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[PP-002]

Retrospective analysis of hysteroscopic isthmocele operation

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Objective: Isthmocele, descriptively, is a partial defect in cesarean scar site in myometrium. According to latest statistics, cesarean section rate has approached almost 50% in Turkey. After cesarean section operations nearly half of patients can develop an anterior uterine wall defect to a certain extent but most of the cases are asymptomatic. Patients with isthmocele may present with postmenstrual spotting, dysparaneu, infertility or recurrent infections. In this report we aimed to evaluate the clinical outcomes of patients who were treated by hysteroscopic correction of uterine wall defect.

Material and Methods: In this study we retrospectively analyzed hysteroscopy operations for isthmocele performed in our research hospital between 2011 December and 2016 May. Thirty patients are included in this analysis. Postoperative symptom relief and fertility outcomes were evaluated by patient visits and/or telephone interviews.

Results: Thirty patients are included in this retrospective analysis. Mean age was 35 years (24-47). Mean number of previous cesarean section operation was 1.79 (min: 1-max: 4). Spotting and postmenstrual abnormal vaginal bleeding was by far the most frequent complaint (19 patients 63.3%). Other complaints were infertility (13 patients 43.3%) and hypomenorrhea (1 patient 3%). Hysteroscopic treatment was either with resection (22/30 patients) or cauterization (6/30). Spotting type of bleeding resolved completely in 47.3% and partial relief in 21% and 31.7% of patients had no improvement in bleeding. Among these 30 patients 25 had pathological examination of resected isthmocele tissue and revealed endometrial polyp in 6 (20%) patients, adenomyozis in 2 (6.7%) patients and active chronic endometritis in 1 (3%) patient. Pregnancy rate was 38.4% (5/13) among 13 secondary infertile patients, two of which were after in vitro fertilization treatment.

Conclusion: In this retrospective descriptive study postmenstrual spotting type of vaginal bleeding was found to be the major symptom of isthmocele. Hysteroscopic istmocele treatment is effective in controlling postmenstrual spotting type of bleeding.

Keywords: Isthmocele, hysteroscopy, intermenstrual bleeding

[PP-003]

The endometrial receptivity array for diagnosis and personalized embryo transfer in patients with repeated implantation failure

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Objective: Embryo implantation failure in unexplained infertility may be due to defective endometrial receptivity in 10% of patients. New molecular diagnostic tools, such as endometrial receptivity array (ERA), have been developed to evaluate the receptivity of endometrium by demonstrating the existence of differential gene expression patterns in different phases, allowing classification of the endometrium based on its molecular signature (receptive, pre- and postreceptive phases). It has been discussed that the ERA guided personalized embryo transfer may help patients with repeated implantation failure (RIF) and displaced window of implantation (WOI).

Material and Methods: To evaluate the applicability and efficacy of (ERA) in patients with RIF. Retrospective cohort study. We included the data of seventy patients who had ERA. The main outcomes were pregnancy and live birth rates.

Results: We included all patients who had ERA test between 2014 and 2016, and completed the follow up until the end of gestations. ERA test 7 days after LH surge or 5 days after progesteron replacement (P+5) showed a non-receptive endometrium in twenty-seven percent of RIF patients. Thirty-seven had a frozen embryo transfer (ET) in subsequent cycles. Eight of them had a displaced WOI, and the timing of ET was personalized (pET) as recommended by ERA (e.g. on P+4, P+6). The overall pregnancy rate after ET was 49% (n=18), and there were 13 patients with births (35%). The twenty-nine patients who had embryo transfer on a standard day (day 3 or day 5) (stET) had PR of 31% and 54%, respectively. The live birth rate for day 3 or day 5 stET were 6% and 46%, respectively. The patients who had pET (n=8) (at cleavage; n=4 or in the stage of blastocyst, n=4) had PR of 50% and 100%, respectively, and the live birth rates were 50% and 100%, respectively. Those patients with a displaced WOI showed no significant differences in obstetrical outcomes compared to those with normal WOI.

Conclusion: The ERA in patients with RIF is feasible. Indeed a considerable part of patients with RIF show a displaced WOI. The pET does not seem to affect the PR negatively. On the contrary, the results are promising and pET guided by ERA test may help patients with displaced WOI. However, well designed randomised controlled trials are needed.

Keywords: Infertility, repeated implantation failure, endometrial receptivity array, window of implantation

[PP-004]

IVF pregnancy after fertility sparing surgery due to mucinous cystadenocarsinoma: A case report

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Ovarian cancer is mostly seen at postmenopausal ages and generally there is abdominal spread at the time of diagnosis. However, 14% of patients are under 40 years of age and 25% of patients are limited to the ovary. During the past 20 years fertility sparing surgery (FSS) and assisted reproductive techniques (ART) have been used in patients with cancer, and their chances of pregnancy increased in those patients. In this article, we presented a pregnancy case using intracytoplasmic sperm injection (ICSI) after FSS. During the follow-up of a 29 years old, infertile and nulliparous, patient, a left adnexal mass was detected. After the laparotomy and surgical staging (since they appear normal, the uterus and right ovary preserved), stage 1c3 mucinous cystadenocarcinoma was diagnosed. Adjuvant chemotherapy was given. One year later, the Committee of Gynecological Oncology approved the application of ART. Partner's semen analysis was normal. Anti-mullerian hormone and body mass index were 0.5 ng/mL and 32.6, respectively. Three antral follicles were observed in the ultrasonography. Ovarian stimulation was started under a multiple dose flexible GnRH antagonist protocol and 300 IU/day human menopausal gonadotropin. Ovulation was triggered with 250 mcg recombinant human chorionic gonadotrophin when the leading follicle was 17 mm. Follicular aspiration took place after 36 h and only one oocyte (M2) was retrieved. This oocyte was inseminated with the partner's semen using ICSI. On the following day (day 2), optimal-quality (Grade 1) embryo was transferred under ultrasound guidance. Serum beta-hCG assayed 15 days after embryo transfer was 440 IU/L. On the 30th day after the transfer, a fetal heartbeat was observed positive in a healthy gestational sac. FSS in ovarian cancer can be performed on selected invasive epithelial or borderline tumors and early germ cell or sex cord tumors. Contralateral ovary and the uterus may be preserved intraoperative if they appear normal. Decisions about fertility sparing techniques must be individualized, depending on patient's desire, age, histological tumor type, surgical stage, type of surgery and adjuvant treatment. Choice of ART depend on the risk of sterility, age, ovarian reserve, cancer prognosis, delay of adjuvant treatment and the risk of tumor cell persistence in frozen ovarian tissue. As fertility reserve techniques, oocyte cryopreservation and ovarian tissue cryopreservation-transplantation can be preferred if the patient is single, or embryo cryopreservation if has a partner. In addition oocyte in vitro maturation can be performed for patients in the pre-pubertal period. Conventional ART methods may be preferred if these procedures are not performed. Prasath et al. reported live births from cryopreserved embryos. Alvarez et al. obtained pregnancy using vitrified-warmed oocyte after FSS and they added this case, resulted in live birth, to the literature. We have achieved pregnancy with a single oocyte from the patient undergoing controlled ovarian stimulation and ICSI after FSS. The use of individualized ART techniques in ovarian cancer patients with the development of a FSS can provide safe pregnancy in these patients without worsening prognosis. Large series and studies will shed light on this issue in the future.

Keywords: Fertility preservation, ovarian cancer, reproductive techniques

[PP-005]

Is frozen embryo transfer over 35 more successful?

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Objective: To compare the pregnancy outcomes between fresh embryo transfer and frozen-thawed embryo transfer and evaluate the benefits of the embryo freeze strategy for advanced maternal age.

Material and Methods: Retrospective study, between January 2014 and April 2017, we reviewed a total of 513 ET cycles in woman over age of 35 years, including 397 fresh ET cycles and 116 frozen-thawed ET cycles. The demographic characteristics, stage and grade of embryos, biochemical pregnancy rates, clinical pregnancy rates, live birth rate were compared between the two groups.

