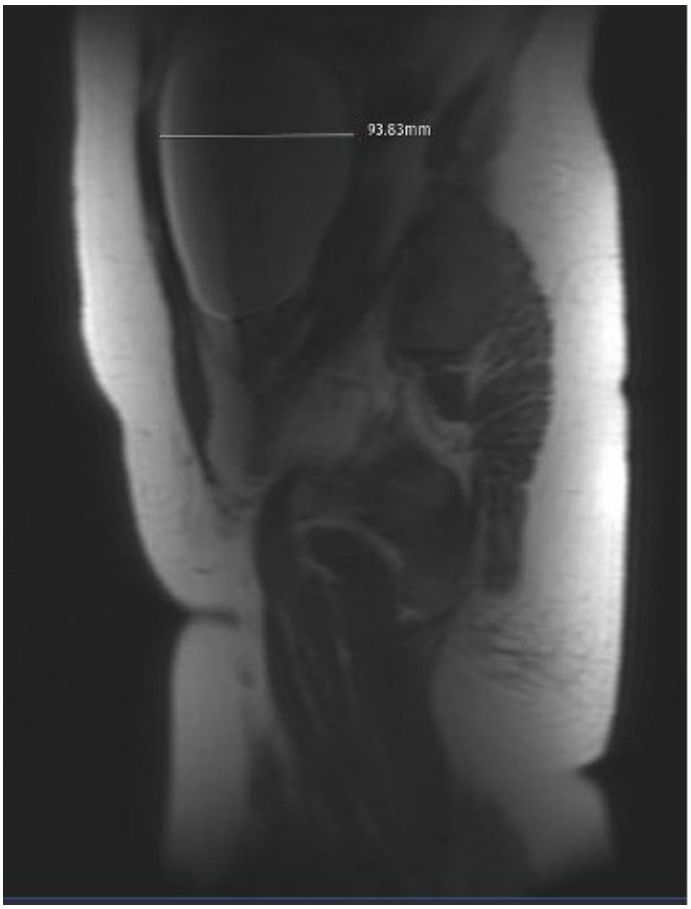
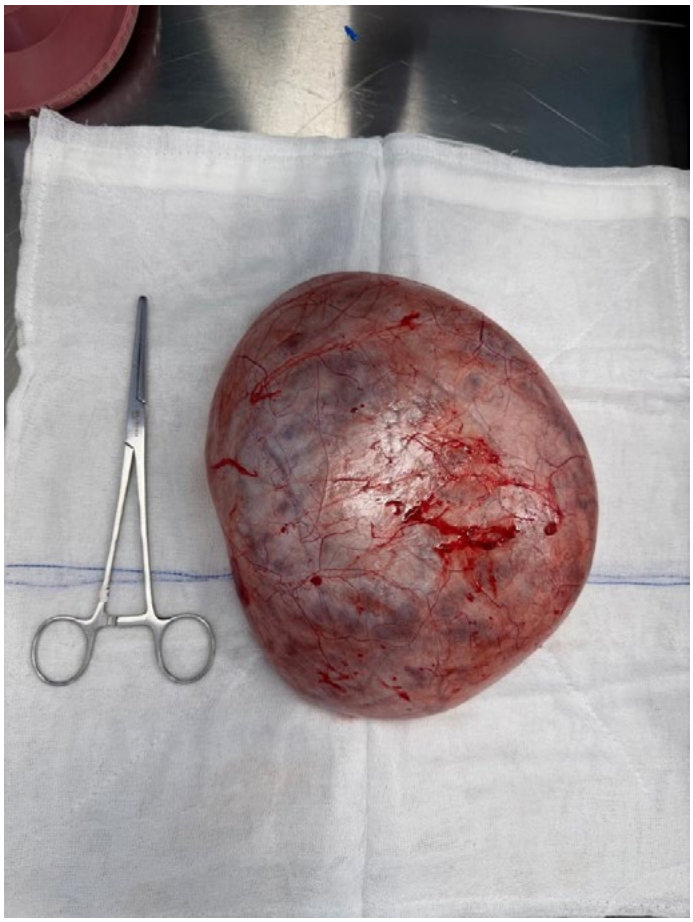


Figure 3. Macroscopic appearance of the surgical specimen after cystectomy performed concomitantly with cesarean delivery at term. The smooth-surfaced cystic mass measured approximately 19 × 15 cm, and final histopathological examination confirmed se



SS-04

Invasive Mole with Persistent β-hCG Elevation Following Complete Hydatidiform Mole: A Case Report and Multidisciplinary Management

Gülten Merve Özalp Çelikçi[1], Metehan Herguner[2], Elmas Korkmaz[3]
[1]Umraniye Training and Research Hospital, Department of Obstetrics and Gynecology, Istanbul, Turkey;Tuzla State Hospital,Department of Obstetrics and Gynecology, Istanbul, Turkey
[2]Umraniye Training and Research Hospital, Department of Obstetrics and Gynecology, Istanbul, Turkey
[3]Umraniye Training and Research Hospital, Department of Gynecologic Oncology, Istanbul, Turkey

OBJECTIVE: Gestational trophoblastic diseases (GTD) encompass a wide spectrum from benign hydatidiform mole to malignant gestational trophoblastic neoplasia (GTN). Persistent β-hCG elevation following complete hydatidiform mole is a critical indicator of malignant transformation. This report presents the multidisciplinary management of a patient who developed invasive mole after complete molar pregnancy.

CASE: A 51-year-old patient (G4P2) with comorbidities including hypertension, hyperthyroidism, and pulmonary hypertension was referred for markedly elevated serum β-hCG (926,420 mIU/mL). Pelvic ultrasound revealed a heterogeneous molar mass of approximately 13 cm filling the uterine cavity without adnexal pathology. Following preoperative stabilization, uterine curettage was performed and pathology confirmed complete hydatidiform mole. Due to insufficient decline in β-hCG levels, methotrexate therapy was initiated. Owing to chemotherapy resistance, total laparoscopic hysterectomy with bilateral salpingo-oophorectomy was performed in this patient with no desire for fertility. Final pathology was consistent with invasive mole. Postoperative imaging revealed no metastasis. The patient was referred to medical oncology for chemotherapy planning. Follow-up demonstrated progressive β-hCG decline and no recurrence on PET-CT.

CONCLUSION: β-hCG monitoring after molar pregnancy is critical for early detection of persistent disease. FIGO risk scoring guides treatment planning. In chemotherapy-resistant cases, surgery is an effective option. Multidisciplinary management improves treatment outcomes.

Keywords: Gestational trophoblastic disease, invasive mole, β-hCG, hysterectomy, FIGO score

FİGO SKORU

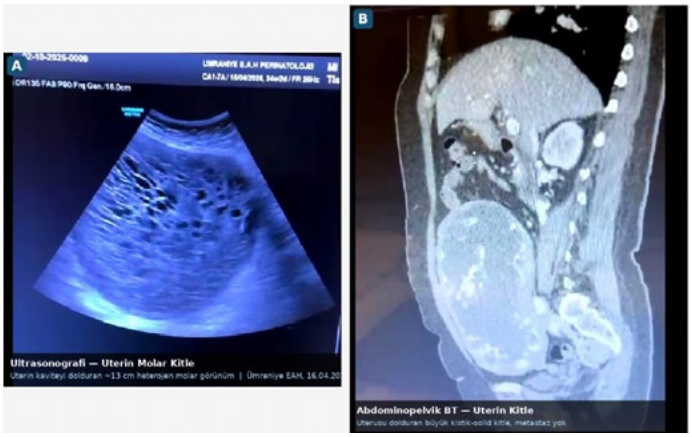
Şekil 2. FIGO/WHO Risk Skoru — Olgumuzun Değerlendirmesi

Risk Faktörü	0	1	2	4	Olgumuz
Yaş	<40	≥40	—	—	51 yaş → 1 puan
Önceki Gebelik	Mol	Düşük	—	Term gebelik	Mol → 0 puan
β-hCG (mIU/mL)	<1.000	1.000–10.000	10.000–100.000	>100.000	926.420 → 4 puan
Tümör Boyutu (cm)	<3	—	3–5	>5	~13 cm → 2 puan
Metastaz	Yok	Dalak/Böbrek	GİS	Beyin/Karaciğer	Yok → 0 puan
Önceki Kemoterapi	Yok	—	Tek ajan	Kombine	Yok → 0 puan

TOPLAM FIGO SKORU: ~7 → Yüksek Riskli GTN Sınırında (Eşik: ≥7)

FIGO/WHO risk skorlama sistemi ve olgumuzun puanlaması (Toplam skor: ~7, yüksek riskli GTN sınırı).

Ultrasonografi ve Abdominopelvik BT



Ultrasonografide uterin kaviteyi dolduran heterojen molar kitle. (B) Abdominopelvik BT'de uterusu dolduran büyük kistik-solid kitle görünümü, metastaz saptanmadı.

SS-05

Ectopic pregnancy diagnosed despite a decline in β-hCG after curettage: a case report

Esra Bilgili, Mustafa Çelik, Eda Güner Özen, Yaşam Kemal Akpak, Yaprak Üstün
Department of Obstetrics and Gynecology, İzmir City Hospital, İzmir, Türkiye

OBJECTIVE: Ectopic pregnancy is an important early pregnancy complication that may clinically and biochemically overlap with early pregnancy loss and pregnancy of unknown location, requiring careful serial beta-human chorionic gonadotropin (β-hCG) monitoring. This case report presents a patient who was diagnosed with ectopic pregnancy after developing a plateau/increasing β-hCG pattern during follow-up, despite an initial decline in β-hCG levels after uterine curettage.

METHODS: A patient whose pregnancy location could not be clearly determined was evaluated with serial β-hCG measurements and transvaginal ultrasonography. Diagnostic and therapeutic uterine curettage was performed to help differentiate early pregnancy loss from ectopic pregnancy. After the procedure, β-hCG levels were monitored serially. When β-hCG values failed to decline as expected and showed a plateau/increasing pattern, the patient was re-evaluated for ectopic pregnancy. Because she was hemodynamically stable, single-dose methotrexate therapy was administered, and treatment response was assessed with serial β-hCG monitoring.

RESULTS: A 22-year-old patient presented to our clinic with preliminary diagnoses of ectopic pregnancy and early pregnancy loss after serial β-hCG follow-up at an external center showed a fluctuating pattern. Initial transvaginal ultrasonography at our clinic demonstrated an anteverted and anteflexed uterus with a 7-mm endometrium. A suspicious ectopic focus measuring approximately 16 × 18 mm was detected in the left paraovarian region, and approximately 28 mm of free fluid was observed in the pouch of Douglas. Serial β-hCG values measured every 48 hours at the external center were 47 mIU/mL, 117 mIU/mL, 307 mIU/mL, and 232 mIU/mL. Diagnostic and therapeutic uterine curettage was therefore performed. The pre-curettage β-hCG value of 232 mIU/mL decreased to 152 mIU/mL in the early post-procedure period, corresponding to an approximately 34.4% decline. This finding was initially interpreted in favor of early pregnancy loss, and the patient was discharged with an outpatient follow-up plan. However, during outpatient follow-up, the β-hCG level was 160 mIU/mL on the third day after curettage and increased to 182 mIU/mL in the subsequent measurement 48 hours later. Due to this plateau/increasing pattern, the possibility of ectopic pregnancy was reconsidered. Repeat ultrasonography showed an 8-mm endometrium and a normal right ovary; a suspicious ectopic focus measuring approximately 12 × 16 mm was observed in the left adnexal/paraovarian region, along with approximately 32 mm of free fluid in the pouch of Douglas. As the patient remained hemodynamically stable, single-dose methotrexate treatment was administered. On the seventh day after treatment, β-hCG decreased to 106 mIU/mL, representing a 41.75% decline compared with the day 4 value. In subsequent weekly outpatient follow-ups, β-hCG values showed a decreasing trend, measuring 114 mIU/mL, 52.6 mIU/mL, and 4 mIU/mL.

CONCLUSION: This case demonstrates that a decline in β-hCG levels after uterine curettage does not always confirm intrauterine pregnancy loss. Ectopic pregnancy should be reconsidered when β-hCG levels do not regress as expected or show a plateau or renewed increase. Continuous serial β-hCG monitoring in patients considered to have early pregnancy loss is critical to prevent delayed diagnosis of ectopic pregnancy.

Keywords: Ectopic pregnancy, β-hCG, early pregnancy loss, curettage, methotrexate

SS-06

Late presenting unruptured ectopic pregnancy

Şenay Ömer[1], Zeynep Ömer[2]
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[2]SBÜ Bakırköy Dr. Sadi Konuk Eğitim ve Araştırma Hastanesi

Although ectopic pregnancy accounts for approximately 1–2% of all pregnancies, it is one of the leading causes of maternal death in early pregnancy. The most common location is the fallopian tubes, and while a significant proportion of tubal ectopic pregnancies are diagnosed early, many rupture by the eighth week. However, rarely, some cases progress to later weeks of gestation, leading to life-threatening complications.

In this presentation, we aim to discuss a rare case of tubal ectopic fertility that completed on the basis of hydrosalpinx and progressed to the 11th week, along with a review of the literature. 36-year-old patient,G2P1 NSD

The patient has a ten-year history of infertility. The patient has received treatment twice for pelvic inflammatory disease. Hysterosaphingografy performed during the patient's infertility treatment shows bilateral hydrosalfinx and open tubes. The patient presented for a pregnancy check-up. based on last menstrual period (lmp), the patient was pregnant at 12 weeks of gestation. vaginal ultrasound revealed an empty uterine cavity, with the fetus located within the abdomen at crl: 11 weeks, consistent with 3g, and positive fetal heart rate (fka). suspecting an abdominal pregnancy, the patient underwent emergency laparotomy. exploration revealed a clear abdominal cavity and an ectopic pregnancy in the right fallopian tube. in this case, contrary to what is commonly known, we observed that tubal pregnancy can continue without rupture until the 12th week.

Keywords: ECTOPİC PREGNANCY, HYDROSALFİNX, UNRUPTURED LATE TUBAL ECTOPİC PREGNANCY

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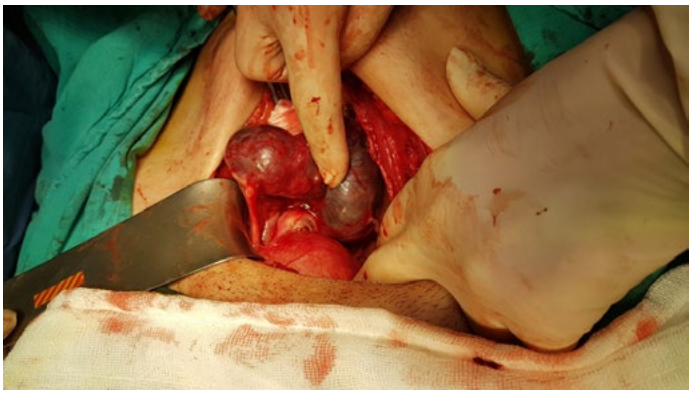

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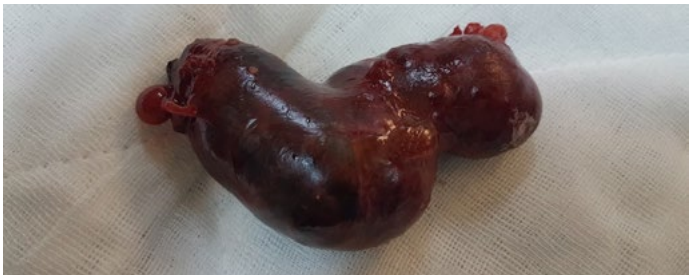
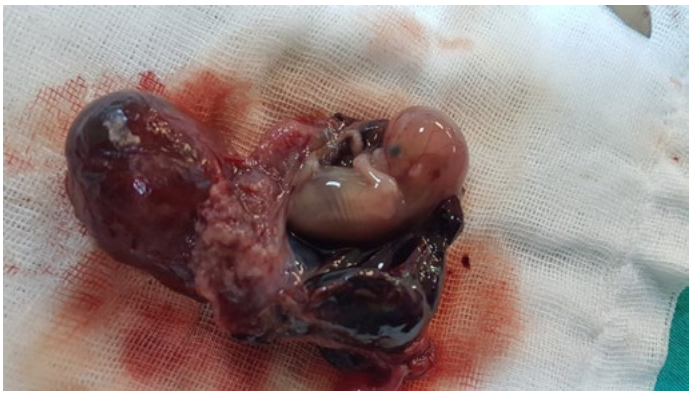


Tubal pregnancy 1



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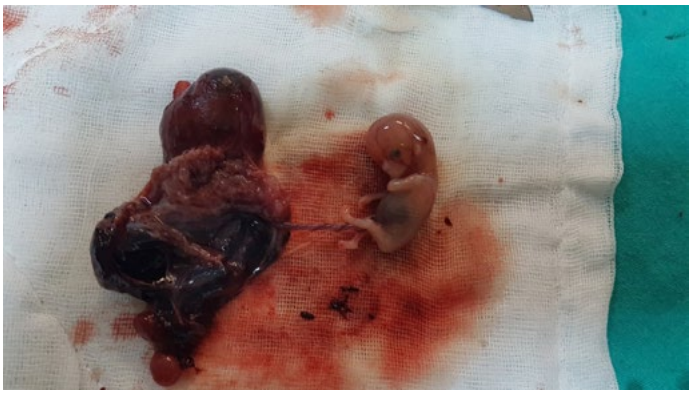
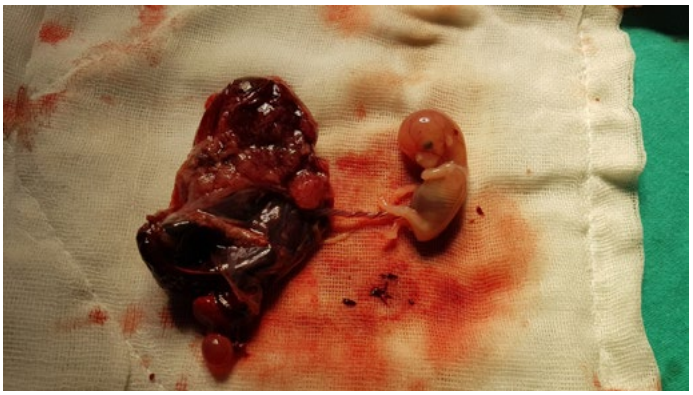


Tubal pregnancy 3



SS-07

Acute abdomen in early pregnancy: laparoscopic management of appendicitis in a twin pregnancy

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OBJECTIVE: Acute abdomen during pregnancy is a high-risk clinical condition requiring prompt diagnosis and intervention due to its potential impact on maternal and fetal morbidity. Diagnosis is often challenging because of anatomical displacement of intra-abdominal organs, physiological leukocytosis, and limitations of imaging modalities. Acute appendicitis is the most common cause requiring surgical intervention during pregnancy, and delayed diagnosis may increase the risk of perforation, preterm birth, and fetal loss. This report aims to present a twin pregnancy case in which acute appendicitis occurred in early gestation, was managed surgically, and resulted in a favorable obstetric outcome at term.

METHODS: An 11-week and 4-day dichorionic diamniotic twin pregnancy achieved via in vitro fertilization (IVF) presented with right lower quadrant pain. The patient had a known methylenetetrahydrofolate reductase (MTHFR) mutation and was receiving prophylactic low molecular weight heparin. On physical examination, rebound tenderness and guarding were present in the right lower quadrant. Transabdominal ultrasonography suggested possible appendicitis, while magnetic resonance imaging failed to clearly visualize the appendix and did not reveal definitive findings supporting appendicitis. Due to the persistence of clinical suspicion, the patient was evaluated in a multidisciplinary setting and underwent emergency surgical intervention following consultation with general surgery.

RESULTS: The patient underwent laparoscopic diagnostic surgery and appendectomy on the same day. The postoperative course was uneventful, and vital signs remained stable. Fetal cardiac activity was confirmed in both fetuses after surgery, with no obstetric complications observed during follow-up. Histopathological examination confirmed suppurative appendicitis. The pregnancy progressed without further complications, and at 36 weeks and 2 days of gestation, the patient underwent cesarean section due to the onset of uterine contractions, resulting in the delivery of live twin neonates. No maternal or neonatal complications were observed in the postpartum period.

CONCLUSION: In the management of acute abdomen during pregnancy, clinical suspicion remains the cornerstone of diagnosis, as imaging modalities may be inconclusive. Delayed surgical intervention can adversely affect both maternal and fetal outcomes; therefore, timely surgical management should be considered in appropriate cases. Laparoscopic surgery is a safe and effective option during pregnancy when performed with proper patient selection. This case demonstrates that early and appropriate surgical intervention in pregnancy can lead to favorable maternal and fetal outcomes and allow continuation of pregnancy to term.

Keywords: acute abdomen, appendicitis, laparoscopy, pregnancy, twin pregnancy

SS-08

Excision of Cornual Pregnancy via vNOTES: A Case Report

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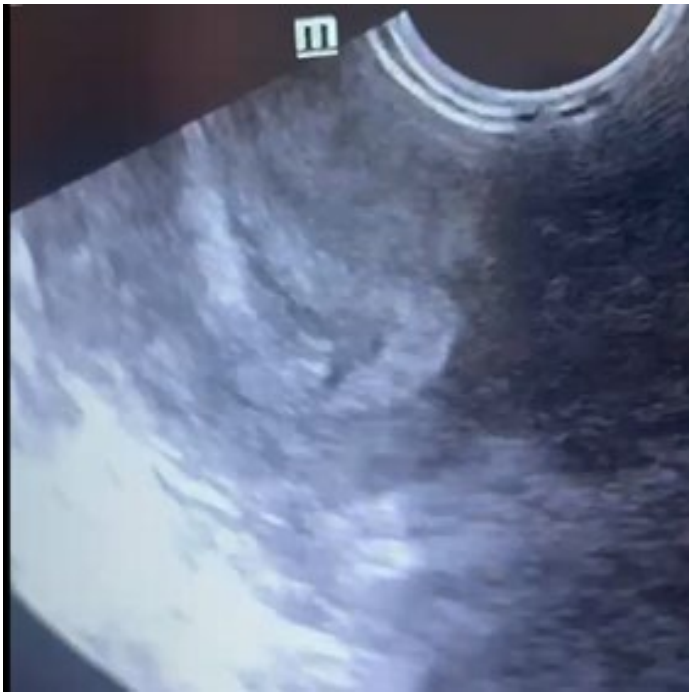
Van Yüzüncü Yıl Üniversitesi, Jinekolojik Onkoloji Cerrahisi Bilim Dalı, Van

Cornual pregnancies account for a small proportion of ectopic pregnancies but carry a significant risk of maternal mortality due to hemorrhage. While traditional surgical management involves laparoscopy, vaginal natural orifice transluminal endoscopic surgery (vNOTES) has emerged as a minimally invasive alternative. We present the case of a 32-year-old patient, G5P4, presenting with acute pelvic pain. Transvaginal USG identified a 20 mm ectopic focus in the left cornual region. A successful left cornual resection and concurrent left salpingectomy were performed using vNOTES. This case demonstrates that vNOTES is a feasible, safe, and highly advantageous approach for managing vascular cornual pregnancies in hemodynamically stable patients, offering profound analgesic and cosmetic benefits.

