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Abstract

Walker-Warburg syndrome (WWS) is a type of congenital muscular dystrophy associated with ocular dysplasia, hydrocephalus, and cerebral malformations. Its incidence is 1.2 per 100,000 live births. It shows autosomal recessive inheritance and the average survival is only four months.

A 27-year-old pregnant woman with Gravity 2 Parity 1 was referred for fetal hydrocephalus at 16 weeks of gestation. In the fetal neurosonographic evaluation, the lateral ventricles were highly enlarged (hydrocephalus), the cerebellar hemispheres were discrete and a Z-configuration was detected in the brain stem. In fetal MRI evaluation, Walker Warburg syndrome was considered with brain stem kinked hydrocephalus findings. The parents was offered the option of genetic examination and termination. . A 2340 gram female baby was born with 6 apgar however, she was followed up in the intensive care unit due to respiratory distress, and her follow-up continues in the 1st month postpartum.

As a result of this report, although there is difficulty in ultrasonographic evaluation of intracranial structures of fetuses with hydrocephalus, evaluation with MRI may enable the diagnosis of rare and difficult-todiagnose diseases such as WWS in early pregnancy error.

Keywords: walker warburg, fetus, neurosonography, magnetic resonance imaging

Background

Cerebro-ocular dysplasia or Walker-Warburg syndrome (WWS) is a type of congenital muscular dystrophy associated with ocular hydrocephalus, dysplasia, and cerebral malformations (1). Ocular abnormalities include cataracts, optic nerve hypoplasia, corneal clouding, and retinal dysplasia or detachment. Brain magnetic resonance imaging (MRI) shows hypodense white matter, hypoplastic cerebellum and pons, ventricular dilatation (with or without hydrocephalus) and abnormal cortical development known as cobblestone brain malformation (also called Type II lissencephaly). Its incidence is 1.2 per 100,000 live births. It shows autosomal recessive inheritance and the average survival is only four months (2). If there is a family history of antenatal diagnosis, if there is cerebellar and brain stem findings at the 20th week of pregnancy, it can be made by genetic examination. In this study, a case diagnosed with walker warburg syndrome in the antenatal period is presented.

Case

A 27-year-old pregnant woman with Gravity 2 Parity 1 was referred for fetal hydrocephalus at 16 weeks of gestation. She and her husband were healthy and had no disease in her history, and had a third degree relative with her husband. In the fetal neurosonographic evaluation, the lateral ventricles were highly enlarged (hydrocephalus) in the transventricular section, and the cavum septum pellicidum and corpus callosum could not be evaluated due to severe hydrocephalus.

In the transcerebellar section, the cerebellar hemispheres were discrete (Fig 1). In the evaluation performed for sagittal the evaluation of the vermis, a Z-configuration was detected in the brain stem (Fig 2). No abnormal finding was detected in the ocular evaluation (Fig 3). In fetal MRI evaluation, Walker Warburg syndrome was considered with brain stem kinked hydrocephalus findings (Fig 4). After genetic counseling, the parents was offered the option of genetic examination and termination, but the family did not accept it. Due to the onset of labor and severe hydrocephalus at the 31st gestational week, she was delivered by cesarean section. A 2340 gram female baby was born with 6 apgar however, she was followed up in the intensive care unit due to respiratory distress, and her follow-up continues in the 1st month postpartum.

Discussion

Walker Warburg syndrome is a rare autosomal recessive disease in which cerebro-ocular malformations are detected and muscle structures may be affected. In clinical findings; Ocular malformations such as cataract, optic nerve hypoplasia, corneal clouding, retinal dysplasia and hypodense white matter, cerebellum hypoplastic and pons, ventriculomegaly, abnormal cortical development (cobblestone) (Type н lissencephaly), rarely Dandy-Walker, posterior encephalocele can be detected. Prenatal cases usually have a family history of walker warbur syndrome or are referred for genetic evaluation. This case was referred because of severe hydrocephalus detected at early gestational week. Evaluation of the development of posterior fossa structures in fetal central nervous system development is recommended after 20 weeks of gestation. Since the discrete appearance of the cerebellar hemisphere observed in this case may be a normal finding in early gestational weeks, it was not sufficient for the diagnosis of posterior fossa anomaly. Type 2 lissencephaly in Walker Warburg syndrome can be detected with International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY

cortical cobblestone appearance, but the case presented at early gestational week in terms of cortical development. Z appearance in the brainstem observed in the sagittal section was a finding specific to Walker Warburg syndrome. Although the family did not accept genetic examination, there is no different disease in the literature in the differential diagnosis. In the study of Dobyns et al in which they examined 63 cases of WWS, the most frequently observed findings were; Although it was stated as type II lissencephaly, cerebellar malformation. retinal malformation. and muscular congenital dystrophy, hydrocephalus, these findings were not necessarily present for the diagnosis to be made (3).

As a result of this report, although there is difficulty in ultrasonographic evaluation of intracranial structures of fetuses with hydrocephalus, evaluation with MRI may enable the diagnosis of rare and difficult-todiagnose diseases such as WWS in early pregnancy error.



Fig 1. Fetal hydrocephalus and cerebellar hemispheres discrepancy



Fig 2. Z shape of the brain stem on ultrasound



Fig 3. Fetal ocular appearance on ultrasound



Fig 4. Z shape of the brain stem on MRI

References

1. Suthar R, Angurana SK, Singh U, Singh P. Walker-Warburg syndrome. Neurology India. 2018;66(6):1849-50.

 Vajsar J, Schachter H. Walker-Warburg syndrome. Orphanet journal of rare diseases.
 2006;1:29.

 Dobyns WB, Pagon RA, Armstrong D, Curry CJ, Greenberg F, Grix A, et al. Diagnostic criteria for Walker-Warburg syndrome.
 American journal of medical genetics.
 1989;32(2):195-210.

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OP02 - Evaluation Of Rhd Antiglobulin Prophylaxis And Neonatal Outcomes In Pregnant Women With Rh Incompatibility According To Maternal Characteristics

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Aim: To investigate the maternal demographic and obstetrical characteristics affecting RhD antiglobulin prophylaxis in pregnant women with Rh incompatibility and compare neonatal outcomes in patients with or without RhD antiglobulin prophylaxis. Methods: In the study, the data of 63 pregnant women with Rh incompatibility who applied to Bursa City Hospital between 01/02/2021 and 01/05/2021 were retrospectively analyzed. As a result, we have divided patients into two groups who had RhD antiglobulin prophylaxis during pregnancy (group 1) and those who did not (group 2). Maternal demographics, obstetric and neonate outcomes were evaluated among these groups.

Results: There was no difference according to age between the groups. There was no difference between the groups in the number of gravida (p=0.809) and parity (p=0.903). There was no difference between the groups according to weight measurements (p=0.950). The 70.30% of patients in group 1 were followed up regularly pregnancy period, and this rate was determined as 58.80% in group 2, and there was no difference between the groups (p=0.407). There was no difference between the two groups according to the week of birth (p=0.873). The type of delivery did not differ between the groups (p=0.467). There was no difference between the neonates' 1st and 5th minute Apgar scores between the groups (p=0.868 and p=0.868). Newborn birth weight, height, and head circumference did not differ between the groups (p=0.487, p=0.741 and p=0.776). In the analysis performed according to nationality, there was no difference between the patients according to

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY age (p=0.154). Also, there was no difference according to the gravida rate between Turkish citizens and patients from other countries (p=0.478). But analysis shows that the rate of prophylaxis was determined as 82.70% in Turkish citizens and 27.30% in patients from other nationalities. The rate of rhogam application was higher in Turkish citizens (p=0.001).

Conclusion: In preventing neonatal jaundice due to Rh incompatibility, administration of "human anti-D globulin" is important in the prophylaxis of the disease. Our study shows that this awareness is gained in pregnant women who are Turkish citizens. However, it is essential to provide detailed information during pregnancy follow-up in patients from other countries.

Keywords: Rh incompatibility, RhD antiglobulin prophylaxis, maternal characteristics, neonatal outcomes

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OP03 - PRENATALLY DIAGNOSED CAUDAL REGRESSION SYNDROME: A CASE REPORT

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Introduction:

Caudal regression syndrome (CRS) is a rare congenital anomaly involving approximately 1 in 25000 live births. The syndrome is characterized by abnormal development of the caudal aspect of the vertebral column and the spinal cord, varying from the absence of a few terminal coccygeal segments to complete lumbosacral agenesis (1, 2). This condition is associated with frequently additional abnormalities in the rectum, urinary system, and lower limbs. CRS is closely associated with pregestational diabetes and is nearly 200 times more prevalent in infants of diabetic mothers (3). In addition to maternal diabetes, genetic predisposition and vascular hypoperfusion have been suggested as possible causative factors (4). CRS is usually diagnosed by antenatal ultrasound, with a more definitive diagnosis made by antenatal or postnatal magnetic resonance imaging (MRI).

Case presentation:

A 36-year-old 33 weeks pregnant woman with a history of pregestational diabetes mellitus for ten years was referred to our perinatology clinic due to polyhydramnios. Her medical history revealed that she was prescribed short and long-acting insulins by her endocrinologist, but she did not use them regularly. It was also noted that she neither attended her routine antenatal visits properly nor had a midtrimester fetal anatomic scan. Her prenatal ultrasound and MRI examination revealed agenesis of the spinal column below the L1 vertebral level with abrupt spinal cord termination at the T10 vertebral level and a "frog-like" position of lower limbs (Figure1,2). Maternal glicolised hemoglobin (HbA1c) level

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY was 8,1 at the time of referral. The mother is hospitalized for blood glucose regulation and fetal monitorization. At 36th weeks of gestation, a male fetus weighing 3400 grams was delivered by Caesarean section (Figure 3). In addition to the vertebral abnormalities, anal atresia was determined after delivery, and a divided sigmoid colostomy was performed on the second day postnatal. The diagnosis was confirmed, and a type 4 CRS (5) was determined using X-rays and MRI (Figure 4,5,6).

Discussion:

Caudal regression syndrome is a rare, most often sporadic disorder that was first described by Duhamel in 1961 (6). The syndrome comprises developmental anomalies of the caudal aspect of the fetus. CRS may range from a milder disease with an absent coccyx as an isolated finding to severe disease with sacral or lumbosacral agenesis (7). It can affect the lower extremities, the lumbar, sacral, and coccygeal vertebrae, and corresponding spinal cord segments. Neurological, orthopedic, gastrointestinal, genitourinary, and cardiac anomalies, imperforate anus, malformed genitalia, renal dysplasia or aplasia, and congenital heart defects are commonly seen (8). Chromosome studies are normal with few exceptions (9), and the recurrence risk of CRS is very low (10).

Maternal diabetes, genetic predisposition, and vascular hypoperfusion have been reported among the etiological factors. Although the exact mechanism of the pathogenesis of CRS is not well understood. It has been reported that the syndrome might be due to defects in the first stage of neurulation or disorders that occurred in the differentiation phase. In a study evaluating the pathogenesis of the CRS, three different doses of retinoic acid were administered to rat fetuses, and experimental CRS was created (11). In the study, the retinoic acid given in 8-9th days of gestation formed CRS regardless of the dose in most of the



Figure 3,4



Figure 5,6



International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY survivors. It was reported that the severity of CRS was dose-dependent, where low doses produced caudal regression while high doses resulted in caudal agenesis. In this study, the authors reported that the pathogenic mechanism that causes the development of CRS might be a combination of cell death, vascular disruption, and tissue deficiency.

The incidence of CRS in healthy pregnancies is very low. CRS is nearly 200 times more prevalent in infants of diabetic mothers. However, the history of maternal diabetes mellitus is present in only 16-22% of the CRS cases. In the present case, the mother had insulin-dependent Type 2 diabetes mellitus with poor glycemic control. Her serum HbA1c level was 8.1, which was high at the time of referral, suggesting the etiology is hyperglycemia in this case.

In CRS, the Renshaw classification was used to describe the severity of the pathology. In this classification system, four types of the syndrome, according to the amount of sacrum remaining and the articulation characteristics between the spine and pelvis, were reported (5) (Table-1).

Table-1: Renshaw Classification

TYPE 1	Either partial or total unilateral sacral agenesis.
TYPE 2	Partial sacral agenesis with bilaterally symmetrical defect, a normal or hypoplastic sacral vertebra, and a stable articulation between the ilia and first sacral vertebra.
TYPE 3	Variable lumbar and total sacral agenesis, with the ilia articulating with the sides of the lowest vertebra present.
TYPE 4	Variable lumbar and total sacral agenesis, with the caudal endplate of the lowest vertebra resting above either fused ilia or an iliac amphiarthrosis.

In the present case, the fetus had; total sacral agenesis and the agenesis of the lumbar vertebra below L1 with abrupt spinal cord termination at the T10 and iliac bones

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY overlapping at midline, which was defined as Renshaw Type-4. The fetus also had concomitant anal atresia.

In CRS, sonographic findings are variable, depending on the defect's extent and severity (12). Prenatal diagnosis by mid-trimester ultrasound is possible due to sudden interruption appearance of the spine and a frog-like position of the lower limbs (13). On the other hand, the first-trimester diagnosis is more difficult because of the incomplete ossification of the sacrum at that time. However, a short crown-rump length has been proposed as an early sonographic sign of CRS (14).

Currently, no definitive treatment option exists for cases with CRS, and the postnatal prognosis is poor, even in milder forms due to neuromuscular deficits of the lower limbs and sphincters. The treatment options are only supportive due to the irreversible nature of the syndrome. The treatment options are only supportive due to the irreversible nature of the syndrome. Therefore early prenatal diagnosis, especially in severe cases, is of significant importance for the patients who decide to terminate their pregnancy.

Conclusions: CRS is a rare entity with a poor prognosis. Ultrasound and fetal MRI can be used to make a prenatal diagnosis. Prenatal detection is crucial to offer the option of pregnancy termination to the family or decrease the risk of postnatal complications and, thus, improve the prognosis in patients who decide to deliver the baby. It seems that good metabolic control of gestational diabetes constitutes the best preventive measure available.

Keywords: Congenital Abnormalities; Prenatal Diagnosis; Magnetic Resonance Imaging; Spinal Cord. 1) Tortori-Donati P, Fondelli MP, Rossi A, Charlers AR, Armando C, Valeria C. Segmental spinal dysgenesis: neuro-radiologic findings with clinical and embryologic correlation. Am J Neuroradiol 1999; 20: 445-456.

2) D. Pang, "Sacral agenesis and caudal spinal cord malformations," Neurosurgery, vol. 32, no. 5, pp. 755–778, 1993.

3) ZawW, StoneDG. Caudal Regression syndrome in twin pregnancy with type II diabetes. J Perinatol 2002; 22: 171- 174.

4) Adra A, Cordero D, Mejides A, Yasin S, Salman F, O'Sullivan MJ. Caudal regression syndrome: etiopathogenesis, prenatal diagnosis, and perinatal management. Obstet Gynecol Surv 1994; 49: 508–516.

5) Renshaw TS. Sacral agenesis. J Bone Joint Surg 1978; 60: 373-383.

6) Duhamel B. From the Mermaid to Anal Imperforation: The Syndrome of Caudal Regression. Arch Dis Child 1961;36(186):152-5.

7) Sen KK, Patel M. Caudal Regression Syndrome (case report) MJAFI 2007; 63: 178-179.

8) Boulas MM. Recognition of caudal Regression Syndrome. Adv Neonatal Care 2009; 9: 61-69.

9) Perrot LJ, Williamson S, Jimenez JF. The caudal regression syndrome in infants of diabetic mothers. Ann Clin Lab Sci 1987;17(4):211-20.

10) Jaffe R, Zeituni M, Fejgin M. Caudal regression syndrome. Fetus Spinal anomalies 1991;7561:1-3.

11) Padmanabhan R. Retinoic acid-induced caudal regression syndrome in the mouse fetus. Reprod Toxicol 1998; 12:139-51

12) Gonzalez-Quintero VH, Lama T, Dibe M, Romaguera RL, Rodriguez MM, Izquierdo LA

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - iZMİR / TURKEY (2002) Case Report sonographic diagnosis caudal regression in the first trimester of pregnancy. J Ultrasound Med 21.1175-1178

13) Halil A, Halil Y, Nurkul C, Gokhan Y, Yavuz C (2001) Prenatal diagnosis of caudal regression syndrome—case report.BMC Pregnancy Childbirth 1:8

14) Benacerraf BR (1998) Caudal regression syndrome and sirenomelia in ultrasound of fetal syndromes. Churchill Livingstone, New York, pp 250–254

OP04-13 WEEKS PREGNANT WITH OVARIAN TORSION

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Introduction

Ovarian torsion is defined as partial or complete rotation of the ovarian ligaments around itself, preventing the feeding of the ovary. It is one of the most common gynecological surgical emergency and can affect women of all ages (1).

Early diagnosis is important to preserve ovarian and/or tubal function and prevent other associated morbidities. However, it can be difficult to diagnose because its symptoms are relatively nonspecific.

Pregnancy is associated with an increased risk of ovarian torsion. In case series with 80 or more patients, the incidence of ovarian torsion was found to be 10-22% (2,3).

In this poster, we present a 13-week pregnant woman who applied with the complaint of sudden onset of abdominal pain and then underwent laparoscopic surgery with the suspicion of ovarian torsion.