Results: The mean age was 37.7±2.91 years in freeze cycles and 38±2.8 in fresh cycles, with no significantcy between two groups (p=0.327). The patients undergoing frozen-thawed ET cycles had significantly higher estradiol level and progesteron level on the day of trigger (estradiol levels: 1675 pmol/L vs 991 pmol/L, progesteron levels: 1.43 pmol/L vs 0.96 pmol/ L p<0.005). No significant differences were found in number of transfered embryos, mean endometrial thickness and infertility etiology. Biochemical pregnancy rates (43% vs 32%, p=0.048), clinical pregnancy rates (38% vs 29% p=0.030) and live birth rates (30% vs 19.6% p=0.013) were significantly higher in frozen-thawed embryo transfer group than fresh embryo transfer group.

Conclusion: The pregnancy outcomes were significantly higher in frozen-thawed embryo transfer group in woman over age of 35 years.

Keywords: Frozen, IVF, embryo, pregnancy, fresh

Table 1. Characteristics of the participants at baseline

Characteristic	Freeze cycles (n=116)	Fresh cycles (n=397)	p value
Patient age (y)	37.7±2.91	38±2.8	0.327
Embryos transferred	1.75±0.42	1.71±0.45	0.333
Endometrial thickness	10.07±2.06	10.46±2.35	0.157
E2 max	1675.2±1124.5	991.42±672.7	<0.005
P4	1.43±1.43	0.96±1.15	0.004

Table 2. Etiology

	Freeze cycles (n, %)	Fresh cycles	p value
Ovulatuar	52 (44.8%)	176 (44.3%)	0.489
Male	34 (29.3%)	126 (31.7%)	0.489
Tubal	9 (7.8%)	17 (4.3%)	0.489
Idiopatic	21 (18.1%)	79 (19.6%)	0.489

Table 3. Pregnancy outcome

	Freeze cycles (n, %)	Fresh cycles (n, %)	p value
Biochemical pregnancy	50 (43.1%)	124 (31.2%)	0.048
Clinical pregnancy	45 (38.8%)	115 (29%)	0.030
Live birth	35 (30.2%)	78 (19.6%)	0.013

[PP-009]

Live birth and endometrial thickness in unexplained infertility

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Objective: Endometrial thickness is one of the most important aspects in IVF procedures. However, there are limited number of research with the focus on live birth rates. In this study, we aimed to demonstrate any possible relationship between endometrial thickness on the day of hCG trigger and live birth rates among unexplained infertile cases of whom controlled ovarian hyperstimulation was applied.

Material and Methods: We restrospectively collected data from İstanbul Zeynep Kamil Women and Children's Diseases Training and Research Hospital, IVF Center archive. 10.000 cases between 2005 and 2013 were collected. Seven hundred-thirty four initially were eligible for this research. Patients between 23-29 years old with BMI <30 were included. Cases with missing data, whom embryo transfer could not be performed, cases with thaw embryo transfer, cases with coasting or with difficult embryo transfer cases were excluded. Endometrial thickness measurements were performed on the day of hCG trigger with transvaginal sonogram at midsagittal axis. Patients were divided into two groups. Group 1 consisted of patients ended up in live birth, Group 2 consisted of patients could not have live birth. SPSS 17 was used for statistical analysis. Student-t test for continuous variables, chi-square test for categorical variables were used. P<0.05 was defined to be statistically significant.

Results: Three hundred-fifty nine patients with one or multiple embryo (maximum 2) transfer were included. Live birth rate in our series was 28.9%. Group 1 was consisted of 104 cases, in Group 2 there were 255 cases. Live birth rates among Group 1 with endometrial thickness of 7 mm, 8 mm, 9 mm, 10 mm, 11 mm, 12 mm, 13 mm, 14 mm and above were 27.3%, 30%, 26.4%, 32.9%, 26.8%, 23.9%, 36.8%, 28.6%, respectively. Differences in live birth rates were not statistically significant in this group in terms of endometrial thickness. When we compare endometrial thickness of 12 mm (live birth rate was highest, 36.8%) to endometrial thickness of 13 mm (live birth rate was lowest 23.9%) there were no significant difference (p=0.450).

Conclusion: There was no statistically significant difference between livebirth rates and endometrial thickness on the day of hCG trigger. But there was a statistically significant association between live birth rates and estradiol (E2) level on the day of hCG trigger. Besides there were no cases with endometrial thickness less than 7 mm. We could have different results if we had cases with endometrial thickness of 4-5 mm.

Keywords: Unexplained infertility, in vitro fertilization, endometrial thickness

Table 1. Characteristics of cycles and findings of ART among unexplained infertility cases

	Group 1	Group 2	p
Ages	31.6±3.8	31.2±4.1	0.550[a]
FSH	6.5±1.4	6.5±1.5	0.772[a]
Basal E2	49.1±18.1	51.5±29.5	0.436[a]
Treatment protocols (Agonist/Antagonist)	78/26	169/86	0.135[b]
Induction time	8.8±1.4	8.8±1.3	0.988[a]
Total Gn doses	2538.6±867.1	2408.2±786.9	0.168[a]
Trigger E2	2517.2±1106.0	2210.8±991.7	0.011[a]
Endometrial thickness	10.3±1.9	10.3±1.8	0.943[a]
Oocyte numbers	10.6±5.1	10.1±4.8	0.337[a]
M2 oocyte numbers	8.5±4.6	8.1±4.1	0.470[a]
Blastocyst transfer	21/83	51/204	0.967[b]

Mean and standart deviation values were used.
[a]: Student-t test, [b]: Chi-square test

[PP-013]

Atypic presentation of sigmoid colon perforation: A case report

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An adnexal mass may be diagnosed after a routine pelvic ultrasonographic examination or an emergent hospital admission due to rupture of ectopic pregnancy, adnexal torsion or rupture of tuboovarian abscess. It is necessary to evaluate the origin of the mass initially and to classify patients who need further evaluation and treatment for an urgent condition.We report a case of sigmoid

colon rupture due to sigmoid colon adenocancinoma presenting as acute abdomen with left adnexal mass in a 28 years old woman. Abdominopelvic computed tomography revealed a left adnexal mass with suspicion of tuboovarian abcess (Figure 1). In laparatomy, rupture of sigmoid colon was observed and resection of sigmoid colon was performed (Figure 2). Histological examination of resection part revealed diagnosis of sigmoid colon adenocarcinoma due to familial adenomatous polyposis. This case may be interesting for clinicians because pelvic pain, fever, increased infection markers in the labarotory and mass at ultrasonography or other screening methods could cause a misdiagnosis of tubaovarian abscess especially in reproductive age women. Before the operation of the pelvic mass of all age women with the diagnosis of tuboovarian abscess other causes of the pelvic abscess should come into mine and necessary preparation for operation must be done.

Keywords: Tuboovarian abscess, sigmoid colon carcinoma, familial adenomatous polyposis

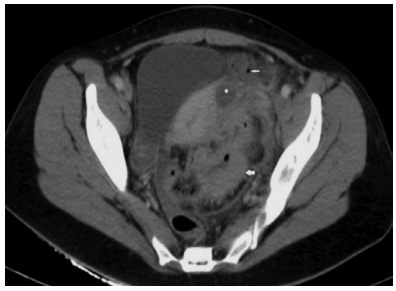


Figure 1. Complex adnexal mass on left adnexa

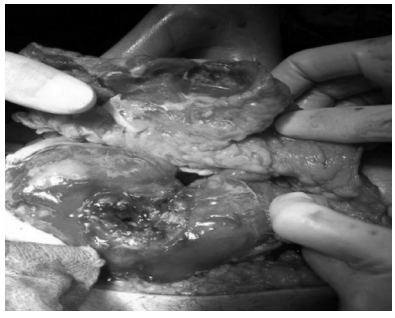


Figure 2. Huge perforation area on sigmoid colon with omental reaction

[PP-014]

Evaluation and comparison of preoperative and postoperative quality of life and sexual functions of patients with total abdominal hysterectomy and total laparoscopic hysterectomy

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Objective: The aim of this study is to evaluate and compare the quality of life and sexual functions of patients with abdominal and laparoscopic hysterectomy before and after surgery.