Keywords: Pregnancy, Ectopic; Pregnancy, Interstitial; Natural Orifice Endoscopic Surgery; Minimally Invasive Surgical Procedures; Gynecologic Surgical Procedures

şekil 1



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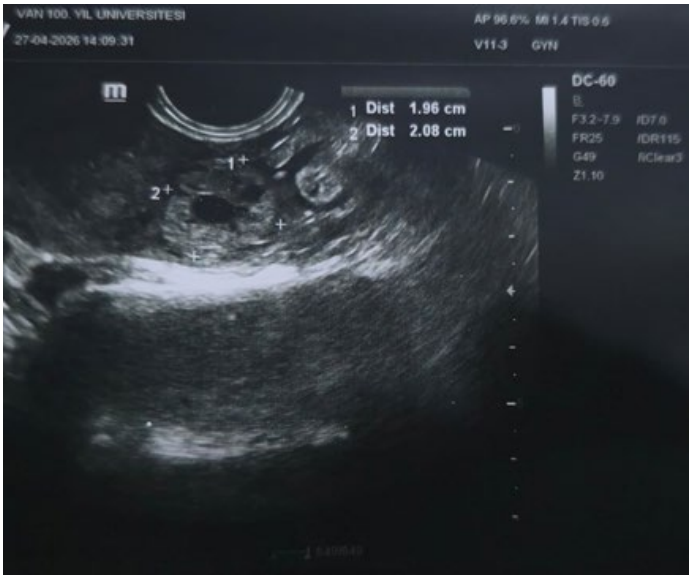

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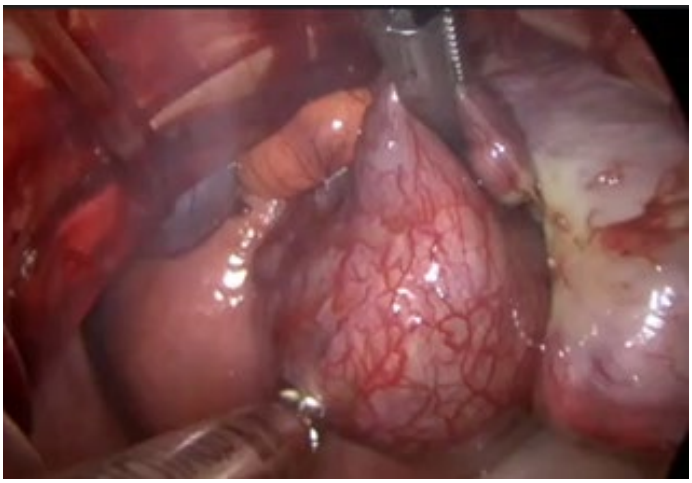

operation photos

SS-09

Laparoscopic diagnosis of undifferentiated small round cell carcinoma in the pelvic/ obturator region: a rare case

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PURPOSE: Small round cell carcinomas are aggressive, poorly differentiated malignant tumors that usually arise from bone or soft tissue. Localization in the pelvic or obturator region is extremely rare and may create diagnostic challenges in gynecologic oncology practice. This case report aims to present a rare pelvic/obturator region undifferentiated small round cell carcinoma diagnosed by laparoscopic excision.

METHODS: A 47-year-old woman was referred to the gynecologic oncology outpatient clinic because of a pelvic mass initially considered to be compatible with lymph node metastasis. Pelvic magnetic resonance imaging demonstrated a 6 cm mass located in the left obturator fossa, extending toward the obturator internus muscle region, with suspected invasion of adjacent bony structures and radiologic features suggestive of soft tissue sarcoma. Tumor markers were within normal limits. Laparoscopic exploration and excisional biopsy were planned for diagnosis.

RESULTS: During laparoscopy, an irregular, firm nodular lesion was identified adjacent to the obturator internus muscle. The lesion was excised laparoscopically and removed from the abdominal cavity in an endobag. Final histopathological examination revealed an undifferentiated small round cell carcinoma. Immunohistochemical analysis showed strong diffuse membranous cluster of differentiation 99 (CD99) positivity, focal terminal deoxynucleotidyl transferase (TdT) and cluster of differentiation 1a (CD1a) positivity, focal vimentin positivity, and a Ki-67 proliferation index of 30-40%. Synaptophysin, chromogranin, pan-cytokeratin (Pan-CK), cluster of differentiation 45 (CD45), desmin, smooth muscle actin (SMA), cluster of differentiation 20 (CD20), and S100 were negative. These findings helped exclude neuroendocrine, lymphoid, smooth muscle, and melanocytic differentiation and supported the diagnosis of an undifferentiated small round cell malignant tumor. The differential diagnosis of small round cell tumors includes Ewing sarcoma/primitive neuroectodermal tumor (PNET), rhabdomyosarcoma, desmoplastic small round cell tumor (DSRCT), and small cell neuroendocrine carcinoma, all of which may share a "small blue round cell tumor" morphology (1). The case was subsequently discussed by the multidisciplinary tumor board, and adjuvant chemotherapy was recommended.

CONCLUSION: Undifferentiated small round cell carcinoma located in the pelvic/obturator region is an extremely rare entity in gynecologic oncology practice (1, 2). Laparoscopic excision provided a safe, minimally invasive diagnostic approach for this deeply located pelvic mass. Reporting such rare cases may increase clinical awareness and contribute to the development of diagnostic and therapeutic strategies for similar pelvic small round cell tumors.

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Keywords: Small round cell carcinoma, pelvic mass, obturator region, laparoscopy

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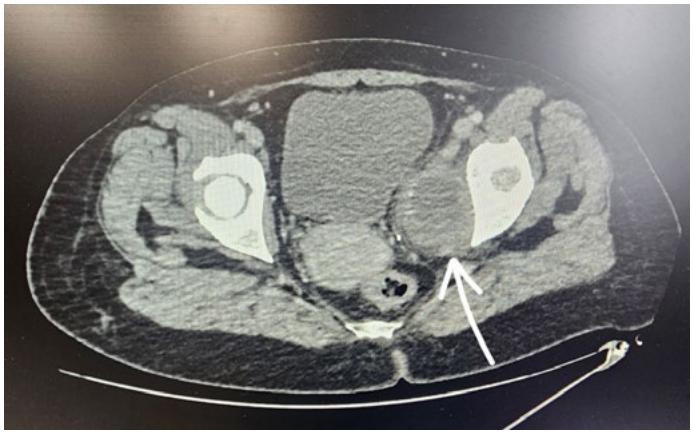

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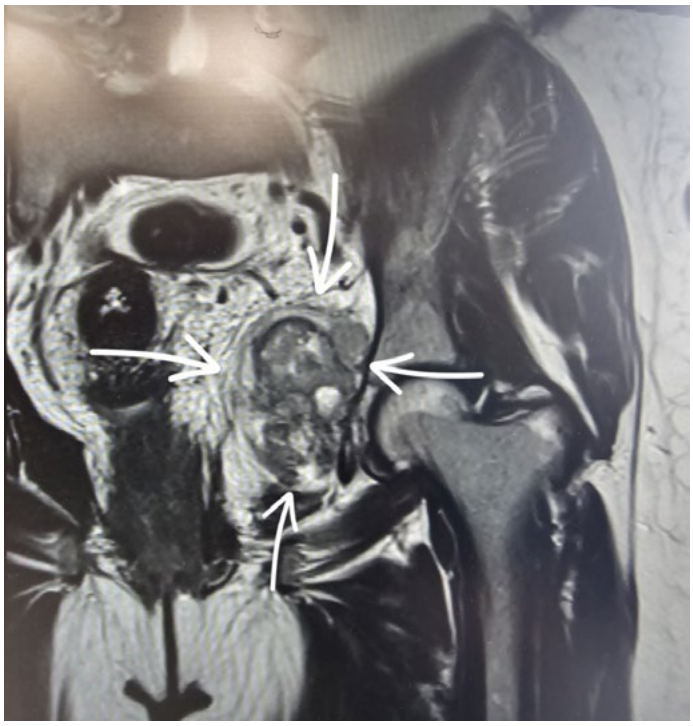
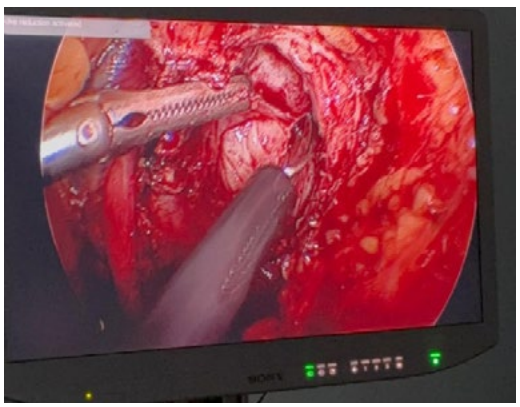


pelvik kitlenin intraoperatif görüntüsü



SS-10

Correlation Between the Peritoneal Carcinomatosis Index Assessed by Computed Tomography and Serum Tumor Markers

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AIM: Peritoneal carcinomatosis represents a significant pattern of disease dissemination that occurs in the advanced stages of many solid tumors and is associated with a markedly poor prognosis. Accurate and reliable assessment of tumor burden is critical for treatment planning and determining surgical eligibility. The Peritoneal Carcinomatosis Index (PCI) is a quantitative scoring system that reflects the extent of peritoneal disease and has established prognostic value. Contrast-enhanced computed tomography (CT), which is widely used in preoperative evaluation, offers important advantages; however, it provides primarily morphological information and may underestimate disease burden in certain anatomical regions. Serum tumor markers, on the other hand, serve as complementary parameters reflecting the biological activity of the disease, and the relationship between CA-125 levels and disease extent has not been clearly established in the literature. In this study, we aimed to evaluate the relationship between CT-based PCI and serum tumor markers in patients with peritoneal carcinomatosis.

MATERIALS-METHODS: Following approval from the Institutional Ethics Committee, a total of 90 patients diagnosed with peritoneal carcinomatosis between January 2020 and February 2026, who underwent contrast-enhanced abdominal computed tomography (CT) at our institution, were included in the study. Patient data were retrospectively evaluated using the PACS system. CT images were analyzed based on the method described by Sugarbaker, with the peritoneum divided into 13 anatomical regions. Each region was scored according to lesion size, and the total Peritoneal Carcinomatosis Index (PCI) was calculated. Additionally, serum tumor marker levels measured within a time interval consistent with the CT examination were recorded. The relationship between PCI and serum tumor markers was statistically analyzed together with demographic data. RESULTS: The mean age of the 90 patients included in the study was 57.76 ± 12.36 years. In the correlation analysis between PCI and serum tumor markers, a moderate, positive, and statistically significant correlation was found between CA-125 and PCI ($r = 0.575$, $p < 0.001$). Similarly, a significant positive correlation was observed between CA 15-3 and PCI ($r = 0.512$, $p < 0.001$). In contrast, no statistically significant correlation was identified between PCI and either CEA or CA 19-9 ($p > 0.05$).

CONCLUSION: In our study, a significant positive correlation was observed between CT-based PCI and, in particular, CA-125 and CA 15-3 levels in patients with peritoneal carcinomatosis. These findings suggest that serum tumor markers may have a complementary role in reflecting disease extent. The main limitations of our study include its retrospective design and single-center setting. In conclusion, the combined evaluation of CT-based PCI and especially CA-125 and CA 15-3 levels may contribute to predicting disease burden and supporting clinical decision-making in patients with peritoneal carcinomatosis.

Keywords: Peritoneal carcinomatosis, Peritoneal Carcinomatosis Index, Computed tomography, Tumor markers

SS-11

Discordance Between NIPT-Reported Fetal Sex and Ultrasonographic Findings Following High-Risk First-Trimester Screening: A Case Report

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OBJECTIVE: To report a case of fetal sex discordance between non-invasive prenatal test (NIPT) and ultrasonography following high-risk first-trimester screening, and to highlight the diagnostic limitations of NIPT and the need for invasive confirmation in discordant cases.

CASE PRESENTATION: A 32-year-old gravida 2, para 1 (one prior cesarean delivery) pregnant woman with no significant medical history underwent first-trimester screening at 11 weeks and 6 days of gestation (CRL: 54 mm). The biochemical and combined screening results indicated a high risk for trisomy 21 (>1/50), while the age-related risk was 1/491. The patient declined invasive diagnostic testing and opted for NIPT. NIPT results were reported as low risk for common trisomies, and the fetal sex was identified as female. However, at the time of detailed second-trimester ultrasonography, the fetus was phenotypically male. No structural anomalies were detected, but fetal growth restriction (FGR) was noted.

Fetal biometric measurements were as follows: biparietal diameter corresponding to 19+4 weeks (4th percentile), head circumference 19+6 weeks (1st percentile), abdominal circumference 19+3 weeks (3rd percentile), femur length 17+5 weeks (<1st percentile), humerus length 17+2 weeks (<1st percentile), and estimated fetal weight 210 g (3.2nd percentile). Doppler parameters, including umbilical artery pulsatility index, were within normal limits for gestational age, and amniotic fluid index was also normal.

Due to the discordance between NIPT-reported fetal sex and ultrasonographic findings, amniocentesis was performed. Cytogenetic analysis confirmed a normal male karyotype (46,XY). (Figure 1)

DISCUSSION: NIPT has significantly improved prenatal screening due to its high sensitivity and specificity for common aneuploidies and its ability to determine fetal sex. However, it remains a screening test based on placental cell-free DNA rather than direct fetal genetic material. Therefore, discrepancies between NIPT results and fetal phenotype may occur.

In this case, the discordance between NIPT-reported female sex and ultrasonographic and cytogenetic confirmation of a male fetus highlights an important limitation of NIPT. The most plausible explanation is a placental-origin discrepancy, most likely related to confined placental mosaicism (CPM), in which placental and fetal karyotypes differ. A predominance of 46,XX cell lines within the placenta may lead to failure in detecting Y chromosome material, resulting in an incorrect female NIPT report.

The presence of FGR in this case further supports the possibility of underlying placental dysfunction, as CPM has been associated with impaired placental development and adverse perinatal outcomes. Alternative explanations, including vanishing twin syndrome, maternal mosaicism, or technical factors such as low fetal fraction, appear less likely in the absence of supporting clinical or laboratory findings.

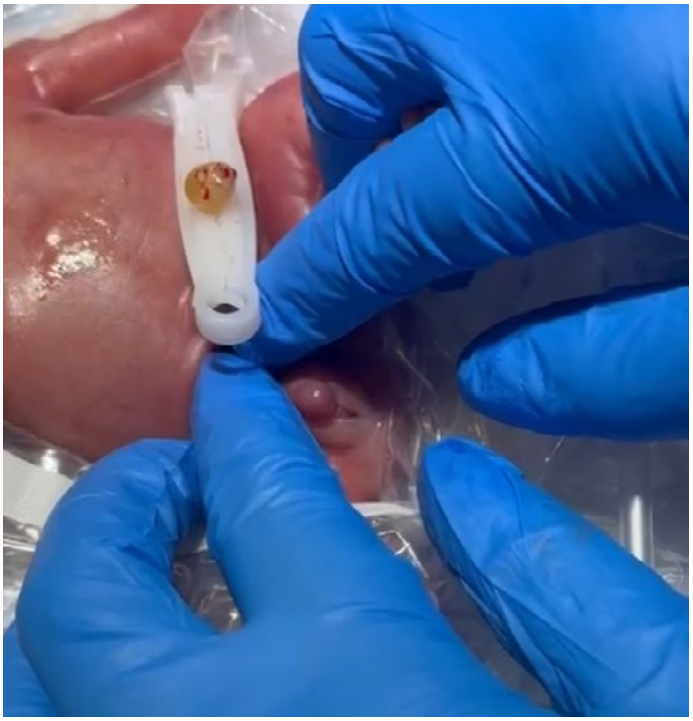
This case underscores that a negative NIPT result does not exclude clinically relevant conditions, particularly when discordant findings are present. Therefore, discrepancies between NIPT and ultrasonographic

findings—especially regarding fetal sex—should be considered a red flag requiring further evaluation.

CONCLUSION: Fetal sex discordance between NIPT and ultrasonography should be regarded as a clinically significant warning sign. NIPT results must always be interpreted in conjunction with clinical and imaging findings, and invasive diagnostic testing is warranted when discrepancies arise.

Keywords: Non-invasive prenatal testing, Fetal sex discordance, Confined placental mosaicism, Fetal growth restriction, Amniocentesis, Prenatal diagnosis

Figure 1. Fetal sex of the case



SS-12

Prenatal Diagnosis of Twin Reversed Arterial Perfusion (TRAP) Sequence in a Monochorionic Monoamniotic Pregnancy: A Case Report

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INTRODUCTION: Twin Reversed Arterial Perfusion (TRAP) sequence is a rare and severe complication of monochorionic multiple pregnancies, occurring in approximately 1 in 35,000 pregnancies and in about 2.6% of monozygotic twin gestations. Its reported incidence has increased in recent years.TRAP sequence is characterized by the presence of an acardiac twin, which lacks a functional heart and exhibits severe structural malformations, and a structurally normal"pump"twin that maintains perfusion for both fetuses through abnormal arterio-arterial placental anastomoses. The acardiac twin is entirely dependent on the pump twin for circulation and typically demonstrates poor development of the upper body, head, and thoracic structures, while the lower body may be relatively preserved.Without intervention, the condition carries a high risk of adverse outcomes for the pump twin, including high-output cardiac failure, polyhydramnios, preterm birth, and intrauterine demise.Although the exact pathogenesis remains unclear, proposed mechanisms include early vascular anastomoses leading to reversed perfusion or primary cardiac developmental failure in the affected twin. Early prenatal diagnosis using Doppler ultrasonography is essential for appropriate monitoring and management.

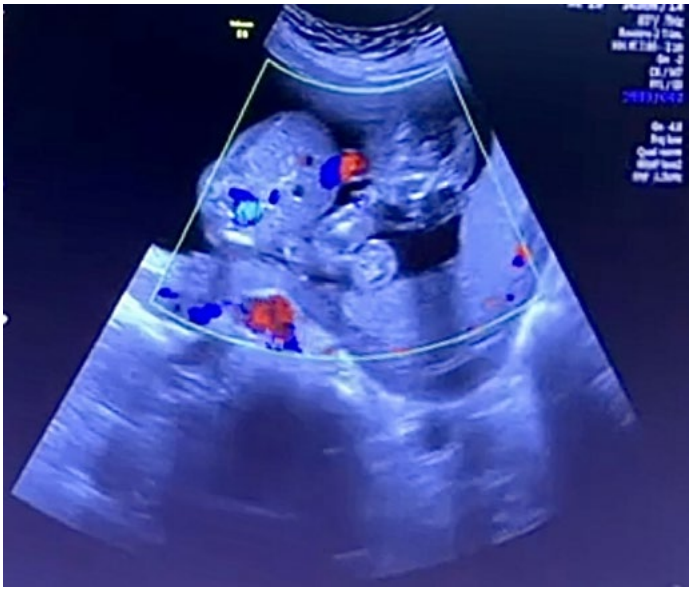
CASE PRESENTATİON: A 27-year-old G3P1A1 patient, who conceived spontaneously without the use of assisted reproductive technologies, was referred to our perinatology outpatient clinic at 18W6D of gestation due to a monochorionic monoamniotic twin pregnancy.Detailed ultrasonographic evaluation demonstrated a structurally normal"pump"twin with biometric measurements consistent with gestational age and normal cardiac activity.The co-twin exhibited severe structural abnormalities. The thoracic cavity was markedly underdeveloped, and no cardiac activity or identifiable cardiac structures were visualized.Pulmonary structures were absent, and cranial and cervical anatomical components above the thoracic level could not be demonstrated.Intra-abdominal organs were poorly visualized and appeared disorganized. Despite the presence of rudimentary lower body structures, the overall morphology was consistent with an acardiac twin.Doppler ultrasonography of the acardiac fetus demonstrated reversed arterial perfusion within the umbilical artery, with blood flow directed toward the fetus rather than away from it.This retrograde flow pattern is considered pathognomonic for the diagnosis of TRAP sequence and represents the principal diagnostic criterion. Additionally, abnormal arterio-arterial placental anastomoses were inferred based on Doppler findings.No evidence of hydrops fetalis was observed in the pump twin; however, mild cardiomegaly suggested an increased hemodynamic burden. The family was extensively counseled regarding the severity of the condition, potential genetic factors, and anticipated perinatal complications. Genetic evaluation, including amniocentesis, chromosomal microarray analysis, and whole exome sequencing, was recommended to investigate a possible underlying etiology. Interventional options, including fetal cord occlusion techniques such as radiofrequency ablation and bipolar cord coagulation, were explained in detail. However, the family declined all invasive interventions due to religious beliefs and opted for expectant management. Follow-up was discontinued after the 23rd week of gestation.

CONCLUSION: TRAP sequence is a rare but life-threatening complication of monochorionic pregnancies requiring early and accurate prenatal diagnosis.Doppler ultrasonography is essential for confirming the diagnosis by demonstrating reversed arterial perfusion.

Close surveillance is critical due to the risk of cardiac failure in the pump twin.Timely counseling and consideration of fetal intervention may improve outcomes, although management should be individualized according to clinical findings and parental preferences.