Case Report

A 20-year-old pregnant woman who was 12 weeks and 6 days old according to her last menstrual period applied to the emergency service with the complaints of sudden onset of pain in the right inguinal and nausea-vomiting.

In the physical examination of the patient; there was tenderness in the right lower quadrant. She had no defense or rebound. Vaginal bleeding was not observed. Her vitals were evaluated as normal. Transvaginal ultrasound findings; the right ovary was 35*39*53 mm in size, had a solid appearance, and the follicles were pushed to the periphery (Figure 1). The left ovary was in normal appearance. There was an intrauterine 13 week and 1 day fetal cardiac beat positive pregnancy.

Figure 1: Transvaginal Ultrasound Screening



In laboratory tests, Hb: 12 g/dl, white blood cell: $9.200/\mu l$ platelet: $200.000/\mu l$, biochemistry and urinalysis results were also found to be normal.

The patient had no known disease and no previous operation history. Based on the patient's clinical findings and imaging studies, an emergency laparoscopy was planned with the suspicion of ovarian torsion.

Laparoscopic examination revealed torsion, edematous and hyperemic around the right ovarian adnex (Figure-2).

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The ovary was detorsioned and normal blood flow to the ovary was restored. A change in the color of the ovary was observed. (Figure-3).

Figure-3: Detorsion view of ovary



Discussion

The approach to acute abdominal/pelvic pain in pregnancy is the same as for non-pregnant women. In addition, there are some difficulties. The aim is to detect life-threatening etiologies with early diagnosis and to intervene quickly. Delay in diagnosis and treatment can increase maternal/fetal morbidity and mortality.

Ovarian torsion is one of the rare causes of acute abdominal/pelvic pain in pregnancy. Definitive diagnosis requires direct imaging during surgery. The advantages of laparoscopic surgery are similar for pregnant and non-pregnant women. However, laparoscopy during pregnancy has been avoided due to concerns that it may be harmful to the fetus. However, multiple case reports and case series describing the safe performance of laparoscopic procedures in pregnant women have been published (4,5).

It seems that laparoscopy is associated with less risk than laparotomy for pregnant women requiring surgery (6). If surgery takes more than 45 minutes, use of low molecular weight heparin is recommended; mechanical thromboprophylaxis is a reasonable alternative to shorter procedures. To avoid significant compression of the aorta and inferior vena cava, the pregnant woman is placed in the supine or lithotomy position (after 16 weeks of pregnancy) to the left. Intra-abdominal pressure should be maintained between 8 and 12 mm/Hg and should not exceed 15 mm/Hg. Fetal heart rate should be verified and documented before and after the procedure.

Laparoscopy in pregnancy is usually performed in the first or second trimester, and it is technically possible even in the third trimester. Based on retrospective evaluation and survey data, laparoscopic surgery appears as safe as laparotomy for the evaluation of abdominal/pelvic pain in pregnancy.

References

1-Sanfilippo JS, Rock JA. Surgery for benign disease of the ovary. In: TeLinde's Operative Gynecology, 11th ed., Jones HW, Rock JA (Eds), Wolters Kluwer, 2015.

2-Houry D, Abbott JT. Ovarian torsion: a fifteen-year review. Ann Emerg Med 2001; 38:156.

3-Tsafrir Z, Hasson J, Levin I, et al. Adnexal torsion: cystectomy and ovarian fixation are equally important in preventing recurrence.

162:203.

4- Cox TC, Huntington CR, Blair LJ, Prasad T, Lincourt AE, Augenstein VA, Heniford BT. Laparoscopic appendectomy and cholecystectomy versus open: a study in 1999 pregnant patients. Surg Endosc. 2016 Feb;30(2):593-602. Epub 2015 Jun 20.

5- Reedy MB, Källén B, Kuehl TJ . Laparoscopy during pregnancy: a study of five fetal outcome parameters with use of the Swedish Health Obstet Gynecol. Registry. Am J 1997;177(3):673.

6- Rojansky N, Shushan A, Fatum M. Laparoscopy versus laparotomy in pregnancy: a comparative study. J Am Assoc Gynecol Laparosc. 2002 Feb;9(1):108-10.

Eur J Obstet Gynecol Reprod Biol 2012;

OP06 - Evaluation Of Maternal Hemorrhage And Complications In Placenta Previa Cases Terminated In Our Clinic

<u>Alper İleri</u>

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Objective: Placenta previa is defined as the presence of placental tissue overlying the inner cervical os. Sequelae include the need for cesarean delivery, potential for severe antepartum hemorrhage, preterm delivery, and postpartum hemorrhage. Our aim to evaluate the results of placenta previa totalis cases in our clinic. Methods: Between January 2020 and July 2021, the demographic and clinical data of 51 individuals whose pregnancy was terminated in our hospital and who were singletons for 24 weeks or longer in our hospital's gynecology and obstetrics clinic were retrospectively analyzed. Ultrasonography and hemogram records, obstetric and surgical results were recorded. Results: The mean age and gestational age of the pregnant women were found to be 29.8±3.6 and 34.3±4.6, respectively. Infant birth weight was determined as 2487±411 grams. 62% of the patients had a history of cesarean delivery, and no patient with a history of placenta previa was found, operation time was found to be 56.2±31.2 minutes. Surgery complications were seen as bladder (11.7%), ureter (3.9%) and bowel (1.96%) injuries, respectively. Postoperative and preoperative hemoglobin difference (Δ Hgb) 2.9 \pm 1.1; Invasion anomalies detected in ultrasonography were seen as placenta accreta (9.8%), placenta increta (5.8%) and placenta percreta (3.9%)respectively. Discussion : In systematic reviews, the prevalence of placenta previa is approximately 4 per 1000 births, but varies worldwide. Major risk factors are previous placenta previa, previous cesarean section,

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY multiple gestations. Maternal morbidity from placenta previa is associated with antepartum and postpartum hemorrhage. Antepartum hemorrhage in 52 percent and postpartum hemorrhage in 22 percent of women with placenta previa is reported in the literature, and bleeding is particularly severe with more invasive placentation due to the excessive hypervascularity of the placental bed. Heavy bleeding was also detected in our patients, and clinicians should be careful in terms of maternal morbidity in cases of placenta previa.

Keywords: Plasenta Previa, Cesarean, Morbidity

OP07 - Long-Term Incidence Of Stress Urinary Incontinence In Pre- And Postmenopausal Patients Underwent Total Abdominal Hysterectomy

Can Ata

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OBJECTIVE: Hysterectomy is a major surgery frequently performed in gynecology practice. It is important to closely monitor morbidity and its consequences, as it occurs frequently. The aim of our study is to evaluate the frequency of stress urinary incontinence in the first year postoperative in premenopausal and postmenopausal patients who underwent total abdominal hysterectomy (TAH). METHODS: Clinical follow-up was performed on volunteer patients who underwent TAH operation in our hospital between January 2018 and 2020 for benign reasons, whose main complaint was not urinarv incontinence, and no urinary incontinence was found in their urogynecological examination. TAH operation consent was obtained from all the patients. Control examinations were performed in the 1st year. In these follow-ups, gynecological examination, Q-tip test, urinary distress questionnaire were applied and the results were reported. The patients were evaluated in two groups as premenopausal and postmenopausal. RESULTS: 25 patients who voluntarily participated in the study and whose data were complete were enrolled. 10 patients were found to be premenopausal. In postmenopausal patients, 20% cystocele and 40% of patients had stress urinary incontinence, and 20% of premenopausal patients had stress urinary incontinence (p<0.05). CONCLUSION: The long-term effects of abdominal hysterectomy on pelvic floor dysfunction are still being studied. In our study, the incidence of stress incontinence was found to be higher in postmenopausal patients who had TAH operation. In the patients undergoing

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY TAH, concomitant menopause may increase stress urinary incontinence in the long term.

Keywords: Stress Incontinence, Total Abdominal Hysterectomy, Menopause

OP08 - Poor Obstetric Outcomes in Anemic Pregnants

Hande İleri

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OBJECTIVE: Socioeconomic status and nutritional characteristics of pregnant women determine regional prevalence and differences. Our aim in our study is to examine the relationship between anemia and low birth weight in our hospital.

METHODS: The medical records of the pregnant women who were followed up in our hospital between July 2020 and 2021 were retrospectively analyzed. Pregnancy anemia was defined as Hb<11, <10.5, and <11g/dl at 1st, 2nd, 3rd trimester respectively; low birth weight was defined as birth weight <2500 grams. Clinical and demographic data were compared between anemic and non-anemic groups.

RESULTS: A total of 241 pregnant women whose pregnancy records were accessed retrospectively were included in the study. Mean maternal age, gestational age at birth, hemoglobin and infants' birth weight were 27.5 ± 3.2 , 38.1 ± 2.8 , 11.3 ± 1.1 , 3110 ± 420 , respectively. In our study, the frequency of anemia was found to be 24.8%. In terms of low birth weight, the rate of low birth weight in infant of mothers who were anemic in any trimester of pregnancy was statistically significantly higher when compared to the nonanemic group (p<0.05).

CONCLUSION: Anemia has traditionally been associated with negative pregnancy outcomes. Compared to non-anemic pregnant women, the rate of low birth weight in the infants of anemic pregnant women is higher. Iron supplementation should be provided to pregnant women who are found to have anemia during pregnancy follow-up, and pregnant women should be informed. **Keywords:** Anemia, Pregnancy, Low birth weight

OP09 - Laparoscopic Hysterectomy Results; Single Center Experience

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Aim: It is aimed to retrospectively examine the total laparoscopic hysterectomies performed in Osmaniye State Hospital Gynecology and Obstetrics Clinic and to make the necessary arrangements for future cases according to the results obtained in the light of the literature.

Materials-Methods: The files of 150 total laparoscopic hysterectomy cases between January 2017 and January 2020 in the gynecology and obstetrics clinic of a state hospital in a small city in the south of Turkey were retrospectively reviewed.

Results: The mean age of the cases was 47.7 years and ranged from 44 to 70 years. Indications for laparoscopy were treatmentresistant menometrorrhagia (56%), uterine fibroids (24%), adenomyosis (10%), endometrial polyp (5%) and endometriosis (3%), chronic pelvic pain (2%). In general, our indications consisted of benign causes in all of our cases. The most common situation observed during observation during laparoscopic procedures was considered as adhesions secondary to previous surgery or infection. The mean operation time was 76±25 minutes, and the mean hospital stay was 2 Complications of ureteral injury davs. developed in 4 cases (2.6%) and bladder perforation in 5 cases (3.3%). These complications were detected at an early stage and the problem was eliminated with conservative methods without any sequelae.

Conclusion: Total laparoscopic hysterectomy is a safe, rapid and widely used minimally invasive surgical technique in all gynecological indications, both malignant and benign. Consistent with the literature in our clinic, it is most commonly applied in cases diagnosed with abnormal uterine bleeding. It is a treatment method that is used safely in clinical

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY indications in emergency situations. Although we are a 2nd level state hospital gynecology clinic, we think that complications frequently seen in abdominal surgery will be prevented to a large extent with laparoscopic surgery, which is becoming increasingly common in our clinic.

Keywords: Laparoscopy, Hysterectomy, Menometrorrhagia, Complication.

OP10 - Total Laparoscopic Hysterectomy Experience of a Tertiary Center in Eastern Anatolia

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Introduction; Hysterectomy was first successfully performed using a vaginal or abdominal incision in the 19th century (1). Technological innovations enabled the first laparoscopic hysterectomy (LH) to be performed in 1989 (2). As of 2009 United States surveillance data, the distribution of surgical approaches to hysterectomy for benign diseases was reported to be 56% abdominal, 20% laparoscopic, 19% vaginal, and 5% robotic (3). There is no specific indication for LH compared to other surgical approaches. According to the 2015 Cochrane analyzes, the first-line surgical method for hysterectomy is vaginal hysterectomy (VH). VH is superior to other approaches and should be the first choice (4). However, even in the hands of experienced surgeons, VH can only be performed at a rate of 50% due to a large uterus, previous vaginal delivery history, adnexal mass, and previous abdominal operation history (5). The American College of Obstetrician and Gynecologist (ACOG) stated that LH should be the standard approach in patients in whom VH cannot be performed (6). On the other hand, the use of the laparoscopic approach in hysterectomy is still not a standard option in gynecological surgery. Although total laparoscopic hysterectomy (TLH) is associated with shorter hospital stay, lower intraoperative blood loss, less postoperative pain, faster recovery, and lower infection rate compared to abdominal hysterectomy (AH), most hysterectomies are still performed abdominally (7).

The aim of this study is to show the feasibility, advantages and disadvantages of TLH operation and to discuss the postoperative findings and complications of TLH cases performed in our clinic in Eastern Anatolia in the light of the literature.

Materials and Methods

All TLH cases performed in our institution between August 2015 and October 2017 were analyzed retrospectively. Informed consent was obtained from all participants. The study was approved by the ethics committee of our institution. Age, weight, height, parity, laparotomy history, medical history, surgery indication, operative findings, intraoperative and postoperative complications, reasons for conversion to laparotomy, and length of hospital stay were recorded. Two experienced surgeons performed all operations together using the same procedure. First, an abdominal incision was made at the base of the navel. A 90° angle of pneumoperitoneum was created using a Veress needle. Then, a 10 mm trocar (Ethicon Endo-Surgery, Cincinnati, Ohio, USA) was placed at the level of the umbilicus. In all cases, 3 additional 5 mm ports were placed. Two of these were just medial and above the anterior superior iliac prominence. The third port was placed in the midline, 8 cm from the umbilical trocar. The Clermont-Ferrand uterine manipulator (Karl Storz, Tuttlingen, Germany) was used for uterine manipulation. After exploration, bilateral round ligaments were coagulated and cut with 5 mm LigaSure (Ligasure Covidien Company, MA, USA) in all patients. Posterior leaves of bilateral ligamentum latums were opened, bilateral infundulopelvic and/or utero-ovarian ligaments were coagulated and cut with the help of LigaSure. The posterior leaf of both broad ligaments was dissected towards the uterosacral ligament. Both uterine arteries were coagulated and cut from the ipsilateral port using LigaSure. Paracervical tissues were cut parallel to the cervix by scraping the cervix. The uterus was removed vaginally by cauterizing the cervicovaginal junction with a 5 mm harmonic scalpel (Ethicon Endo-Surgery) under the guidance of the outer sheath of the uterine manipulator. The vaginal dome was sutured intracorporeally or vaginally with No: 1 polygalactin 910 one bv one. An anesthesiologist evaluated intraoperative bleeding by measuring the amount of blood in the aspirator cup. The operative time was measured by the time from the incision to closure. Complete blood count was performed at the postoperative 24th hour. The length of stay in the hospital was evaluated as the time from surgery to discharge. The reasons for returning to laparotomy were surgical difficulties. (Insufficient field of view and dense adhesions due to lower segment leiomyoma). Export SPSS for statistical analysis. 11 (Chicago-IL) program was used, data were expressed as mean ± SD (± standard deviation) and percentiles.