Material and Methods: Study group consisted of 121 pre and postmenopausal women who were sexually active. 65 of them underwent TAH and 56 of them underwent TLH for benign indications between March and October in 2017 in University of Health Sciences, Zekai Tahir Burak Women's Health Practice Training and Research Center, Gynecology Clinic. Quality of life and sexual functions were assessed before and 6 months after operation by using questionnaires: WHOQOL-BREF (World Health Organization Quality of Life Scale-Short Form) and GRISS-Woman (Golombock-Rust Inventory of Sexual Satisfaction).

Results: Independent from the route of surgical procedure, postoperative patients had better outcomes in quality of life scale but they had problems in frequency of intercourse. Postoperative WHOQOL-BREF scores were significantly higher in TLH group than TAH group (Table 1). When we compare the groups, difference between the postoperative and preoperative scores were significantly higher in TLH group in general health, physical health and psychological health parameters (Table 2). There was no difference between the groups in GRISS scores preoperatively and postoperatively ($p>0.05$). In TAH group, patients had problem in dissatisfaction, in TLH group they had problem in frequency of intercourse. TLH group had been suffering from infrequent intercourse 6 months after procedure. In TAH group, patients had developed new problems such as infrequency, noncomminucation, avoidance, nonsensuality beside dissatisfaction. Smoking, independent from the procedure and in TLH group, was associated with worse outcomes in sexuality.

Conclusion: Laparoscopic surgery instead of abdominal surgery should be performed on suitable patients considering its positive effects on quality of life. Women undergoing hysterectomy occasionally have problems in sexual functions. Assessment and counseling of these women for sexual functions before surgery may result with better outcomes following surgical treatment regardless of hystrectomy route.

Keywords: Hysterectomy, laparoscopy, quality of life, sexual functions

Table 1. Comparison of postoperative WHOQOL-BREF scores of TAH and TLH groups

	TAH	TLH		
	Mean±SD* Median (min-max)	Mean±SD* Median (min-max)	P value**	Z / t
General health	50.00 (13-100)	75.00 (25-100)	**<0.001**	Z=3.536
Physical health	46.43 (21-79)	71.43 (32-96)	**<0.001**	Z=6.564
Psychological health	58.33 (38-83)	66.67 (29-88)	**<0.001**	Z=4.121
Social relationships	54.17 (17-92)	58.33 (0-83)	**0.011**	Z=2.540
Environment	45.37±8.43	54.13±11.51	**<0.001**	t=4.448

*Mean values have been presented for "environment" parameter; median values have been presented for "general health, physical health, psychological health and social relationships" parameters due to normal distribution states **Independent samples T test has been used for comparison of "environment" parameter; other all parameters have been compared by using Mann Whitney U test

Table 2. Postoperative and preoperative WHOQOL-BREF score differences between TAH and TLH groups

	TAH	TLH		
	Mean±SD* Median (min-max)	Mean±SD* Median (min-max)	P value**	Z / t
General health	0.13 (-0.38–0.75)	0.38 (-0.13–1.00)	<**0.001**	Z=5.023
Physical health	-0.03±0.17	0.30±0.22	<**0.001**	t=8.469
Psychological health	0.00 (-0.29–0.42)	0.08 (-0.08–0.75)	**0.002**	Z=3.129
Social relationships	0.00 (-0.42–0.50)	0.00 (-0.25–0.67)	0.673	Z=0.422
Environment	-0.03 (-0.25–0.28)	0.00 (-0.03–0.13)	0.191	Z=1.307

*Mean values have been presented for "physical health" parameter; median values have been presented for "general health, psychological health, social relationships and environment" parameters due to normal distribution states **Paired samples T test has been used for physical health difference among TAH and TLH groups; Wilcoxon signed- rank test has been used for general health, psychological health, social relationships and environment parameters

[PP-015]

Surgical removal of an extrauterine device disapperad into omentum with abdominal anterior wall

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Intrauterine contraception is highly effective, very safe, and generally well tolerated by most women We aimed to report one of the complications of extrauterine and intrauterine devices. A 29 year-old woman was admitted to our hospital with mislocated intrauterine device. She had no symptoms. Extrauterine intrauterine device (IUD) device was checked by ultrasound and X-ray. She had normal blood test count with a negative pregnancy test. There are several cases of complications with intrauterine devices, but this is the first case report about an extrauterine Copper T embedded by inflame omentum and parietal periton with abdominal anterior wall. A 29 year-old Gravida 3, Parity 3, Abortion 0, Live 3, and she was on postpartum third month. She had 3 normal vaginal deliveries and was breastfeeding. The Last one was three months ago. She had soft abdomen and normal vital findings (afebrile, 110/80 mmHg, 100/min). She had a Copper T A380 IUD, inserted one week ago. In her perspeculum examination, there was no thread of IUD. Ensuing ultrasonography evaluation, a mislocated IUD was seen. The position of the uterus was anteverted with endometrial thickness of 6 millimeters and no fluid at pouch of douglas An X-ray of her abdomen was performed and finally Copper T was revealed in the right below side of her abdomen (Figure 1). In laboratory, she had normal blood test count. We inform patient about operation and complication and then she wrote informed consent, then we planned laparoscopic surgery. We seen thread of IUD omentum with adherent to anterior wall of abdomen (Figure 2). There was no scar tissue on uterin fundus or corpus. IUD was embedded in the omentum and omentum was adherent to abdominal anterior wall and abscess formation was observed. We used grasper and bipolar sealing device in laparoscopic surgery. We disected omentum to bottom of adhesive tissue. We pull thread of IUD restrained and carefully. Because of inflamed omentum and abscess formation (Figure 3), we invited general surgery to operation. Partial omentectomy was performed. There was no intraoperative complication. During postoperative period patient received dual antibiotics treatment. Vital findings and infection parameter were observed postoperative period. The patient did well after operation and was discharged on the second postoperative day. Intrauterine contraceptive device is a safe and effective method of contraception, widely used all over the world. Ultrasonography should be applied in the follow-up of the patients after IUD insertion. During postpartum period (breastfeeding or not breastfeeding) IUD methods are proposed more than four weeks after delivery. Transvaginal sonography should be combined with abdominal X-ray to reach a definitive diagnosis of mislocated IUD. IUD which outside the uterine cavity can be managed by laparoscopy as a first choice in appropriate patients.

Keywords: Disapperad intrauterine device, surgical approach, postpartum IUD

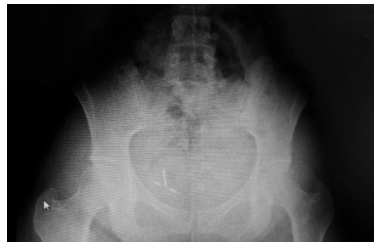


Figure 1. Abdomen X-ray of the patient. Copper T device was in the right below side of the pelvis

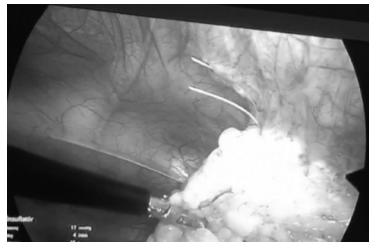


Figure 2. Screenshot of laparoscopic surgery. Thread of IUD omentum with adherent to anterior wall of abdomen



Figure 3. IUD and adherent tissue with abscess formation

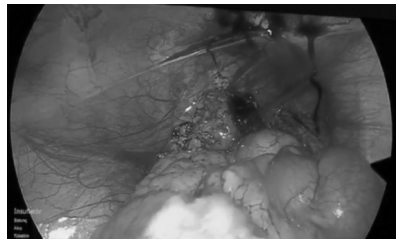


Figure 4. Final wiev of the scene

[PP-016]

Ovarian hyperstimulation syndrome in a spontaneous pregnancy after stopping long-term combined oral contraceptive use: A case report