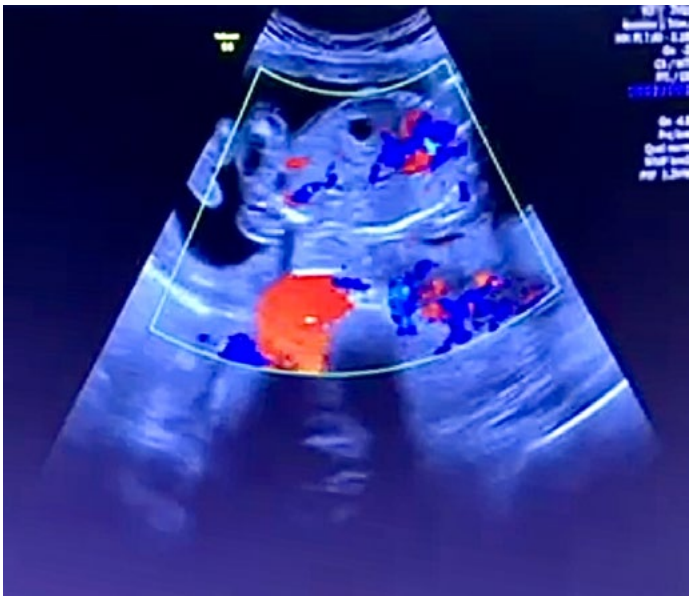
Keywords: acardiac twin, doppler ultrasonography, monochorionic monoamniotic pregnancy, prenatal diagnosis, TRAP sequence

Twin Reversed Arterial Perfusion (TRAP) Sequence in Monochorionic Twin Pregnancy



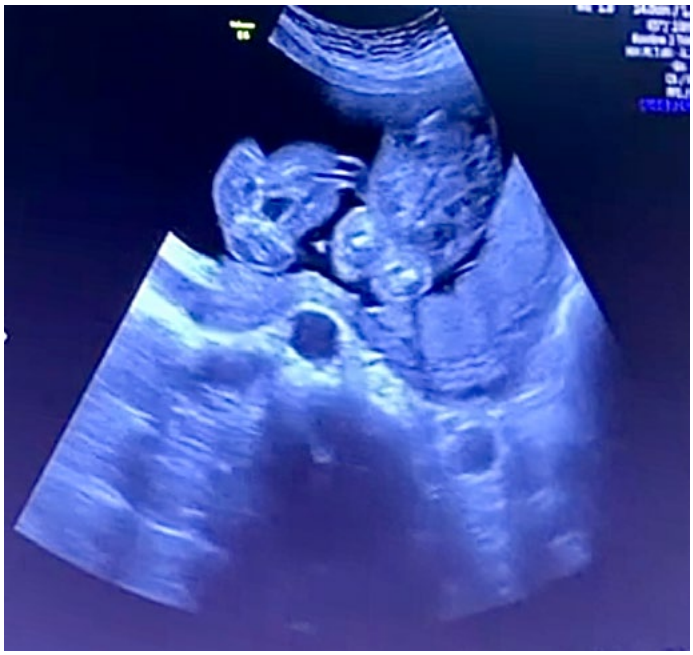
Color Doppler ultrasound demonstrates retrograde arterial blood flow from the pump fetus to the acardiac fetus via placental vascular anastomoses, illustrating the pathognomonic hemodynamic mechanism of TRAP sequence and the associated increased cardiac load on the pump fetus.

Twin Reversed Arterial Perfusion (TRAP) syndrome: Hemodynamic burden in the pump twin



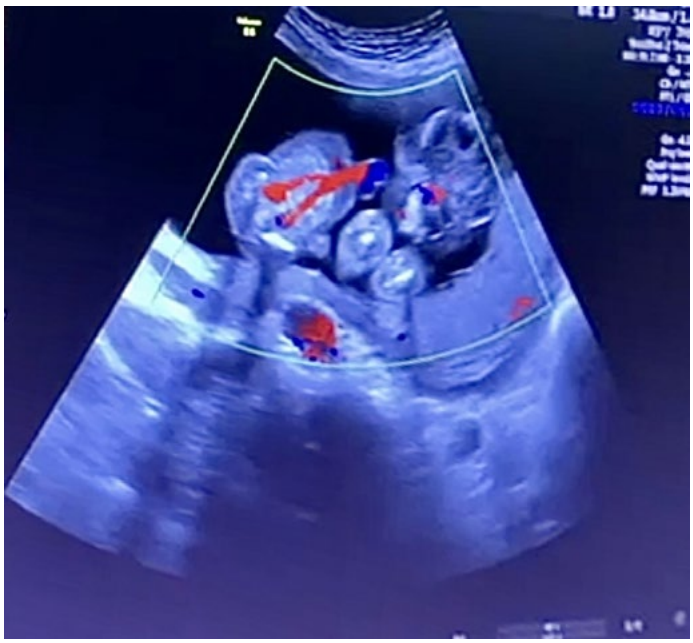
On Doppler ultrasonography, the structurally normal pump twin with active cardiac function demonstrates increased perfusion consistent with compensatory hemodynamic load in TRAP sequence.

Twin Reversed Arterial Perfusion (TRAP) syndrome: Pump twin with acardiac twin lacking upper body structures



In monochorionic twin pregnancy with Twin Reversed Arterial Perfusion (TRAP) syndrome, a structurally normal pump twin coexists with an acardiac twin demonstrating absent upper body development, consistent with reversed arterial perfusion.

Twin Reversed Arterial Perfusion (TRAP) syndrome: Reversed arterial perfusion on Doppler ultrasonography



In monochorionic twin pregnancy with Twin Reversed Arterial Perfusion (TRAP) syndrome, Doppler ultrasonography demonstrates retrograde arterial flow from the pump twin to the acardiac twin, reflecting pathognomonic hemodynamic overload.

SS-13

Recurrent TRIP11-Related Achondrogenesis Type 1A in a Pregnancy Following Preimplantation Genetic Testing: A Case Report

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AIM: The thyroid hormone receptor interactor 11 (TRIP11) gene encodes Golgi microtubule-associated protein 210 (GMAP-210), which is required for Golgi apparatus function. Biallelic pathogenic variants in the TRIP11 gene have been associated with lethal achondrogenesis type 1A and odontochondrodysplasia, which presents with milder phenotypes. Achondrogenesis type 1A is a rare skeletal dysplasia characterized by severe micromelia, hypomineralized skeleton, narrow thorax, skin edema, and prenatal or neonatal death. In this case report, we aimed to present the clinical, ultrasonographic, and genetic features of two sibling cases in which the same mutation was detected again in the prenatal period in the current pregnancy obtained after preimplantation genetic testing, in a patient with a history of termination due to TRIP11-related lethal skeletal dysplasia in a previous pregnancy.

METHOD: The patient's obstetric history, prenatal ultrasonographic findings, and genetic test results were retrospectively evaluated. The first pregnancy had been terminated due to severe skeletal dysplasia findings detected in the prenatal period, and a homozygous likely pathogenic variant located in exon 15 of the TRIP11 gene had been detected in the fetus. Both parents were determined to be heterozygous carriers for the same TRIP11 variant. Following genetic counseling, the current pregnancy was achieved by in vitro fertilization and preimplantation genetic testing for monogenic diseases (PGT-M). In the current pregnancy, fetal structural evaluation was performed by ultrasonography, and amniocentesis was performed for advanced genetic analysis.

FINDINGS: In the current pregnancy of a 25-year-old patient, G2P0A1, with a first-degree consanguineous marriage, fetal ultrasonography performed at 17 weeks of gestation revealed marked shortening of the bilateral upper and lower extremities. The marked shortening of the upper extremity was consistent with severe micromelia (Figure 1). In addition, hypoplastic thorax, hypoplastic nasal bone, skin edema in the scalp and thoracic region, and perimembranous ventricular septal defect were detected. On fetal sagittal evaluation, the narrow thorax and abnormal skeletal morphology supported the diagnosis of severe skeletal dysplasia (Figure 2). The ultrasonographic findings were considered compatible with lethal skeletal dysplasia. Molecular genetic analysis performed after amniocentesis confirmed the same TRIP11 mutation in the fetus as that detected in the previous pregnancy. When the clinical, ultrasonographic, and genetic findings were evaluated together, the condition was considered compatible with achondrogenesis type 1A, and the pregnancy was terminated after obtaining family consent.

CONCLUSION: TRIP11-related achondrogenesis type 1A is a rare and lethal skeletal dysplasia that may be suspected in the prenatal period based on severe limb shortening, hypoplastic thorax, skin edema, and skeletal mineralization abnormalities, and is confirmed by molecular genetic analysis. Although genetic counseling and preimplantation genetic testing are important in families with consanguineous marriage and a history of a previously affected pregnancy, this case emphasizes the necessity of confirmation by invasive prenatal diagnosis even in pregnancies achieved after PGT-M. In recurrent fetal anomalies, targeted reassessment of the variant detected in the previous pregnancy is critically important for accurate diagnosis and appropriate pregnancy management.

Keywords: TRIP11, achondrogenesis type 1A, preimplantation genetic testing, prenatal diagnosis, skeletal dysplasia, consanguineous marriage

Figure 1. Prenatal ultrasonographic image obtained at 17 weeks of gestation demonstrating marked shortening of the fetal upper extremity. The finding is consistent with severe micromelia in the setting of suspected lethal skeletal dysplasia.

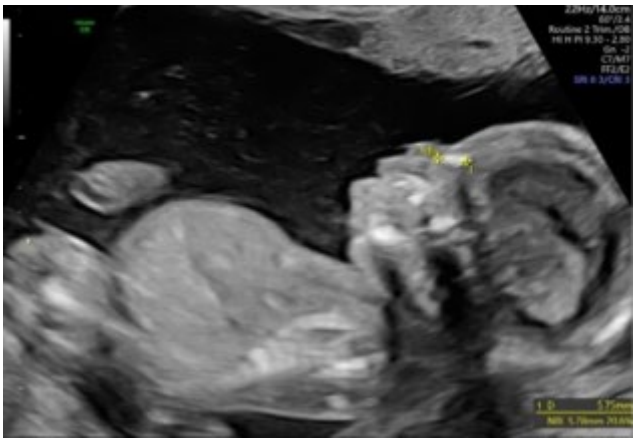
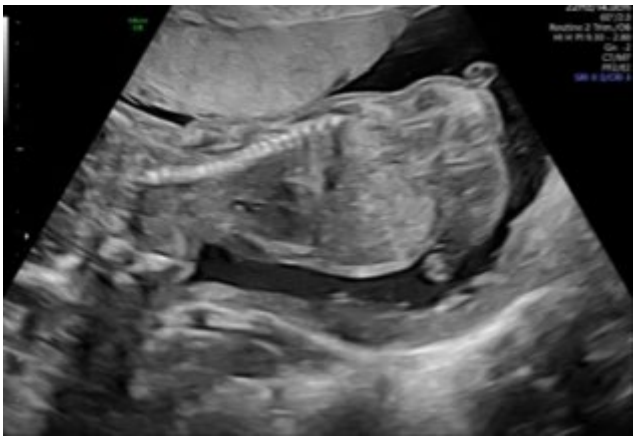


Figure 2. Prenatal ultrasonographic sagittal view of the fetus at 17 weeks of gestation showing a narrow thorax and abnormal skeletal morphology, supporting the diagnosis of severe skeletal dysplasia.



SS-14

Multidisciplinary management of severe intraabdominal adhesions during cesarean section in a twin pregnancy: a case report

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OBJECTIVE: Intraabdominal adhesions following abdominal trauma and previous surgery may cause substantial technical difficulty during repeat operations. In obstetric patients, severe adhesi-ons can complicate cesarean delivery by limiting access to the uterus and increasing the risk of bowel and bladder injury. This case report presents the multidisciplinary management of severe intraabdominal adhesions encountered during cesarean section in a dichorionic di-amniotic twin pregnancy in a patient with a history of multiple abdominal surgeries.

METHODS: A 48-year-old woman in her second pregnancy, with a previous pregnancy loss at 17 we-eks of gestation, had undergone laparotomy for multiple stab injuries 26 years earlier, fol-lowed by approximately three months of colostomy. Six years before the current preg-nancy, bilateral salpingectomy had been performed after surgical exploration demonstrated severe tubal adhesions and obstruction. The current pregnancy was a dichorionic diamniotic twin pregnancy achieved through assisted reproductive technology. The patient had chronic hypertension and developed superimposed preeclampsia, refractory cholestasis, selective fetal growth restriction in the maternal-left fetus, and absent end-diastolic flow on umbilical artery Doppler. Cesarean delivery was therefore planned at 31 weeks of gestation.

RESULTS: After abdominal entry through a Pfannenstiel incision, extensive dense intraabdominal ad-hesions were encountered. During adhesiolysis, a full-thickness bowel injury of app-roximately 1 cm occurred in a small bowel loop adherent to the right lateral abdominal wall, and the general surgery team was consulted. A bladder injury was subsequently identified, and the urology team joined the operation. The first fetus, located on the maternal right side, was delivered in cephalic presentation, weighed 1520 g, and had 1- and 5-minute Apgar scores of 6 and 8. The second fetus, located on the maternal left side, was delivered in bre-ech presentation, weighed 1360 g, and had Apgar scores of 4 and 6.

The urology team repaired a full-thickness 10-cm bladder dome defect primarily. No leaka-ge was observed after filling the bladder with 300 mL saline. General surgery performed adhesiolysis and resected a compromised 15–17 cm small-bowel segment approximately 10 cm proximal to the ileocecal valve, followed by side-to-side anastomosis. The operation lasted approximately six hours. Estimated blood loss was 250 mL. The patient received two units of erythrocyte suspension, one unit of fresh frozen plasma, tranexamic acid, and broad-spectrum antibiotics. She was monitored in the intensive care unit for six days, un-derwent urinary catheterization for one week, and catheter removal was performed after control cystography showed no extravasation. She was discharged on postoperative day ten without bowel or urinary complications. Both neonates were discharged from the neonatal intensive care unit without major complications.

CONCLUSION: Cesarean delivery in patients with multiple previous abdominal surgeries may carry a high risk of severe adhesions and adjacent organ injury. Careful preoperative risk assessment, preparation for possible complications, and timely multidisciplinary involvement are essen-tial for favorable maternal and neonatal outcomes.

Keywords: Intraabdominal adhesions, cesarean section, multidisciplinary management, infertility, abdominal surgery, dichorionic diamniotic twin pregnancy

SS-15

Optic Chiasm Compression Due to Granulomatous Hypophysitis Mimicking Pituitary Adenoma During Late Pregnancy: A Case Report

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OBJECTIVES: The aim of this study is to present the management of a rare case diagnosed with a sellar mass compressing the optic chiasm at 35 weeks of gestation, and to demonstrate a multidisciplinary approach involving simultaneous cesarean section and transsphenoidal surgery.

METHOD: A 28-year-old pregnant woman, gravida 2, at 35 weeks of gestation was admitted to our clinic with a 2-week history of persistent headache and progressive visual impairment. Her past medical history was unremarkable. Following evaluation of maternal condition and fetal well-being, the patient was consulted with the neurology and ophthalmology departments.

RESULTS: Cranial magnetic resonance imaging revealed a sellar mass lesion extending into the suprasellar cistern and causing significant compression of the optic chiasm, radiologically suggestive of a pituitary macroadenoma (Figures 1 and 2). Due to progressive vision loss, an urgent operation was planned by the neurosurgery team with a preliminary diagnosis of pituitary adenoma. Considering the gestational age of 35 weeks and the history of previous cesarean section, a multidisciplinary decision was made to first perform cesarean delivery, followed by total excision of the sellar mass via an endoscopic transsphenoidal approach in the same session. A healthy newborn was delivered.

Histopathological evaluation of the mass demonstrated dense lymphohistiocytic infiltration with multinucleated giant cells, consistent with granulomatous hypophysitis. Immunohistochemical analysis revealed prominent CD68-positive histiocytic components, co-expression of PIT-1 and SF-1 across multiple adenohypophyseal cell lineages, absence of findings suggestive of monoclonal adenoma, and accompanying elevation of serum angiotensin-converting enzyme levels, all of which supported the diagnosis of granulomatous hypophysitis. Postoperatively, the patient was treated for central hypothyroidism and was discharged on postoperative day 6 together with her newborn.

CONCLUSION: Hypophysitis is a rare inflammatory disease of the pituitary gland and is classified into five histological subtypes: lymphocytic, granulomatous, xanthomatous, IgG4-related, and necrotizing. The lymphocytic form is the most common subtype and is more frequently observed in women during pregnancy or the postpartum period. Granulomatous hypophysitis is the second most common subtype and may present with more severe clinical manifestations compared with the lymphocytic type, including headache, chiasmal compression, and hypopituitarism. Granulomatous hypophysitis is a rare condition that can clinically and radiologically mimic pituitary adenoma, and definitive diagnosis can only be established by histopathological examination. Therefore, hypophysitis should always be considered in the differential diagnosis of sellar masses in pregnant patients presenting with sudden or progressive vision loss. In cases of severe and/or progressive visual loss due to optic chiasm compression, surgical intervention is recommended regardless of pregnancy status. Through a multidisciplinary approach involving neurosurgery, endocrinology, ophthalmology, obstetrics, neonatology, and anesthesiology, successful resection of the sellar mass, recovery of visual function, and delivery of a healthy neonate were achieved.

Keywords: Pregnancy, Hypophysitis, Granulomatous hypophysitis, Vision loss, Optic chiasm compression, Pituitary adenoma

Figure 1. Axial cranial magnetic resonance image at the sellar and suprasellar level demonstrating a mass lesion extending superiorly from the sellar region toward the suprasellar cistern. The lesion was associated with compression of the optic pathw

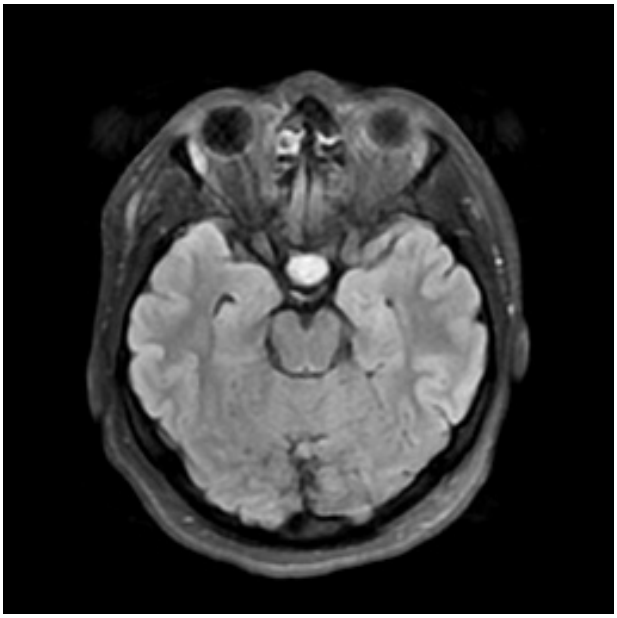
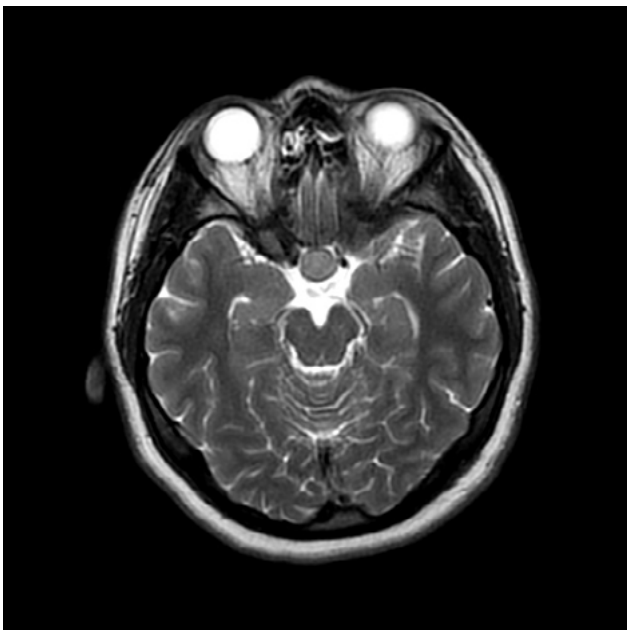


Figure 2. Axial T2-weighted cranial magnetic resonance image showing the sellar/suprasellar mass in close relationship with the optic chiasm and adjacent neurovascular structures. The radiological appearance supported optic chiasm compression, explai



SS-16

Periviable preterm premature rupture of membranes following aspiration-based fetal reduction in a triplet pregnancy conceived by IVF: a case report

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OBJECTIVE: This case report aims to present the clinical management and outcome of periviable preterm premature rupture of membranes (PPROM) developing after aspiration-based multifetal pregnancy reduction (MFPR) in an in vitro fertilization (IVF)-conceived triplet pregnancy, and to highlight the ethical and clinical challenges encountered when the patient declined termination.

METHODS: A 46-year-old G2P0A1 woman with a trichorionic triamniotic triplet pregnancy conceived via IVF presented at 16 weeks of gestation with vaginal fluid leakage. She had undergone aspiration-based fetal reduction from triplets to twins at 9 weeks due to the risks of higher-order multiple pregnancy. Medical history was notable for hypothyroidism and a prior spontaneous abortion. The Amnisure test (placental alpha microglobulin-1, PAMG-1) was positive, confirming PPROM. Ultrasonography revealed anhydramnios in the posterior fetus (Twin B) and normal amniotic fluid index in the anterior fetus (Twin A). Perinatology mg consultation was obtained. The patient received antibiotic therapy (ampicillin G 4*2 g IV, azithromycin 2*500 mg, amoxicillin 875 mg 2*1), tocolysis, and progesterone supplementation. Serial ultrasonographic surveillance and C-reactive protein monitoring were performed. Antenatal corticosteroids (betamethasone) and magnesium sulfate for neuroprotection were administered at 21+6 weeks. Detailed fetal anatomical assessment at 21 weeks revealed persistent oligohydramnios in Twin B, right ventricular echogenic focus, and possible bilateral talipes equinovarus. Pregnancy termination was recommended by perinatology given the poor fetal prognosis; however, the patient, who had no living children and was of advanced maternal age, declined termination on multiple occasions.

RESULTS: Despite conservative management, cervical dilation progressed from 4 cm to 8 cm. At 22+3 weeks of gestation, an emergency cesarean section was performed following completion of magnesium sulfate neuroprotection and antenatal corticosteroids, due to increasing uterine contractions and advanced cervical dilation. Twin A (male, 320 g) and Twin B (female, 380 g) were delivered alive. Five nuchal cord loops were noted in Twin A. Both neonates were admitted to the neonatal intensive care unit (NICU). Twin A died on the day of delivery, and Twin B died two days postpartum. The maternal postoperative course was uneventful.

CONCLUSION: This case illustrates the complex clinical and ethical dilemmas of periviable PPROM following aspiration-based MFPR in an IVF-conceived triplet pregnancy. According to Society for Maternal-Fetal Medicine (SMFM) guidelines, individualized counseling regarding expectant management versus termination should be offered to all patients with periviable PPROM. Antibiotic prophylaxis, tocolysis, and serial monitoring are the cornerstones of expectant management. The neonatal survival rate for periviable PPROM at 15–23+6 weeks is approximately 26.8%. In our case, the patient's strong desire to continue the pregnancy, combined with advanced maternal age and absence of living children, led to prolonged expectant management despite poor fetal prognosis. Both neonates were born at the threshold of viability and could not survive. This case underscores the importance of preconception counseling regarding the risks of higher-order multiple pregnancies, potential complications of MFPR, and the necessity of multidisciplinary team involvement when periviable PPROM occurs in multiple gestations.