Results

Table 1 shows the demographic characteristics of the patients. The mean age of the patients was 52.20±8.17 ±SD, and the oldest patient was 73 years old and the youngest patient was 40 years old. The most common surgical indication for TLH was Cervical intraepithelial lesion (CIN) with a rate of 24%. Table 2 shows the intraoperative and postoperative variables. The mean operation time was 105.12±26.33±SD, and it took 190 minutes in 1 (one) patient with bladder injury. Only one (4%) patient was switched from TLH to laparotomy due to lower segment fibroids and severe intestinal adhesions. Bladder injury in one (4%) patient and hemorrhage requiring transfusion occurred as major complications in one (4%) patient. Bladder injury was repaired laparoscopically and control cystoscopy was It was observed that performed. no complications (vesicovaginal fistula, etc.) developed in the patient who was followed up until the postoperative 14th month. No intra-International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY

transfused patient. The bleeding, which was determined to be from Stumph, was followed by 3 units of ervthrocyte transfusion to the patient. Bleeding regressed spontaneously on the 2nd postoperative day. Bleeding that did not require transfusion occurred in three (12%) patients. Bleeding was detected with the decrease in hemoglobin and hematocrit values postoperatively, and conservative treatment was given (Tranexamic acid 250 mg 4 amp and hemogram follow-up). The decrease in hemoglobin and hematocrit values regressed. One (4%) patient developed wound infection at the trocar entry site in the umbilicus on the 8th postoperative day, and was treated with debridement and daily dressing. Cervical cuff problems occurred in three (12%) patients, cuff cellulitis in two (8%) patients, and bunion in one (4%) patient. It was treated locally.

abdominal bleeding was observed in the

Discussion

Although there has been no change in hysterectomy indications for a long time, alternative application options have recently started to increase in terms of applied methods. TLH has recently become an option that has grown rapidly in popularity and applicability. In the committee decision published in 2009, ACOG stated that LH should be the standard approach in patients who cannot undergo VH (6). The potential complications and treatments for LH are generally the same as for AH. Data from large LH studies report the following complication rates; Conversion to laparotomy 2.7-3.9%, bleeding 2-5%, urinary tract injury 1.2-3%, vaginal cuff dehiscence 1-2%, intestinal injury 0.2-0.4%. (8-12). Compared with AH or VH, the risk of urinary tract injury and vaginal cuff dehiscence appears to be higher with the laparoscopic approach. A meta-analysis of 27 randomized trials involving 3643 women found that urinary tract trauma was significantly higher in LH compared to AH (2.7 vs 0.8 percent; odds ratio [OR] 2.61, 95% CI 1.22-5.60), but LH and Insufficient data were

available to detect the difference between VH because the confidence interval included both increased and decreased risk (1.4 vs 1.6%; OR 1.00, 95% CI 0.36-2.75) (13). Data from a Finnish study involving more than 62,000 hysterectomies from 1990 to 1995 rates bladder injury rates of .089% for TLH; 0.3% for supracervical laparoscopic hysterectomy; 1.3% for AD; and 0.2% for VH. The risk of ureteral injury was reported as 13.9%, 0.3%, 0.4%, and 0.2%, respectively (14). In our study, bladder injury occurred in one patient (4%) and was repaired laparoscopically. In the follow-up, the bladder catheter was applied for two weeks, and at the end of the second week, the catheter was removed under control cystoscopy. No complications (vesicovaginal fistula, etc.) developed in the patient who was 14 months postoperatively. Complication of bladder injury in our study was observed in only one patient, and the rate was 4% due to the low number of cases; We believe that when the number of cases is increased, this rate will be similar to the study mentioned above, and the complication rates will decrease as the surgical experience and experience increases. In another Finnish registry study of 10,000 performed hysterectomies in 1996, complication rates of ureteral injury were 0.2 to 0.5% in AH; 1.1 - 1.3% in LH; and 0.2% in VH (11). In particular, a follow-up of this observational study showed a significant reduction in the risk of ureteral injury with LH (0.2 to 0.3% risk) in 2006 compared to the original report in 1996, reflecting increased surgical skill and experience (15). Similar to the findings in this study, none of the patients in our Study had ureteral injury. Prevention of urinary tract trauma depends on meticulous surgical technique and knowledge of anatomy. The ureters, adnexa, and uterine vessels should be visualized prior to surgical treatment. Some prefer to routinely perform surgeons cystoscopy during LH to evaluate the urinary system, while others do it selectively in complicated cases (16). While the American Association of Gynecological Laparoscopists

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY making cystoscopy an integral component for laparoscopic hysterectomy (17). Prolongation of bladder catheterization is not required after laparoscopic hysterectomy unless there is an intraoperative complication.

Vaginal cuff dehiscence is a rare complication, but its incidence is highest following laparoscopic hysterectomy. For example, in a retrospective study of more than 12,000 hysterectomies, vaginal cuff dehiscence rates were 0.38% in AH; 0.11% in VH; and 0.75% in LH (18). In this study, there were no patients complicated with vaginal cuff dehiscence.

In this study, the conversion rate to laparotomy was 4%, and the overall complication rate was 36%; these rates are consistent with the rates recently reported for TLH series (19).

Patients undergoing LH may be sent home the same day or usually stay in the hospital overnight. Observational studies report that same-day discharge is safe and less costly and may be associated with fewer postoperative complications (20-22). In this study, patients who did not develop complications were discharged on the 2nd postoperative day.

Limitations of this study; its retrospective nature and small study population. Despite these limitations, our study demonstrates that TLH can be safely administered in eligible patients.

Conclusion

TLH is a surgical technique that can be applied safely. Appropriate patient selection and an experienced surgical team can help to eliminate the complication rate differences between patients undergoing AH and patients undergoing TLH. **Table 1.** Demographic characteristics of the patients (n=25)

Age ±SD	52,20±8,17
BMI (kg/m2) ±SD	28,92±2,27
Parity ±SD	3,48±2,10
History of Cesarean	5 (20%)
History of lower abdominal surgery	3 (12%)
Hysterectomy indications	
-Myoma uteri	3 (12%)
- Endometrial hyperplasia	4 (16%)
- Cervical intraepithelial neoplasia (CIN)	6 (24%)
- Treatment-resistant menorrhagia	4 (16%)
-Adenomyosis	1 (4%)
- Postmenopausal bleeding	3 (12%)
- Endometrial cancer	1 (4%)
- Postmenopausal ovarian cyst	2 (8%)
- Chronic pelvic pain	1 (4%)
Operations other than hysterectomy	
- Pelvic lymphadenectomy + Bilateral salpingo-	
oophorectomy	2 (8%)
- Bilateral salpingo-oophorectomy	17 (68%)
- Unilateral salpingo-oophorectomy	1 (4%)
- Transobturator tape (TOT)	2 (8%)

 Table 2. Postoperative results (n=25)

Operation time (min) ±SD	105,12±26,33
Length of stay in hospital (d) ±SD	2,96±1,09
Preoperative Hb (g/dL) ±SD	12,12±26,33
Postoperative Hb (g/dL) ±SD	11,37±1,55
Postoperative Hb decrease (%) ±SD	0,928±0,96
Need for narcotic analgesics	7 (28%)
Transition from laparoscopy to laparotomy	1 (4%)
Major complications	
- Major hemorrhage requiring transfusion	1 (4%)
- Hematoma requiring surgical drainage	
- Intestinal damage	1 (4%)
- Bladder damage	
- Ureteral damage	
- Pulmonary embolism	
- Wound dehiscence	
- Vesicovaginal fistula	
Minor complications	
- Hemorrhage not requiring transfusion	3 (12%)
- Spontaneous draining hematoma	
- Deep vein thrombosis	3 (12%)
- Cervical cuff problems	2 (8%)
- Cuff cellulite	1(4%)
- Burjorman	1 (4%)
- Wound infection	
Total complications	9 (36%)

Postoperative pathology results

-Adenomyosis	4 (16%)
-Endometrial carcinoma	2 (8%)
-Leiomyoma	7 (28%)
-Chronic endometritis	1 (4%)
-Simple ovarian cyst	2 (8%)
-Chronic cervicitis	4 (16%)
-Endometrial polyp	3 (12%)
-Cervical intraepithelial Neoplasia 3 (CIN 3)	2 (8%)

References

1. Burnham W. Extirpation of the uterus and ovaries for sarcomatous disease. Nelson's Am Lancet 1854; 8: 147.

2. Reich H, DeCaprio J, McGlynn F. Laparoscopic hysterectomy. J Gynecol Surg 1989; 5: 213.

3. Cohen SL, Vitonis AF, Einarsson JI. Updated hysterectomy surveillance and factors associated with minimally invasive hysterectomy. JSLS. 2014; 18(3). pii: e2014.00096. doi: 10.4293/JSLS.2014.00096.

4. Aarts JW, Nieboer TE, Johnson N, Tavender E, Garry R, Mol BW et al. Surgical approach to hysterectomy for benign gynaecological disease. Cochrane Database Syst Rev 2015;12:8:CD003677.

5. David-Montefiore E, Rouzier R, Chapron C, Darai E. Surgical routes and complications of hysterectomy for benign disorders: a prospective observational study in French university hospitals. Hum Reprod 2007; 22(1): 260-265. 6. ACOG Committee Opinion No. 444: choosing the route of hysterectomy for benign disease. Obstet Gynecol 2009; 114(5): 1156-1158.

7. Wright JD, Herzog TJ, Tsui J, Ananth CV, Lewin SN, Lu YS, et.al. Nationwide trends in the performance of in-patient hysterectomy in the United States. Obstet Gynecol 2013; 122(2 pt 1): 233-241.

8. Canis M, Botchorishvili R, Ang C, Rabischong B, Jardon K, Wattiez A, et al. When is laparotomy needed in hysterectomy for benign uterine disease? J Minim Invasive Gynecol 2008; 15(1): 38-43.

9. Garry R, Fountain J, Brown J, Manca A, Mason S, Sculpher M. et al. EVALUATE hysterectomy trial: a multicentre randomised trial comparing abdominal, vaginal and laparoscopic methods of hysterectomy. Health Technol Assess 2004; 8:1.

10. Morelli M, Caruso M, Noia R, Chiodo D, Cosco C, Lucia E, et al. [Total laparoscopic hysterectomy versus vaginal hysterectomy: a prospective randomized trial].[Article in Italian] Minerva Ginecol 2007; 59(2): 99-105.

11. Mäkinen J, Johansson J, Tomás C, Tomás E, Heinonen PK, Laatikainen T. et al. Morbidity of 10110 hysterectomies by type of approach. Hum Reprod 2001; 16:1473.

12. Hur HC, Donnellan N, Mansuria S, Barber RE, Guido R, Lee T. Vaginal cuff dehiscence after different modes of hysterectomy. Obstet Gynecol 2011; 118:794.

13. Johnson N, Barlow D, Lethaby A, Tavender E, Curr L, Garry R. Methods of hysterectomy: systematic review and meta-analysis of randomised controlled trials. BMJ 2005; 330:1478.

14. Härkki-Sirén P, Sjöberg J, Tiitinen A. Urinary tract injuries after hysterectomy. Obstet Gynecol 1998; 92:113.

15. Mäkinen J, Brummer T, Jalkanen J, Heikkinen AM, Fraser J, Tomás E. et al. Ten years of progress--improved hysterectomy outcomes in Finland 1996-2006: a longitudinal observation study. BMJ Open 2013; 3:e003169.

16. Ibeanu OA, Chesson RR, Echols KT, Nieves M, Busangu F, Nolan TE. Urinary tract injury during hysterectomy based on universal cystoscopy. Obstet Gynecol 2009; 113:6.

17. American Association of Gynecological Laparoscopists (AAGL) Practice Report: Practice guidelines for intraoperative cystoscopy in laparoscopic hysterectomy. J Minim Invasive Gynecol 2012; 19:407.

18. Hur HC, Donnellan N, Mansuria S, Barber RE, Guido R, Lee T. Vaginal cuff dehiscence after different modes of hysterectomy. Obstet Gynecol 2011; 118:794.

19. Twijnstra AR, Blikkendaal MD, van Zwet EW, Jansen FW: Clinical relevance of conversion rate and its evaluation in laparoscopic hysterectomy. J Minim Invasive Gynecol 2013; 20: 64–72

20. Taylor RH. Outpatient Laparoscopic Hysterectomy with Discharge in 4 to 6 Hours. J Am Assoc Gynecol Laparosc 1994; 1:S35.

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY 21. Thiel J, Gamelin A. Outpatient total laparoscopic hysterectomy. J Am Assoc Gynecol Laparosc 2003; 10:481.

22. Morrison JE, Jacobs VR. Outpatient laparoscopic hysterectomy in a rural ambulatory surgery center. J Am Assoc Gynecol Laparosc 2004; 11:359.

OP11 - How Do Commercial Uterine Manipulators Affect Patient Parameters in Laparoscopic Hysterectomy Cases?

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Introduction; One of the most common gynecological surgical procedures that can be performed abdominal, vaginal and laparoscopic is hysterectomy(LH)[1]. In laparoscopic hysterectomy cases, which have become more preferred with the rapid development of technology in recent years; In addition to the experience of the surgeon, the characteristics of the instruments and devices used have gained importance and various companies have produced different products. Uterine manipulators are one of these instruments. We aimed to investigate whether these commercial manipulators have an effect on real patient parameters by retrospectively examining LH cases performed in our hospital from this perspective.

Material-Method; 163 LH cases performed at İzmir Katip Çelebi University Atatürk Training and Research Hospital between 01/01/2016-29/07/2021 were analyzed retrospectivelyCases which have been used a commercial uterine manipulator were evaluated according to the preferred manipulator type were evaluated in two groups ; Group 1 (RUMI-I Cooper Surgical, Trumbull, CT, USA) (n=62) and Group 2 (Clermont-Ferrand Karl StorzGmbhandCo., Tuttlingen, Germany)(n=35). Both groups were evaluated in terms of age and operation indications and compared with parameters such as operation time, hospital stay, pre-op hemoglobin-post-op hemoglobin values, absolute hemoglobin loss (mg/dl),

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY development of complications and uterus length (cm) in pathology specimen.

Results; When the two groups were compared in terms of operation times, the time was longer in the 1st group (189.2 \pm 49.6; 172.6 \pm 78.8 p=0.206), but the difference was not statistically significant. Also duration of hospital stay was similar in both groups (2.1 \pm 0.7 days; 2.2 \pm 0.7 days, p=0.680). When we look at the pre-op/ post-op absolute hemoglobin change in order to evaluate blood loss more real, although blood loss seems to be higher in the 2nd group, no statistically significant difference was observed (1. Group 1.8 \pm 0.8 mg/dl; 2. Group 2.0 \pm 1.2 mg/dl p=0.181).

Conclusion; In general terms, the effect of both manipulators on patient parameters is not very different. Clermont-Ferrand (CF) seems to be more advantageous than RUMI, although it is not statistically significant, in terms of making the surgeon's work easier in terms of operation time only.

OP12 - Conservative Surgical Treatment in the Placenta Accreta Spectrum: Myometrial Resection

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Introduction

The placenta accreata spectrum (PAS) is defined as the partial or complete invasion of the placenta to the uterine wall [1, 2]. Primary uterine anomaly or secondary damage to the uterine wall structure is blamed in its pathophysiology [3]. A previous cesarean section is one of them [4]. While it is reported to occur at a rate of 3.4 per 1000 births today [5], it is striking that this rate is increasing gradually when compared to the past [6, 7]. Since surgical treatment is difficult, the risk of complications during treatment is high.

It is the most important condition associated with high morbidity and mortality in the obstetric population [8, 9]. The hysterectomy procedure with cesarean section has proven to be effective and safe [10]. However, many conservative approaches have been described, such as suturing the placental bed, uterine and internal iliac artery ligations, uterine packing, intrauterine release of the placenta, and then following its spontaneous resolution, and benefiting from interventional radiological methods [2, 11, 12]. The American College of Obstetricians and Gynecologists (ACOG) stated that surgical treatment for PAS should be personalized [10]. One of these personalized surgical treatments is uterine segmental resection, which is defined as an organ-sparing surgical method. This method has been tried in tertiary centers and successful results have been reported [9, 13, 14].

In this article, we present a case of PAS who underwent a conservative approach, segmental uterine resection.

Case Report

A 38-year-old patient, who had a cesarean section, a postabortal curettage, and an ectopic pregnancy surgery in her obstetric history, was evaluated as placenta previa totalis in the ultrasonography performed at 30 weeks of gestation in her current IVF pregnancy, and there were suspicious PAS ultrasonography findings.

In the ultrasonographic evaluation, Doppler examination revealed lacunae with intense turbulent flow, the bladder-uterine line was erased, and the vascular structures extended into the bladder. The patient, who was hospitalized at 34th gestational week, was operated after dexamethasone application for fetal lung maturation and preparation of erythrocyte suspension. A 2200 g girl with 6/8 Apgar score was delivered.

The steps applied to the patient during the operation are listed below;

1- Entering the abdomen with a pfannenstiel incision while under spinal anesthesia,

2- Entering the cleavage between the bladder and uterine serosa in order to create the uterovesical space and removing the bladder from the uterus with vessel ligations between the bladder and uterus for this purpose,

3- Delivery of the baby with Kerr incision in the lower uterine segment,

4- Return to general anesthesia

5- Local resection of the placental invasion area with the help of scissors by targeting the Kerr incision,

6- Controlling bleeding in the placental bed with hemostatic sutures,

7- Closing the uterine incision area with double-layer suturing and bringing it closer together

8- Post-procedure intrauterine balloon (preferably foley catheter) application

In the early postoperative period, 3 units of erythrocyte suspension and 3 fresh frozen plasma were replaced. On the 1st postoperative day, the intrauterine balloon was gradually lowered and withdrawn. The patient was discharged on the 3rd day, as the general condition of the patient was good and there was no problem in the postoperative follow-ups.

Discussion

PAS is one of the most important obstetric problems due to the increased risk of morbidity and mortality and the difficulty of surgical treatment options [15]. It is known that placenta previa is an independent risk factor for PAS development. Placenta percreta can be seen in 40% of cases with placenta previa with a history of repeated cesarean section [15, 16]. It was thought that the presence of placenta previa and the history of curettage and cesarean section were effective in the development of PAS in our case.

There is no consensus on surgical options in the treatment of PAS. In the current approach, the necessity of personalizing the surgical treatment is expressed [2]. Therefore, conservative approaches [5-7] have been gaining popularity in recent years. One of these surgical approaches is myometrial resection. First, Palacios et al. In 2004, they defined myometrial segmental resection as full-thickness removal of the invading myometrium in PAS cases [9]. In the described surgical technique, following bilateral internal iliac artery ligation, the invasive myometrial region was locally resected full-thickness and then the uterus was reshaped. Successful preservation

of the uterus has been reported in 71% of cases [5]. The patient's age and desire for fertilization are the main factors in determining the surgical treatment method to be chosen. Reducing perioperative surgical complications depends especially on the duration of the operation and the amount of bleeding. In this context, in the segmental myometrial excision technique applied in our patient, shorter operation time and less bleeding are observed compared to the cesarean hysterectomy technique.

In conclusion, PAS is a life-threatening serious condition associated with maternal morbidity and mortality. Since it is an effective technique in preventing organ loss, segmental myometrial excision reduces complications in PAS surgery.