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Ovarian hyperstimulation syndrome (OHSS) is an iatrogenic complication of ovulation induction or controlled ovarian hyperstimulation (COH). Its clinical manifestations are cystic enlargement of the ovaries, abdominal pain, nausea, vomiting, ascites, tense distention, dyspnea, oliguria, electrolyte imbalance and hemoconcentration. This disease frequently occurs due to the the administration of human chorionic gonadotrophin (hCG) in COH cycles. Hovewer, OHSS has been reported rarely in normal spontaneous pregnancy cases. In this paper, we reported a case of mild OHSS at 10 weeks 5 days of gestation in a woman with singleton gestation, who conceived naturally after stopping long-term combined oral contraceptive (OCP) use. A 31-year-old Turkish woman, gravida 2, para 1, visited our hospital initially at the ten week of gestation for an antenatal check. Seven years ago, the patient delivered a healthy female baby at full term. She had been on birth control pills containing 30 microg ethinylestradiol and 3 mg drospirenone (Yasmin®, Schering AG, Berlin, Germany) for six years non-stop. She had no history of ovulation induction or any medication within the last 6 months except oral contraceptive. Se had stopped using oral contraceptives one month ago. She had no polycystic ovary syndrome and diabetes mellitus. The general appearance was good, she had mild abdominal distension and pain. Her blood pressure was 120/70 mmHg; pulse rate was 75 beats per min and respiration rate was 18/min. Ultrasonographic examination revealed an intrauterine pregnancy, with a fetal crown-rump length of 38.6 mm, which corresponded to the 10th week 5 days of gestation and normal heart beat (Figure 1). Ultrasonography also showed bilateral multilocular cystic masses measuring 16.5 cm in size on the left and 16 cm on the right (Figure 2). She had a hemoglobin level of 11.9 g/dL, hematocrit was 37.1%, the white blood cell count was 12.700/mm^3 and platelet count was 320.000/mm^3. Estradiol level was 5.500 pg/mL. Other laboratory findings, including blood coagulation, liver function, renal function tests and blood electrolytes were normal. The diagnosis of mild spontaneous OHSS was considered. She was carefully monitored; body weight, abdominal circumference were measured every other day. Also, ultrasonography and laboratory tests were measured every other day. Ten days after admission, the laboratory findings remained stable and she was discharged. During the following 8 weeks, laboratory findings remained within normal ranges and ultrasound examination revealed that the right adnexus had decreased to 6 cm in diameter and the left to 5 cm in diameter. The pregnancy progressed to term and at 39 weeks of pregnancy. The patient had spontaneous onset labor and underwent an uncomplicated vaginal delivery of a healthy normal female baby of 3600 g was delivered. Oral contraceptive pills are widely used as adjunct treatment prior to ovarian stimulation during in vitro fertilization cycles. To the best of our knowledge this is the first case of ovarian hyperstimulation syndrome in a spontaneous pregnancy after stopping long-term combined oral contraceptive use. Early diagnosis and appropriate supportive therapy is essential to avoid the potentially life-threatening complications of OHSS.

Keywords: Ovarian hyperstimulation syndrome, combined oral contraceptive, spontaneous pregnancy



Figure 1. Intrauterine live fetus at 10 weeks 5 days of gestation

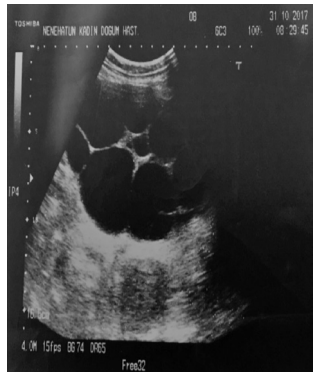


Figure 2. Ovarian enlargement with multiloculated cyst

[PP-017]

Dienogest for the treatment of symptomatic endometriomas: A cross-sectional study

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Objective: Endometriosis is a prevalent disease that affects 5-15% of women of reproductive age. The aim of this study is to assess the effect of dienogest in the treatment of endometriosis.

Material and Methods: The data of 77 women were evaluated during time period between 1 March 2015 to 1 March 2017. The patients were

divided in to two groups if they are receiving dienogest or denied to use any medication. There were 46 patients in dienogest group and 31 patients were in non medication group. The main presenting symptoms were graded regarding visual analogue scale. The study groups were compared in terms of age, gravidity, parity, BMI, previous type and number of surgeries, main presenting symptom, maximum diameter of the pelvic mass in ultrasound examination, the duration of follow up, the need of surgery after treatment failure.

Results: The most common presenting symptom was dysmenorrhea (79.2%) and the second was chronic pelvic pain (37.7%). There was no significant difference between study groups in terms of, age, gravidity, parity, BMI, previous type and number of surgeries, main presenting symptom VAS scores, maximum diameter of the pelvic mass in ultrasound examination, the duration of follow up and the need of surgery after treatment failure between the study groups. There was significant difference between study groups regarding pre and post treatment decrease in terms of dysmenorrhea, dyspareunia, dyschesia and pelvic pain VAS scores between study groups that more decrease was observed in Dienogest than no medication group ($p<0.001$, $p=0.04$, $p=0.009$, $p=0.01$, respectively).

Conclusion: Dienogest should be considered as an alternative for controlling symptoms related to endometriosis. However, dienogest showed no significant change in the size of the cyst when comparing with no medication group.

Keywords: Endometriosis, treatment, ultrasound

Table 1.

	No Medication (n:31)	Dienogest (n:46)	
	Mean±SD	Mean±SD	*P* value
Age (years)	34.000±77.974	32.130±72.743	0.31
Gravidity	.935±11.236	.848±10.543	0.73
Parity	.903±10.442	.696±.8659	0.42
Geç. op şekli	.194±.4016	.217±.4170	0.8
Op sayısı	.290±.5884	.413±.7476	0.53
VAS(1) dysmenorrhea	4.903±41.260	6.739±33.956	0.09
VAS(2) dysmenorrhea	4.419±39.646	3.696±35.520	0.43
VAS(1) dyspareunia	1.161±26.845	2.152±30.838	0.14
VAS(2) dyspareunia	1.000±26.331	1.370±22.741	0.27
VAS(1) dyschesia	.710±19.527	1.783±33.593	0.17
VAS(2) dyschesia	.710±19.527	.935±21.848	0.51
VAS(1) urinary symptom	.604±22.074	.804±22.073	0.21
VAS(2) urinary symptom	.459±13.934	.457±13.937	0.24
VAS(1) pelvic pain	1.806±30.705	2.457±32.021	0.39

[PP-018]

A rare complication of episiotomy: Perineovaginal fistula

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Objective: In this case report, we presented a perineovaginal fistula case originating from the episiotomy line and its surgical treatment.

Material and Methods: A 42-year-old patient applied to our gynecology outpatient clinic with the complaint of discharge from perineal skin. Approximately 2 cm long fistula tract was observed in the vulvovaginal examination with internal orifice approximately 1 cm superior to hymen at the left side of the midline of the posterior vaginal wall, and external orifice opening to the inferior of the right labium majus. Her complaint has been lasting for 19 years, since her spontaneous vaginal delivery with right mediolateral episiotomy. It was also learned that she had 2 more deliveries with caesarian section after her first vaginal delivery. The patient noted that, except the routine pregnancy controls and the three deliveries, she did not visit gynecologist for any reason. The patient had smoking history for 22 pack-year, and clinically euthyroid Hashimoto tiroiditis with levothyroxine sodium use for 10 years. Preoperative routine serum biochemical analysis, complete blood count and complete urinalysis were observed as normal.

Results: Under general anesthesia and at the lithotomy position, the fistula tract was demonstrated and circumferentially resected (Figure 1a, b). The fistula tract was primarily repaired with 2/0 vicryl suture, and the rectovaginal fascial defect was also repaired by performing perineoplasty in the same session (Figure 2). The patient was discharged on the postoperative 1st day. It was observed that the fistula tract was closed with proper healing and there was no active complaints in the routine control examination at the end of the postoperative 1st month.

Conclusion: Perineovaginal fistula after episiotomy is a rarely seen complication. The use of appropriate surgical technique in the repairment of episiotomy has a great importance in the prevention of perineovaginal fistula formation.

Keywords: Perineovaginal fistula, complication of episiotomy, fistula tract excision.