Keywords: periviable PPROM, fetal reduction, triplet pregnancy

SS-17

Bilateral Fetal Ovarian Cysts: A Rare Prenatal Diagnosis

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BACKGROUND: Fetal ovarian cysts are uncommon cystic lesions, typically detected in the third trimester due to increased ovarian responsiveness to maternal estrogens, placental human chorionic gonadotropin, and fetal gonadotropins. Most cases are unilateral, whereas bilateral fetal ovarian cysts are rare and present additional diagnostic and management challenges. Careful sonographic assessment is essential to distinguish these cysts from other fetal pelvic cystic lesions and to identify complications such as torsion, hemorrhage, rupture, or mass effect.

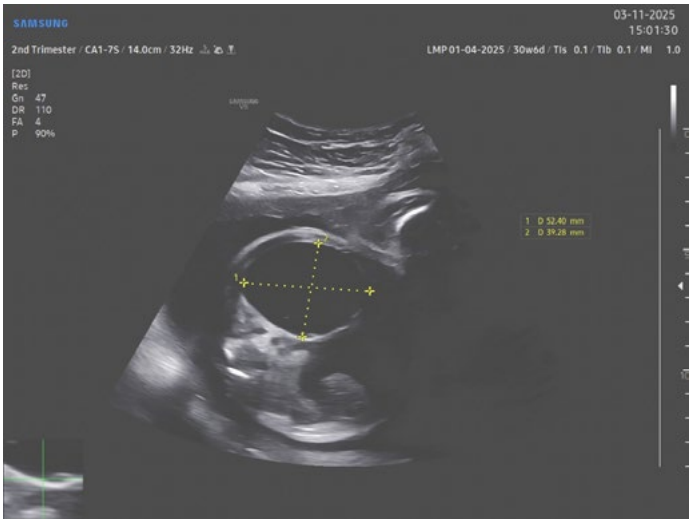
CASE PRESENTATION: A 29-year-old nulliparous pregnant woman had low-risk non-invasive prenatal testing and an unremarkable second-trimester fetal anomaly scan. At 30 weeks, routine follow-up ultrasonography revealed bilateral fetal pelvic cystic lesions in a female fetus. The larger left-sided cyst was thin-walled and predominantly anechoic, measuring 52.4 × 39.3 mm. A contralateral right-sided cystic lesion was also present, measuring 45x33 mm, confirming bilateral fetal ovarian cysts. Intracystic hemorrhage was initially suspected based on the internal appearance of one cyst. However, serial ultrasonographic follow-up showed no growth, progressive complex morphology, ascites, rupture, obstruction, or signs of torsion. At 34 weeks, one cyst was no longer visible, and the remaining right-sided cyst had regressed to 3 cm. At 37 weeks, the residual cyst further decreased to 1.5 cm. The patient delivered at 40 weeks and 5 days, and a healthy newborn was born.

Postnatal pelvic ultrasonography showed normal-sized ovaries, measuring 13 × 10 × 11 mm on the left and 9 × 5 × 6 mm on the right. A few tiny anechoic follicle-like cysts were observed, the largest measuring 4 mm in the left ovary. No large residual ovarian cysts or abnormal Doppler findings were detected.

CONCLUSION: Bilateral fetal ovarian cysts are rare but important considerations in the differential diagnosis of fetal pelvic cystic lesions. This case demonstrates that fetal ovarian cysts can develop after an unremarkable second-trimester anomaly scan and may resolve favorably, even with bilateral presentation and large initial size. In the absence of progressive complexity, mass effect, obstruction, or sonographic signs of torsion, individualized conservative management with close prenatal surveillance and postnatal imaging can be safe and effective, potentially avoiding unnecessary antenatal or neonatal intervention.

Keywords: Bilateral,fetal,ovarian,cyst

week 30 usg



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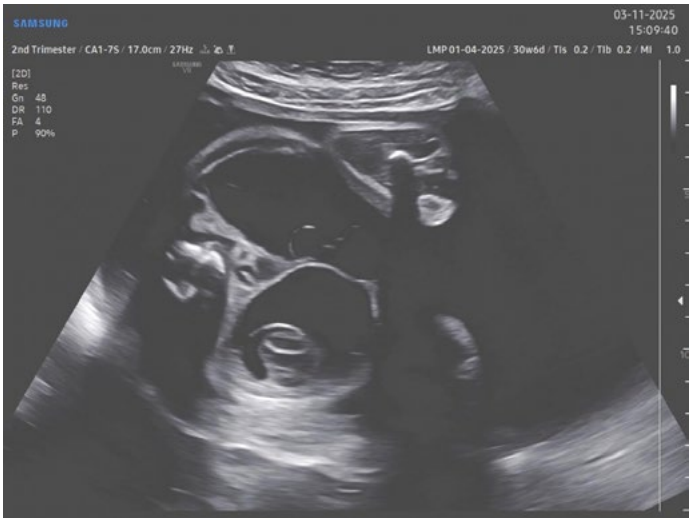

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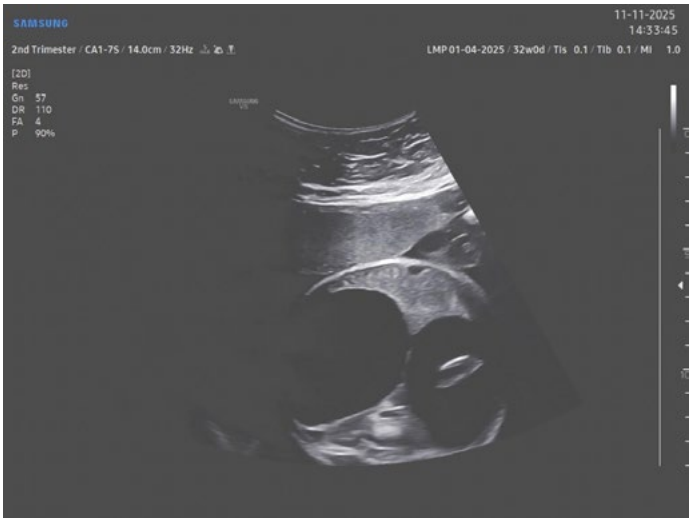

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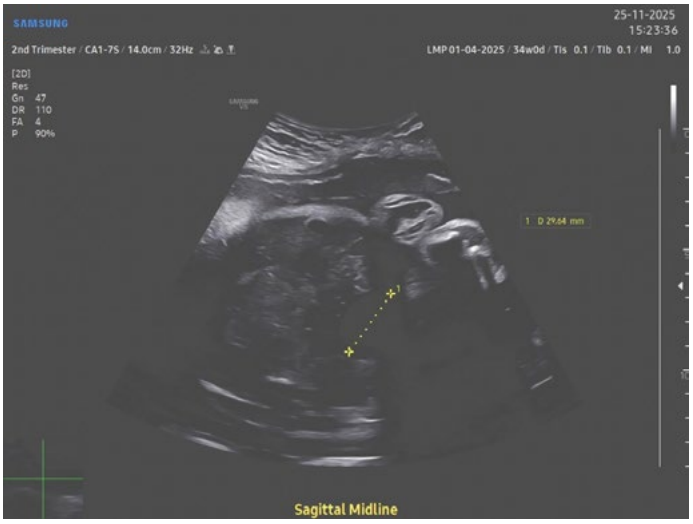

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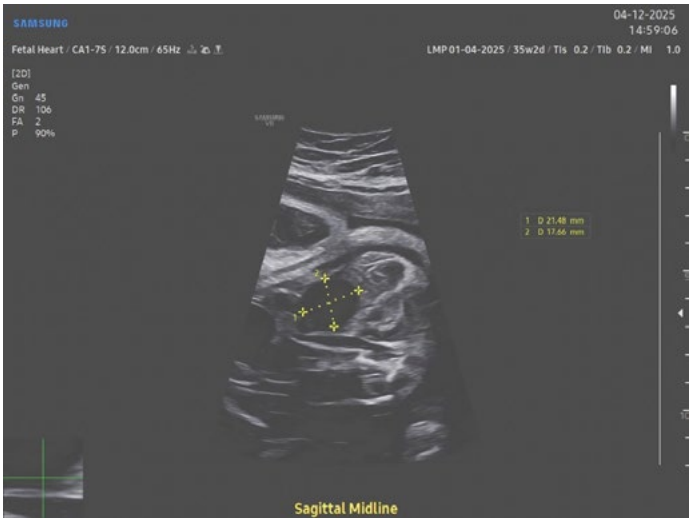

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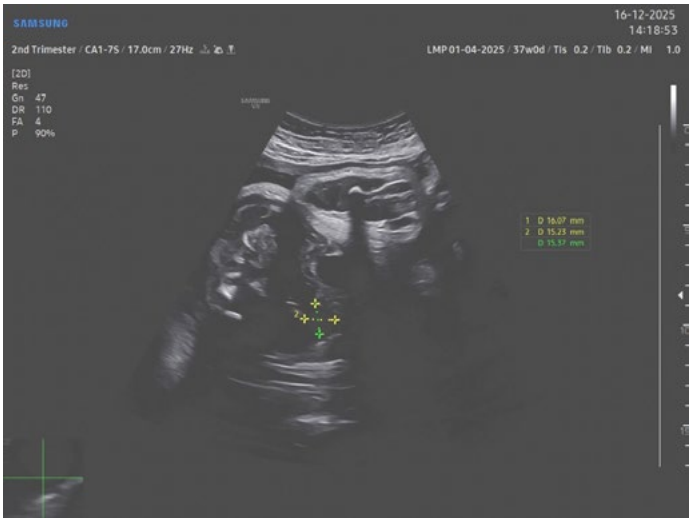

SS-18

Previable PPROM With Systemic Inflammation: A Diagnostic Challenge of Miliary Tuberculosis

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AIM: To present a pregnancy terminated after previable preterm prelabor rupture of membranes (PPROM) with early anhydramnios and marked systemic inflammation, and to compare the clinical findings of this patient with contemporary reports of miliary tuberculosis (TB) in pregnancy, highlighting key elements in differential diagnosis (1,2).

CASE: A 34 year old pregnant woman presented at 16+5 gestational weeks with previable PPROM and anhydramnios. Ultrasound examination confirmed a singleton fetus with cardiac activity, anterior placenta, cephalic presentation, and biometric measurements consistent with 16 weeks, with an estimated fetal weight of 133 g. Laboratory evaluation revealed marked systemic inflammation with a C reactive protein level of 107 mg/L.

Given the disproportionate inflammatory response, tuberculosis was evaluated as a differential diagnosis. Interferon-gamma release assay, QuantiFERON-TB Gold, returned positive. Thoracic computed tomography demonstrated diffuse, bilateral, randomly distributed micronodular opacities measuring approximately 1–3 mm, involving all lung fields without zonal predominance, findings highly consistent with miliary pulmonary tuberculosis (Figure 1). Chest radiography also showed diffuse bilateral reticulonodular/micronodular pulmonary infiltrates, supporting disseminated pulmonary involvement (Figures 2 and 3). No cavitary lesion was identified.

Mycobacterial cultures were obtained and were pending at the time of clinical decision making. Based on the combination of positive IGRA results and characteristic radiologic findings, empirical antituberculosis therapy was initiated according to standard treatment protocols. Following evaluation by a perinatology council, the patient was counseled regarding poor fetal prognosis related to previable PPROM with anhydramnios and potential maternal risks in the setting of disseminated infection. She declined expectant management, and pregnancy termination was performed using vaginal misoprostol, with inpatient monitoring and supportive care documented.

DISCUSSION: In this case, pregnancy termination occurred primarily due to severe obstetric pathology, namely previable PPROM with anhydramnios, while simultaneous evaluation revealed confirmed tuberculosis infection with miliary pulmonary involvement. This presentation is consistent with the diagnostic complexity described in the literature, where miliary TB in pregnancy often manifests with nonspecific or subtle symptoms and may coexist with obstetric complications (1–3).

Published case series report that miliary TB during pregnancy frequently presents in the first or second trimester and is characterized radiologically by diffuse micronodular pulmonary involvement, a key diagnostic feature when clinical findings are nonspecific (3–5,8). Similar to our patient, microbiological confirmation is often delayed or inconclusive, and diagnosis is frequently supported by imaging and immunologic testing (2,4,5).

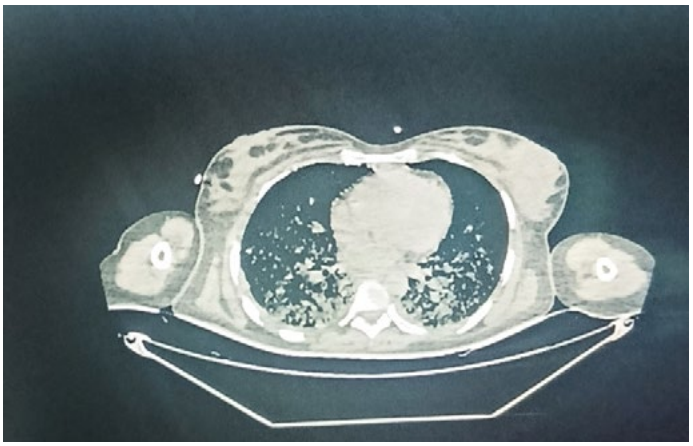
Retrospective studies demonstrate that many pregnant patients with miliary TB experience pregnancy loss or termination, often driven by maternal clinical deterioration rather than primary obstetric indications (4,5). Systematic reviews and large cohorts further confirm that active TB in pregnancy increases the risk of miscarriage, preterm birth, intensive care admission, and adverse maternal outcomes, particularly

in disseminated disease (1,2,6).

CONCLUSION: This case illustrates abortion following previable PPROM with early anhydramnios in the setting of confirmed miliary tuberculosis. Comparison with contemporary literature emphasizes that miliary TB can mimic or coexist with obstetric inflammatory conditions in pregnancy and should be considered when systemic inflammation is present. Early recognition and timely initiation of therapy remain essential to optimize maternal outcomes.

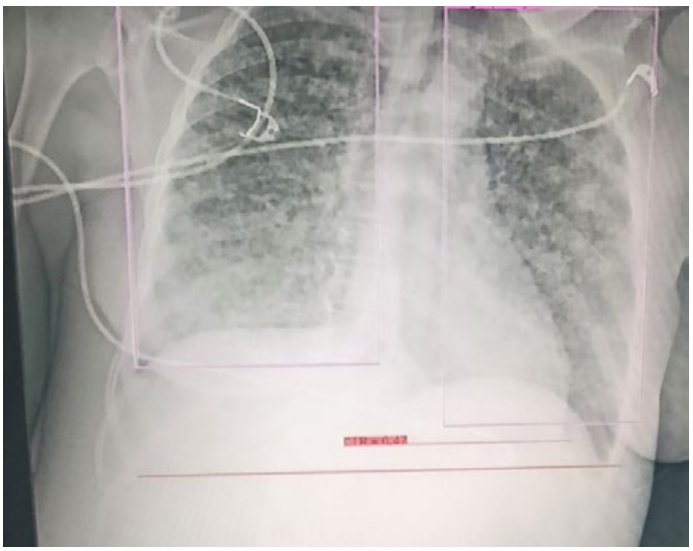
Keywords: Previable PPROM, anhydramnios, miliary tuberculosis, QuantiFERON-TB Gold, pulmonary tuberculosis, pregnancy termination

Figure 1. Axial thoracic computed tomography image showing diffuse bilateral micronodular pulmonary involvement.



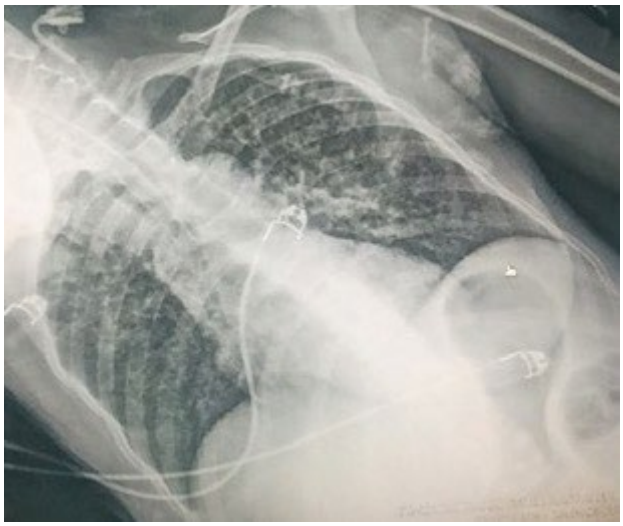
Axial thoracic CT demonstrates numerous randomly distributed micronodular opacities involving both lungs. The diffuse bilateral micronodular pattern was considered highly compatible with miliary pulmonary tuberculosis in the appropriate clinical and laboratory context.

Figure 2. Anteroposterior chest radiograph demonstrating diffuse bilateral pulmonary infiltrates.



Chest radiography shows widespread bilateral reticulonodular/micronodular opacities involving both lung fields. These findings supported disseminated pulmonary involvement and were consistent with a miliary pattern.

Figure 3. Lateral chest radiograph showing diffuse reticulonodular pulmonary involvement.



Lateral chest radiograph demonstrates diffuse pulmonary micronodular/reticulonodular infiltrates, complementing the anteroposterior radiographic findings and supporting the diagnosis of miliary pulmonary tuberculosis.

SS-19

Do the levels of hepcidin and tenascin-C change in patients with pretermprematurе rupture of membranes? Can these markers help in diagnosis?

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The study project was supported by the Van Yüzüncü Yıl University Scientific Research Projects Commission (TTU-2021-9697).

AIM: Preterm premature rupture of membranes (PPROM) is an important obstetric complication associated with increased maternal and neonatal morbidity and mortality. Intrauterine infection and inflammation are considered major mechanisms in the pathogenesis of PPROM. Novel biomarkers beyond conventional inflammatory markers are needed for early diagnosis and prediction. This study aimed to investigate the role of hepcidin and tenascin-C levels in the diagnosis of PPROM.

METHODS: This prospective cohort study was conducted between March 31, 2021 and March 15, 2022 at the Department of Obstetrics and Gynecology, Van Yuzuncu Yil University Dursun Odabasi Medical Center. One hundred pregnant women diagnosed with PPROM between 24 and 37 weeks of gestation were included as the case group, and 100 healthy pregnant women were enrolled as the control group. Demographic characteristics including age, gestational week, body mass index, gravida, and parity were recorded. Venous blood samples were collected from all participants for measurement of C-reactive protein (CRP), leukocyte count, neutrophil count, hepcidin, and tenascin-C levels. PPROM diagnosis was established by visualization of amniotic fluid leakage during speculum examination or a positive placental alpha microglobulin-1 test. Statistical analyses were performed using SPSS 21.0. Continuous variables were compared using the Mann-Whitney U test, and $p<0.05$ was considered statistically significant.

RESULTS: A total of 200 pregnant women were included in the study. The mean maternal age was 28.13±5.94 years and the mean gestational age was 31.41±4.12 weeks. There were no statistically significant differences between the groups regarding age, gestational week, body mass index, gravida, or parity ($p>0.05$). CRP, leukocyte, and neutrophil levels were significantly higher in the PPROM group compared with the control group ($p=0.010$, $p<0.001$, and $p<0.001$, respectively). Mean hepcidin level was 41.03±17.66 ng/mL in the control group and 37.57±19.31 ng/mL in the PPROM group, indicating significantly lower hepcidin levels in patients with PPROM ($p=0.003$). No significant difference was found between the groups regarding tenascin-C levels ($p=0.161$). Cesarean delivery rates were similar between the groups ($p=0.514$).

CONCLUSION: Hepcidin levels were significantly lower in patients with PPROM and may serve as a potential biomarker in the diagnosis of PPROM. In contrast, tenascin-C levels did not differ significantly between PPROM and healthy pregnancies. Larger multicenter prospective studies are needed to further evaluate the predictive value of hepcidin and the possible role of tenascin-C in PPROM.

Keywords: Preterm premature rupture of membranes, Hepcidin, Inflammation

SS-21

Prenatal Suspicion and Postnatal Confirmation of Type C Esophageal Atresia

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OBJECTIVE: To present the prenatal ultrasonographic findings, diagnostic challenges, and postnatal outcome of a fetus diagnosed with type C esophageal atresia (esophageal atresia with distal tracheoesophageal fistula), emphasizing the importance of serial fetal assessment in cases with subtle sonographic findings.

CASE PRESENTATION: A 29-year-old gravida 2 para 1 pregnant woman was referred at 31 weeks of gestation because of progressive polyhydramnios. Detailed fetal ultrasonographic examination revealed persistent polyhydramnios, a small fetal stomach with intermittent visualization, and a dilated blind-ending proximal esophageal pouch in the cervical/thoracic region during dynamic scanning. No major structural anomalies were identified. Fetal growth parameters and Doppler indices were within normal limits for gestational age. Serial ultrasonographic examinations demonstrated persistence of polyhydramnios and recurrent visualization of the proximal esophageal pouch, raising suspicion of esophageal atresia despite the presence of a visible stomach. Based on these findings, prenatal diagnosis of esophageal atresia associated with distal tracheoesophageal fistula (type C) was considered.

At 38 weeks of gestation, delivery was performed due to obstetric indications. Postnatal evaluation confirmed the diagnosis of type C esophageal atresia. The neonate underwent surgical repair in the early neonatal period, with favorable postoperative recovery.

DISCUSSION: Prenatal diagnosis of esophageal atresia remains challenging, particularly in type C cases, which account for approximately 85–90% of cases. In these fetuses, distal tracheoesophageal fistula allows passage of amniotic fluid into the stomach, often masking the classic sonographic findings. Therefore, the prenatal detection rate remains limited.

Dynamic assessment of the fetal neck and upper thorax, identification of the proximal esophageal pouch sign, and serial monitoring of amniotic fluid volume are critical for improving diagnostic accuracy. Early prenatal suspicion enables multidisciplinary counseling, optimized delivery planning, and timely postnatal surgical intervention.

CONCLUSION: Type C esophageal atresia may be prenatally suspected even in the presence of a visible stomach. Persistent polyhydramnios combined with repeated visualization of the proximal esophageal pouch should alert clinicians to this diagnosis. Careful serial ultrasonographic evaluation can facilitate prenatal recognition and improve perinatal management.