References

(1) Carusi DA. The placenta accreta spectrum: epidemiology and risk factors. Clinical obstetrics and gynecology. 2018;61:733-42.

(2) Jauniaux E, Chantraine F, Silver R, Langhoff-Roos J. FIGO Placenta Accreta Diagnosis and Management Expert Consensus Panel. FIGO consensus guidelines on placenta accreta spectrum disorders: Epidemiology. Int J Gynaecol Obstet. 2018;140:265-73.

(3) Belfort MA, Committee P, Medicine SfM-F. Placenta accreta. American journal of obstetrics and gynecology. 2010;203:430-9.

(4) Higgins MF, Monteith C, Foley M, O'Herlihy C. Real increasing incidence of hysterectomy for placenta accreta following previous caesarean section. European Journal of Obstetrics & Gynecology and Reproductive Biology. 2013;171:54-6.

(5) Shabana A, Fawzy M, Refaie W. Conservative management of placenta percreta: a stepwise approach. Archives of gynecology and obstetrics. 2015;291:993-8.

(6) Chandraharan E, Rao S, Belli AM, Arulkumaran S. The Triple-P procedure as a

conservative surgical alternative to peripartum hysterectomy for placenta percreta. International Journal of Gynecology & Obstetrics. 2012;117:191-4.

(7) Sakhavar N, Heidari Z, Mahmoudzadeh-Sagheb H. Cervical inversion as a novel technique for postpartum hemorrhage management during cesarean delivery for placenta previa accreta/increta. International Journal of Gynecology & Obstetrics. 2015;128:122-5.

(8) Cırpan T, Akdemir A, Okmen F, Hortu I, Ekici H, Imamoglu M. Effectiveness of segmental resection technique in the treatment of placenta accreta spectrum. The Journal of Maternal-Fetal & Neonatal Medicine. 2019:1-7.

(9) Palacios Jaraquemada JM, Pesaresi M, Nassif JC, Hermosid S. Anterior placenta percreta: surgical approach, hemostasis and uterine repair. Acta obstetricia et gynecologica Scandinavica. 2004;83:738-44.

(10) Obstetric Care Consensus No. 7: Placenta Accreta Spectrum. Obstet Gynecol. 2018;132:e259-e75.

(11) Alkazaleh F, Geary M, Kingdom J, Kachura JR, Windrim R. Elective non-removal of the placenta and prophylactic uterine artery embolization postpartum as a diagnostic imaging approach for the management of placenta percreta: a case report. Journal of Obstetrics and Gynaecology Canada. 2004;26:743-6.

(12) Butt K, Gagnon A, Delisle M-F. Failure of methotrexate and internal iliac balloon catheterization to manage placenta percreta. Obstetrics & Gynecology. 2002;99:981-2.

(13) Karaman E, Kolusarı A, Çetin O, Çim N, Alkış İ, Yıldızhan R, et al. Local resection may be a strong alternative to cesarean hysterectomy in conservative surgical management of placenta percreta: experiences from a tertiary hospital.

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY The Journal of Maternal-Fetal & Neonatal Medicine. 2017;30:947-52.

(14) Kilicci C, Sanverdi I, Ozkaya E, Eser A, Bostanci E, Yayla Abide C, et al. Segmental resection of anterior uterine wall in cases with placenta percreta: a modified technique for fertility preserving approach. The Journal of Maternal-Fetal & Neonatal Medicine. 2018;31:1198-203.

(15) Jauniaux E, Collins S, Burton GJ. Placenta accreta spectrum: pathophysiology and evidence-based anatomy for prenatal ultrasound imaging. American journal of obstetrics and gynecology. 2018;218:75-87.

(16) Irving F. A study of placenta accreta. Surg Gynecol Obstet. 1937;64:178-200.

OP13 - Prolapsed giant cervical polyp

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Introduction; Cervical polyps are mostly benign cervical masses of endocervical origin, which are frequently observed in the 5th decade (1). It presents with symptoms of leukorrhea, vaginal bleeding, malodorous discharge. They are often discovered incidentally and their size is less than 2 cm (2). Excision for treatment is controversial in the literature due to the low probability of malignancy.

Bigger than 4 cm polyp is defined giant cervical polyp. Giant cervical polyps are uncommon (3). It was aimed to report the presentation and management of the prolapsed giant cervical polyp.

Case; A 41-year-old pre-menopausal patient was admitted to the hospital because of a prolapsed mass from vagina and vaginal bleeding. Multiparous patient had no co-morbidity, vital signs were stable. She was not cervical cancer screening participant and smoker. Hemoglobin value was 14.2 mg/dl and β -hCG was negative.

Vaginal examination revealed a polypoid giant mass originating between the cervix and the lateral vaginal fornix. (Figure-1). The mass exceeded the introitus and was palpable without a speculum. (Figure-2) Its dimensions were 8x4x3 cm.

The mass was excised with electrocoagulation and cold knife under sedo-analgesia. Bleeding did not occur during the procedure. Endometrial sampling and cotesting (HPV testing in combination with cytology) were performed after excision. Endometrial sampling and cotesting pathological results were normal. Colposcopy showed a normal squamocolumnar junction. Figure



Figure 2



Giant cervical mass's pathological result was defined as fibroepithelial stromal cervical polyp.

Discussion; Giant cervical polyps are extremely rare. In the review published in 2017, 13 cases

were identified (4). The size of giant cervical polyps was between 5-17 cm which is published (3,4).

In most of the cases, pre-diagnosis was cervical malignancy. A case report pre-diagnose was 3rd degree uterine prolapse (5). In another case, giant cervical polyp mimicked uterine inversion (6).

In the same clinic scenario alternative diagnosis may be myoma in status nascendi , endometrial polyps, endocervical carcinoma, carcinosarcoma, incomplete abortion and, rhabdomyosarcoma (7).

The clinical presentation of giant cervical masses is similar to cervix cancer. Although excisional biopsy in cervical polyps is controversial in the literature, we strongly recommended that.

Keywords: Uterine cervical neoplasms, polyps , prolapse

References

1. Kanmaz AG, Budak A. Clinical and pathological investigation and management of cervical polyples; single central data. İzmir Eğitim ve Araştırma Hastan Tıp Derg 2019 23(1):21–4.

2. Bucella D, Frédéric B, Noël J-C. Giant cervical polyp: a case report and review of a rare entity. Arch Gynecol Obstet 2008 2783 [Internet]. 2008 Jan 31 [cited 2021 Aug 16];278(3):295–8

3. Simavli S, Kinay T. Giant Cervical Polyp: A Case Report and Review of the Literature. J Clin Obstet Gynecol [Internet]. 2013 [cited 2021 Aug 16];23(2):119–22.

4. Ota K, Sato Y, Shiraishi S. Giant Polyp of Uterine Cervix: A Case Report and Brief Literature Review. 2017

5. Gothwal, Singh P, Bharti JN, Yadav G, Solanki V. Giant cervical angiomyomatous polyp masquerading third-degree uterine

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY prolapse: A rare case with review of literature. Int J Appl Basic Med Res 2019 9(4):256

6. Das. Giant fibroid polyp mimicking uterine inversion. J Sci Soc [Internet]. 2020 [cited 2021 Aug 17];47(3):192.

7. Wu WY, Sheu BC, Lin HH. Giant Cervical Polyps: Report of two Cases and Literature Review. Taiwan J Obstet Gynecol. 2005 Mar 1;44(1):65–8.

OP14 - Is Emergency Peripartum Hysterectomy for Hemorrhage A Risk Factor For Postpartum Depression?

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Aim; Emergency peripartum hysterectomy is the procedure performed in cases with high risk of maternal mortality and morbidity, especially in postpartum hemorrhage. Although it is life-saving, it can cause depression, fear of death, anxiety and posttraumatic stress disorder in postpartum period. Here, we aimed to compare the depression scale between hysterectomy and nonhysterectomy groups in postpartum hemorrhage and also to investigate the effect of emergency peripartum hysterectomy on depression.

Methods; We conducted a cross-sectional study at University of Health Sciences, Bursa Yuksek Ihtisas Research and Training Hospital, Department of Obstetrics and Gynecology between January 2021 and February 2021. Patients who had postpartum hemorrhage were divided into two groups as hysterectomy(n=38) and nonhysterectomy(n=48) groups. Age, gravida, deliverv mode. neonatal outcome, complications and Edinburgh postnatal depression scale scores were recorded. Depression was diagnosed to patients who have scores \geq 12. None of the patients were using antidepressant or had diagnosis of depression. Demographic findings, obstetric features and scale scores were compared between groups and the effect of hysterectomy on depression was determined by regression analysis.

Results; Median age was 36(29-43) years in the hysterectomy group and 34(26-40) years in the non-hysterectomy group (p=0.432). A total of 16(42.1%) patients gave vaginal birth in

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY hysterectomy group while 29(60.4%) patients gave vaginal birth in non-hysterectomy group. There was no difference between groups according to deliverv mode (p=0.213). Complications such as disseminated intravascular coagulopathy, adjacent organ injury and abcess formation were significantly higher in hysterectomy group (23.7% vs 6.3%,p<0.001). Depression was diagnosed in 14 patients (36.8%) in hysterectomy group and in 6 patients (12.5%) in nonhysterectomy group. The median Edinburgh scale score was 11 (6-19) in hysterectomy group while it was 6(3-14) in non-hysterectomy group. Edinburgh scale score was statistically significantly higher in hysterectomy group (p<0.001). In regression analysis, it was found that neonatal mortality increases the depression risk by 3 folds (p=0.031) and peripartum hysterectomy increases by nearly 6 folds (p<0.001).

Conclusion; We found that emergency peripartum hysterectomy can lead to postpartum depression via losing of organ, fertility and menstruation. Therefore, this issue should be thought as public health problem and these patients should be followed with long-term psychiatric visits.

Keywords: depression, Edinburg scale, peripartum hysterectomy

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Objective; OEIS complex is a rare syndrome consisting of omphalocele, bladder exstrophy, imperforated anus and spinal defect(1).This condition is also called cloaca exstrophy and occurs once in 200,000-400,000 pregnancies(2).It was first described in 1978 by Carey et al. Although it occurs sporadically in many cases, familial cases have also been reported(3).In this case report, we presented a case of rare OEIS complex. and discussed the prenatal approach to these cases.

Method; A patient who applied to our clinic with 13 weeks of pregnancy was evaluated genetically and underwent ultrasonographic examination.

Results; A 29-year-old, 13-week-old patient with a history of 2 gravida, 0 parity and 1 abortion was referred to our clinic with the suspicion of fetal anomaly. In the ultrasonographic examination, 13 weeks of single, live pregnancy was diagnosed. Omphalocele sac with liver in the anterior abdominal wall, kyphoscoliosis and bladder exstrophy were observed. Anus could not be identified due to the early weeks of pregnancy. A normal constitutional karyotype was found in the chorionic villus sampling. The patient accepted the termination of pregnancy option which was offered to her.

Conclusion; OEIS complex refers to a combination of defects consisting of major structural abnormalities. Due to the course of the disease and its long-term sequelae, termination should be recommended after appropriate counseling. Detection of malformations in the early weeks will provide the family with the option of early medical evacuation and will minimize the psychological

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY and obstetric complications that the mother may experience.



Keywords: omphalocele, bladder exstrophy, imperforated anus, spinal defect

Resources

1-Carey JC, Greenbaum B, Hall BD. The OEIS complex (omphalocele, exstrophy, imperforate anus, spinal defects). Birth Defects Orig Artic Ser. 1978;14(6B):253-63

2-Hurwitz RS, Manzoni GA, Ransley PG, Stephens FD. Cloacal exstrophy: a report of 34 cases. J Urol. 1987;138(4 Pt 2):1060-1064

3-Smith NM, Chambers HM, Furness ME, Haan EA. The OEIS complex (omphaloceleexstrophy-imperforate anus-spinal defects): recurrence in sibs. J Med Genet 1992;29:730-732

OP16 - Prune Belly Syndrome: Early Prenatal Diagnosis

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Prune belly syndrome, also known as Eagle Barret syndrome, is a rare congenital condition of unknown aetiology and is characterised by abnormalities of the genitourinary system, a deficiency of abdominal musculature and bilateral cryptorchidism in males. Also known as Eagle-Barrets syndrome. The severity of the disease is variable and this condition makes prenatal diagnosis difficult. Although the etiology of the disease is not known exactly, some studies have shown its relationship with genetic inheritance and chromosomal abnormalities. In this study, we examined a case diagnosed with prenatal Prune Belly Syndrome, who applied to the perinatology outpatient clinic of our hospital. Our patient was a 21-year-old Syrian woman and had no additional disease. She was G2P0A1 at 15t weeks of gestation. In the first ultrasound examination of the patient, there was megacystitis and increased nuchal translucency. In the control ultrasonography performed at the 16th week of the patient ,hypoplastic nasal bone, flattened nasofrontal angle, increased echogenicity of the renal parenchyma, bilateral mild pelvictasia, dilated penile urethra and skeletal system anomalies were detected. The findings were evaluated as compatible with Prune Belly Syndrome. Invasive karyotyping and vesicocentesis were performed. The karyotype result of the fetus was 46XY and renal dysfunction was detected as a result of vesicocentesis. Prune Belly Syndrome and CHRM3 gene mutation were studied in the amniocentesis material of the patient. No mutation detected. In the control ultrasound performed at the 18th week of the patient, it was observed that the megacystitis regressed. The family was offered the option of termination due to the poor prognosis. We conclude that suspicion of such anomalies through an early antenatal scan require an further follow-up scan

Keywords: Prune belly syndrome; Urinary bladder enlargement; Abdominal distention; Cryptorchidism; Dilated penile urethra;Megacystitits

OP17 - Pregnancy Outcomes After Laparoscopic Myomectomy

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Abstract

Objective; To determine the safety of laparoscopic myomectomy (LSM) for women who desire pregnancy.

Material & Method; We performed a retrospective review of medical records of all consecutive patients who underwent laparoscopic myomectomy (LSM) at Izmir Economy University Medicalpark Hospital between 2016 and 2020.

Results; We identified a total of 14 women who had pregnancy after laparoscopic myomectomy (LSM) of 44 patients. The mean age of the LSM patients was 31.7 years, and most (75%) were nulliparous. One myoma was removed in (36/44) 81.8% of cases and multiple myomas were removed in (8/44)18.1% of cases. The mean diameter of the largest myoma removed was 5.2 cm (range, 4-11 cm). Approximately half (24/44)(54.5%) of the myomas were subserosal, and the other half (20/44)(45.4%) were intramural. After myoma excision, uterine suturing was performed in (38/44)86.3% of cases, and nosuture methods, such as bipolar hemocoagulation was used in (6/44) 13.6% of cases.

Seven percent of the pregnancies resulted in miscarriage, (2/14)14.2% in preterm deliveries, and (11/14)78.5% in full-term deliveries. All patients delivered via cesarean section and there were no obstetric complications like uterine rupture and placental abnormalities, such as placenta previa, accreta or percreata.

Conclusion; Our data support that LSM is a safe surgical technique in women who intend to have pregnancy.

Keywords;

Myomectomy

Pregnancy,

Laparoscopic

OP18 - Laparoscopic sacrocolpopexy: initial experience in a private hospital

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OBJECTIVES; To present the results of laparoscopic sacrocolpopexy (LSC) operations performed in a private hospital.

MATERIALS-METHODS; We evaluated 8 women who underwent LSC for pelvic organ prolapse repair between July 2017 and August 2021at one private hospital. Preoperative, intraoperative, postoperative, and demographic data were retrieved from patients' electronic charts. Pelvic organ support was assessed objectively using the Pelvic Organ Prolapse Quantification scale (POP-Q). Anatomic failure was determined as POP-Q stage \geq II.

RESULTS; Seven of patients had stage 3 prolapse .One of patients had stage 2 prolapse. Three of patients underwent only LSC, one of patients underwent LSC+ colporrhaphy posterior, four of patients underwent LSC+colporrhaphy anterior posterior procedure. The median POP-Q was III (II–III). Mean age of all patients was 57 (44-75) years. Mean operation time was 260,6 (180-300) minutes. Preoperative and postoperative hemoglobine (Hb) levels were evaluated and mean Hb level decrease was 1,4 (0-3,1).No intraoperative complication was experienced but postoperatively grade 2 hydronephrosis due to intraoperative left uretheral stricture was detected in one patient who had duplex collecting system in kidneys.One of patients (first LSC case of our clinic) had left peroneal nerve injury due to inapropriate operating table and restricted flexion on her left knee . One patient had de novo stress urinary incontinence and needed tension-free vaginal procedure after three months.No tape

recurrent prolapse was recorded in our followup.

CONCLUSION; Indication areas and popularity of the laparoscopic procedures in gynecology increasing everv dav. Currently. are laparoscopic or robotic techniques for POP repair are increasing in popularity and continuing to evolve. Laparoscopy provides shorter hospital stay, less pain and high patient satisfaction. The widespread utilisation of LSC in the management of female genital organ prolapse is hampered by its presumed length and technical difficulties. LSC, in the hands of an expert surgeon, can be considered a safe, effective procedure for the treatment of vaginal vault prolapse but learning is a challenge for unexperienced surgeons. The learning curve of LSC shows a steady decrease in the duration of surgery. According to the literatüre, turning point is observed after 18-24 procedures. During the learning curve there is no increased morbidity.