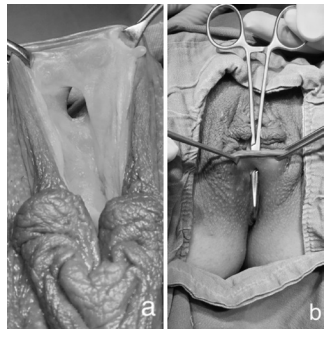


Figure 1. a, b) Perineovaginal fistula



Figure 2. Primary repair of fistula tract

[PP-021]

Can TRPM2 and TRPM7 ion channels immunoreactivity and gene expressions be a new marker on diagnosis of endometrial hiperplasia progression to endometrial carcinom?

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Objective: Ion channels, especially TRP channels are involved in many physiological processes. These channels have been shown to be associated with some serious diseases, such as cancer. During the onset and progression of cancer, altered expression of one or more TRP channels is very important. We aimed to investigate the immunohistochemical staining scores and gene expressions of TRPM2 and TRPM7 ion channels in the progression of endometrial hyperplasia to early stage endometrial carcinoma (EC).

Material and Methods: A total of 120 patients who underwent hysterectomy in the Department of Obstetrics and Gynecology of School of Medicine, Fırat University, were re-sectioned from paraffin blocks in the pathology clinic. Group 1 (n=20): Control group (proliferative endometrial group (PE), Group 2 (n=20): Endometrial hiperplasia group without atypia (AEH), Group 3 (n=20): Endometrial hiperplasia with atypia (AH), Group 4 (n=20): Stage 1A endometrial adenocarcinom (EC), Grade 1, Group 5 (n=20): Stage 1A EC, Grade 2, Group 6 (n=20): Stage 1A EC, Grade 3, Sections were taken from paraffin blocks for RNA isolation, immunohistochemical evaluation was performed by taking sections to the polylysinized lamellae. A histoscore was derived from the distribution (0.1: <25%, 0.4: 26%-50%, 0.6: 51%-75%, 0.9: 76%-100%) and intensity (0: no staining, +0.5: very little staining, +1: little staining, +2: medium, +3: very strong) of staining immunoreactivity (histoscore= distribution × intensity). One-way analysis of variance and post-hoc Tukey's HSD test were used. Differences between the groups were evaluated by independent-samples t-test. The level of significance was set at $p<0.05$.

Results: There wasn't any significant difference between all groups in TRPM2 immunreactivity ($p>0.05$). TRPM7 immunreactivity was significant lower in Group 4, 5 and 6 when compared with Group 1, 2 and 3 ($p<0.05$). TRPM2 miRNA expressions were significantly lower in all groups except Group 6 when compared with control group ($p=0.00$). TRPM7 miRNA expressions were significantly lower in all groups when compared with control group ($p=0.00$).

Conclusion: The best molecular biomarker will be a biomarker that will allow reliable/reproducible differentiation of normal/benign, premalign, and malignant endometrium, allowing the transition between these three groups to be demonstrated. Until this time, there has not been a single candidate who fully fulfills this role and studies are continuing. Several immunohistochemical biomarkers have been investigated in the literature to assist in the diagnosis and classification of EH and to predict the likelihood of transition from EH to EC. We showed that TRPM2 and TRPM7 gene expressions decreased significantly in endometrial hyperplasia endometrium adenocarcinoma progression. TRPM7 is also decreased immunohistochemically in EC. Immunohistochemical staining of TRPM2 and TRPM7 staining in endometrial hyperplasia cases can be investigated to investigate whether these ion channels can be a histopathologic marker for progression of EH to EC in larger case series.

Keywords: Endometrial carcinoma, endometrial hiperplasia, TRPM2, TRPM7

[PP-022]

Comparison of transvaginal ultrasonography, dilatation and curratage and operative hysterosopy H/S findings with final hystopathologic results in the evaluation of endometrial pathologies of the cases with abnormal uterine bleeding

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Objective: Endometrial pathologies are common gynecological problems. Patients are usually present with abnormal uterine bleeding. The purpose of our study was compare the effectiveness of biopsy results combined hysteroscopy and D&C and TVS detection in the

diagnosis of endometrial pathologies by retrospectively analysing the results of the endometrial pathologies that are detected by TVS, operative hysteroscopy and D&C.

Material and Methods: Our study took place in our obstetrics and gynecology clinics in between July 2012 and June 2017. All patients underwent pelvic examination TVS, office hysteroscopy and endometrial sampling through suction curettage. Our retrospective study was conducted in 160 patients who were admitted to our clinic with complaint of abnormal uterine bleeding and who were supposed to have an endometrial pathology during the TVS which was done by us routinely after the physical examination and before the D&C and H/S. The TVS findings, the operative hysteroscopy and D&C findings were investigated for all our cases, retrospectively. The findings acquired from these procedures are compared. The last pathological reports were used as a reference test to calculate, sensitivity, specificity, positive predictive value, negative predictive value of the D&C, hysteroscopy and transvaginal ultrasonography. The results of the transvaginal ultrasound, D&C and the hysteroscopy which were applied to all patients compared in the literature evaluating. For the statistical analysis 24.0 SPSS and Microsoft Excel 2010 were used.

Results: Histopathological results were as follows: 81 patients (51%), the most frequent pathology of endometrial polyps; 27 patients (16%), endometrial hyperplasia; 21 patients (13%), submucous myoma; 2 patients (1.2%), endometrial cancer; 29 patients (18.1%), normal endometrial tissue. Sensitivity, specificity, positive and negative predictive values of biopsy combined with hysteroscopy for the pathology detection were found as 100%, 87.2%, 78%, 100%, respectively. On the other hand, the corresponding values for dilatation curettages were found as 67.2%, 34.9%, 100%, and 52.3%, the values for TVS were found as 82.7%, 83.9%, 53.3%, 95.6% and the values for hysteroscopic provisional diagnosis were found as 93.1%, 86.2%, 60%, 98.2% respectively.

Conclusion: Transvaginal ultrasonography is a useful non-invasive diagnostic method in the assessment that endometrial pathology. TVS is non-invasive first choice modality for the differential diagnosis of patients with abnormal uterine bleeding. Biopsy combined with hysteroscopy was considered to be superior to D&C for the local intracavitary lesions such as endometrial polyps and submucous myoma. On the other hand, D&C was considered to be superior to hysteroscopy for the diffuse lesions such as endometrial hyperplasia and cancer.

Keywords: Abnormal uterin bleeding, transvaginal ultrasonography, dilatation and curattage, operative hysteroscopy

[PP-023]

A case of a giant sacrococcygeal teratoma in adult draining to the vagina

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Saccrococcygeal teratomas (SCT) are derived from embryonic germ cell layers. They frequently present at the base of the coccyx within the pelvis. SCT are exceedingly rare in adults and they are generally found in newborns or children, having an incidence of 1 in 30.000 to 43.000 live births. In adults, a majority of these tumors are intrapelvic and associated with a low risk of malignant transformation. Therefore, this contributes to a good prognosis following resection of mostly benign lesions. We present an extremely rare case SCT which drainage to the vagen. A 72-year-old female with pelvic pain presented with a SCT. She was immobile and her general condition was not good. The tumor in her left buttock, presented since birth. She had been operated twice for this reason but the sacrococcygeal teratoma was recurred. There was a large mass approximately 30x26x22 cm diameter on the sacrococcygeal region which push the rectum and the vagina. She had a complaint of profuse, yellow colored and viscous vaginal discharge. Digital vaginal examination indicated that sacrococcygeal teratoma had been draining from the 2 cm defect onto the posterior vaginal wall. Dense mucinous discharge flow was detected. Patient refused hospitalization, MRI imaging procedüre and any surgical intervention. SCT are multipotential cell tumors most commonly seen in neonates but only rarely in adults. SCTs carry a female preponderance of 4:1. A vast majority of SCT are benign and have a low potential for malignancy. Although surgical resection carries an excellent prognosis, there is a high 37% postoperative recurrence rate for these lesions. The clinical presentation in adults includes bowel dysfunctions, urinary incontinence, lower back pain, and/or venous engorgement of the lower limbs. The location of the SCT can be changed, most adult SCTs are inside the pelvis. They are cystic and less liable to demonstrate malignant transformation (incidence 1-2%) compared to those seen in children and infants. Adult SCT are also primarily intrapelvic with no obvious physical cutaneous or dermatologic presence, and are often recognized following unresolved symptoms associated with a tumor mass compressing adjacent organs (e.g., vagina, uterus, or rectum). In this case the teratoma changed the rectum and the vagina position and she had diffuculty in defecation. SCTs in adults are frequently benign, slowly growing intrapelvic masses best seen on MR studies. Mature benign SCT are highly susceptible to complete and early excision, without the additional need for chemotherapy or radiation. The specific location of the tumor and the relationship with the surrounding organs should be defined before the operation to select the appropriate surgical approach for resection of giant SCT. When a resection is made at the perineum, it is important to try to avoid the anus, as it is easy to cause infection due to fecal contamination of the incision. In cases of large tumors, in which the residual cavity is large, a drainage tube should be placed in the cavity to reduce the risk of hematoma formation.