Keywords: Esophageal atresia, Tracheoesophageal fistula, Prenatal diagnosis, Fetal ultrasound, Polyhydramnios, Congenital anomalies

Figure 1. Esophageal pouch image on ultrasonography

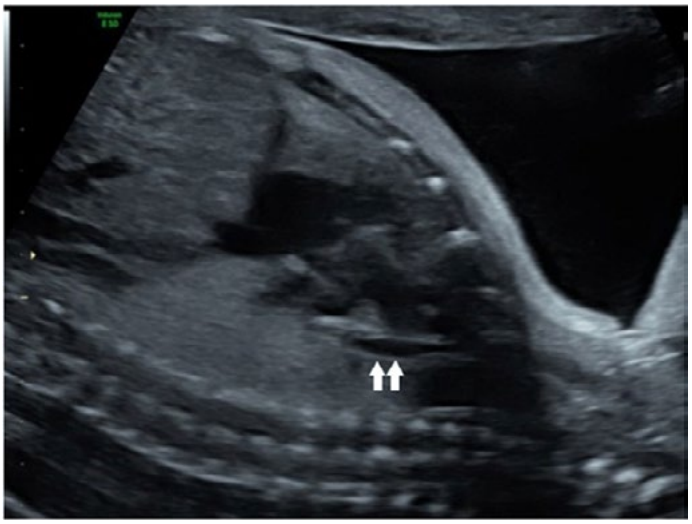
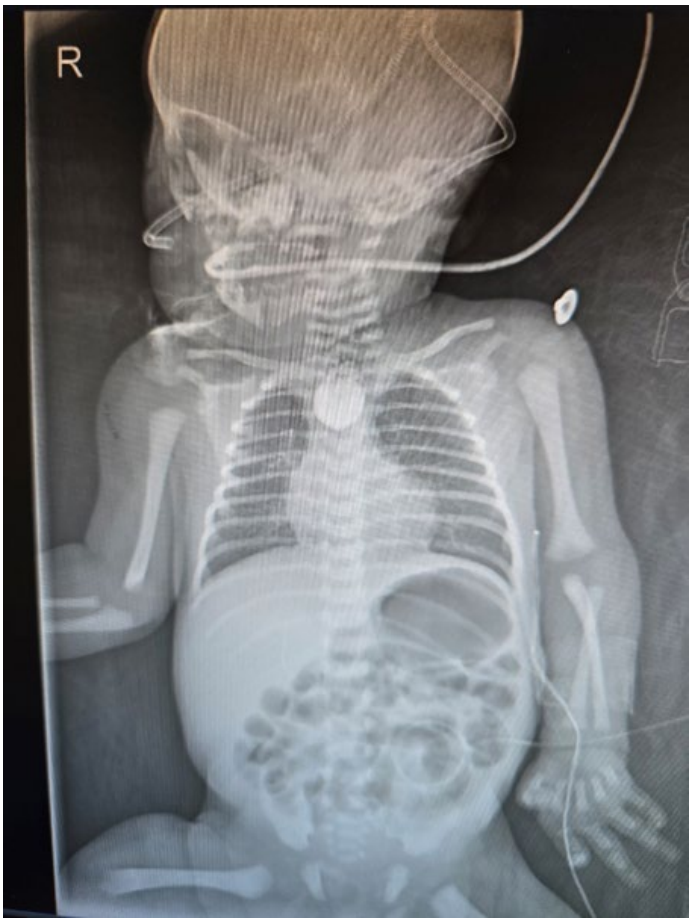


Figure 2. Neonatal X-ray shows esophageal pouch



SS-22

Parvovirus B19 infection presenting with fetal ascites and hyperechogenic bowel: a case report

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OBJECTIVE: Parvovirus B19 infection during pregnancy may cause severe fetal complications including fetal anemia, nonimmune hydrops fetalis, and intrauterine fetal loss. Fetal ascites and hyperechogenic bowel are uncommon prenatal ultrasonographic findings. We aimed to present a rare case of Parvovirus B19 infection associated with fetal ascites and hyperechogenic bowel without evidence of severe fetal anemia.

METHODS: Clinical course, prenatal ultrasonographic findings, maternal serologic tests, and fetal Doppler measurements of a 33-year-old gravida 3, para 1 pregnant woman were evaluated. Serial fetal ultrasonography and middle cerebral artery peak systolic velocity (MCA-PSV) assessments were used to monitor fetal anemia and disease progression throughout pregnancy.

RESULTS: The patient was referred to the perinatology clinic at 28 weeks of gestation because of fetal ascites detected on ultrasonography. Detailed fetal ultrasonography demonstrated diffuse fetal ascites and hyperechogenic bowel without additional structural anomalies. Maternal serologic evaluation revealed positive Parvovirus B19 immunoglobulin M (IgM) and immunoglobulin G (IgG) results. Weekly MCA-PSV measurements remained within normal limits throughout follow-up, and no evidence of severe fetal anemia was detected. Invasive prenatal diagnostic procedures including amniocentesis and cordocentesis were recommended but declined by the family. Spontaneous regression of fetal ascites was observed at 34 weeks of gestation. Pregnancy was managed conservatively until 38 weeks of gestation, when a 2600 g live female infant with an Apgar score of 8 was delivered by cesarean section.

CONCLUSION: Parvovirus B19 infection should be considered in the differential diagnosis of fetal ascites and hyperechogenic bowel, even in the absence of severe fetal anemia. Close ultrasonographic follow-up and MCA Doppler surveillance may allow favorable perinatal outcomes with conservative management in selected clinically stable cases.

Keywords: Parvovirus B19, fetal ascites, hyperechogenic bowel, MCA Doppler, prenatal ultrasonography

SS-23

A Case of Myelomeningocele Diagnosed Late in the Prenatal Period

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AIM: Myelomeningocele is an open neural tube defect resulting from incomplete embryologic closure of the neural tube and may be associated with severe neurological morbidity. Early prenatal diagnosis is essential for planning pregnancy management, estimating fetal prognosis, determining the mode of delivery, and providing appropriate family counseling. This case report presents the ultrasonographic findings, obstetric management, patient decision, delivery process, and neonatal surgical course of a large myelomeningocele diagnosed late in pregnancy because detailed fetal anatomical assessment had not been performed.

METHOD: This case report retrospectively reviewed the pregnancy follow-up, prenatal diagnostic process, perinatology council assessment, delivery management, and neonatal course of a 24-year-old G1P0 patient. Obstetric history, prenatal ultrasonographic findings, intrapartum clinical findings, and postnatal neurosurgical management were evaluated.

FINDINGS: The patient's first-trimester combined screening test had been reported as low risk, and the TORCH panel was negative. However, no detailed second-trimester obstetric ultrasonography had been performed. At 32 weeks of gestation, ultrasonography revealed severe bilateral ventriculomegaly, with the left and right lateral ventricles measuring 19 mm and 17 mm, respectively. The third ventricle was dilated to 8.28 mm. Cranial examination demonstrated a positive lemon sign, and the cavum septi pellucidi could not be clearly visualized (Figure 1). A large open neural tube defect measuring approximately 88 × 75 mm was identified in the lumbosacral region, and the findings were considered consistent with myelomeningocele. The case was discussed by the perinatology council. Fetal prognosis, potential neonatal morbidity, pregnancy management, and the need for postnatal surgery were explained to the family in detail. The patient chose to continue the pregnancy.

At 38 weeks of gestation, the patient presented with rupture of membranes. On admission, she had full cervical dilatation, breech presentation, and meconium-stained amniotic fluid. Emergency cesarean delivery was planned to protect the known large myelomeningocele sac. However, because of late presentation and fetal advancement in the birth canal, the sac had already lost its integrity (Figure 2).

A 3100-g female infant was delivered by cesarean section. Severe neonatal depression was noted, with a 1-minute Apgar score of 1. Neonatal resuscitation was initiated because no heart rate was detected; by approximately the first minute, the heart rate increased above 100 beats/min. The 5-minute Apgar score was 6, and the intubated newborn was admitted to the neonatal intensive care unit. Initial physical examination showed no active movement in the lower extremities.

After neurosurgical evaluation and preparation, myelomeningocele repair was performed on postnatal day 2 (Figure 3). Due to subsequent hydrocephalus, a ventriculoperitoneal shunt was placed on postoperative day 9. The newborn remained clinically stable, on room air and full enteral feeding, under neonatal intensive care follow-up (Figure 4).

CONCLUSION: This case emphasizes that low-risk prenatal screening tests do not exclude structural fetal anomalies. Timely detailed second-trimester fetal anatomical ultrasonography is critical for early diagnosis of open neural tube defects. Late diagnosis after labor onset limits obstetric options, complicates protection of the fetal lesion, and may increase neonatal morbidity. Regular antenatal care, perinatology counseling, and multidisciplinary management respecting patient autonomy are essential.

Keywords: Myelomeningocele, neural tube defect, late prenatal diagnosis, ventriculomegaly, detailed ultrasonography, patient autonomy

Figure 1. On prenatal ultrasonography performed at the 32nd gestational week, the lemon sign appearance, characterized by inward scalloping of the bilateral frontal bones, is observed in the fetal cranial axial section. This finding is one of the cra

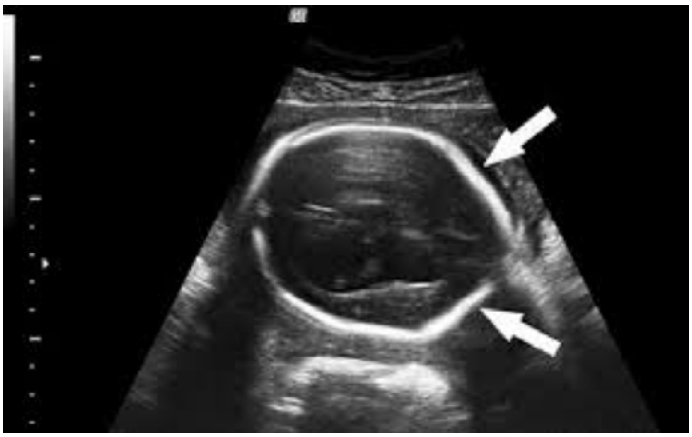


Figure 2. A large myelomeningocele defect is observed in the lumbosacral region after delivery. Following late presentation and progression within the birth canal, loss of integrity of the myelomeningocele sac is seen.

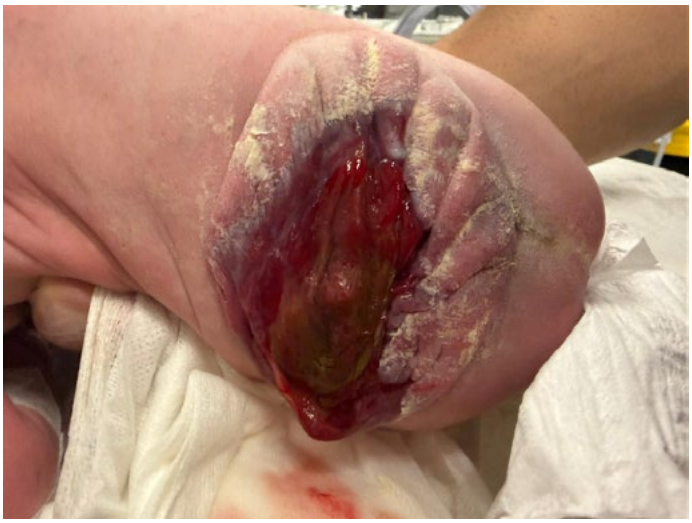


Figure 3. Postoperative appearance of the primarily closed defect area in the lumbosacral region after surgical repair performed by neurosurgery during the neonatal period.

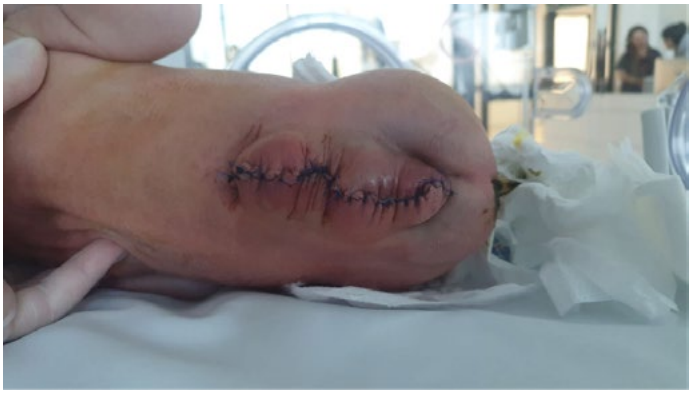
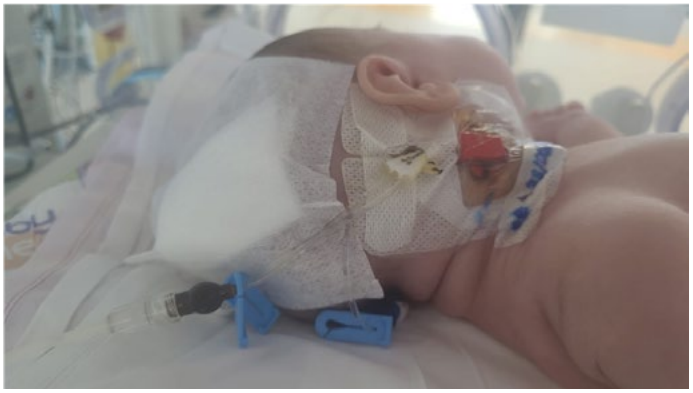


Figure 4. Postoperative follow-up image of the newborn in the neonatal intensive care unit after placement of a ventriculoperitoneal shunt due to the development of hydrocephalus. The newborn is being followed on room air and with full enteral nutrit



SS-24

Pregnancy complicated by preterm birth in a bicornuate uterus: a case report

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OBJECTIVE: A bicornuate uterus is a congenital uterine anomaly resulting from incomplete fusion of the Müllerian ducts and is associated with adverse obstetric outcomes, including pregnancy loss, preterm birth, malpresentation, and preterm premature rupture of membranes (PPROM). Previous studies have reported pregnancy loss rates of approximately 36%, preterm delivery rates of 21–23%, and fetal survival rates of 50–60% in patients with bicornuate uterus. In addition, fetal growth restriction and fetal malpresentation are more frequently observed in these patients. This case report aimed to present the obstetric management and perinatal outcomes of a pregnant woman with bicornuate unicollis uterus complicated by recurrent preterm birth and PPROM.

METHODS: A 25-year-old pregnant woman with a known bicornuate uterus had a significant obstetric history of two previous cesarean deliveries, both resulting in preterm birth. Her first pregnancy resulted in preterm delivery following PPROM at 26 weeks of gestation. In the second pregnancy, cesarean delivery was performed at 32 weeks of gestation because of progressive cervical dilatation and preterm labor. In the current pregnancy, the patient was admitted for close observation at 32 weeks of gestation because of uterine contractions.

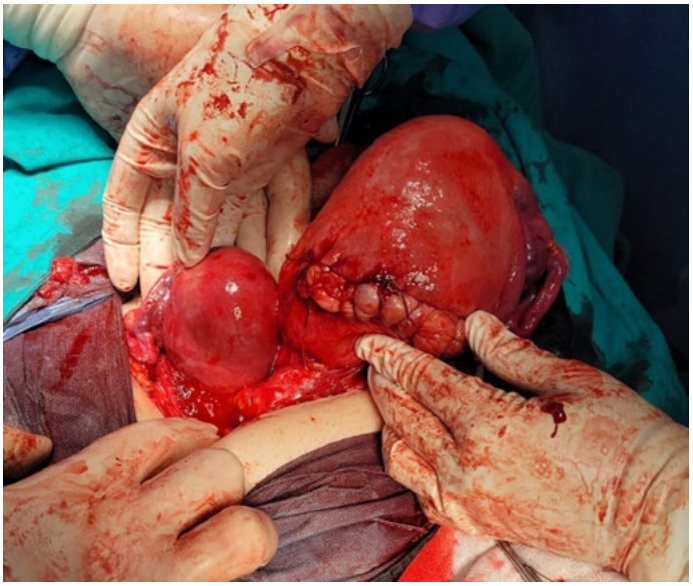
RESULTS: Tocolytic therapy with nifedipine and antenatal betamethasone administration for fetal lung maturation were initiated. Following tocolytic therapy, uterine contractions regressed and pregnancy was prolonged for approximately two weeks. At 34 weeks of gestation, the patient was readmitted to our clinic because of amniotic fluid leakage. Due to PPROM and active labor, a decision for delivery was made, and repeat cesarean section was performed because of the history of previous cesarean deliveries.

Intraoperative evaluation revealed a bicornuate uterus with the pregnancy located in the left uterine horn. A live male infant weighing 2300 g with a 1-minute Apgar score of 7 was delivered. The neonate was admitted to the neonatal intensive care unit because of prematurity. Vaginal examination demonstrated a single cervix, confirming the diagnosis of bicornuate unicollis uterus. Postoperative maternal and neonatal follow-up was uneventful.

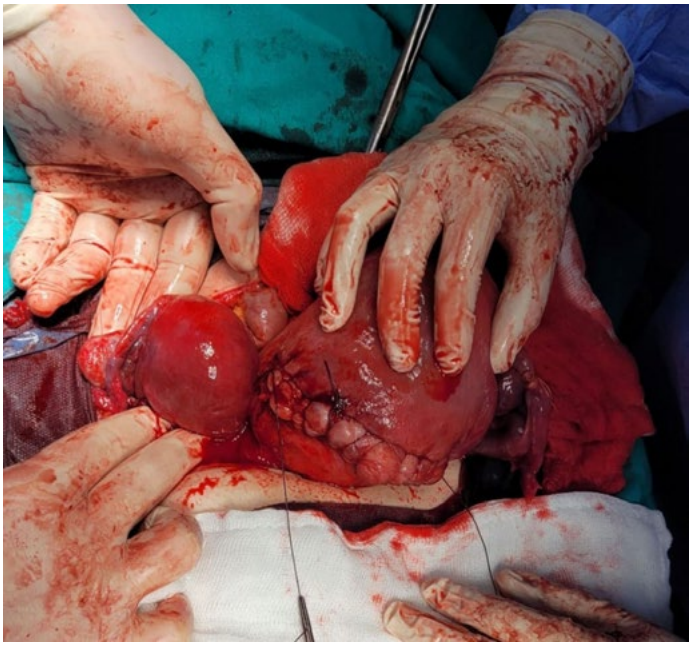
CONCLUSION: Pregnancies complicated by bicornuate uterus are associated with an increased risk of recurrent preterm birth and PPROM. However, individualized antenatal surveillance, timely hospitalization, antenatal corticosteroid administration, and appropriate obstetric management may contribute to prolongation of pregnancy and improved neonatal outcomes compared with previous pregnancies. This case highlights the importance of close antenatal follow-up and individualized obstetric management in high-risk pregnancies complicated by congenital uterine anomalies.

Keywords: Bicornuate uterus, Müllerian anomaly, Preterm birth, Preterm labor, Recurrent preterm birth

Intraoperative view of bicornuate uterus



Intraoperative view of bicornuate uterus



Intraoperative cesarean section image demonstrating a bicornuate uterus with the pregnancy located in the left uterine horn

SS-25

The effect of smoking on birth weight and perinatal outcomes in low-risk term singleton vaginal deliveries

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OBJECTIVE: This study aimed to evaluate the effect of maternal smoking on neonatal birth weight and perinatal outcomes in comorbidity-free term singleton pregnancies with vaginal delivery, and to investigate the dose-response relationship between daily cigarette consumption and birth weight.

METHODS: Comorbidity-free term (≥37 weeks) singleton pregnancies with vaginal delivery at Ankara Etlik City Hospital, Department of Obstetrics and Gynecology between January 1 and March 1, 2026 were retrospectively screened. Consecutive patients meeting inclusion criteria were enrolled. Exclusion criteria were preeclampsia, gestational diabetes mellitus (GDM), chronic hypertension, placenta previa/abruption, fetal anomaly, multiple pregnancy, cesarean delivery, and alcohol/substance use. Fifty active smokers (Smoking+ group) and 50 non-smokers (Smoking− group) were included. Sample size was calculated using G*Power (d=0.60, α=0.05, power=80%). The primary outcome was birth weight difference. Secondary outcomes included Apgar scores (1st and 5th minute), umbilical artery pH, acidosis rate (pH <7.20), and neonatal intensive care unit (NICU) admission. Normality was assessed by the Shapiro-Wilk test. Continuous variables were compared using independent samples t-test or Mann-Whitney U test, and categorical variables using Chi-square or Fisher's exact test. Independent predictors were evaluated by multiple linear regression, and the dose-response relationship by Spearman correlation.

RESULTS: Groups were comparable regarding age (p=0.801), gravidity (p=0.609), parity (p=0.716), body mass index (BMI) (p=0.844), gestational age (p=0.671), and fetal sex (p=1.000) (Table 1). Mean birth weight was 3073.2 ± 335.9 g in the Smoking+ group and 3314.8 ± 307.1 g in the Smoking− group; the 241.5 g difference was statistically significant (t=−3.752, p<0.001, Cohen's d=0.75) (Figure 1). First-minute Apgar score was significantly lower in the smoking group (median 8 vs 9, p=0.004). Although the median fifth-minute Apgar was 10 in both groups, the distribution was wider in smokers (range 6–10 vs 9–10, p=0.028). NICU admission (14.0% vs 8.0%, p=0.525), acidosis rate (8.0% vs 6.0%, p=1.000), and umbilical artery pH (p=0.724) did not differ significantly. A significant negative correlation was observed between daily cigarette consumption (range 2–30/day) and birth weight (Spearman r=−0.360, p=0.010) (Figure 2). After adjusting for age, BMI, parity, gestational age, and fetal sex, smoking independently reduced birth weight by 246.6 g (β=−246.57, 95% confidence interval [CI]: −374.24 to −118.90, p<0.001). In the dose-response model, each additional cigarette per day decreased birth weight by 17.7 g (β=−17.74, 95% CI: −25.02 to −10.47, p<0.001; Adjusted R^2=0.193).

CONCLUSION: Even in comorbidity-free term singleton vaginal deliveries, maternal smoking significantly reduces neonatal birth weight and adversely affects Apgar scores in a dose-dependent manner. The dose-response pattern suggests that reducing cigarette exposure may also be potentially beneficial for fetal growth; however, this inference requires confirmation through prospective studies.

Keywords: Smoking, pregnancy, birth weight, dose-response, Apgar score

Figure 1

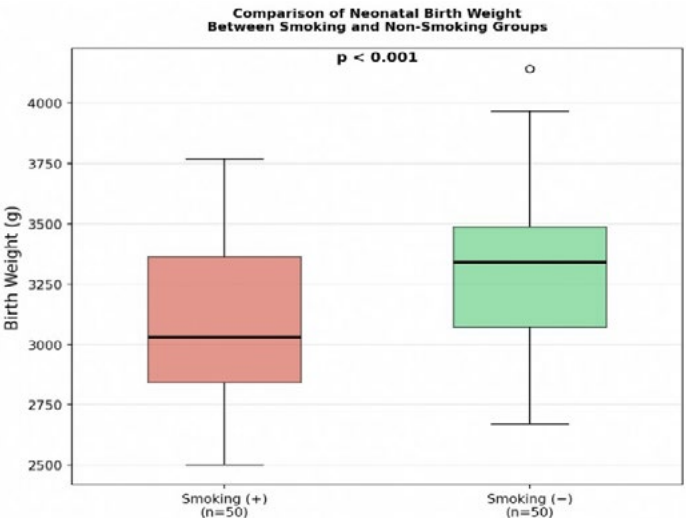

Figure 1. Comparison of neonatal birth weight between smoking and non-smoking groups. The 241.5 g difference was statistically significant (p<0.001, Cohen's d=0.75).