Keywords; laparoscopic sacrocolpopexy, pelvic organ prolapse

OP19 - Minimal invasive approach for tubo-ovarian abscess: Transabdominal ultrasound-guided drainage of tuboovarian abscess in a young woman

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Introduction: Tubo-ovarian abscess (TOA) is a severe, even life-threatening form of pelvic infection. TOA's forms as a complication of pelvic inflammatory disease. Majority of cases are polymicrobial origin including anaerobic, aerobic and facultative microorganisms (1). The use of broad-spectrum antibiotics, minimally invasive drainage procedures or surgery in combined with antibiotics are the management options for TOA's (2). Using the image-guided TOA drainage has been associated with fewer complications and with shorter hospital stay than laparoscopic drainage in large TOA's, recently (3). Here, we report a case of TOA in a young woman who has been successfully treated with transabdominal ultrasound-guided abscess drainage in combined with broad-spectrum antibiotic therapy.

Case presentation: A 35-year-old woman, gravida-0, parity-0 admitted to the emergency department with severe bilateral lower quadrant pain and fever of two days' duration. Her history included a laparoscopic right tubal proximal cauterization due to visible hydrosalpinx with an unsuccessful IVF cycle 1.5 years ago. Her physical examination revealed a right palpable mass with abdominal tenderness. The axillary temperature of 38°C and the pulse rate of 102/min was noted. The pelvic ultrasound demonstrated a 6x7 cm hyperechoic cystic mass on the right adnexal area with a normal uterus and left ovary. Laboratory tests showed leukocytosis (Wbc:22.630) with high C-reactive protein level

12 hours plus metronidazole 500 mg every 8 hours, intravenously initiated, MRI showed a 6 and 2.8 cm in diameter, thick walled, bilobular cyst including content with high signal in the right adnexal area with a dilated right tuba. On the 4th day of treatment, because the lack of regression of the clinical and laboratory findings, antibiotic regimen was changed to the piperacillin 4 g and tazobactam 0.5 g IV for every 8 hours plus doxycycline 100 mg, orally, every 12 hours. On the 7th day of hospitalization, the regression of clinical findings was not observed and drainage of TOA decided. A transabdominal ultrasound-guided abscess drainage and catheter placement was performed at the interventional radiology department. E.coli isolated from the culture of the purulent fluid. Same antibiotic regimen was continued. Six days later complete response to treatment was obtained and patient discharged from the hospital with full recovery. Continuation of an oral antibiotic therapy for a week was also suggested. At the 3rd month of

(178.2 mg/dL). Serum BHCG test was negative. Patient hospitalized, and ceftriaxone 1 g every

Discussion and Conclusion:

imaging findings for the disease.

Prompt diagnosis and initiation of appropriate treatment for TOA's is crucial.

the follow-up, she was free of any clinical or

The broad-spectrum antibiotics are usually the first-line strategy for unruptured TOA's in hemodynamically stabile patients. However, large size of the abscess is one of the significant risk factors for failure of conservative antibiotic treatment (4). Surgery or the minimal invasive drainage procedures are the options for these conditions . Minimal invasive procedures such image-guided drainage of abscess especially for those fertility needs to be preserved may be a better option. In conclusion, ultrasoundguided drainage of abscess in combination with antibiotic therapy can be considered in reproductive-aged women with large TOA's. **Keywords:** Tubo-ovarian abscess, imageguided drainage, ultrasonography

References;

1. Chappell CA, Wiesenfeld HC. Pathogenesis, diagnosis, and management of severe pelvic inflammatory disease and tuboovarian abscess. Clin Obstet Gynecol. 2012 Dec;55(4):893-903.

2. Shigemi D, Matsui H, Fushimi K, Yasunaga H. Laparoscopic Compared With Open Surgery for Severe Pelvic Inflammatory Disease and Tubo-Ovarian Abscess. Obstet Gynecol. 2019 Jun;133(6):1224-1230.

3. Goje O, Markwei M, Kollikonda S, Chavan M, Soper DE. Outcomes of Minimally Invasive Management of Tubo-ovarian Abscess: A Systematic Review. J Minim Invasive Gynecol. 2021 Mar;28(3):556-564.

4. Fouks Y, Cohen A, Shapira U, Solomon N, Almog B, Levin I. Surgical Intervention in Patients with Tubo-Ovarian Abscess: Clinical Predictors and a Simple Risk Score. J Minim Invasive Gynecol. 2019 Mar-Apr;26(3):535-543.

OP20 - Management of a noncommunicating unicornuate uterus with laparoscopic hemysterectomy

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Introduction; The uterus, fallopian tubes, cervix, and 2/3 proximal part of the vagina originate from the Müllerian ducts. During embryogenesis, any defect in Müllerian duct development causes uterovaginal structural defects called Müllerian duct anomalies. It occurs when one of the Müllerian ducts develops normally, but the development of the opposite duct is completely or almost completely interrupted. In our case, we found a class 2 b uterine anomaly that was not associated with the uterus (noncommunicating) and had a rudimentary horn containing the endometrial cavity.¹

Case; A 17-year-old virgin patient, who had no previous surgery and nochronic disease, was referred to our center, who applied for the last 2 years due to increased inguinal pain especially during menstrual periods. MRI revealed that there was a double endometrial cavity, onlythe left cavity was opened to the cervix, and these findings were in favor of a non-communicating unicornuate uterus (class 2B). No urinary anomaly was detected in urinary ultrasonography. First vagina inflated with co2 to 8 mmHg pressure and vaginoscopy performed with 4 mm laparoscope. There was no vaginal anomaly and there was one cervix. The right rudimentary horn was observed in the diagnostic laparoscopy and was excised laparoscopically with harmonic without damaging the cavity of the normal uterus. Salpingectomy was not performed in the 17year-old patient in order not to reduce the left ovarian blood flow. The patient underwent diagnostic cystoscopy and jet stream was seen from both orifices. In case of a possible future

pregnancy, she was discharged from the tertiary center with the recommendation of cesarean section at 37weeks.

Discussion; Accurate identification and diagnosis of the Mullerian anomaly are crucial to evaluate the correct surgical approach, as the procedure is greatly influenced by the specific subtype and anatomical features of the uterus, such as the extent of the connection between the rudimentary horn and the unicornuate uterus.² Since the first data of laparoscopic removal of the rudimentary horn by Canis et al. in 1990, it has become the standard treatment due to its advantages such as shorter operation time, less blood lossand shorter hospital stay.³



a Laparoscopic view of a non communicating unicornuate uterus

b The laparoscopic view after excision of the non-communicating rudimentary horn

c Laparoscopic view of the final uterus

d Appearance of single cervix with vaginoscopy



Different MRI sequences and images of noncommunicating unicornuate uterus

Keywords; hemihysterectomy, unicornuate uterus, Müllerian duct anomaly

Referances

- Buttram VC, Gomel V, Siegler A, DeCherney A, Gibbons W, March C. The American Fertility Society classifications of adnexal adhesions, distal tubal occlusion, tubal occlusion secondary to tubal ligation, tubal pregnancies, Mullerian anomalies and intrauterine adhesions. *Fertil Steril*. 1988;49(6):944-955. doi:10.1016/s0015-0282(16)59942-7
- Fedele L, Bianchi S, Zanconato G, Berlanda N, Bergamini V. Laparoscopic removal of the cavitated noncommunicating rudimentary uterine horn: Surgical aspects in 10 cases. *Fertil Steril*. 2005;83(2):432-436. doi:10.1016/j.fertnstert.2004.07.966
- Canis M, Wattiez A, Pouly JL, Mage G, Manhes H, Bruhat MA. Laparoscopic management of unicornuate uterus with rudimentary horn and unilateral extensive endometriosis. *Hum Reprod*. 1990;5(7):819-820. doi:10.1093/oxfordjournals.humrep.a1 37190

OP21 - Comparison of Imaging Methods in Infertility Patients

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Objective; In this study, it was aimed that compare the effectiveness of imaging methods (transvaginal ultrasonography [TVUS], hysterosalpingography [HSG] and saline infusion sonography [SIS]) which used in the evaluation of female infertility, and to determine their advantages and weaknesses. Materials and

Methods; The study included 193 patients who were diagnosed with primary or secondary infertility between May 2016 and August 2020 in University of Health Sciences Tepecik Training and Research Hospital, Gynecology and Obstetrics Clinics. The information was obtained retrospectively from the hospital information management system (HIMS) and the medical records of the patients. All patients were selected from patients who were evaluated by TVUS and HSG and who underwent hysteroscopy at the same time.

Results; It was found that 111 of 193 (57,5%) patients who met our criteria had laparoscopy and 12 (6,2%) patients underwent saline infusion sonography. The number of primary infertile patients was 102 (52,6%) and the number of secondary infertile patients was 92 (47,4%). While the most common uterine pathology for both groups was uterine anomaly, uterine septum was the most common one among uterine anomalies. Uterine pathology was found in 63,7% (n = 123) of the patients included in the study, uterine anomaly in 32,6% (n = 63) and tubal pathology in 49,5% (n = 56). The sensitivity, specificity,

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY PPV and NPV values of HSG were 81,3%, 44,29%, 71,94% and 57,41% for uterine pathologies and it was detected as 73,02%, 90%, 77.97% and 87,31% for uterine anomalies, respectively. The detected sensitivity, specificity, PPV and NPV values of TVUS were 40,65%, 87,14%, 84,75% and 45,52% for uterine pathologies and it is 42,86%, 96,92%, 87,1% and 77,78% for uterine anomalies, respectively. For tubal pathologies, sensitivity, specificity, PPV and NPV values of HSG were 78,5%, 52,73%, 62,86% and 70,7%, respectively.

Conclusion; We found that HSG had higher sensitivity and lower specificity compared to TVUS for uterine pathologies and anomalies. Due to the advantages and disadvantages of imaging methods, we are of the opinion that management and selection should be made according to the patient, and that they are not interchangeable, but complementary procedures.

Keywords: Infertility, hysterosalpingography, ultrasonography, hysteroscopy

OP23 - Surgical Treatment Of Aggressive Retroperitoneal Angiomyxoma: Case Report

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Introduction:

Aggressive Angiomyxoma was first described by Steeper and Rosai in 1983 and is a rare mesenchymal tumor with high local infiltration and high risk of local recurrence [2,3,5,8]. It is often seen in 4 to 5 decades of life, 6 times more in women than men, and mainly in the vulvovaginal region, perineum and pelvis. [1-5]. It is diagnosed by histopathology. Surgical excision was the gold standard in treatment, but potential alternative and complementary treatments included gonadotropin-releasing hormone (GnRH) agonists, tamoxifen, raloxifene, as well as radiotherapy and hormone therapy [6,7,10].

Case Report:

Thirty-seven-year-old female patient was admitted to our outpatient clinic with the complaint of a firm, painless mass growing in the right gluteal region within 6 months. Medical background and family history were unremarkable. Laboratory parameters were normal. On physical examination, there was a mass of approximately 10 centimeters in the right gluteal region, and the mass could be palpated by vaginal examination.In the sonographic examination a hypo-anechoic lesion with lobulated contours, approximately

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY 14 * 6.5 cm in size, was detected in the right perianal area.Computed tomography (CT) finding shows that; it was in the form of a mass lesion that deviated to the right of the rectum. vagina and cervix, showing heterogeneous enhancement of approximately 130 * 88 * 65 millimeters, adjacent to the sigmoid colon, and thought to be of well-defined mesenchymal origin (Figure 1). Magnetic resonance imaging (MRI) finding; in the form of a mass lesion be mesenchymal thought to origin. approximately 15 * 8 * 7 cm in size in the heterogeneous signal in T1A and T2A series deviating to the right of the cervix, vagina and rectum (Figure 2). Surgical exploration was decided. Laparotomy was performed for transabdominal approach. The sigmoid colon was freed from the mass, but when it was not possible to resect the entire mass transbdominally, a second incision was made in the right gluteal region and the mass was excised in a single block.



There were no complications after the operation and the patient was discharged on the 5th postoperative day. Histopathological examination revealed a hypocellular tumor with spindle, stellate cells, collagen fibers, dilated capillaries in a myxoid stroma (Figure 1). Tumor cells were diffuse positive with estrogen receptor (ER) (Figure 2), PR, focal positive with CD34, Desmin; negative with CD68, S100 and HMB45 immunohistochemical stains. Ki67 proliferative index was <%1, mitotic figure was absent. Surgical excision margins were negative for tumor.

Figure 1



Figure 2



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Aggressive Angiomyxoma is rare а mesenchymal tumor with high local infiltration and recurrence risk [6]. Mainly seen in the vulvovaginal region. perineum and pelvis[2,6,8,10]. Patients are usually asymptomatic at diagnosis, but have characteristic findings on radiological imaging. CT scans are variable, but may be hypointense homogeneous mass or cystic close to solid components. On MRI, the mass has "swirling" linear low-intensity signal areas on both T1weighted and T2-weighted images, suggesting a fibrovascular stroma and hypointense on T1weighted images and hyperintense on T2weighted images. [1,2,7,8]. However, the definitive diagnosis is made histopathologically [3]. Histopathologically, nuclear atypia, mitosis and reticular vascular formation are not observed.[4,5]. Estrogen (ER) and progesterone (PR) receptors are positive in immunohistochemical examination.There is immunoreactivity for desmin and vimentin, and immunonegativity for Cytokeratin and S100.; CD34 and SMA can vary[1,4,5,6,7,8].

First treatment option is extensive local surgical excision.[2,4,7,10]. Negative surgical resection margins are difficult to reach due to the lack of tumor capsule structure [2]. It is important to completely excise the tumor, as it has a high recurrence rate [3]. The role of sentinel lymph node biopsy and lymphadenectomy is unclear [6]. Hormonal therapy with tamoxifen, raloxifene and GnRH analogues can be useful as pre-operative or adjuvant therapy [3,6,7,9]. Chemotherapy and radiation therapy do not have a well-defined role due to low mitotic index.[2,3,6,7]. The prognosis is good, despite recurrence of the tumor and morbidity associated with repeat surgery [2,10]. Recurrence rates are between 35-72% and 85% of these occur within the first 5 years after surgery [2,4]. Long-term follow-up is recommended due to high recurrence rates.[1,7,8].

Figure legend:



Figure 1. Axial CT image of 37-year-old female. Solid white arrows show the solid homogeneous mass in the right perirektal area. Rectum is collapsed on the left site of the mass (dashed arrow). Cervix (C) is deviated left anteriorly due to compression of the mass.



Figure 2. Sagittal T2-weighted magnetic resonance image shows solid mass (arrows) arising from the ischioanal fossa and extending upwards into the pelvis. Lesion has T2 hyperintensity with T2 hypointense lineer septae in it, with accompanying signal void vascular structures (arrow heads). Those findings were in consistent with angiomyxoma radiologically.

Keywords: Keywords: angiomyxoma, pelvic mass, cervix, vagina, rectum.

References:

[1] Wahid A, Hakeem A, Khan S. Aggressive angiomyxoma in the ischiorectal fossa. J Pak Med Assoc. 2020 Jul;70(7):1304-1306. doi: 10.5455/JPMA.30242. PMID: 32799303. [PubMed] [2] Sutton BJ, Laudadio J. Aggressive angiomyxoma. Arch Pathol Lab Med. 2012 Feb;136(2):217-21. doi: 10.5858/arpa.2011-0056-RS. PMID: 22288973. [PubMed]

[3] Chong C. Aggressive angiomyxoma. Nurse
Pract. 2016 Sep 22;41(9):1-4. doi:
10.1097/01.NPR.0000490398.27464.0b. PMID:
27552685. [PubMed]

[4] Xie Y, Qian Y, Zou B. A giant aggressive angiomyxoma of vulva in a young woman: A case report. Medicine (Baltimore). 2019 Jan;98(2):e13860. doi: 10.1097/MD.00000000013860. PMID: 30633159; PMCID: PMC6336651. [PubMed]

[5] Sun NX, Li W. Aggressive angiomyxoma of the vulva: case report and literature review. J Int Med Res. 2010 Jul-Aug;38(4):1547-52. doi: 10.1177/147323001003800439. PMID: 20926030. [PubMed]

[6] Ribeiro JC, Vieira SC, Silva BB, Santos LG, Costa PV, Fonsêca LA. Aggressive angiomyxoma of the vulva: case report. Einstein (Sao Paulo). 2015 Apr-Jun;13(2):276-8. doi: 10.1590/S1679-45082015RC2952. Epub 2015 Jun 9. PMID: 26061077; PMCID: PMC4943823. [PubMed]

[7] Benson JC, Gilles S, Sanghvi T, Boyum J, Niendorf E. Aggressive angiomyxoma: case report and review of the literature. Radiol Case Rep. 2016 Oct 28;11(4):332-335. doi: 10.1016/j.radcr.2016.10.006. PMID: 27920855; PMCID: PMC5128564. [PubMed]

[8] Cordeiro Filho R, Carvalho AA, Carvalho RA, Cordeiro MP, Cordeiro GS, Teixeira CD, Cordeiro RS, Pedro RN. Endourologic Treatment for Aggressive Angiomyxoma of the Bladder. J Endourol Case Rep. 2019 Mar 18;5(1):19-21. doi: 10.1089/cren.2018.0106. PMID: 30989123; PMCID: PMC6461054. [PubMed]

[9] Beuran M, Ciubotaru C, Runcanu A, Enache V, Negoi I. Surgical Resection of Retroperitoneal Aggressive Angiomyxoma:

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY Case Report and Review of the Literature. Cureus. 2017 Jul 18;9(7):e1485. doi: 10.7759/cureus.1485. PMID: 28944124; PMCID: PMC5602455. [PubMed]

[10] Dalvi AN, Garale MN, Churiwala JJ, Landge A, Husain S, Rewatkar A. Pararectal angiomyxoma: a diagnostic dilemma. J Surg Case Rep. 2019 Dec 17;2019(12):rjz331. doi: 10.1093/jscr/rjz331. PMID: 31867095; PMCID: PMC6917470. [PubMed]

OP24 - Postpartum Congestive Heart Failure Presenting with Cough in a Pregnant Woman with No Known Disease

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ABSTRACT

Maternal heart disease has emerged as a major threat to safe pregnancy and the long-term cardiovascular health. In this study, we presented a case of postpartum congestive heart failure, which could not be diagnosed in the early period despite coughing in a patient without a known disease. The only complaint of the patient was cough. She had cough from time to time during her pregnancy, but the diagnosis could not be made. When postpartum cough persisted, echocardiography revealed 60% ejection fraction, pulmonary hypertension, severe mitral stenosis, grade 1-2 mitral regurgitation, grade 2 tricuspid regurgitation, and left atrial dilatation. The patient who underwent percutaneous balloon valvuloplasty due to severe mitral stenosis did not have any complaints in the 10-day follow-up. In conclusion, cardiology opinion can be obtained in patients with recurrent cough complaints during pregnancy. The follow-up of pregnant women with a diagnosis of cardiovascular disease should be carried out with a multidisciplinary approach with obstetricians and cardiologist.