Keywords: Saccrococcygeal, teratoma, adult



Figure 1. Saccrococcygeal teratoma

[PP-026]

Retrospective evaluation of cases with papanicolaou smear positive for actinomycetes

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Objective: Actinomyces suppurative is an anaerobic Gram-positive bacteria that normally colonize the human mouth and digestive and genital tracts. Female genital Actinomyces infection is characterized by local swelling, suppuration, abscess formation, tissue fibrosis, tubal-ovarian mass and fistula formation. Clinical signs are usually pelvic inflammatory symptoms including vague lower abdominal pain, dyspareunia, fever and bleeding between menstrual periods. Positive papanicolau stained cervicovaginal smears have been found adequate for diagnosis. It was reported that pelvic actinomycosis is strongly related to long-lasting intrauterine contraceptive device (IUD) application. In the presence of pelvic inflammatory disease, IUD should be removed the and patient should be treated for 2-6 weeks with wide spectrum antibiotic coverage. In suspected actinomyces suppurative genital and pelvic inflammatory disease, intravenous and subsequent long-term oral penicillin therapy should be given. In this retrospective study, we aimed to evaluate the cases detected actinomycetes on routine cervical smear. For this purpose, we analyzed cervical smears sent to the pathology department from our gynecology clinic in the period of 2015-2016 and cases with actinomyces in cervical smears were included in this study.

Material and Methods: Ethical approval for this study was provided by the Ethical Committee of Atatürk University Faculty of Medicine, Erzurum, Turkey. This study was conducted at the Gynecology Clinic, Nenehatun Hospital, Erzurum, Turkey. Nine hundred and ninety cervical smears sent to the pathology department in the period of 2015-2016 were analyzed and 118 cases detected actinomyces in cervical smears were included in this study. Cases were retrospectively evaluated for sociodemographic characteristics, the presence of IUD, the duration of IUD usage, clinical symptoms such as dyspareunia, fever, pelvic pain and spotting; and the obtained data were recorded.

Results: The number of cases with actinomyces-positive cervical smears was 118 (11.9%). Most of the them were IUD (Copper T) users (97.45%). Also, the majority of them have been used IUD for 5 years or more (62.6%). The most frequent complaint in cases with actinomyces-positive smears was pelvic pain (76.27%). Intrauterine device was removed in all symptomatic cases and they were treated with intravenous penicillin for 4 weeks followed by oral penicillin for 6 months. Asymptomatic cases with Papanicolaou smear positive for actinomycetes were called to regular 6 month follow up visits.

Conclusion: Annual pelvic examination should be done in all IUD users and they should be evaluated for inflammatory symptoms. Intrauterine devices must be changed every 5 years in order to limit the occurrence of genital Actinomyces infection. Low cultural level and using IUD for 5 years or more are risk factors for pelvic actinomycosis. Removal of an IUD should be advised to patients with an incidental finding of actinomycetes on routine cervical smear. It is unclear whether the relationship between a Papanicolaou smear positive for actinomycetes and eventual development of pelvic actinomycosis. Studies reported that antibiotic treatment is no need in the asymptomatic patient with an incidental finding of actinomycetes on routine cervical smear. But, recent consensus guidelines advise removal of an IUD in this cases.

Keywords: Actinomyces, cervical smear, intrauterine contraceptive device

Table 1. Sociodemographic and clinical characteristics of 118 cases detected actinomyces in cervical smears

Age (year)	38.64±7.65
Gravidity	3.82±1.26
The number of university graduates	4 (3.38%)
The numbers of patients using an IUD	115 (97.45%)
The numbers of patients using an IUD for 5 years or more	72 (62.6%)
Malodorous vaginal discharge	88 (74.57%)
Fever	1 (0.84%)
Pelvic pain	90 (76.27%)
Dyspareunia	18 (15.25%)
Spotting	14 (11.86%)
Values are mean ± SD or n (%), IUD: Intrauterine device	

[PP-027]

Prevalence of violence against pregnant women in Yozgat

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This study was carried out as a descriptive study to determine the violence exposure of pregnant women living in Yozgat. The universe of the research constitutes pregnants who apply to the Obstetrics and Gynecology Clinic at Bozok University Research and Practice Hospital. As a result of the evaluation of the data based on the 21-item questionnaire, 56.9% of the participant 664 pregnant women were in secondary school, 21.5% were college-university graduates and 84.9% were not working in any job. 52.7% of spouses are middle school-high school, 30.1% are college-university graduates and 93.5% are working. 34.3% of the monthly income is less than 1500 TL. Among them, 43.3% of the violent women are middle school-high school and 23.3% are college-university graduates. 86.6% of them do not work in any job and the monthly income of 46.6% is 1500 TL less. 46.6% live in the province center. 4.5% of respondents stated that they were exposed to violence. Of these, 30.7% stated that their partner, 61.5% were mother-in-law, 30.7% were siblings, and 7.6% were exposed to violence by their father-in-law. In order to reach meaningful data, it is recommended that this study be repeated in larger sample groups and educational studies on violence definition for collecting.

Keywords: Partner, pregnant, violence

[PP-028]

Torsion of a giant ovarian cyst during pregnancy: A case report

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It is aimed to present a case of ovarian cyst torsion with a diameter of 30 cm during the pregnancy. A 32-years-old gravida: 3 parity: 2 pregnant women who underwent caserean section in the prior pregnancies admitted to the obstetrics clinic of a tertiary level university hospital with the complaints of nausea and vomitting and abdominal pain. The signs of acute abdomen was detected during the physical examination. There was no bleeding and cervical dilatation and effacement in speculum examination. The ultrasonographic imaging revealed a single healthy fetus at 33- gestational age and a multiseptated ovarian cyst with a diameter of 30 cm at the right adnexial area (Figure 1). No blood flow was detected in the right ovary on the Doppler ultrasonography. Based on the clinical and ultrasonographic findings, the patient was hospitalised with the diagnosis of ovarian cyst torsion. During the emergent laparatomy, performed with median supraumbilical and infraumbilical incision, it was observed that a giant haemorrhagic reguler contoured cyst with no papillary projections on the surface led to diffuse enlargement and 3-times torsion of the right ovary and right fallopian tube. The left adnexia and uterus were normal. Right salphingoopherectomy was done due to active haemorrhagic area on the cyst surface (Figure 2). The postoperative period was uneventful and the patient was discharged on the third day. The pathologic report was disclosed as serous cystadenoma of the ovary (Figure 3). She gave birth to a healthy female baby weighing 3100 grams at the 39th weeks of gestation by caserean section. Dermoid cysts and serous cystadenomas are among the most common cysts associated with ovarian torsion (1). Pregnancy has ben detected as a predisposing factor for ovarian torsion (2). In the literature, the rate of surgery applied for adnexial masses in pregnancy was 1-2.3%. In a retprospective report of 20 pregnancies with ovarian cyst, torsion was diagnosed in 5 patients. In that study, all of the torsions occured in the first or second trimesters and the mean diameter of the benign cysts was 10.3 cm (3). In the current study, the torsion occured in the 3rd trimester and the cyst had a very huge diameter. As in non-pregnant patients, detorsion of the ovary or oopherectomy could be performed in pregnant women with ovarian torsion. The risk of thromboembolism has reported to be similar (0.2%) in cases underwenting detorsion or oopherectomy (2). In the current case report, salphingoopherectomy was performed due to actively bleeding area on the cyst surface. In detorsioned ovaries, oophoropexy may be performed to prevent the recurrence of ovarian torsion (2). This case report is of value since it reports the torsion of a huge ovarian cyst during pregnancy.