Figure 2

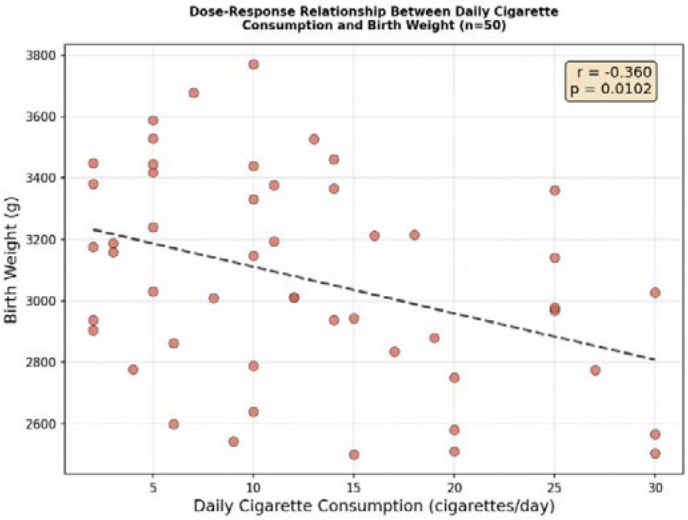

Figure 2. Dose-response relationship between daily cigarette consumption and birth weight in the Smoking+ group (n=50). Spearman r=−0.360, p=0.010.

Table 1

Variable	Smoking+ (n=50)	Smoking− (n=50)	Test	p
Age (years)	29.00 (18–41)	28.00 (20–43)	MWU	0.801
Gravidity	2.00 (1–6)	2.00 (1–7)	MWU	0.609
Parity	1.00 (0–5)	1.00 (0–5)	MWU	0.716
BMI (kg/m²)	30.52 ± 6.59	30.28 ± 5.51	t-test	0.844
GA (days)	274.72 ± 10.27	275.60 ± 10.36	t-test	0.671
Birth weight (g)	3073.24 ± 335.92	3314.78 ± 307.14	t-test	<0.001*
Length (cm)	50.90 ± 0.67	51.09 ± 0.78	t-test	0.190
Head circ. (cm)	34.76 ± 0.57	34.64 ± 0.55	t-test	0.256
Apgar 1 min	8.00 (4–9)	9.00 (7–9)	MWU	0.004*
Apgar 5 min	10.00 (6–10)	10.00 (9–10)	MWU	0.028*
Umbilical artery pH	7.30 ± 0.08	7.30 ± 0.07	t-test	0.724
Categorical	*n (%)*	*n (%)*		
Sex (Male)	21 (42.0)	21 (42.0)	Chi-sq	1.000
Induction	28 (56.0)	18 (36.0)	Chi-sq	0.071
NICU admission	7 (14.0)	4 (8.0)	Fisher	0.525
Acidosis (pH<7.20)	4 (8.0)	3 (6.0)	Fisher	1.000
Low Apgar 5m (<7)	1 (2.0)	0 (0.0)	Fisher	1.000

MWU: Mann-Whitney U test. Normally distributed variables: mean ± SD (t-test); non-normally distributed: median (min–max) (MWU). Categorical variables: n (%). *p<0.05

Table 1. Comparison of demographic, clinical, and neonatal characteristics between groups

SS-26

Misconceptions in Active Management of the Third Stage of Labor: A Gateway to Uterine Inversion

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Ankara Eğitim ve Araştırma Hastanesi

BACKGROUND: Active management of the third stage of labor is an evidence-based approach recommended to reduce postpartum hemorrhage. It consists of uterotonic administration, controlled cord traction, and uterine massage. However, incorrect application of controlled cord traction may lead to serious complications, including uterine inversion, a rare but life-threatening obstetric emergency. Known risk factors for uterine inversion include cord traction before placental separation and excessive fundal pressure. Despite established guidelines, these incorrect practices may persist in clinical settings. This study aims to evaluate the discrepancy between theoretical knowledge and clinical practice among resident physicians.

OBJECTIVE: To assess the level of knowledge and practical approach of resident physicians regarding active management of the third stage of labor, with a particular focus on the technique of controlled cord traction.

METHODS: This descriptive study was conducted among 20 resident physicians using an open-ended questionnaire. Participants were asked three questions regarding:
(1) the definition of active management of the third stage of labor,
(2) its main components, and
(3) the technical application of controlled cord traction.

Responses were analyzed using content analysis, categorized, and presented as percentages.

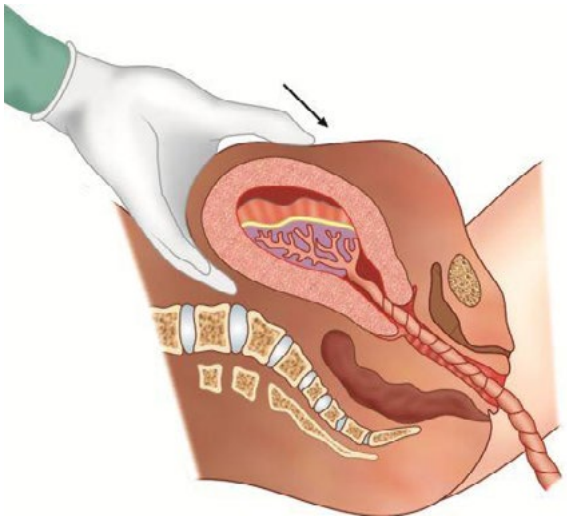
RESULTS: All participants (100%) correctly defined active management of the third stage of labor and accurately listed its main components, including uterotonic administration, controlled cord traction, and uterine massage.

However, significant discrepancies were observed in the technical description of controlled cord traction. None of the participants (0%) mentioned uterine stabilization using suprapubic counter traction. The majority (85%) described applying fundal pressure during cord traction, while the remaining 15% did not describe any form of uterine stabilization.

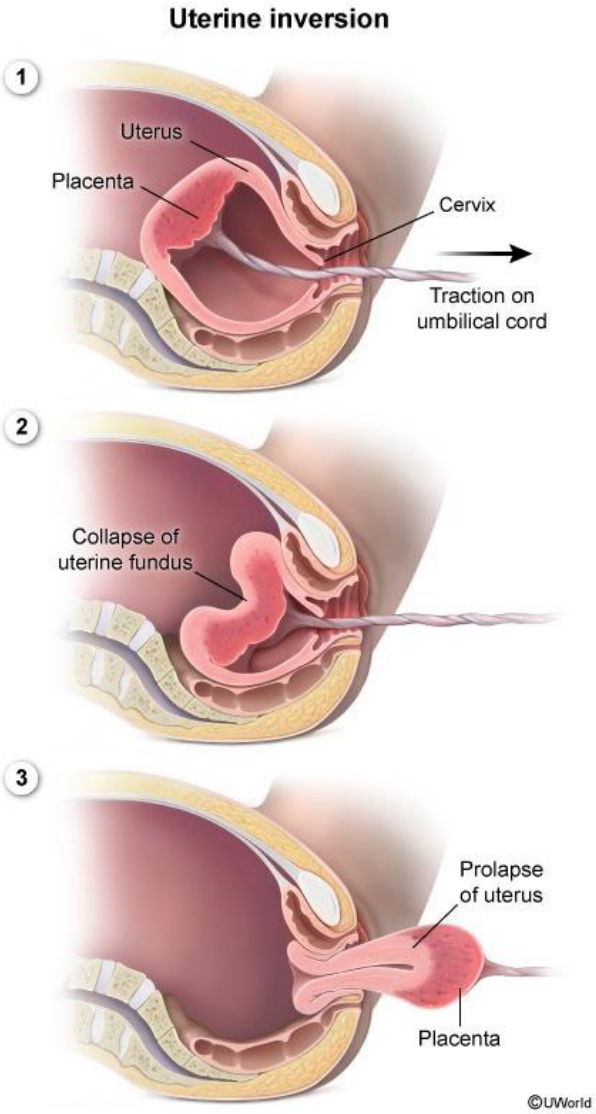
CONCLUSION: Although theoretical knowledge regarding active management of the third stage of labor appears to be adequate, there is a critical gap in the correct application of controlled cord traction. The widespread description of fundal pressure instead of suprapubic counter traction suggests that incorrect practices may be embedded in clinical routines. Given that fundal pressure, particularly when combined with cord traction before placental separation, may increase the risk of uterine inversion, these findings highlight a potentially preventable risk in obstetric practice. Strengthening hands-on training and emphasizing correct techniques are essential to bridge the gap between knowledge and practice and to reduce the risk of severe complications.

Keywords: Countertraction, Inversion, Labor, Traction

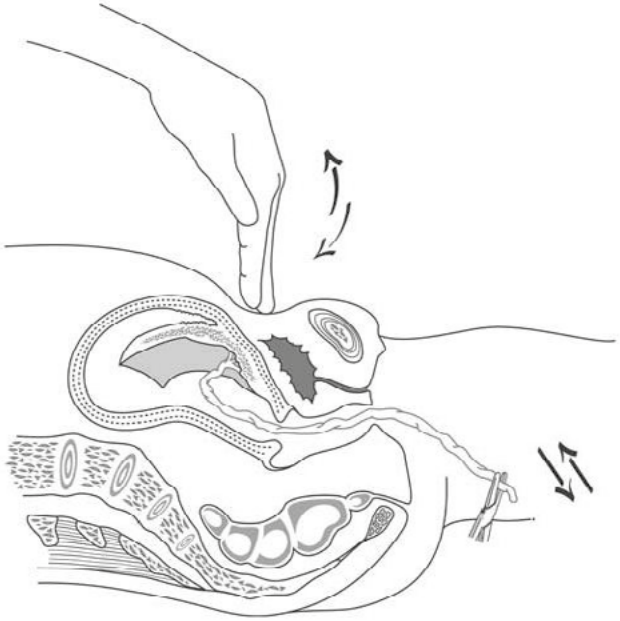
fundal bası



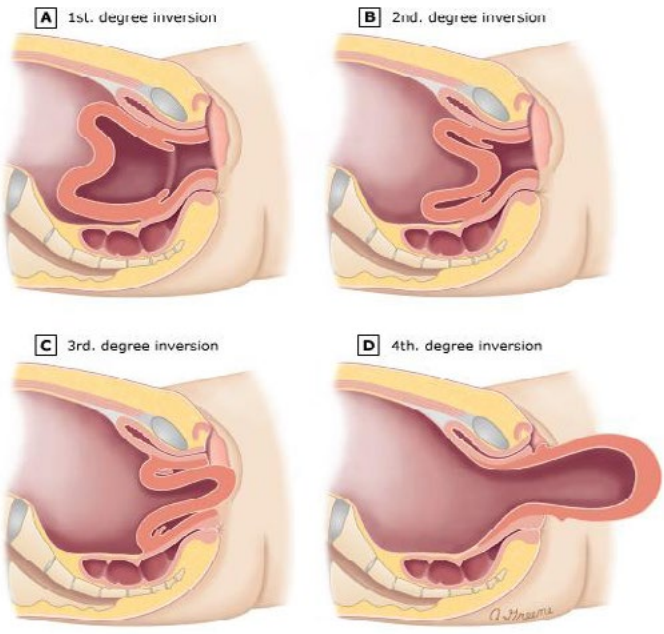
uterin inversiyon 2



uterin stabilizasyon



uterşn inversiyon



SS-27

Cesarean delivery in a pregnancy with uterus bicornis unicollis: a rare case report

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OBJECTIVE: Uterus bicornis unicollis is a rare congenital uterine anomaly among Müllerian duct fusion defects, characterized by two uterine corpora and a single cervix. These anomalies may be associated with increased risks of malpresentation, preterm birth, fetal growth restriction, and cesarean delivery. This case report aims to present the intraoperative anatomical findings and surgical approach during cesarean delivery in a patient with uterus bicornis unicollis whose pregnancy was localized in the right hemiuterus.

METHODS: A 33-year-old gravida 2, para 1 patient was being followed with a known diagnosis of uterus bicornis unicollis. The diagnosis of uterine anomaly had been confirmed by pelvic magnetic resonance imaging performed before her first pregnancy after a suspected uterine anomaly was detected on routine ultrasonography. A single cervix was observed on vaginal examination. Her previous pregnancy had also been localized in the right hemiuterus and had been delivered uneventfully by elective cesarean section at 39 weeks at an external center due to breech presentation and uterine anomaly. The current pregnancy was also localized in the right hemiuterus. The patient underwent cesarean delivery at 38 weeks and 6 days of gestation because of abdominal pain and marked thinning of the previous cesarean incision site on ultrasonographic evaluation. RESULTS: The operation was initiated through a Pfannenstiel incision. Intraoperative exploration clearly demonstrated the anatomy of uterus bicornis unicollis. The pregnancy was confirmed to be localized in the right hemiuterus. The previous Kerr incision scar was also observed on the right hemiuterus. The lower uterine segment of the right gravid hemiuterus was markedly thinned, and the uterine incision was made only on the lower segment of the gravid right hemiuterus (Figure 1).

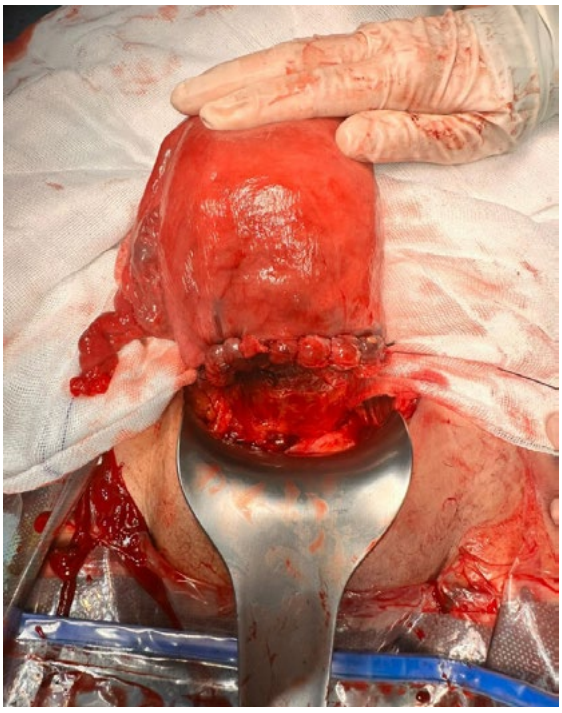
A male neonate in breech presentation was delivered with a birth weight of 3450 g. The 1- and 5-minute Apgar scores were 8 and 9, respectively. The amniotic fluid was normal. The placenta was fundally located and separated spontaneously. No neonatal intensive care unit admission was required.

After uterine cavity cleaning, the incision on the right hemiuterus was closed in a single layer. Intraoperative evaluation showed that the left hemiuterus was non-gravid, smaller in size, and did not interfere with the surgical field (Figure 2). Bladder dissection proceeded uneventfully. Hemostasis was achieved. The operative time was approximately 40 minutes, and the estimated blood loss was 150 mL. No blood transfusion was required, and no intraoperative complication occurred.

CONCLUSION: Accurate anatomical orientation during cesarean delivery is critical in pregnant patients with uterus bicornis unicollis. In this case, the key surgical point was the intraoperative confirmation that the pregnancy was localized in the right hemiuterus and that the uterine incision was applied only to the lower segment of the gravid hemiuterus. Identification of the previous cesarean scar on the same hemiuterus and recognition of lower uterine segment thinning were decisive for surgical planning. In pregnancies complicated by uterine anomalies, the mode of delivery and surgical approach should be individualized according to the location of the pregnancy, fetal presentation, previous uterine incision site, and integrity of the lower uterine segment.

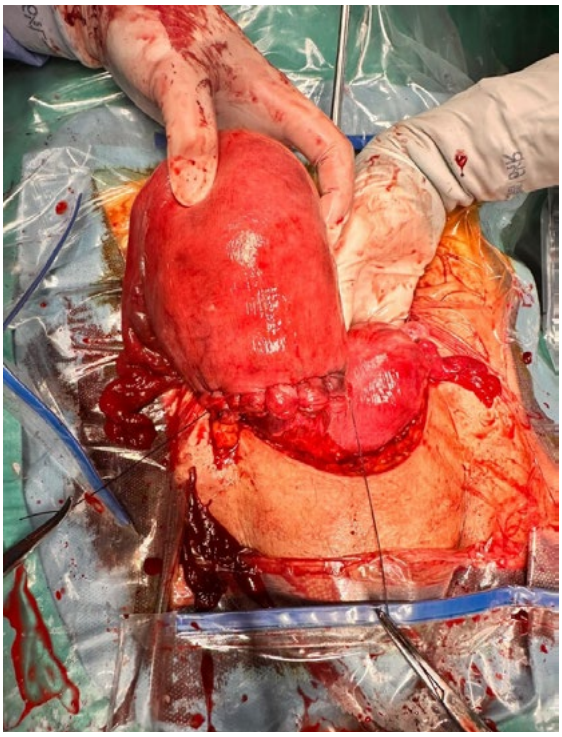
Keywords: Uterus bicornis unicollis, Müllerian anomaly, hemiuterus, cesarean delivery, breech presentation, uterine scar thinning

Figure 1. Intraoperative appearance of the right gravid hemiuterus during cesarean delivery.



The uterine incision was made on the lower segment of the gravid right hemiuterus.

Figure 2. Intraoperative appearance of uterus bicornis unicollis anatomy.



After cesarean delivery, the right hemiuterus appeared enlarged in the postpartum state, whereas the left hemiuterus was non-gravid and smaller in size.

SS-28

Fulminant Early-Onset HELLP Syndrome Overlapping with Pregnancy-Associated Thrombotic Microangiopathy: Challenges in Management and Diagnostic Velocity

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Early-onset HELLP syndrome, presenting before 28 weeks of gestation, is an aggressive obstetric complication associated with significant maternal and fetal morbidity. The underlying systemic endothelial disruption can trigger a refractory coagulation cascade, leading to disseminated intravascular coagulation (DIC) and multiorgan failure. We report a case of a 25-year-old primigravida at 25 weeks of gestation who presented with sepsis, chorioamnionitis, and severe HELLP-like features. Despite immediate tertiary-level intervention, including emergency cesarean delivery and aggressive multidisciplinary intensive care, the patient's clinical course was characterized by a rapid, refractory decline. Proactive diagnostic measures, including ADAMTS13 activity testing, were initiated promptly; however, the biological velocity of the disease outpaced the diagnostic turnaround time, with results returning within normal limits post-mortem. This normal ADAMTS13 value, in retrospect, points toward pregnancy-associated atypical Hemolytic Uremic Syndrome (p-aHUS) triggered by severe intra-amniotic infection. This report highlights that even with optimal, proactive management and massive transfusion protocols, certain fulminant microangiopathic storms remain highly resistant to current therapeutic paradigms, emphasizing the critical need for immediate consideration of advanced therapies like therapeutic plasma exchange.

Keywords: HELLP Syndrome; Thrombotic Microangiopathies; Chorioamnionitis; Disseminated Intravascular Coagulation; Diagnosis, Differential; Pregnancy Complications, Hematologic

SS-29

An early complication of caesarean section: abdominal wall defect-related herniation

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INTRODUCTION: As caesarean section rates continue to rise worldwide, early recognition of rare postoperative complications has become increasingly important. Although postoperative ileus is relatively common, true mechanical obstruction particularly, internal herniation through the abdominal wall layers, is exceedingly rare after cesarean delivery. Clinical presentation may be nonspecific, leading to delayed diagnosis and increased risk of bowel ischemia or necrosis. This report presents a rare case of closed-loop small-bowel obstruction caused by internal herniation at the incision site in the early postoperative period following caesarean section.

CASE PRESENTATION: A 35 year old patient with a history of previous caesarean section and placenta previa totalis underwent emergency caesarean section on January 5, 2026. The operation was performed under spinal anesthesia using a pfannenstiel incision, during which the uterus and abdominal layers were routinely closed. The patient was monitored without complications on the first postoperative day.

On postoperative day 2, the patient developed nausea, vomiting, presyncope, and abdominal distension. Bowel sounds were hypoactive, and no stool passage was noted. Initial evaluation suggested postoperative ileus; however, symptoms persisted despite supportive management.

Contrast-enhanced abdominal computed tomography performed on 7 January 2026 revealed:

- Distal ileal loops herniating toward the rectus sheath,
- Small bowel dilation up to 4 cm,
- Findings consistent with closed-loop obstruction,
- Air and density increase along the incision line.

Given the suspicion of mechanical obstruction, the general surgery team proceeded with urgent diagnostic laparoscopy. Intraoperatively, a segment of small bowel was found entrapped between the fascia and peritoneum, with proximal loops showing ischemic discoloration. Due to the inability to laparoscopically release the trapped bowel loop, conversion to open surgery was required. The bowel loops were released, and warm compresses restored normal coloration, avoiding the need for resection. A drain was placed in the douglas pouch.

Postoperatively, bowel function gradually returned, the drain was removed on 13 January, and the patient was discharged in good condition on 15 January 2026.

DISCUSSION: This case raises an important surgical question: Should the peritoneum and abdominal wall musculature be routinely sutured during caesarean delivery? Current guidelines generally recommend nonclosure of the visceral and parietal peritoneum due to shorter operative time and reduced shortterm morbidity. However, these recommendations are based primarily on early postoperative outcomes.

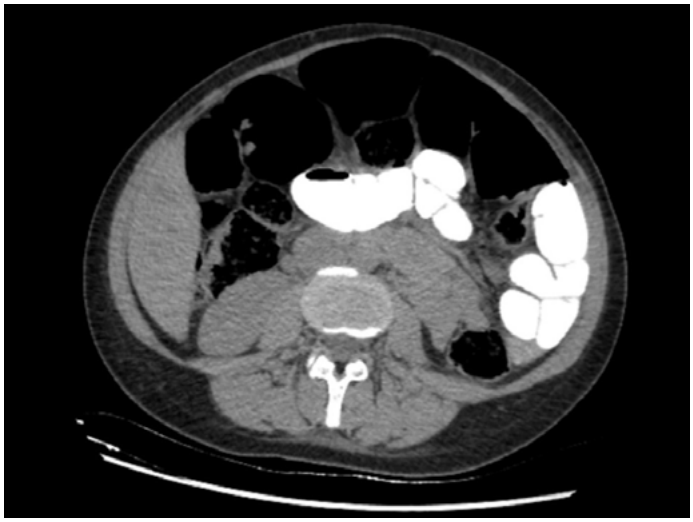
Longterm data suggest a more complex view. A systematic review and metaanalysis demonstrated that nonclosure significantly increases adhesion formation, with odds ratios ranging from 2.60 to 4.23, indicating a consistent association across prospective studies. Adhesions are clinically relevant, contributing to chronic pelvic pain, infertility, prolonged operative time, and smallbowel obstruction. The Cochrane review similarly acknowledges improved shortterm outcomes with nonclosure but highlights insufficient evidence regarding longterm risks.