KEYWORDS

Pregnancy, heart disease, maternal morbidity

Introduction

Heart disease continues to be one of the most important causes of maternal morbidity and mortality today. Its frequency in pregnancy varies between 1-4% [1]. Significant hemodynamic changes occur during pregnancy. The diaphragm rises, the heart International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - iZMiR / TURKEY turns left-up and along its long axis. During pregnancy, blood volume increases by 40-50%. Since this increase in blood volume is greater than the mass increase in erythrocytes, the hemoglobin concentration decreases. Arterial blood pressure decreases compared to prepregnancy due to vasodilation in peripheral vessels. Cardiac output rises 30-50% above baseline by 20-24 weeks [2].

It should be considered that the signs and symptoms such as palpitation, dyspnea, pretibial edema that may occur during pregnancy may be physiological or may have arisen due to the underlying cardiovascular disease becoming symptomatic. For this reason, the diagnosis of heart diseases during pregnancy may be delayed and missed. The risk for the mother increases significantly in pregnant women with heart disease, especially in the delivery and early postpartum period. In this study, we wanted to present a case of postpartum congestive heart failure, which could not be diagnosed in the early period despite coughing in a patient who had no known disease and had given birth seven times before.

Case Report

According to the last menstrual period, 36 weeks and 2 days pregnant; a 35-year-old patient with gravida 8, parity 7, and 7 living children (6 normal spontaneous delivery and 1 cesarean section) was admitted to our obstetrics emergency department because she felt contractions. It was learned that she did not have a known disease and that she had a pregnancy without follow-up. She had not had any examinations such as double scan, triple scan, and detailed ultrasound before. In ultrasonography, measurements in intrauterine single fetus were consistent with biparietal diameter 36+2, abdominal circumference 36+6, femur length 36+1 weeks. The measurements were in agreement with the dating. She was taken to the delivery room due to 3 centimeter dilatation and 50% effacement in the vaginal examination.

Physical examination findings were heart rate 72 beats/min and blood pressure 110/70 mmHg. Hemogram, biochemistry, complete urinalysis and coagulation were studied. +2 protein +2 leukocytes were observed in the complete urinalysis, other tests were normal. It was decided to deliver by cesarean section in labor with the indication of old cesarean section. A 2800 gram female fetus with an Apgar score of 8 was delivered. Tubal ligation was performed to the patient who requested tubal ligation. Posteroanterior (PA) chest X-ray and radiological ultrasound of the entire abdomen were performed on the patient who was hostipialized for 2 days after the operation, complaining of increasing dyspnea. There was hepatomegaly on sonography, and the inferior vena cava and hepatic veins were dilated (congestive hepatomegaly). Massive pleural effusion was observed bilaterally. When the patient's anamnesis was deepened, it was learned that he applied to an external center twice due to cough in the 16th and 24th weeks. In echocardiography performed by cardiology, the patient was admitted to the coronary intensive care unit, with 60% ejection fraction, pulmonary hypertension, severe mitral stenosis, mitral regurgitation grade 1-2, grade 2 tricuspid regurgitation, and dilated left atrium. In the coronary intensive care unit; It was learned that percutaneous balloon valvuloplasty was planned due to severe mitral stenosis on the postoperative 5th day of the patient whose clinical symptoms decreased with diuretic. The patient who underwent balloon valvuloplasty did not have any complaints in the 10-day follow-up.

Discussion

Pregnancy places an increased load on the cardiovascular system. In most pregnant women with heart disease, this condition is well tolerated. However, heart diseases during pregnancy are an important factor affecting

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY maternal and fetal mortality and morbidity. Its frequency in pregnancy varies between 1-4% [1]. The incidence increases with age.

Heart diseases are confused with fatigue, shortness of breath, orthopnea, palpitations, edema, systolic murmur and third heart sound, which are the normal signs of pregnancy. Therefore, making the diagnosis is stronger and the diagnosis takes time. Diagnosis is made by a complete history and physical examination. Sometimes the first symptom may be recurrent cough, similar to our patient. In a normal pregnancy, the heart is examined by noninvasive methods such as electrocardiography, chest radiography and echocardiography. Severe systolic murmurs, carotid ejaculate murmurs, all diastolic murmurs, and those with accompanying abnormal findings should be carefully evaluated [3].

Counseling should be given to women with heart disease on contraception, fetomaternal risks during pregnancy, and long-term morbidity and mortality. The functional classification of the New York Heart Association is generally used to determine the prognosis [4]. Patients with New York Heart Association stages III-IV during pregnancy are at high risk regardless of the underlying heart disease because these patients do not have cardiovascular reserve and pregnancy is not recommended for these patients [5].

If the patient is pregnant, he should be evaluated for the heart at the first visit. All risks for himself and the fetus should be explained. If maternal health is at serious risk, termination may be recommended [6]. If a decision is made to continue the pregnancy, clinicians must pay close attention to the signs and symptoms of worsening congestive heart failure. Vital signs, neck veins, carotid arteries, heart sounds, respiratory sounds, abdominal examination, and extremities should be examined at each visit [7]. Vaginal delivery is preferred in most cases with a diagnosis of cardiovascular disease, and labor induction can generally be performed safely. Cesarean delivery is mostly limited to obstetric indications [8]. Dehydration/fluid overload should be avoided during labor. Heart rate and blood pressure monitoring should be done continuously [9]. The patient should be prevented from straining by using vacuum at the exit.

Conclusion

Cardiac failure often occurs in the postpartum period. Cardiology opinion can be obtained in patients with recurrent cough complaints during pregnancy. The follow-up of pregnant women with a diagnosis of cardiovascular disease should be carried out in a multidisciplinary manner (obstetricians and cardiologist), starting before pregnancy and including the postpartum period, considering both maternal and fetal health.

REFERENCES

[1] K.P. Ramlakhan, M.R. Johnson, J.W. Roos-Hesselink, Pregnancy and cardiovascular disease, Nat Rev Cardiol. 17 (2020) 718–731. https://doi.org/10.1038/s41569-020-0390-z.

[2] H.H. Klein, S. Pich, [Cardiovascular changes during pregnancy], Herz. 28 (2003) 173–174. https://doi.org/10.1007/s00059-003-2455-2.

[3] S. Nanda, C. Nelson-Piercy, L. Mackillop, Cardiac disease in pregnancy, Clin Med (Lond). 12 (2012) 553–560. https://doi.org/10.7861/clinmedicine.12-6-553.

[4] H. Liu, J. Xu, X. Zhao, T. Ye, J. Lin, Q. Lin, Pregnancy outcomes in women with heart disease, Chin Med J (Engl). 123 (2010) 2324– 2330.

[5] R. Madazli, V. Sal, T. Cift, O. Guralp, A. Goymen, Pregnancy outcomes in women with heart disease, Arch Gynecol Obstet. 281 (2010)

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY 29–34. https://doi.org/10.1007/s00404-009-1050-z.

[6] A.M. Darlington, J.D. Fleisher, J.E. Briller, Peripartum Cardiomyopathy: Management Strategies for Pregnancy Termination. Womens Health Rep (New Rochelle). (2020)463-467. 1 https://doi.org/10.1089/whr.2020.0078.

[7] D.L. Adamson, M.K. Dhanjal, C. Nelson-Piercy, The normal cardiac examination in pregnancy, Oxford University Press, n.d. https://oxfordmedicine.com/view/10.1093/m ed/9780199574308.001.0001/med-

9780199574308-chapter-002 (accessed August 30, 2021).

[8] S.R. Easter, C.E. Rouse, V. Duarte, J.S. Hynes, M.N. Singh, M.J. Landzberg, A.M. Valente, K.E. Economy, Planned vaginal delivery and cardiovascular morbidity in pregnant women with heart disease, Am J Obstet Gynecol. 222 (2020) 77.e1-77.e11. https://doi.org/10.1016/j.ajog.2019.07.019.

[9] T.P.E. Ruys, J. Cornette, J.W. Roos-Hesselink, Pregnancy and delivery in cardiac disease, Journal of Cardiology. 61 (2013) 107– 112.

https://doi.org/10.1016/j.jjcc.2012.11.001.

OP25 - Concurrent Hellp Syndrome in Pregnant Woman with Covid 19: Could there be a synergistic effect?

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Abstract

Corona Virus Disease (COVID) has been in our lives for over a year. Although we know about the effect of infection on the general population in this process, its effect on sensitive populations such as pregnant women is still being discussed. There are overlapping clinical and laboratory parameters between COVID and Hellp Syndrome (haemolysis, elevated liver enzymes and low platelet), which is one of the most important complications in pregnant women. In this case, severe Hellp syndrome, which developed in a 35-week pregnant woman with COVID symptoms and progressed with extremely high D-dimer values, is presented. COVID and Hellp which have syndrome, similar pathophysiological features such as intravascular hemolysis, endothelial damage, platelet activation, may have a possible synergistic effect. Clinicians should be alert in terms of the possibility of COVID aggravating pregnancy complications.

Key words: COVID, Hellp Syndrome, Pregnancy

Introduction

The number of people infected with the Severe Acute Respiratory Syndrome-CoronaVirus-2 (SARS-CoV-2) is increasing day by day. It is obvious that the number of infected pregnant women will increase during this period. Although most pregnancies infected with COVID-19 had good outcomes, 3% of pregnancies were shown to be associated with severe maternal morbidity (1). When the findings of known and serious syndromes during pregnancy and the findings of COVID-19 International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - iZMIR / TURKEY infection significantly overlap, treatment management may become a clinical enigma. Experts are of the opinion that it is important to present cases with COVID-19 coexistence, especially with syndromes with low prevalence.

Hemolysis, elevated liver enzymes, low platelet count is referred to as the Hellp Syndrome. Mississippi classification measures the severity of the syndrome using the lowest observed platelet count along with the other two main clinical criteria (Lactate Dehydrogenase; LDH and aspartate aminotransferase;AST). Hellp Syndrome is a life-threatening condition (2). The mortality rate of women with Hellp Syndrome is 0%-24% (2). Laboratory abnormalities commonly seen in COVID-19 patients include thrombocytopenia and elevated liver enzymes (3). This case report describes the management of a pregnant who had a positive COVID-19 test and developed Hellp syndrome.

Case presentation

This case describes a 28-year-old woman at 35 weeks gestation, who had two miscarriages before and had a twin pregnancy with the help of in vitro fertilization (Gravida 3, Parity 0, Abortus 2). The patient presented to the Emergency Department of İzmir Tepecik Education and Research Hospital on 31 October 2020 with symptoms of nasal discharge and mild shortness of breath. Respiratory rate 24 / min, O₂ saturation 98%, temperature was 36.8°C. In the obstetric examination, ultrasound measurements were consistent with the last menstrual period, and there was a dicarionic diamniotic twin pregnancy at 34 weeks. The vital signs and laboratory values of the patient were completely normal. Consultation was requested from the Infectious Diseases Department due to the suspicion of COVID. A nasopharyngeal swab of the pregnant woman was taken for the diagnostic test, real-time polymerase chain reaction (RT-PCR). The PCR

result of the case was positive. Since her vital signs were stable and symptoms were mild, she was observed at home. In addition, enoxaparin sodium 6000 anti-Xa IU/day was started for thromboprophylaxis.

One week later, at 10 pm on November 7, the presented to our patient Emergency Department again. On admission, the patient described right upper quadrant pain, headache, photopsia, nausea, and vomiting for two days. Although she reported severe abdominal pain, there were no signs of defense or rebound on abdominal examination. Mild shortness of breath was still continuing. In addition, the patient noticed that fetal movements decreased. She had a temperature of 37.2 °C, blood pressure 170/110 mm Hg, pulse 92 beats/minute and respiratory rate 23/min. In ultrasound imaging, the first fetus was breech and the second vertex presentation. Measurements in both fetuses were compatible with 35th gestational week. Umbilical artery dopplers and the amount of amniotic fluid were within normal limits. Fetal heartbeat of both fetuses was normal in cardiotocography, but uterine contractions that the patient did not feel were detected. Primarily, 10 mg of nifedipine was given to the patient to reduce arterial blood pressure. The control arterial blood pressure of the patient measured after 15 minutes was 150/90 mmHg. Afterwards, the patient was admitted to the Covid pandemic service to ensure the isolation of the patient. Patients who have a positive Covid-19 PCR result or are suspected of having Covid are followed up and treated in an isolated department in the Obstetrics and Gynecology Clinic. There is a delivery room and operating room arranged for these patients.

The most remarkable parameters in the patient's laboratory results were anemia (hemoglobin : 8,7 g/L) elevated liver function tests (AST:307 unit/L, AST: 105 unit/L, LDH: 1710 unit/L), thrombocytopenia (Platelet count :115.000mm³) and excessively elevated d-dimer (10370 mg / L). Urinalysis was also International Congress of Hysterectomy in All Aspects 17-19 September 2021 Cesme - iZMiR / TURKEY

noted to have +3 protein. Other laboratory values were within the normal reference range. After the laboratory values were determined, the patient was decided to have a cesarean section with the diagnosis of Hellp syndrome. Magnesium sulfate was administered for prevention of eclamptic seizures.

The cesarean protocol recommended for SARS-CoV-2 positives was applied to the patient. As part of this protocol, all personnel in the operating room wore their personal protective

equipment, senior assistants were included in the operation, and spinal anesthesia was applied to the patient to prevent aerosolization. Cesarean section was performed without any complications. The 1st minute Abgar scores were 8 in both babies with a birth weight of 2400 and 2300 g. The total estimated blood loss was 500 mL.

During the operation, the patient's vital signs and respiratory functions were completely normal. It was decided that the patient was followed up in the intensive care unit in the postpartum period due to COVID and Hellp Syndrome. When the patient had tachycardia 3 hours after surgery, a warning was given by the nurse. The monitored patient's pulse rate was 124 / min, blood pressure was 120/70 mmHg, and oxygen saturation was 97%. The patient had no vaginal bleeding, no respiratory distress or pain. Upon suspicion of intraabdominal bleeding, abdominal USG was performed, but there was no free fluid. Blood samples were taken for laboratory assessments. Hemoglobin showed 4.3 g / L, platelet count 121,000 mm³, alanine aminotransferase (ALT) 176 IU, aspartate aminotransferase (AST) 575 IU, lactate dehydrogenase (LDH): 1568 unit/L and serum creatinine 1.4 mg / dl. Coagulation parameters were normal. The patient was given 4 units of erythrocyte suspension, 2 units of fresh frozen plasma and 2 g of fibrinogen. After transfusion, the hemoglonin level of the patient increased to 9.3g/L. The heart rate decreased. During this period, blood pressure and blood gas values remained normal. During the follow-up of the patient liver enzymes, renal function and d-dimer level decreased (Figure 1). The patient was discharged on POD 5. She was followed up in the outpatient postnatal clinic a week later with complete resolution of both liver function and renal tests.

Discussion

Over the past year, it has been understood that COVID is a disease that can be overcome asymptomatically or can lead to fatal conditions. Since the age group most affected by the virus includes reproductive women, the course of this disease in pregnancy and what can be done for the management of the disease has become important for the mother and baby.