Keywords: Ovarian cyst, pregnancy, serous cystadenoma, torsion

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Figure 1. Ultrasonographic image of the multiseptated giant ovarian cyst



Figure 2. Intraoperative view of the torsioned haemorrhagic ovarian cyst

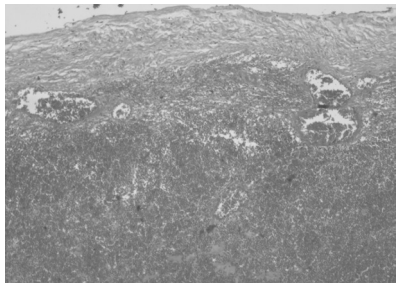


Figure 3. Diffuse haemorrhagic necrosis destroying ovarian stroma (Hematoxylin-eosine staining x100 magnification)

[PP-029]

A large placental chorioangioma without fetal and neonatal complications: A case report

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Chorioangioma is the most common benign vascular, non-trofoblastic tumor of the placenta. Prevelance of this tumor is approxiamtely 1%, but giant type (>4 cm diamater) is seen in 1:9000-50000 of pregnancies. Small size chorioangiomas are usually asymptomatic and they frequently can not be determined during the macroscopic examination. Giant type chorioangioma may be associated with variably complications such as anemia, fetal hydrops, polyhydramnios, intrauterine growth restriction, antepartum hemorrhage, preterm labor and increased perinatal mortality. In this case, we reported a case with a large asymptomatic placental chorioangioma that does not cause fetal and neonatal complications. A 35-year-old patient, gravida 2, parity 1, who did not have routine antenatal follow-up, admitted to our clinic in the 38th gestational week due to increasing uterine contractions. She previously had a vaginal delivery. Ultrasound examination revealed a normally growing fetus with no gross fetal anomalies. In sonographic examination of the placenta, a heterogeneus multipl anechoic cystic hypoechoic area measuring sized 170x120x40 mm near the insertio of the cord, protrude into to amniotic cavity, was identified (Figure 1). Colour Doppler examination showed highly vascularization suggesting chorioangioma (Figure 2). She had regulary uterine contractions. She had a dilatation greater than 5 cm and she was in active labor. A female baby with normal Apgar score and birth weight of 3 kilograms was delivered via vaginal delivery. Baby had a normal pink color, normal flexed posture and strength, good activity and resposiveness to the exam and physical findings were consistent with term gestational age (skin, ears, etc.). Placenta was delivered by controlled cord traction. The placenta weighed 900 g. It was circular in shape and 20 cm in diameter. There was a mass measuring 15x12x4 cm beneath the fetal surface of the placenta, between the insertion and the placental margin. The histopathological examination of the placental mass confirmed the diagnosis of placental chorioangioma. The mother recovered normally and was discharged on the second day postpartum. Large chorioangiomas may cause serious complications including polyhydramnios, preterm labor, fetal hemolytic anemia, fetal thrombocytopenia, fetal cardiomegaly, intrauterine growth restriction, toxemia, placental abruption, preeclampsia, and congenital abnormalities. On the other hand, advanced maternal age, hypertension and diabetes mellitus have been reported as maternal risk factors associated with chorioangioma. In this case report, we presented a case with an asymptomatic large placental chorioangioma. Cases with a large placental chorioangioma should be monitored intensively via ultrasound examinations in order to minimize maternal and neonatal complications.

Keywords: Chorioangioma, placenta, ultrasound, neonate



Figure 1. The gray-scale sonographic image of the placenta: Heterogeneus multipl anechoic cystic area measuring sized 170x120x40 mm

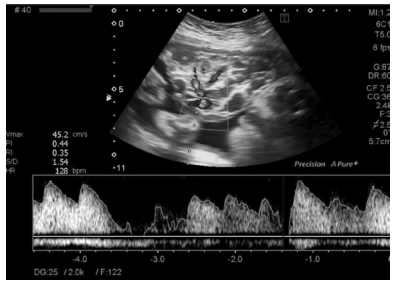


Figure 2. A color Doppler image revealed highly vascularization suggesting chorioangioma

[PP-030]

The anesthesia technique preferences of primipar and multiparous patients in elective caesarean section operations

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Objective: Most patients are afraid of regional blocks depending on various reasons. Patients who have previously undergone surgery may decide easier to prefer anesthesia method. We aimed to compare the anesthesia preferences of primipar and multiparous patients undergoing elective caesarean section. Also, we aimed to investigate the factors that affect the differences in the preference of anesthesia technique.

Material and Methods: The protocol of this study was approved by the Ethics Committee of our institute and informed consent was obtained from all of the participants. One hundred primiparous pregnant women (patients with caesarean section for the first time) and one hundred multiparous pregnant women (patients who have undergone one or more cesarean operations) scheduled for elective caesarean section were asked to complete a questionnaire including 20 questions. Patients with contraindications to general or regional anesthetic technique were excluded from the study. The questionnaire included demographic features, anesthesia preferences, experiences related to anesthesia technique and causes of preoperative fears. Participants were questioned about whether they had knowledge about anesthesia technique, the most important source of this knowledge, their preferred anesthesia method for their current pregnancy and the reasons for refusal of general or regional anesthesia techniques. Individual informing about anesthesia technique was performed by an anesthetist and the effect of information about regional anesthesia methods on preferred anesthesia technique was evaluated. Likewise, postoperative patient satisfaction in relation to anesthesia technique was recorded. Demographic-obstetric information of patients and data concerning their attitudes towards general (GA) and spinal anesthesia (SA) were recorded. SPSS software 12.0 (SPSS Inc., Chicago, IL, USA) was used for the statistical analysis, $p<0.05$ was considered as significant.

Results: The women's clinic characteristics are presented in Table 1. Ninety-eight women (98%) of multiparous patients and 65 (65%) of primiparous patients were knowledgeable about anesthesia technique ($p<0.001$). Most of the patients (n=59, 36.19%) said that they have received most information from their anesthesia doctors. Twenty one (21%) primiparous patients and 9 (9%) multiparous patients refused RA at the first preoperative anaesthesia visit. After being informed about anesthesia techniques in detail, 9 (9%) of primiparous patients who previously refused RA approved the RA procedure. Almost all of them who preferred RA were satisfied following the procedure (Table 2, 3). In patients, reasons for rejecting general anesthesia technique were fear of awakening, dissatisfaction with the general anesthesia technique used in the previous surgery, the desire to see the baby during surgery, satisfaction with the regional anesthesia technique used in the previous surgery and the fear of postoperative pain after general anesthesia. On the other hand; reasons for rejecting regional anesthesia technique were dissatisfaction with the regional anesthesia technique used in the previous surgery, do not want to be awake during surgery, fear of being paralyzed and anxiety about being a headache and back pain after surgery.

Conclusion: Receiving detailed information about the advantages and disadvantages of anesthesia techniques provides an increase patients' preference about regional anaesthesia.