In our case, internal herniation occurred through a narrow defect between fascial and muscular layers, suggesting that even small discontinuities may predispose to bowel entrapment. While rectus muscle re-approximation may increase postoperative pain, leaving muscular planes unsutured may also create potential spaces for herniation.

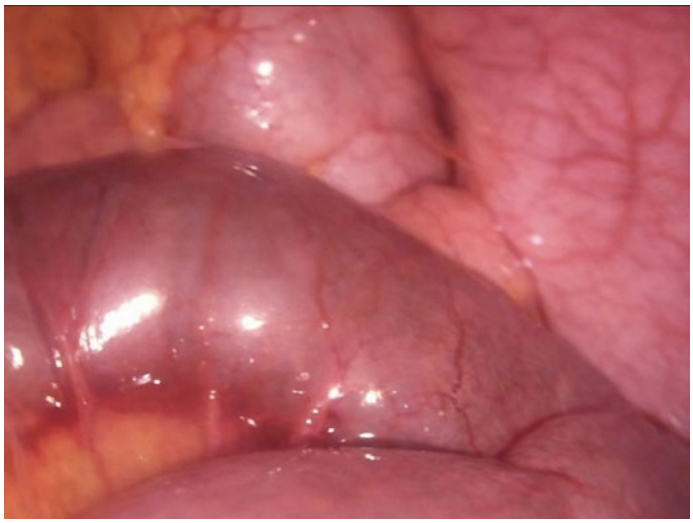
Overall, this case supports emphasizing awareness of longterm risks when deciding whether to close the peritoneum and muscle layers.

Keywords: Cesarean, internal herniation, peritoneal closure

Contrast-enhanced abdominal computed tomography



Entrapped small bowel between fascia and peritoneum on diagnostic laparoscopy



SS-30

The Relationship Between Health Literacy and Pelvic Examination Anxiety In Women

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OBJECTIVE:: This study aimed to examine the relationship between health literacy and anxiety specific to gynecological examination in women, and to evaluate the levels of state anxiety experienced during the examination process. In addition, the study sought to explore the influence of sociodemographic and clinical factors, as well as prior examination experiences and informational adequacy, on anxiety levels.

MATERIALS-METHODS: This cross-sectional study was conducted with 300 women who applied to the gynecology outpatient clinic of Ankara Training and Research Hospital between February and March 2026. Participants were selected using a convenience sampling method. Data were collected through face-to-face interviews using a structured questionnaire package, which included the Descriptive Information Form, Gynecological Examination Anxiety Scale (GEAS), Turkish Health Literacy Scale-32 (THLS-32), and the Visual Analog Scale for Anxiety (VAS-Anxiety). The Descriptive Information Form captured sociodemographic characteristics, obstetric history, previous gynecological examination experiences, and perceived adequacy of information regarding the examination process. Statistical analyses were performed using SPSS software. Descriptive statistics were used to summarize the data. Non-parametric tests, including the Mann–Whitney U test and Kruskal–Wallis test, were employed to compare anxiety scores across groups. Spearman correlation analysis was conducted to evaluate the relationship between health literacy and anxiety measures. A p-value of <0.05 was considered statistically significant.

RESULTS: The majority of participants were found to have inadequate or problematic–limited levels of health literacy. Women with higher health literacy levels demonstrated significantly lower scores on both gynecological examination–specific anxiety and state anxiety measures. A statistically significant negative correlation was identified between health literacy scores and both GEAS and VAS-Anxiety scores. Furthermore, anxiety levels were significantly higher among women who reported negative prior gynecological examination experiences, insufficient information about the examination procedure, and a tendency to postpone or avoid examinations due to anxiety. Sociodemographic variables such as age, education level, and previous childbirth experience also showed varying degrees of association with health literacy and anxiety levels, although these associations were not consistently significant across all measures.

CONCLUSION: The findings of this study indicate that health literacy is significantly associated with both gynecological examination–specific anxiety and general state anxiety. Higher levels of health literacy appear to play a protective role by reducing anxiety related to gynecological examinations. In addition to health literacy, prior experiences and the adequacy of information provided to patients were identified as important determinants of anxiety levels. These results underscore the multidimensional nature of psychological responses to gynecological examinations and highlight the importance of patient-centered communication, education, and supportive clinical environments. Interventions aimed at improving health literacy and enhancing the quality of information provided to women may contribute to reducing anxiety and improving compliance with gynecological examinations.

Keywords: Gynecological examination, anxiety, health literacy, women's health

SS-31

Hysteroscopic myomectomy during the early learning curve in a rural secondary care hospital: a case report

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OBJECTIVE: To present the feasibility and perioperative outcomes of hysteroscopic myomectomy performed during the early learning curve in a low-volume rural secondary care hospital with limited hysteroscopic surgery experience and infrastructure.

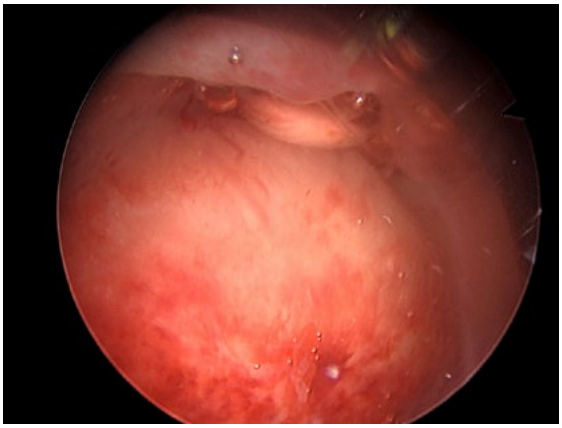
METHODS: A 38-year-old gravida 4 para 4 woman with a history of four previous cesarean deliveries presented with abnormal uterine bleeding for two months. Gynecological examination and transvaginal ultrasonography revealed an anteverted uterus and an approximately 20×27 mm intracavitary leiomyoma located near the right lateral fundal wall, compatible with a Fédération Internationale de Gynécologie et d□Obstétrique (FIGO) type 0 submucosal myoma. The patient was scheduled for operative hysteroscopy with a preliminary diagnosis of abnormal uterine bleeding associated with leiomyoma (AUB-L). Her medical history included controlled hypertension and diabetes mellitus. Preoperative beta-human chorionic gonadotropin test was negative, hemoglobin level was 12.5 g/dL, and hematocrit level was 38.2%. Sublingual misoprostol was administered 30 minutes before surgery for cervical preparation. The operation was performed in a rural secondary public hospital with limited access to advanced minimally invasive gynecologic surgery training. The surgeon had no previous independent hysteroscopic surgical experience and had participated in only four supervised hysteroscopy procedures alongside an experienced minimally invasive gynecologic surgeon.

RESULTS: Hysteroscopic myomectomy was successfully completed without intraoperative or postoperative complications. Complete resection of the FIGO type 0 myoma was achieved with satisfactory visualization. No uterine perforation, excessive hemorrhage, fluid overload, or anesthetic complications occurred. The postoperative period was uneventful, and the patient was discharged in stable condition.

CONCLUSION: This case demonstrates that hysteroscopic myomectomy may be safely implemented in selected patients during the early learning curve, even in rural secondary care hospitals with limited resources. Careful patient selection, structured mentorship, and appropriate perioperative preparation may facilitate the safe expansion of minimally invasive gynecologic surgery in underserved regions while reducing unnecessary referrals to tertiary centers.

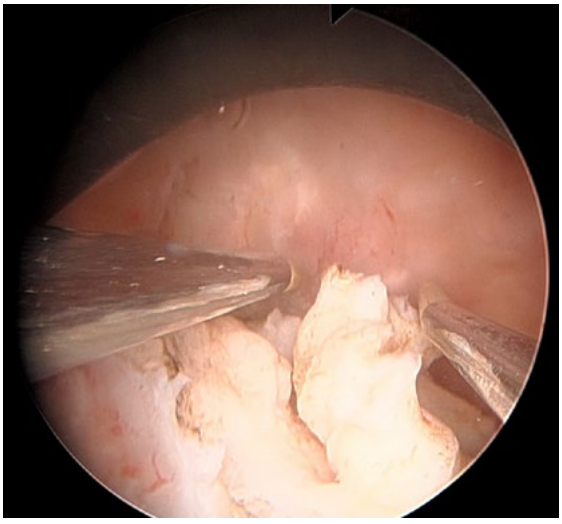
Keywords: Abnormal uterine bleeding, Hysteroscopic myomectomy, Leiomyoma, Rural health services

Figure 1



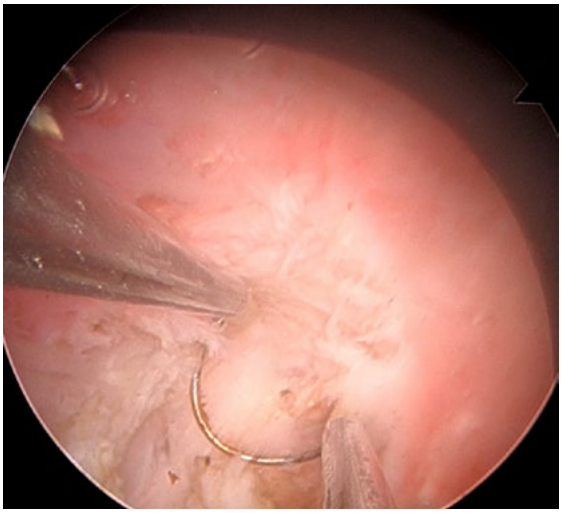
Intraoperative hysteroscopic visualization of the intracavitary submucosal leiomyoma

Figure 2



Intraoperative view during hysteroscopic myoma enucleation

Figure 3



Post-resection hysteroscopic visualization of the uterine cavity

SS-32

Effects Of Resected Tubal Length On Abnormal Uterıne Bleedıng In Patıents Wıth Tubal Lıgatıon: A Retrospectıve Observatıonal Study

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[4]kadın hastalıkları ve doğum anabilim dalı/istanbul medipol mega üniversitesi

OBJECTIVE: The aim of this study was to investigate the relationship between the length of resected tube, patient age, surgical technique, and tissue morphology, and the occurrence of abnormal uterine bleeding (AUB), chronic pelvic pain, and feelings of regret in the postoperative period in patients who underwent tubal ligation (TL).

MATERIALS-METHODS: Pathology data and contact information were obtainable for 184 patients who underwent TL (postpartum, laparoscopic, minilaparotomy) at Mardin State Hospital between 2017 and 2024; of these, 157 patients who met the inclusion criteria were retrospectively included. Survey questions were administered to patients by telephone or during outpatient visits. Data recorded from the pathology reports included total specimen length and specimen morphology. The effects of independent variables on symptoms were assessed using logistic regression analysis.

RESULTS: Each 1-cm increase in the total resected tubal length was associated with a 10.6-fold increase in the risk of AUB (OR = 10.617; $p < 0.001$). Advanced age was associated with a decreased risk of AUB ($p = 0.025$). Specimens reported as “normal” on pathology had a higher risk of AUB compared with those reported as “edematous” ($p = 0.025$). Surgical technique and time elapsed since the operation had no significant effect on symptoms ($p > 0.05$).

CONCLUSION: The amount of tissue resected during tubal ligation is the strongest predictor of postoperative menstrual irregularities. Minimizing tissue resection, while preserving sterilization efficacy, may reduce postoperative morbidity.

Keywords: tubal ligation, abnormal uterine bleeding, post-tubal sterilization syndrome

Relationship total tubal length and abnormal uterine bleeding

variables	B	Odds Ratio (Exp(B))	%95 CL	p value
total tuba lenght	2,362	10,617	4,852-23,233	<0,001
age	-1,124	0,325	0,122-0,866	0,025
patology	-0,103	0,902	0,822-0,990	0,029
constant	-0,364	0,695		0,852

tubal ligasyon sırasında çıkarıln toplam tubal uzunluk, yaş anormal uterin kanama meydana gelişi arasındaki ilişkiye dair tablo

SS-33

Facilitating V-NOTES bilateral tubal ligation using a laparoscopic fan retractor: A case report

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Minimally invasive surgical techniques are increasingly preferred in gynecological practice due to their ability to reduce postoperative morbidity, accelerate recovery, and improve patient comfort. Vaginal natural orifice transluminal endoscopic surgery (V-NOTES) has emerged as an innovative approach that enables endoscopic access via the vaginal route, thereby eliminating the need for abdominal incisions. This technique offers several advantages, including reduced postoperative pain, shorter hospital stay, faster recovery, and improved cosmetic outcomes.

Bilateral tubal ligation (BTL) is a widely used and effective method for permanent contraception in women. It is based on occlusion of the fallopian tubes to prevent fertilization and has a high efficacy rate. In recent years, bilateral salpingectomy has been proposed as an alternative approach due to its potential to reduce the risk of ovarian cancer in addition to its contraceptive effect.

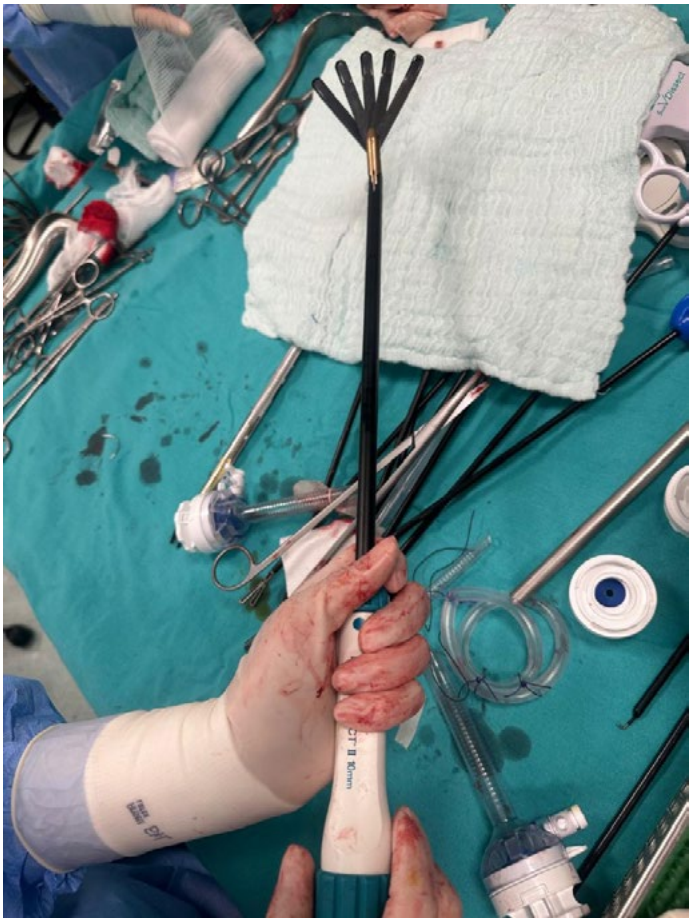
In this study, we present a case of BTL performed using the V-NOTES approach. A 32-year-old multiparous woman (gravida 6, para 6) with a request for permanent contraception underwent bilateral tubal ligation via V-NOTES following appropriate preoperative evaluation. During the procedure, a laparoscopic fan retractor was used to atraumatically elevate the uterus, allowing improved visualization of pelvic anatomical structures. This approach was observed to enhance the surgical field, shorten operative time, and potentially reduce the risk of complications.

The operation was completed in a short duration without any intraoperative or postoperative complications. Postoperative analgesic requirement was minimal, early mobilization was achieved, and the patient was discharged on the first postoperative day without any adverse events.

CONCLUSION: V-NOTES-assisted bilateral tubal ligation appears to be a safe and effective minimally invasive option in appropriately selected patients. The use of a laparoscopic fan retractor may further optimize surgical visualization and contribute to reduced operative time and complication rates. Larger prospective studies are needed to evaluate long-term outcomes.

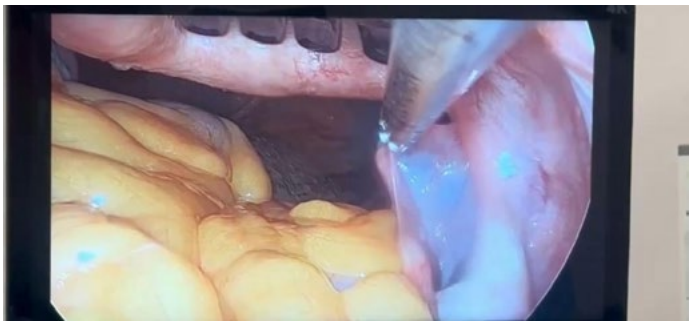
Keywords: Adnexal surgery, bilateral tubal ligation, laparoscopic fan retractor, V-NOTES

şekil-1



Laparoskopik fan retraktör

şekil-2



Laparoskopik fan retraktör ile bilateral tuba ligasyonu

SS-34

Successful single-port laparoscopic treatment of tubal ectopic pregnancy by a novice surgeon in a rural hospital

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OBJECTIVE: To present the feasibility and perioperative outcomes of single-port laparoscopic management of tubal ectopic pregnancy during the early laparoscopic learning curve in a rural secondary care hospital.

METHODS: A 39-year-old gravida 2 para 2 woman with a history of two previous cesarean deliveries presented at 7 weeks and 2 days of gestation after a positive home pregnancy test. Initial ultrasonographic evaluation demonstrated an anteverted uterus with an endometrial thickness of 19.9 mm and a serum beta-human chorionic gonadotropin level of 20,778 mIU/mL. Repeat transvaginal ultrasonography revealed a right tubal ectopic pregnancy with positive fetal cardiac activity and a crown-rump length corresponding to 6 weeks and 3 days of gestation. The patient was hospitalized for surgical management. Preoperative hemoglobin and hematocrit levels were 13.2 g/dL and 38.4%, respectively.

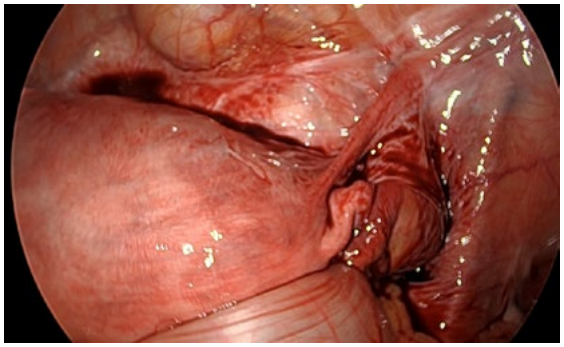
The procedure was performed in a rural secondary public hospital where advanced minimally invasive gynecologic procedures are not routinely performed and access to structured laparoscopic training is limited. Before attempting single-port laparoscopy, the operating surgeon had experience with only five supervised laparoscopic bilateral tubal ligation procedures performed using a conventional two-port approach consisting of a 10-mm umbilical camera trocar and a 5-mm suprapubic accessory trocar. Compared with the conventional two-port technique, single-port laparoscopy may provide improved cosmetic outcomes and reduced abdominal wall trauma; however, it is technically more demanding because of limited triangulation, instrument crowding, restricted maneuverability, and ergonomic difficulties, particularly during the early learning curve.

RESULTS: Single-port laparoscopic surgery for right tubal ectopic pregnancy was successfully completed without conversion to multiport laparoscopy or laparotomy. No intraoperative complications, including excessive hemorrhage, bowel injury, or vascular injury, occurred. Postoperative sixth-hour hemoglobin and hematocrit levels were 11.7 g/dL and 33.2%, respectively. Follow-up beta-human chorionic gonadotropin level decreased to 9,983 mIU/mL. The postoperative course was uneventful, and the patient was discharged in stable condition.

CONCLUSION: This case demonstrates that single-port laparoscopic management of selected ectopic pregnancies may be feasible during the early surgical learning curve, even in rural secondary care hospitals with limited minimally invasive surgery exposure. Careful patient selection, gradual transition from basic laparoscopic procedures, and appropriate mentorship may contribute to the safe implementation of advanced minimally invasive gynecologic surgery in underserved regions.

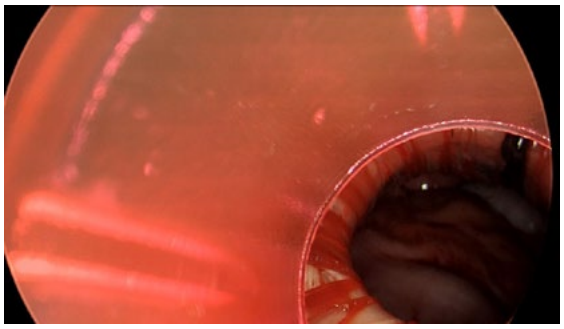
Keywords: Ectopic pregnancy, Laparoscopy, Learning curve, Single-port surgery

Figure 1



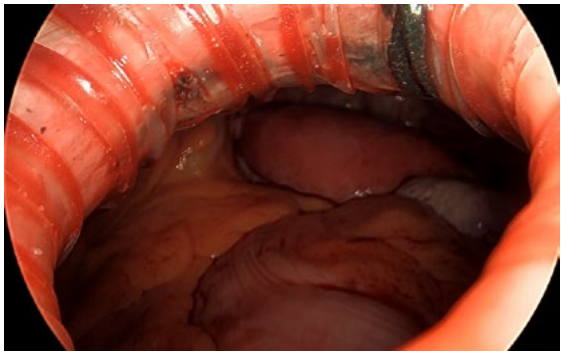
Conventional laparoscopic view of the right tubal ectopic pregnancy

Figure 2



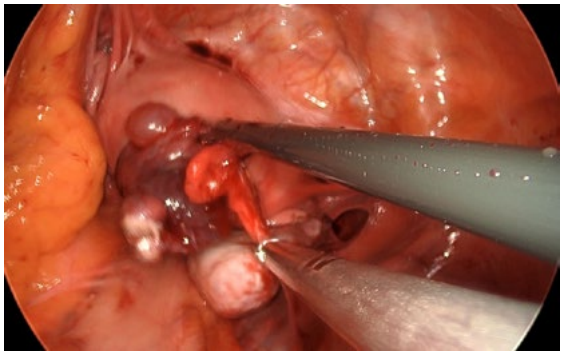
Intra-abdominal view through the GelPOINT single-port access system

Figure 3



Umbilical access obtained using an Alexis 7.5 cm wound retractor

Figure 4



Salpingectomy and specimen extraction during single-port laparoscopic surgery

SS-35

Clinical progression despite initial medical management in tubal ectopic pregnancy following ulipristal acetate use during lactation: a case report

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OBJECTIVE: Ectopic pregnancy is an important cause of morbidity in women of reproductive age. Lactation may lead clinicians to underestimate pregnancy risk, while bleeding following emergency contraception may delay diagnosis. We aimed to present a tubal ectopic pregnancy with clinical progression despite initial medical management following ulipristal acetate use during lactation.