The symptoms and laboratory findings of infected pregnant women are similar to those who are not pregnant. Endothelial damage, thrombocyte activation, thrombocytopenia, elevated liver function tests, and increased creatinine values can be seen in COVID-19 patients (3). As is known, in Hellp Syndrome, which is a severe form of preeclampsia, elevated liver enzymes, thrombocytopenia and intravascular hemolysis are observed (2). As in the patient we presented, the coexistence of two diseases with similar pathophysiology can create a synergy that may worsen the maternal situation. Although we do not have strong evidence, Coronado et al suggested in their case series that SARS-CoV-2 infection induced a proinflammatory state, making the course of preeclampsia more severe even in the absence of severe respiratory symptoms in pregnant women (4). More scientific evidence is needed to confirm this possible relationship. However, clinicians should be careful about possible synergistic effects in this process.

In addition, obstetricians knowing the similarities between COVID-19 and Hellp Syndrome clearly will enable them to focus on

the criteria that will distinguish between the two. Otherwise, iatrogenic preterm births may occur due to overlapping symptoms of both diseases. In their case series, Mendoza et al. reported that some of the severe COVID patients met the criteria for preeclampsia and that these patients improved with the improvement of their respiratory functions (5). Whereas, recovery in Hellp Syndrome is expected to occur after birth. In COVID patients, recovery will probably be unrelated to birth.

In fact, an important question awaiting an answer, can we predict whether the patient's condition will worsen if preeclampsia develops in asymptomatic COVID patients? The most remarkable preoperative laboratory value in our case was d-dimer. While the reference range was 0-440 mg / L, the patient's d-dimer value was 10370 mg / L. D-dimer is produced as a result of fibrin breakdown and is a sign of both active coagulation process and fibrinolysis. D-dimer is known to increase in both preeclampsia and COVID. However, such high values are not expected in preeclampsia. Kinsey et al claimed that excessive d-dimer elevation in pregnant women infected with SARS-CoV-2 is likely to increase the risk of maternal complications (6). In conclusion, it should not be forgotten that COVID can exacerbate pregnancy complications.

References

1- Zaigham M, AnderssonO. Maternal and perinatal outcomes with COVID-19: A systematic review of 108 pregnancies. Acta Obstet Gynecol Scand. 2020 Jul;99(7):823-829.

2- Aloizos S, Seretis C, Liakos N.HELLP syndrome: understanding and management of a pregnancy-specific disease.J Obstet Gynaecol. 2013 May;33(4):331-7.

3- Stasi C, Fallani S, Voller F, Silvestri C.Eur .Treatment for COVID-19: An overview.

J Pharmacol. 2020 Dec 15;889:173644.

4-Julia Cristina Coronado-Arroyo, Marcio José Concepción-Zavaleta, Francisca Elena Zavaleta-Gutiérrez, Luis Alberto Concepción-Urteaga. Is COVID-19 a risk factor for severe preeclampsia? Hospital experience in a developing country. Eur J Obstet Gynecol Reprod Biol.2021 Jan;256:502-503.

5- Mendoza M, Garcia-Ruiz I, Maiz N, Rodo C, Garcia-Manau P, Serrano B, et al. Preeclampsia-like syndrome induced by severe COVID-19: a prospective observational study. BJOG An Int J Obstet Gynaecol 2020, doi:http://dx.doi.org/10.1111/ 1471-0528.16339 1471-0528.16339.

6- Kinsey E , Ganz E., Khalil S,Brustman L. Intraoperative coagulopathy during cesarean section as an unsuspected initial presentation of COVID-19: a case report.BMC Pregnancy Childbirth.2020 Aug 24;20(1):481.

OP26 - Cornual Pregnancy Management

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Introduction; An ectopic pregnancy is when a developing blastocyst is implanted in the uterus outside of the endometrium. Extrauterine pregnancy can be seen as tubal, cervical, ovarian, abdominal and uterine pregnancy. The clues in ultrasonography in the diagnosis of cornual pregnancies are eccentric location and myometrial wall thickness below 5 mm.

Case; A 35-year-old infertile patient became pregnant with IVF. The previous pregnancy of our G2p0eu1 patient was also an IVF pregnancy and had a right salpingectomy. The patient was left previously salpingectomy due to hydrosalpenx. Cornual pregnancy was detected in the patient who underwent IVF when she was 6+6 w according to the transfer date. The patient was started on methotrexate therapy. The patient's bhcg values are 1-4-7 the day is 40.160-42.019-45.503. In the ultrasound follow-ups, there was a negative pregnancy with a fetal heart rate of 1.7 mm crl in a 15 mm gestational sac on the 1st day. On the 7th day, a positive fetus with a crl 11 mm fetal heartbeat was observed in the ultrasound. Then, because the patient also had pain, laparoscopic cornual pregnancy resection was performed in our case. Since the bhcg value decreased by 50% on the 1st day in the postoperative period, our patient was taken to weekly bhcg and ultrasound follow-up.

Discussion; Depending on the localization of cornual pregnancy, the diagnosis can be made in later weeks compared to tubal ectopic pregnancies. However, it is the most risky type of ectopic pregnancy in terms of complications such as hemorrhage and related hysterectomy. Methotrexate treatment may be preferred in hemodynamically stable patients. In our case,

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY mtx treatment was started first because of previous surgeries, not having a healthy child and not wanting to have surgery. However, due to the increase in bhcg values and exacerbation of the patient's pain despite mtx treatment, cornual pregnancy resection was performed by without damaging laparoscopy the endometrium, and the myometrium was closed. The patient with bilateral salpingectomy was referred to the IVF clinic 3 months later.

Keywords; ectopic pregnancy , interstitial or cornual pregnancy





OP27 - Incarceration of the appendix vermiformis into the endometrial cavity from the uterine perforation area after dilation and curettage: A rare case report

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Abstract

Introduction: Dilatation and curettage (D&C), which is used for diagnosis or treatment and is the most frequently applied in gynecology practice, is considered a safe procedure in which cervical dilators, curettes and aspirators of different sizes are used. Although rare, uterine perforation is a life-threatening complication of D&C. We report the incarceration of the appendix vermiformis from the perforation area to the endometrial cavity as a result of a very rare uterine perforation with ultrasonographic, computed tomography and images from the operation.

Case Report: A 22-year-old patient was admitted to our gynecology ward with the diagnosis of 17+3 weeks missed abortion. In the first examination, the uterus was anteverted, anteflex, 16 weeks gestational size. Observation of the cervix was normal. It was decided to administer misoprostol to the patient and informed consent was obtained. The patient had a miscarriage approximately 8 hours after 3 vaginal and 2 oral misoprostol administrations. Under general anesthesia, dilatation and curettage were performed after retained product of conception was observed in the ultrasonography exam after abortion. The process was completed without any complication. The patient was re-evaluated when the endometrial thickness was measured as 22 mm in the transvaginal ultrasonography performed at the 2nd hour after the procedure. The patient was evaluated with contrast-enhanced CT, considering uterine International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY

perforation due to nausea and accompanying abdominal pain. The decision of laparotomy was taken because uterine perforation and tubular organ located in the endometrial cavity were observed with CT and the patient's abdominal pain increased. In laparotomy, appendix vermiformis was observed within 1-2 cm perforated area posterior to uterus (Fig. 3). The appendix was removed from the perforation area and appendectomy was performed. Myometrial defect was repaired with 0 PGA. The patient was discharged uneventfully on the 2nd postoperative day.

Discussion and conclusion: Uterine perforation is reported at a rate of 0.6-15% after dilation and curettage, and most of these cases heal without diagnosis. In uterine perforation, reintervention is rarely required for reasons such as bleeding, infection and pain, and most of these cases are treated conservatively. Although incarceration of the omentum and appendix into the cavity after uterine perforation has been reported in the literature before, we present the first case to the literature, which was diagnosed by ultrasonography and CT and viewed at the time of operation. Evaluation of intestinal injuries with CT and ultrasonographic evaluation of the uterine cavity in patients who present with abdominal pain, nausea and vomiting after D&C, considering uterine perforation, will provide the clinician with valuable information for management.

Figure 1. Transvaginal ultrasonography after D&C



Figure 2. Computed Tomography image



Figure 3, 4: Images of uterus and appendix in surgery





OP28 - Should myomectomy performed without removing the uterus in the hysterectomy procedure?

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Introduction; Uterine leiomyomas are benign smooth muscle tumors that typically originate from the myometrium and are the most common pelvic tumors in women. lts incidence is generally reported as 20-25% among women. However studies used in histological or sonographic evaluation have reported rates as high as 70-80%. The rate of diagnosis of these tumors increases with advancing age in the reproductive years. Although the rate seems to decrease in postmenopausal women, studies show that the risk of leiomyoma decreases by 70-90% in postmenopausal women. 27% of the patients admitted to the gynecology clinic are followed up for leiomyoma. Women with leiomyoma are usually asymptomatic. However, affected women may experience bleeding, pain, infertility. pressure, and The treatment management of leiomyomas includes follow-up, medical treatment, radiological interventional techniques and surgical treatment. The definitive and most common surgical management of leiomyomas is hysterectomy.

In the case we presented, a different method was followed in order to reduce the amount of bleeding, not to damage the vaginal cuff and to provide visualization with laparoscopic hysterectomy to the uterus with myoma. With this method, after the uterine artery was coagulated, the small fibroid was enucleated, while the large fibroid was reduced by wadge resection and the exit of the uterus from the vaginal cuff was provided.

Case Report; 49 years old patient, G4P4 operation: tubal ligation with laparotomy was presented to our clinic with complaints of

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY vaginal bleeding and pelvic pain that had been going on for one year. In the examination performed: patient cooperative orianta: 120/80 mmHg, HR: 90_/min fever: 36.5 celcius degree Pvv-coll: bleeding, Transvaginal ultrasonography: 6x5 cm in uterus fundus and 3x3 cm in corpus left lateral, type 3 myoma was observed according to FIGO classification. Apart from this, the adnexa were observed naturally.

The result of probe curettage performed on the patient in an external center: endometrium in proliferation, cervical smear: inflammation. While Hb: 12 g/dl, hct: 36%, plt: 229 $000/\mu$ _in the triggers, biochemical parameters were normal.

As the patient's complaints continued despite medical treatment and she did not want other medical treatment, the patient and his relatives were informed and hysterectomy was recommended, and their written consent was obtained.

Material and methods; The patient was duly prepared for laparoscopic hysterectomy. In the exploration performed after trocar insertions and after creating the pneumoperitoneum, 6x5 cm myoma in the fundus and 3x3 cm in the left lateral corpus were observed. Uterine manipulator was placed. Bilateral ureters were dissected and the bladder was rejected anteriorly after the manipulator was rotated uterine 180 degrees. After the bilateral uterine arteries were coagulated in the neutral position of the uterus, wadge resection was performed from the myoma in the fundus with a monopolar hook in order not to damage the vaginal cuff and the amount of bleeding due to the large size of the uterus due to fibroids. Left lateral myoma myomectomy was performed. The vaginal cuff was cut and the spaceman was removed. Myoma remaining in the abdomen was removed from the vagina with an endobeg. The procedure was successfully terminated in the case with no intraoperative

complications. The patient was discharged on the second postoperative day with recommendations. No complications were found in the control examination.

Conclusion; In the success of minimally invasive surgery, modern equipment, meticulous dissection, surgical anatomy and technical knowledge, appropriate patient selection and the ability to manage complications play a key role in terms of patient safety and satisfaction. In this successful operation, a different method was followed in order to reduce the amount of bleeding, not to damage the vaginal cuff and to provide visualization with laparoscopic hysterectomy to the uterus with myoma. With this method, after the uterine artery was coagulated, the small fibroid was enucleated, while the large fibroid was reduced by wadge resection and the exit of the uterus from the vaginal cuff was provided.

Key words: Laparoscopy, hysterectomy, myomectomy, uterus with myoma, vaginal cuff, wadge resection



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OP29 - Oophorectomy and/or Hysterectomy in Patients with Breast Cancer

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Objective; While making a video presentation of our case of oophorectomy and hysterectomy that we performed in a case with a diagnosis of breast ca that we operated in our clinic, we also aimed to discuss the results of oophorectomy and hysterectomy operation in 15 cases with a diagnosis of breast cancer, which we operated within 2 years, together with a video presentation, accompanied by literature information.

Introduction; Breast cancer is the most common type of cancer in women. Less than one third of the cases are premenopausal patients. Bunların yaklaşık %5-10 'u genetik mutasyonlarla ilişkilidir. In high-risk patients (patients with pathologically involved lymph nodes, large tumor size, genetic mutation/high-risk group, diagnosed under 35 years of age, with high risk of recurrence, and hormone receptor positive metastases), hormone suppression therapy significantly reduces recurrence.

Results; We evaluated the results of hysterectomy and oophorectomy in 15 patients with breast cancer that we operated Eight (53%) of the cases on. were 7 premenopausal and (47%) were postmenopausal patients. 1 case was operated due to BRCA-1 mutation. Pathology results were reported consistent with EIN (Endometrial Intraepithelial Neoplasia) in 1 case, endometrial polyp in 2 cases, breast + ovarian ca coexistence in 1 case, and breast ca ovarian metastasis in 2 cases. Thirteen (87%) of the patients were operated with the Laparoscopic method and 2 with Laparotomy. No early complications occurred after the operation.

Discussion; Estrogen is suppressed by using Aromatase inhibitors and Gonadotropin inhibitors in adjuvant hormonal therapy recommended for high risk and hormone receptor positive patients with breast cancer. Effective and permanent treatment is provided with surgical oophorectomy. Along with oophorectomy, hysterectomy is also performed in the same surgical session in suitable patients. The operation can be performed laparoscopically (closed method) or laparotomy (open method). The laparoscopic method allows patients to return to their daily lives in a shorter time and to start/continue chemotherapy treatment without losing time in patients who progress under treatment or whose treatment continues. In oophorectomy, the entire abdomen is explored, a cytological fluid sample is taken, and rapid evaluation can be made in terms of suspicion of malignancy by frozen examination. In patients with genetic mutations that increase the risk of ovarian cancer, such as BRCA mutation, oophorectomy is also performed to prevent increased ovarian cancer risk.

Conclusion; Breast cancer, which ranks first among female cancers all over the world, is the main basis of treatment and follow-up, especially in the follow-ups after surgical medical treatment. and/or Therefore, hormone suppression therapy and surgical oophorectomy are effectively applied in patients with hormone receptor positive and high-risk patients with breast cancer. However, hysterectomy is also recommended for patients with secondary uterine pathology and postmenopausal patients, after obtaining their consent. In the pathology of these patients after the operation, ovarian and uterine pathologies are also detected, except for the breast, incidentally. This result both constitutes an important step in the treatment for the breast and provides the treatment of other pathology of the uterus and ovaries.

Keywords: Breast Cancer, Oopherectomy, Hysterectomy.

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POSTER PRESENTATIONS

P01 - Can OPN Levels in Blood Be Used as Tumor Marker or Prognostic Marker in Endometrial Cancer?

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OBJECTIVE: Endometrial cancers are the 4th most common cancer among women. Although it is found in the highest amount in bone, osteopontin is also produced in kidney, brain, smooth muscle tissue, macrophages and many epithelial and cancer cells. Overproduction of osteopontin (OPN) is associated with the oncogenic potential of the tumor.

In our study, it is aimed to evaluate the use of OPN molecule as a tumor marker in detecting endometrial cancer or as a molecule that can be used to follow prognosis.

METHODS: All endometrial cancer cases who applied to the Gynecology and Obstetrics Clinic of İzmir Çiğli Training and Research Hospital between 2022 and 2025 and have not received any treatment before will be included in the study. RESULTS: In cases with endometrial cancer, blood OPN levels will be determined as pre-op and post-op according to the stage.

CONCLUSION: The study is in the suggestion stage.

DISCUSSION QUESTIONS:

 Is it appropriate to check the OPN level? Do you have any other suggestions?
 Do you have any suggestions for the evaluation of the findings?

KEYWORDS: Endometrial cancer ,Osteopontin, Tumor Marker

P02 - Uterus-sparing myomectomy for idiopathic uterine pyomyoma in a young woman: A case report

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Introduction: Pyomyoma, or suppurative leiomyoma, is a rare but serious complication of uterine fibroids [1]. Cases usually occur in the premenopausal period. As it can be seen during the course of pregnancy, it may occur after abortion or birth [2]. It can also develop after uterine instrumentation or due to cervical stenosis [3]. Pyomyoma cases have also been reported after uterine artery embolization, which has recently gained popularity as an alternative to surgical treatment of myomas [4].

The mechanism of pyomyoma is infection caused by microorganisms coming from ascending or hematogenously on the ground of necrosis following ischemia and infarction [5]. Since pyomyoma is rare and can take a long time to develop, its diagnosis is difficult. Patients often present with pain and fever. It should be considered in cases had no other etiology of fever and had a history of uterine fibroids [1,4]. The patients may have signs of peritonitis caused by ruptured pyomyoma [6]. There are no specific findings in MRI and CT or other imaging techniques [2,3]. Diagnosis and treatment are often delayed due to nonspecific presentation and imaging findings. This delay increases the risk of mortality and morbidity such as fertility loss [7].

The case we presented is a premenopausal and sexually inactive woman without any history of pregnancy or uterine instrumentation or immunocompromised. She desired to preserve her fertility. This patient is the 5th case of idiopathic uterine pyomyoma and the 3rd case that was successfully treated with myomectomy. Knowing the proper treatment

International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY of pyomyoma will be beneficial to prevent potential mortality and morbidity.

Case presentation: The patient, 36 years old, applied with a complaint of increasing pelvic pain for a week. There was only one birth in her obstetric story, which was performed 8 years ago by cesarean (G1P1). She stated that she had a fever for 2 days, although it was not measured. She said that her menstrual cycles are regular but the amount of menstrual bleeding has increased in the last 1 year and she has not applied for gynecological examination. She had no known additional diseases. In her evaluation, it was determined that there was tenderness in the lower pelvic region, and the uterus was mobile, painful and large about the age of 12 weeks gestation. The cervix had a nullipar appearance and no abnormal discharge was observed. Bilateral ovaries and fallopian tubes were observed normally and a 12 cms solid uterine mass originated from corpus anterior was detected with magnetic resonance imaging (MRI). The mass was pressing the endometrium and containing cystic areas compatible degeneration. (Figure 1) With these findings, the mass was thought as degenerative leiomyoma. In the complete blood count, hemoglobin (Hb): 10.1 grams/dL and white blood cell count (WBC): 14.000 cells/mcL were detected. C-reactive protein (CRP) value was 15 mg/L and CA-125 value was 76 U/mL. Apart from this, routine preoperative examinations were usual. An abdominal myomectomy was planned for the patient due to uterine leiomyoma.

Before the operation, 1 gr of intravenous cefazolin was administered, and it was entered into the abdomen under regional anesthesia in a supine position with a pfannenstiel incision. 10 cms vertical incision made from the anterior of the uterus. The fibroid could not be easily dissected from the surrounding myometrium. The 12 cms fibroid was ruptured while trying to extrude. Smelly yellow grey coloured pus was emptied from inside. The fibroid center is grey

and fragmented. A culture antibiogram was taken from cavitation containing pus and at the border of the myometrium, which seemed clean. Without entering the endometrial cavity, fibroid was enucleated. Myometrium and uterine serosa were closed three layers with absorbable sutures. The abdomen was washed with 2000 mL saline. A 0.8 mm diameter silicone drain was placed in the Douglas and the abdominal layers were closed in accordance with the anatomy.

In the postoperative 1st day, intravenous 1 gr ceftriaxone 2 times a day and 500 mg metronidazole 3 times a day were started as empirical antibiotherapy. For thromboembolism prophylaxis, 4000 IU of enoxaparin sodium was started. The patient had an uneventful postoperative first day and had 100 mL of serohemorrhagic drainage and vital signs were normal. In laboratory examination, WBC: 20 cells/mcL Hb: 7.6 grams/dL CRP: 16 mg/L procalcitonin: 1.7 ng/mL were detected. The patient was mobilized and oral food intake was started. In the evening of the 2nd postoperative day, the patient's body temperature reached 39 degrees Celcius. Urine and blood cultures were taken. Fever control was achieved with When intravenous paracetamol. whole abdominal computerised tomography (CT) scan was performed, In the location of the fibroid, 6 cms hypodense area included irregular air formation was detected consistent with abscess. (Figure 2) In the postoperative 3rd day, since aerobic and anaerobic blood cultures were positive, meropenem parenteral was started 1g 3 times a day. Other antibiotherapies were stopped. In laboratory examination, WBC: 23 cells/mcL Hb: 7.3 grams/dL CRP: 19 mg/L procalcitonin: 1.9 ng/mL were detected. Two units of erythrocyte suspension were transfused. In the following days, despite fever reached 39 degrees Celsius, since the patient's clinic was improved the treatment meropenem was continued. Between the postoperative 7th and 10th day,

fever was not detected. In the CT scan, the diameter of the abscess decreased to 3 cms. (Figure 3) After the clinical findings completely returned to normal, the abdominal drain was removed, parenteral meropenem treatment was stopped and oral metronidazole 500 mg 3 times a day and cefixime 400 mg 2 times a day was prescribed, and the patient was discharged.

One week after discharge, it was observed that the patient's complaints completely disappeared and in the ultrasonographic evaluation, the pelvic genital organs returned to their normal anatomy. During this time, the pathology result was confirmed. In the pathological examination, it was reported that polymorph nuclear cells surrounding the necrotic myometrium fibers were observed and the specimen was compatible with pyomyoma.

Discussion: Pyomyoma is a rare but serious complication of uterine fibroids and is mostly seen in the pregnancy-related and postmenopausal status or after uterine instrumentation [8]. Our case is a rare exception, as the patient had no risk factor in terms of development of pyomyoma. The patient did not have a history of fibroids since she had not applied for a gynecological examination for a long time. It is possible that she had rapid growth of the fibroid leading to ischemic changes and degeneration.

Cases usually occur in the premenopausal period. As it can be seen during the course of pregnancy, it may occur after abortion or birth. can also develop after uterine It instrumentation or due to cervical stenosis [9]. Only 3 cases that developed during the course of pregnancy were reported. The cause of postmenopausal cases may be related to both vascular and immune deficiency caused by diseases such as diabetes, atherosclerosis and hypertension. Infections are generally polymicrobial [13]. In addition, the infection can occur with hematogenous or lymphatic

spread [14]. In cases developing in the early period or postpartum after uterine instrumentation, ascending infection is thought to be responsible [7]. Especially in postpartum hemorrhage, intrauterine balloon application causes both infarction due to bleeding and development of infection [15]. After 1996, with the increase of uterine artery embolization as an alternative to surgical treatment of myomas, the number of associated pyomyoma cases increased [4]. Eight cases related to UAE have been reported and the frequency of reporting has increased especially after 2010 [4]. This is thought to be a result of ischemia.

Since 1986, 48 pyomyoma cases have been reported in MEDLINE Database. 23 of these cases were associated with pregnancy, while only 3 cases were seen during pregnancy. Among the cases not related to pregnancy, the most common reason was UAE. While 6 cases with postmenopausal were associated conditions, there is any etiological cause for 4 cases as in our case. Our case is the fifth case with no etiological cause. Apart from these, rare causes such as IUD, PID, bacterial sepsis, diabetes and torsion of the pedunculated fibroid have also been reported. The mean age and min-max range of all cases and their subgroups are summarized in Table 1.

Since pyomyoma is rare and can take a long time to develop, its diagnosis is difficult. Patients often present with pain and fever. It should be considered in cases had no other etiology of fever and had a history of uterine fibroids. Postmenopausal patients may have symptoms of malignancy such as abdominal distention and bloating, anorexia, and changes in defecation [17]. There may be a serious elevation in Ca 125 level [21], but usually, a moderate elevation occurs, as in our case. Imaging techniques are generally not diagnostic. The definitive diagnosis is usually made by surgery. Ultrasound shows a heterogeneous uterine mass containing areas of cystic degeneration [20,22]. Abulafia et al. International Congress of Hysterectomy in All Aspects

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argued that an anechoic halo of normal myometrium surrounding the mass can be diagnostic ultrasound [22]. CT shows findings similar to ultrasound, but its diagnostic value is higher than USG, as it shows more prominent intra-abdominal and intra-mass air formation [3,20]. MRI does not show any specific findings like USG and has no diagnostic value [2]. The differential diagnoses are also conditions that require surgical treatment and includes pyometra, tuba ovarian abscess, an infected ectopic pregnancy, malignancy, intestinal perforation, or degenerating fibroids [15,23]. The most serious complication of pyomyoma is rupture. Afterwards, sepsis and even death can be seen [4,14]. In the presence of clinical signs such as deterioration in the patient's vital values, imaging techniques may show irregularity in the mass wall, free fluid and air in the abdomen.

The appropriate treatment is mostly delayed because the symptoms of pyomyoma patients are non-specific and there is no definitive diagnostic imaging technique [21]. Treatment of pyomyoma is almost always surgical [9]. It is managed with hysterectomy or myomectomy according to the fertility request and the severity of the patient's condition. Occasionally, conservative treatment with drainage, accompanied by antibiotics, can be an alternative treatment. In the case series presented by Laubach et al, they reported that antibiotic therapy and drainage with interventional radiology was successful in 2 of 3 cases, but in 1 of 3 cases hysterectomy was required [24]. There are 3 more cases in the literature that have been successfully managed with drainage. There is only one case, presented by Stroumsa et al, treated with parenteral antibiotics without major surgery or drainage [25]. Greenspoon et al reported that the patient treated with antibiotics alone died [14]. Hysterectomy was performed in 24 (50%) of 48 cases in the literature, and myomectomy was performed in 17 (35.4%). The mean age of hysterectomy cases was 47, while the mean age of myomectomy cases was 34. Twelve (70%) of myomectomy cases were associated with pregnancy. It seemed that patient age and fertility request are determinants of hysterectomy or myomectomy decision. We also decided to treat with myomectomy since our patient was 36 years old and has fertility request. (Table 2)

The mean age and standard deviation of 4 cases with unknown etiological causes are 39.8 \pm 10.7 and the min-max interval (24-47). Zengeneh et al were treated with hysterectomy because the patient was 47 years old and there was no fertility request [19]. Liu H et al, on the other hand, made a diagnosis in the diagnostic laparotomy in a 42-year-old case who developed sepsis due to ruptured pyomyoma and marsupialized and drained the ruptured myom [20]. They preferred minimally invasive treatment to the patient whose vital signs were critical. Read et al, at the age of 24 and is the youngest case in the literature performed a successful myomectomy [9]. Chen et al. also treated the 46-year-old pyomoyoma case with a successful myomectomy [8]. Considering the literature, our case is 18th case treated with myomectomy, 5th case of unknown cause and 3rd case in which pyomyoma developed in the absence of predisposing factor was successfully treated with myomectomy. (Table 3)

Pyomyoma is a rare gynecological emergency that can occur in cases of vascular or immunodeficiency, where uterine instrumentation is performed mostly in pregnancy and postmenopausal women. It is often a polymicrobial infection that develops on the background of fibroid ischemia. It is a local infection initially, but when ruptured it can cause peritonitis and sepsis. It is an entity that has a mortality risk and may cause fertility loss when treatment is delayed. It can develop in the absence of predisposing factor, as in the case we present. In the presence of uterine fibroids, fever and pelvic pain, a rare gynecological urgent mind should also be International Congress of Hysterectomy in All Aspects 17-19 September 2021 Çeşme - İZMİR / TURKEY

considered when there is no reason to explain these symptoms. Empirical broad-spectrum antibiotics should be started as soon as possible and surgical intervention should be performed.

Keywords: Pyomyoma; Leiomyoma; Uterine Myomectomy; Fertility Sparing

References

[1] Bagga R, Rai R, Kalra J, Saha PK, Singh T. An unusual cause of postabortal fever requiring prompt surgical intervention: A pyomyoma and its imaging features. Oman Med J. 2017 Jan 1;32(1):73–6.

[2] Ono H, Kanematsu M, Kato H, Toyoki H, Hayasaki Y, Furui T, et al. MR imaging findings of uterine pyomyoma: Radiologic-pathologic correlation. Abdom Imaging. 2014;39(4):797– 801.

[3] Karcaaltincaba M, Sudakoff GS. CT of a Ruptured Pyomyoma. Am J Roentgenol. 2003;181(5):1375–7.

[4] Obele CC, Dunham S, Bennett G, Pagan J, Sung LY, Charles HW. A Case of Pyomyoma following Uterine Fibroid Embolization and a Review of the Literature. Case Rep Obstet Gynecol. 2016;2016.

[5] Yeat SK, Chong KM, Pan HS, Cheng WC, Hwang JL, Lee CC. Impending sepsis due to a ruptured pyomyoma with purulent peritonitis: A case report and literature review. Taiwan J Obstet Gynecol. 2005 Mar 1;44(1):75–9.

[6] Del Borgo C, Maneschi F, Belvisi V, Morelli F, Vetica A, Marocco R, et al. Postpartum fever in the presence of a fibroid: Sphingomonas paucimobilis sepsis associated with pyomyoma. BMC Infect Dis. 2013 Dec 5;13(1).

[7] Pinton A, Aubry G, Thoma V, Nisand I, Akladios CY. Pyomyoma after abortion: Uterus conserving surgery is possible to maintain fertility. Case report. Int J Surg Case Rep. 2016 Jan 1;24:179–81. [8] Chen ZHY, Tsai H Der, Sun MJ. Pyomyoma: A Rare and Life-threatening Complication of Uterine Leiomyoma. Taiwan J Obstet Gynecol. 2010;49(3):351-6.

[9] Read S, Mullins J. Spontaneous Ruptured Pyomyoma in a Nulligravid Female: A Case Report and Review of the Literature. Case Rep Obstet Gynecol. 2018;2018.

[10] Prahlow JA, Cappellari JO, Washburn SA. Uterine pyomyoma as a complication of pregnancy in an intravenous drug user. South Med J. 1996;89(9):892–5.

[11] Grüne B, Zikulnig E, Gembruch U. Sepsis in second trimester of pregnancy due to an infected myoma: A case report and a review of the literature. Fetal Diagn Ther. 2001;16(4):245–7.

[12] Kobayashi F, Kondoh E, Hamanishi J, Kawamura Y, Tatsumi K, Konishi I. Pyomayoma during pregnancy: A case report and review of the literature. J Obstet Gynaecol Res. 2013 Jan;39(1):383–9.

[13] Sah SP, Rayamajhi AK, Bhadani PP. Pyomyoma in a postmenopausal woman: a case report. Southeast Asian J Trop Med Public Health. 2005 Jul;36(4):979–81.

[14] Greenspoon JS, Ault M, James BA, Kaplan L. Pyomyoma Associated with Polymicrobial Bacteremia and Fatal Septic Shock: Case Report and Review of the Literature. Obstet Gynecol Surv. 1990 Sep 1;45(9):563–9.

[15] Kaler M, Gailer R, Iskaros J, David AL. Postpartum Pyomyoma, a Rare Complication of Sepsis Associated with Chorioamnionitis and Massive Postpartum Haemorrhage Treated with an Intrauterine Balloon. Case Rep Obs Gynecol. 2015;2015(2015):609205.

[16] Chen JR, Yang TL, Lan FH, Lin TW. Pyomyoma mimicking advanced ovarian cancer: A rare manifestation in a [17] Genta PR, Dias ML, Janiszewski TA, Carvalho JP, Arai MH, Meireles LP. Streptococcus agalactiae endocarditis and giant pyomyoma simulating ovarian cancer. South Med J. 2001 May;94(5):508–11.

[18] Gupta A, Gupta MM, Manaktala U. Ascending infection causing pyomyoma in a young woman. Egypt J Radiol Nucl Med. 2014 Sep 1;45(3):1017–20.

[19] Zangeneh M, Alsadat Mahdavi A, Amini E, Davar Siadat S, Karimian L. Pyomyoma in a premenopausal woman with fever of unknown origin. Obstet Gynecol. 2010 Aug;116(2 PART 2):526–8.

[20] Liu HS, Chen CH. Subserosal pyomyoma in a virgin female: Sonographic and computed tomographic imaging features. Ultrasound Obstet Gynecol. 2011;37(2):247–8.

[21] Iwahashi N, Mabuchi Y, Shiro M, Yagi S, Minami S, Ino K. Large uterine pyomyoma in a perimenopausal female: A case report and review of 50 reported cases in the literature. Mol Clin Oncol. 2016;5(5):527.

[22] Abulafia O, Shah T, Salame G, Miller MJ, Serur E, Zinn HL, et al. Sonographic features associated with post-uterine artery embolization pyomyoma. J Ultrasound Med. 2010 May 1;29(5):839–42.

[23] DeMaio A, Doyle M. Pyomyoma as a Rare Source of Postpartum Sepsis. Case Rep Obs Gynecol. 2015;2015(2015):263518.

[24] Laubach M, Breugelmans M, Leyder M, Demey J, Foulon W. Nonsurgical treatment of pyomyoma in the postpartum period. Surg Infect (Larchmt). 2011 Feb 1;12(1):65–8.

[25] Stroumsa D, Ben-David E, Hiller N, Hochner-Celnikier D. Severe Clostridial Pyomyoma following an Abortion Does Not Always Require Surgical Intervention. Case Rep Obs Gynecol. 2011;2011(2011):364641.

postmenopausal virgin. Taiwan J Obstet Gynecol. 2014;53(1):101–3.

OP30- Laparoscopic Step-ups of Hysterectomy in Endometrial Cancer

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Abstract

The standard treatment for endometrial cancer is the surgical removal of the uterus, bilateral tubes, ovaries, and lymph nodes. Minimally invasive surgical methods are frequently preferred in patients with gynecological cancer, as they provide a shorter hospital stay, faster recovery, and return to daily activities. The initial approach for medically fit patients with endometrial cancer is total laparoscopic hysterectomy bilateral salpingo-+ oophorectomy, and lymph node dissection. Some patients require surgical staging, including pelvic and paraaortic lymphadenectomy, which can be performed by trained specialists. Apart from simple laparoscopic hysterectomy, which is frequently used in gynecology practice, in patients who will undergo surgical staging, the anatomy of vessels, nerves, ligaments, and potential spaces that are closely adjacent to the uterus and ovaries should be well-identified. We aimed to present the steps of hysterectomy, anatomical important structures, and contiguity by video images in patients who underwent staging surgery for endometrial

cancer, including laparoscopic hysterectomy + bilateral salpingo-oophorectomy.

Keywords: Endometrial Cancer, Laparoscopic Hysterectomy, Step-ups, Treatment