METHODS: A 35-year-old gravida 3 para 2 lactating woman with a history of two previous cesarean deliveries presented with persistent abdominal pain. The patient had used ulipristal acetate after unprotected intercourse and was initially treated for presumed cystitis. Clinical findings, serum beta-human chorionic gonadotropin levels, laboratory parameters, and transvaginal ultrasonography findings were evaluated.

RESULTS: Transvaginal ultrasonography demonstrated free intraperitoneal fluid and a left adnexal hematoma. Initial beta-human chorionic gonadotropin level was 1356 mIU/mL. Since the patient was hemodynamically stable, single-dose methotrexate therapy was administered. However, on the third day of follow-up, the patient developed worsening abdominal pain, syncope, hemoglobin decline, and hemoperitoneum requiring emergency laparotomy. Left salpingectomy was performed and ectopic pregnancy was histopathologically confirmed. Postoperative beta-human chorionic gonadotropin follow-up demonstrated biochemical regression.

CONCLUSION: Lactation does not exclude ectopic pregnancy, and ulipristal acetate use may contribute to delayed diagnosis. Close clinical follow-up remains essential even in initially stable patients undergoing medical management for ectopic pregnancy.

Keywords: ectopic pregnancy, emergency contraception, ulipristal acetate, lactation, methotrexate

SS-37

Severe Osteoporosis and Spontaneous Fracture Associated with GnRHa + Aromatase Inhibitor Therapy in Premenopausal High-Risk ER(+) Breast Cancer: A Case Report

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In premenopausal patients with hormone receptor–positive breast cancer, the combination of ovarian function suppression with an aromatase inhibitor is a well-established and effective adjuvant treatment strategy. However, this regimen induces profound hypoestrogenism, which is associated with accelerated loss of bone mineral density and may lead to an increased risk of osteoporosis and fractures.

In this case report, we present a patient with high-risk premenopausal breast cancer who developed severe osteoporosis and a low-energy spontaneous fracture while receiving combined therapy with a gonadotropin-releasing hormone agonist (GnRHa) and an aromatase inhibitor. Significant bone loss was detected early during the course of treatment, followed by the development of a clinically relevant fracture, despite the absence of major baseline skeletal risk factors.

Consistent with the existing literature, this case highlights the critical importance of evaluating bone health at the initiation of therapy and closely monitoring patients during treatment. It also underscores the need for early initiation of antiresorptive therapy, particularly in high-risk individuals, to prevent severe skeletal complications. In addition, this case emphasizes the importance of reassessing treatment strategies in patients who develop osteoporosis, including individualized risk–benefit analysis and potential modification of endocrine therapy.

Furthermore, this report draws attention to the fact that maximal estrogen suppression may not always represent the optimal approach in all premenopausal patients. While aggressive endocrine therapy improves oncologic outcomes, it may come at the cost of significant long-term adverse effects, particularly on bone health. Therefore, treatment decisions should be carefully individualized, taking into account patient-specific risk factors, baseline bone density, comorbidities, and overall prognosis.

In conclusion, a multidisciplinary approach is essential in the management of premenopausal hormone receptor–positive breast cancer patients receiving ovarian suppression and aromatase inhibitor therapy. Early risk stratification, proactive bone-protective strategies, and ongoing monitoring are crucial to minimizing treatment-related morbidity and optimizing both oncologic and quality-of-life outcomes.

Keywords: Aromatase inhibitors, Denosumab, Fracture, Osteoporosis, Ovarian function suppression, Premenopausal breast cancer

SS-38

The Impact of Phenotypes, Body Mass Index, and Hyperandrogenism on Depression and Body Image in Women with Polycystic Ovary Syndrome: A Cross-Sectional Study

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OBJECTIVE: Polycystic ovary syndrome (PCOS) is a prevalent endocrine disorder in women of reproductive age that threatens not only physical but also psychosocial health. This study aimed to evaluate body image perception and depression levels in women with different PCOS phenotypes and to compare these parameters with healthy controls.

METHODS: In this cross-sectional observational study, 220 women diagnosed with PCOS according to Rotterdam criteria (case group) and 220 healthy women without gynecological pathology (control group) were enrolled (N=440). Sociodemographic and clinical data were recorded. Depressive symptoms were assessed using the Beck Depression Inventory (BDI), and body image perception was evaluated using the Body Image Scale (BIS). Data analysis was performed using SPSS 20.

RESULTS: The mean age of participants was 24 years, and the mean Body Mass Index (BMI) was 23.2 kg/m². The prevalence of body image dissatisfaction (49.5% vs. 35.0%; p=0.002) and depression (66.4% vs. 50.0%; p<0.001) was found to be significantly higher in the PCOS group compared to controls. In the phenotypic analysis, Phenotype A exhibited the highest rates of body image dissatisfaction (66.7%) and depression (81.7%). No significant difference was observed between hyperandrogenic (A–B–C) and non-hyperandrogenic (D) phenotypes. Regression analysis revealed that every 1-unit increase in BMI increased the risk of body image dissatisfaction by 1.1-fold.

CONCLUSION: PCOS is a significant risk factor negatively affecting women's psychosocial well-being. Our findings demonstrate high levels of depression and body image dissatisfaction, particularly in patients with the classic phenotype (Phenotype A). Holistic treatment approaches incorporating body image and mental health should be an integral part of standard care.

Keywords: Polycystic Ovary Syndrome, Body Image, Depression, Phenotypes, Beck Depression Inventory

1.Descriptive Statistics Regarding the Demographic and Clinical Characteristics of the Participants.

Variables		PCOS Group (220)	Control Group (220)	Total (440)	p
Age		23,00 (18,00-39,00)	24,00 (18,00-39,00)	24,00 (18,00-39,00)	0,190
Menarche		13,00 (8,00-17,00)	13,00 (11,00-18,00)	13,00 (8,00-18,00)	0,357
Menstrual Duration		5,00 (1,00-10,00)	5,00 (3,00-10,00)	5,00 (1,00-10,00)	0,274
Menstrual Irregularity	Yes	130 (59,1)	15 (6,8)	145 (33,0)	**<0,001**
	No	90 (40,9)	205 (93,2)	295 (67,0)	
Acne	Yes	125 (56,8)	62 (28,2)	187 (42,5)	**<0,001**
	No	95 (43,2)	158 (71,8)	253 (57,5)	
Alopecia	Yes	117 (53,2)	50 (22,7)	167 (38,0)	**<0,001**
	No	103 (46,8)	170 (77,3)	273 (62,0)	
Hirsutism	Yes	66 (30,0)	10 (4,5)	76 (17,3)	**<0,001**
	No	154 (70,0)	210 (95,5)	364 (82,7)	

2.Comparison of Participants Based on Body Image Scale (BIS) and Beck Depression Inventory (BDI) Cut-off Scores.

Variables		PCOS Group (220)	Control Group (220)	Total (440)	p
BIS	<135	109 (49,5)	77 (35,0)	186 (42,3)	**0,002**
	≥135	111 (50,5)	143 (65,0)	254 (57,7)	
BDI	<10	74 (33,6)	110 (50,0)	184 (41,8)	**<0,001**
	≥10	146 (66,4)	110 (50,0)	256 (58,2)	

3.Comparison of PCOS Phenotypes Based on BDI and BIS Cut-off Scores.

Variables		Phenotype A(60)	Phenotype B(53)	Phenotype C (55)	Phenotype D (52)	p
BIS	<135	40 (66,7)	20 (37,7)	28 (50,9)	21 (40,4)	**0,008**
	≥135	20 (33,3)	33 (62,3)	27 (49,1)	31 (59,6)	
BDI	<10	11 (18,3)	33 (62,3)	12 (21,8)	18 (34,6)	**<0,001**
	≥10	49 (81,7)	20 (37,7)	43 (78,2)	34 (65,4)	

4.Comparison of BIS and BDI Scores Across PCOS Phenotypes.

Variables	Phenotype A(60)	Phenotype B(53)	Phenotype C (55)	Phenotype D (52)	p
BIS	127,00 (85,00-183,00)	140,00 (95,00-185,00)	133,00 (96,00-182,00)	139,50 (102,00-191,00)	**0,010**
BDI	17,50 (3,00-42,00)	8,00 (1,00-37,00)	12,00 (2,00-40,00)	13,50 (3,00-40,00)	**<0,001**

5.Logistic Regression Analysis of Factors Associated with Body Image Dissatisfaction.

	B	S.E.	df	Sig.	Odds Ratio	95% C.I.for EXP(B)	
						Lower	Upper
Age	0,019	0,026	1	0,471	1,019	0,968	1,015
BMI	0,082	0,026	1	**0,002**	1,086	1,032	0,978
PCOS (Yes)	0,449	0,211	1	**0,033**	1,567	1,037	3,509

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Prognostic factors associated with disease-free survival in surgically staged stage I endometrioid endometrial cancer

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OBJECTIVE: Stage, tumor grade, depth of myometrial invasion, and lymphovascular space invasion are well-established determinants of oncologic outcomes in uterine corpus confined endometrioid endometrial cancer (EC) [1–5]. This study aimed to evaluate the clinicopathologic characteristics of patients with stage I endometrioid EC and to identify prognostic factors associated with disease-free survival.

Materials and METHODS: A total of 149 patients with surgically staged stage I endometrioid EC who underwent lymphadenectomy were retrospectively evaluated. Patients with non-endometrioid histology or synchronous malignancy were excluded. Disease-free survival (DFS) was defined as the interval from primary surgery to recurrence or the last follow-up visit. Survival analysis was performed using the Kaplan-Meier method, and survival curves were compared with the log-rank test. Disease stage was assigned according to the 2009 FIGO staging system.

RESULTS: The mean age of the study cohort was 61.9±9.9 years. The median tumor size was 40 mm (range, 2–120 mm) and the median number of removed lymph nodes was 35 (range, 2-105). Overall, 59.7% of patients had stage IA disease. Tumor grade was grade 1 in 54.4%, grade 2 in 36.2%, and grade 3 in 9.4% of patients. Myometrial invasion was absent in 6% of cases, whereas deep myometrial invasion, defined as ≥50% invasion, was present in 40.3%. Lymphovascular space invasion was identified in 14.8% of the cohort. Peritoneal cytology was negative in all patients (Table 1). Adjuvant radiotherapy was administered to 44.3% of patients and was used significantly more frequently in patients with stage IB disease than in those with stage IA disease (90% vs. 13.5%; p<0.0001). The median follow-up period was 25 months, with a range of 1–50 months. During follow-up, recurrence occurred in 7 patients (4.7%), and 1 patient (0.7%) died of disease. Four recurrences were systemic. The 5-year DFS was 93% for the entire cohort. Age, stage, tumor grade, presence and depth of myometrial invasion, tumor size, cervical glandular involvement, lymphovascular space invasion, number of removed lymph nodes, and receipt of adjuvant treatment were not individually associated with DFS. However, both stage and tumor grade showed a trend toward statistical significance. 5-year disease-free survival was lower in patients with stage IB disease than in those with stage IA disease (87% vs. 96%; p=0.071) and was also lower in patients with grade 3 tumors than in those with grade 1–2 tumors (75% vs. 95%; p=0.054) (Table 2).

When stage and grade were evaluated together, patients with both stage IB disease and grade 3 tumors had significantly poorer DFS than the remaining cohort. The 5-year DFS was 33% in patients with stage IB grade 3 disease, compared with 95% in all other patients (p<0.001).

CONCLUSION: Although surgically staged stage I endometrioid endometrial cancer is generally associated with favorable oncologic outcomes, prognosis appears to be substantially impaired in patients with stage IB grade 3 disease. Our findings suggest that this subgroup represents a clinically relevant high-risk population and support the use of adjuvant treatment in these patients.

Keywords: Disease free survival, Endometrial endometrioid cancer, Prognostic factors

table 1

Table 1. General Characteristics (n=149)

Factor		Mean±SD	Median (Range)
Age (years)		61.9±9.9	62 (27-81)
Tumor size (mm)		44.4±24.2	40 (2-120)
Number of removed lymph nodes		36.3±19.6	35 (2-105)
		n	%
2009 FIGO stage	IA	89	59.7
	IB	60	40.3
FIGO grade	1	81	54.4
	2	54	36.2
	3	14	9.4
Myometrial invasion	None	9	6
	<1/2	80	53.7
	≥1/2 [1]	60	40.3
Cervical involvement	None	144	96.6
	Glandular	5	3.4
Lymphovascular space invasion	Negative	127	85.2
	Positive	22	14.8
Peritoneal cytology	Negative	149	100
	Positive	-	-

[1]:Patients with serosal involvement were not included

table 2

Table 2. Factors associated with disease-free survival

Factor		5-year Disease-Free Survival (%)	p Value
Age [1]	<62	94	0.698
	≥62	93	
Age [2]	<65	95	0.295
	≥65	91	
FIGO 2009 stage	IA	96	0.071
	IB	87	
FIGO grade	1	95	0.155
	2	96	
	3	75	
FIGO grade	1 and 2	95	0.054
	3	75	
FIGO 2009 stage and FIGO grade	Others	95	**<0.001**
	IB and grade 3	33	
Myometrial invasion	None	100	0.187
	<1/2	96	
	≥1/2 [3]	87	
Tumor size (mm) [1]	≤40	96	0.155
	>40	90	
Cervical involvement	Negative	94	0.088
	Glandular	80	
Lymphovascular space invasion	Negative	94	0.939
	Positive	91	
Number of removed lymph nodes [1]	≤35	94	0.626
	>35	93	
Adjuvant treatment	No	93	0.956
	Yes	94	

[1]: Mean values;
[2]: Geriatric age;
[3]: Patients with serosal involvement were not included;

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Factors affecting pulmonary morbidity in patients with epithelial ovarian cancer undergoing diaphragmatic surgery

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OBJECTIVE: In advanced epithelial ovarian cancer, upper abdominal surgical techniques are used to achieve optimal cytoreduction. While diaphragmatic surgery, as part of cytoreductive techniques, is performed to improve oncologic outcomes, it is also associated with an increased risk of pulmonary morbidities [1,2]. This study aimed to evaluate the incidence of pulmonary morbidity and the clinicopathological and surgical factors influencing it in patients who underwent diaphragmatic surgery.

Materials and METHODS: Patients who underwent diaphragmatic surgery between September 2019 and January 2026 were evaluated retrospectively. Only patients diagnosed with epithelial ovarian cancer who underwent primary cytoreductive surgery were included in the study. Patients with non-epithelial tumors, those who received neoadjuvant chemotherapy, recurrent disease, pulmonary co-morbidities, preoperative pulmonary involvement or pleural effusion, or intraoperative thoracic drainage were excluded from the study. All patients underwent standard preoperative preparation and received antibiotic prophylaxis and thromboprophylaxis. During the intraoperative period, a nasogastric tube, a central venous catheter, and an abdominal drain were placed. In the postoperative period, thromboprophylaxis was continued, compression stockings were used, and routine pulmonary exercises were performed. Defects following diaphragmatic resection were primarily repaired in all patients, and no synthetic mesh was used in any case. Pulmonary morbidity was defined as the development of atelectasis, infection, pulmonary embolism, or pleural effusion.

RESULTS: The mean age of the 65 patients included in the study was 59.3±11.6 years. The median operative time was 345 minutes (range, 120-570), and the median intraoperative blood loss was 900 mL (range, 100-3000). Co-morbidities were present in 53.8% of the patients. Ascites was detected in 60% of the patients. Thoracic entry was observed in 47.7% of patients, and full-thickness diaphragmatic resection was performed in 36.9% of patients. Diaphragmatic tumor involvement was present in 98.5% of the patients (Table 1). Pulmonary morbidity developed in 14 patients (21.5%). Pleural effusion was the most common complication and occurred in 15.4% of entire cohort. Other than pulmonary morbidity, myocardial infarction occurred in only one patient in the study group. Patients who developed pulmonary morbidity were discharged following appropriate management. The median time to development of pulmonary morbidity was 4.5 days (range, 2–12). No statistically significant association was found between pulmonary morbidity and age, operative time, intraoperative blood loss, duration of intensive care stay, preoperative hospital stay, presence of co-morbidities, ascites, thoracic entry, diaphragmatic resection, surgical complexity, or cardiophrenic lymphadenectomy (Table 2).

In the postoperative period, catheter placement in the pleural space was required in four patients. In all of these patients, thoracic entry during surgery and diaphragmatic tumor involvement were observed (Table 3).

CONCLUSION: In patients with epithelial ovarian cancer undergoing diaphragmatic surgery, the rate of pulmonary morbidity was 21.5%. The absence of significant associations between the evaluated clinical and surgical variables suggests that pulmonary complications may be difficult to predict. Therefore, close postoperative pulmonary monitoring is important in this patient group. Nevertheless, with appropriate perioperative management, diaphragmatic surgery can be performed safely with acceptable morbidity rates.

Keywords: Diaphragmatic surgery, Epithelial ovarian cancer, Pulmonary morbidity

Table 1

Table 1. General characteristics of entire cohort

Characteristics		Mean±SD	Median (range)
Age (year)		59.3±11.65	58 (34-83)
Operation duration (minute)		338.4±101.03	345 (120-570)
Blood loss during surgery (cc)		967.9±609.29	900 (100-3000)
Length of stay in the intensive care unit (day)		1.9±2.05	1 (1-14)
Length of hospital stay before operation (day)		4.6±5.97	3 (1-38)
Length of hospital stay after operation (day)		11±5.30	9.5 (1-31)
		n	%
Histopathology	High grade serous	57	87.7
	Clear	3	4.6
	Karsinosarkom	1	1.5
	Mixed type	4	6.1
Co-morbidity	Absent	30	46.2
	Present	35	53.8
Ascites	Absent	26	40
	Present	39	60
Thoracic entry	No	34	52.3
	Yes	31	47.7
Full thickness diaphragmatic resection	Not performed	41	63.1
	Performed	24	36.9
Presence of tumor at diaphragm [1]	No	1	1.5
	Yes	64	98.5
Surgical complexity	No	17	26.2
	Yes	48	73.8
Cardiophrenic lymphadenectomy	Not performed	45	69.2
	Performed	20	30.8
Pulmonary morbidity	Not developed	51	78.5
	Developed	14	21.5
Pulmonary morbidity type	Atelectasis	7	10.8
	Infection	8	12.3
	Pulmonary thromboemboli	2	3.1
	Pleural effusion	10	15.4

SD: Standard deviation

[1]: Metastasis to the diaphragm muscle and/or diaphragmatic peritoneum

Table 2

Table 2. The factors predicting pulmonary morbidity

Factor		Pulmonary morbidity		*p* Value
		Not developed	Developed	
		n (%)	n (%)	
Age [1]	<65 years	32 (76.2)	10 (23.8)	*0.547*
	≥65 years	19 (82.6)	4 (17.4)	
Operation duration [2,3]	<345 minutes	22 (78.6)	6 (21.4)	*0.915*
	>345 minutes	24 (77.4)	7 (22.6)	
Blood loss during surgery [2,4]	<900 cc	19 (82.6)	4 (17.4)	*0.764*
	≥900 cc	19 (79.2)	5 (20.8)	
Length of stay in the intensive care unit [2,5]	1 day	34 (82.9)	7 (17.1)	*0.390*
	≥2 days	17 (73.9)	6 (26.1)	
Length of hospital stay before operation [2,6]	<3 day	24 (80)	6 (20)	*0.780*
	≥3 days	27 (77.1)	8 (22.9)	
Co-morbidity	Absent	21 (70)	9 (30)	*0.124*
	Present	30 (85.7)	5 (14.3)	
Ascites	Absent	19 (73.1)	7 (26.9)	*0.389*
	Present	32 (82.1)	7 (17.9)	
Thoracic entry	No	26 (76.5)	8 (23.5)	*0.683*
	Yes	25 (80.6)	6 (19.4)	
Full thickness diaphragmatic resection	Not performed	32 (78)	9 (22)	*0.916*
	Performed	19 (79.2)	5 (20.8)	
Presence of tumor at diaphragm [7]	No	1 (100)	-	*0.597*
	Yes	50 (78.1)	14 (21.9)	
Surgical complexity	No	12 (70.6)	5 (29.4)	*0.358*
	Yes	39 (81.3)	9 (18.8)	
Cardiophrenic lymphadenectomy	Not performed	34 (75.6)	11 (24.4)	*0.393*
	Performed	17 (85)	3 (15)	

[1]: Geriatric age
[2]: Median value
[3]: n=59 (Operation time wasn't reported in 6 patients)
[4]: n=47 (Blood loss during surgery wasn't available in 18 patients)
[5]: n=64 (Length of stay in the intensive care unit wasn't reported in 1 patient)
[6]: n=XX (Length of hospital stay before operation wasn't reported in X patient)
[7]: Metastasis to the diaphragm muscle and/or diaphragmatic peritoneum

Table 3

Table 3. Features of patients with chest tube catheter introduced into the pleural space

Factors	Patient no			
	1	2	3	4
Age (year)	49	53	58	57
Time of postoperative chest tube insertion (day)	5	3	8	4
Operation duration (min)	360	300	480	480
Blood loss during surgery (cc)	1000	NR	1250	2400
Length of stay in the intensive care unit (day)	1	1	14	3
Length of hospital stay before operation (day)	15	8	22	25
Co-morbidity	Absent	Absent	Absent	Absent
Ascites	Present	Present	Present	Present
Thoracic entry	Yes	Yes	Yes	Yes
Full thickness diaphragmatic resection	Not performed	Performed	Performed	Performed
Presence of tumor at diaphragm [1]	Yes	Yes	Yes	Yes
Surgical complexity	Yes	No	Yes	Yes
Cardiophrenic lymphadenectomy	Performed	Not performed	Performed	Performed

[1]: Metastasis to the diaphragm muscle and/or diaphragmatic peritoneum
NR: Not reported

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Laparoscopic Transabdominal Cerclage Management in a Patient with a History of Failed Transvaginal Cerclage

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Cerclage is a surgical procedure involving the placement of sutures around the cervix to enhance mechanical support and ensure the pregnancy reaches term in patients with or at risk of cervical insufficiency. Laparoscopic transabdominal cerclage is a safe and effective method for the treatment of cervical insufficiency in patients who have not previously benefited from transvaginal cerclage. (3) This report aims to present a detailed management of laparoscopic transabdominal cerclage performed in a patient referred to our clinic with a history of preterm birth and failed cervical cerclage.

Keywords: cerclage, cervical insufficiency, laparoscopic cerclage, transabdominal cerclage

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