Keywords: General anesthesia, regional anesthesia, preference, primiparous, multiparous

Table 1. The demographic and clinic characteristics of patients in groups

	Primiparous patients (n=100)	Multiparous patients (n=100)	p value
Age (year)	26.82±6.13	29.37±4.88	0.014*
Length (cm)	159.12±6.61	159.00±6.41	0.526
Weight (kg)	74.49±10.91	73.63±11.59	0.384
Gestational week	38.05±2.20	37.37±1.78	0.187
University graduates (n, %)	12 (12%)	17 (17%)	0.315
Duration of surgery (minutes)	45.88±3.46	46.00±3.16	0.812
All the values were given as mean ± standard deviation, *: $p<0.05$			

Table 2. The comparison of patients' knowledge and preferences about anesthesia technique

	Primiparous patients	Multiparous patients	p value
The number of patients that have knowledge about anesthesia technique (n, %)	65 (65%)	98 (98%)	<0.001*
The number of patients preferring regional anesthesia	79 (79%)	91 (90%)	0.032*
The number of patients preferring regional anesthesia following information about anesthesia methods	98 (98%)	91 (91%)	0.017*
The number of patients satisfied with the regional anesthetic technique	95 (95%)	89 (89%)	0.400
Values are n (%). *: $p<0.05$			

Table 3. The most importance source of knowledges about anesthesia technique in patients

	Patients (n=163)
My friends	34 (20.85%)
Television	2 (1.22%)
Internet	7 (4.29%)
Anesthetist	59 (36.19%)
Obstetrician	39 (23.92%)
Assistant health personnel	7 (4.29%)
Relatives	15 (9.20%)
All the values were given as n (%)	

[PP-032]

Female genital mutilation treatment during pregnancy

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Female genital mutilation (FGM) as described by World Health Organisation (WHO) is the procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia. FGM is a traditional practice with serious health consequences to women. Health professionals should be aware of the adverse effects and how this affect obstetric, gynaecological and sexual function and general quality of life. Twenty seven years old 36 week pregnant woman from Sudan approached to our clinic for obstetric examination for the first time. At the physical examination it is seen that bilateral labium majus are densely adherent. Vaginal opening was narrowed even not appropriate for the coitus. A covering seal to the vaginal opening was created by the mutilation procedure. Deinfibulating operation is performed for vajinal delivery possibility. At the operation synechias are decomposed by vertical incisions from the midline. It is understood that clitoridectomy was not performed; after the covering seal was removed. Suturation with 4.0 vicryl was done for bleeding control. After operation is performed at 36th week of pregnancy; weekly control obstetric ultrasonography was done. At 40 weeks 2 days of the pregnancy the women approached by memrane rupture. The patient hospitiliased for the normal spontaneous delivery. At the labor room, when the effacement of the cervix was 70%, dilatation was 5 cm and head position was at -1; cesarrean was done due to fetal distress endication. According to WHO; FGM is classified into 4 major types: Type 1: Also known as clitoridectomy, this type consists of partial or total removal of the clitoris and/or its prepuce. Type 2: Also known as excision, the clitoris and labia minora are partially or totally removed, with or without excision of the labia majora. Type 3: The most severe form, it is also known as infibulation or pharaonic type. The procedure consists of narrowing the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or labia majora, with or without removal of the clitoris. The appositioning of the wound edges consists of stitching or holding the cut areas together for a certain period of time (for example, girls' legs are bound together), to create the covering seal. A small opening is left for urine and menstrual blood to escape. An infibulation must be opened either through penetrative sexual intercourse or surgery. Type 4: This type consists of all other procedures to the genitalia of women for non-medical purposes, such as pricking, piercing, incising, scraping and cauterization. In our case Type 3 (infibulation) mutilation was performed. Even though the vaginal opening was narrowed; the woman was 36 week pregnant. Deinfibulation is the surgical procedure that divides the infibulation scar of FGM Type 3. It is performed at the present case. Deinfibulation should be offered antenatally to all women who will get benefit from the procedure. The Royal College of Obstetricians and Gynecologists and The American College of Obstetrics and Gynecology advise that the procedure should be carried out in the second trimester as an elective procedure.

Keywords: Female genital mutilation, female genital cutting, harm reduction, genital mutilation treatment



Figure 1. Female genital mutilation treatment for a 36 week pregnant woman

[PP-033]

The effect of body mass index on fetomaternal blood flow parameters in women with term pregnancy: An observational prospective study

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Objective: Doppler ultrasonography provides noninvasive haemodynamic monitoring in human pregnancy. Commonly performed Doppler assessments include that of umbilical artery (UA), middle cerebral artery (MCA), uterine artery (UtA) and ductus venosus. Obesity is a significant health problem in many other developing

countries. The aim of this study was to evaluate a possible relationship between BMI and fetomaternal blood flow parameters in women with term pregnancy.

Material and Methods: Ethical approval was provided and written informed consent was obtained from all participants. This observational prospective study was performed on all consecutive pregnant women undergoing routine tird trimester ultrasound scans. Patients between 20-40 years with term pregnancy were included in this study. Inclusion criteria were as follows: singleton pregnancy, gestational age ≥37 weeks, absence of fetal abnormalities and maternal comorbidities and no drugs intake. All the women recruited underwent a feto-maternal assessment at term (≥37 weeks of gestation). Maternal weight and height were measured, and BMI was calculated and recorded on a dedicated database. Women were divided into four groups [underweight (<18.5 kg/m^2), normal weight (18.5-24.9 kg/m^2), overweight (25-29.9 kg/m^2), obese (≥30-kg/m^2)], according to the World Health Organization based on associated health risks. Another study group including obese patients with additional disease such as diabetes or hypertension was created. Demographic and clinical data were recorded. At the same appointment, a fetal ultrasound examination was performed using an Aplio 300 ultrasound system (Toshiba Medical Systems, Tokyo, Japan) with a 3.5-MHz convex probe. The UtA, UA and MCA were examined using color Doppler according to the standard protocols. The systole/diastole (S/D) ratio, pulsatility index (PI), and resistance index (RI) values of UtA, UA and MCA were recorded.

Results: Three women were underweight, 40 normal weight, 40 overweight, 40 obese and 40 obese with additional disease. Because of the number of underweight pregnant women was extremely low, we excluded them from our analysis. Demographic and clinical data of patients in groups were similar except for BMI (Table 1). As seen in Table 2, mean UtA-RI, UA-RI and MCA-RI values were significantly higher in obese with additional disease women compared with other groups. Mean UA-PI and MCA-S/D values were significantly lower in normal weight and overweight women compared with obese with additional disease women. All doppler findings were found to be similar among normal weight, overweight and obese women. There was a positive correlation between UtA-RI and maternal BMI (r2=0.63; p=0.006; Figure 1). There was a positive association between both UA-PI and UA-RI values with maternal BMI, respectively (r2=0.71; p=0.003; r2=0.48; p=0.021, respectively) (Figure 2, 3). Also, we observed a positive association between both MCA-RI and MCA-S/D values with maternal BMI, respectively (r2=0.64; p=0.005; r2=0.49; p=0.019, respectively) (Figure 4, 5).

Conclusion: In the presence of an additional disease such as diabetes or hypertension, obesity leads to negative effects on maternal and fetal blood flow. We concluded that obese women should be informed about the risks of obesity during pregnancy, and they should be supported to lose weight before conception.

Keywords: Body mass index, doppler ultrasonography, middle cerebral artery, umbilical artery, uterine artery, obesity

Table 1. Demographic properties of patients in groups

Baseline characteristics	Normal weight	Overweight	Obese	Obese with additional disease	p value
Maternal age (year)	28.22±6.03	29.09±6.08	28.25±6.46	28.25±5.33	0.921
Maternal BMI (kg/m^2)	23.67±1.05	27.50±1.47	31.85±1.81	35.89±3.55	<0.001
Gestational age (week)	37.47±0.78	37.70±0.99	37.67±0.84	37.61±1.13	0.707
Gravidity	2.45±1.37	2.60±1.51	2.40±1.29	2.37±1.42	0.893
Parity	1.32±1.24	1.47±1.35	1.37±1.16	1.30±1.28	0.930
Estimated fetal weight (g)	3127±292.23	3149±320.19	3286±333.01	3286±402.56	0.058
Amniotic fluid index	128.77±42.38	116.37±45.76	142.50±56.23	121.00±44.24	0.077
Glucose (mg/dL)	91.97±17.71	94.15±20.43	93.32±16.26	91.62±23.86	0.935
Triglyceride (mg/dL)	283.27±83.90	284.32±108.10	329.05±145.36	330.20±155.90	0.160
Hemoglobin levels (g/dL)	12.6±51.35	12.51±1.33	12.67±1.28	12.65±0.99	0.931
MPV values (fL)	10.88±1.88	10.63±0.95	10.55±1.68	10.70±0.80	0.478
LDL: Low-density lipoprotein, MPV: Mean platelet volume					

Table 2. The comparison of Doppler findings in study groups

	Normal weight	Overweight	Obese	Obese with additional disease
UtA PI	0.92±0.64	0.74±0.30	0.73±0.30	0.96±0.71
UtA RI	0.42±0.07*	0.44±0.09$^{\alpha}$	0.42±0.08$^{\infty}$	0.72±0.73
UtA S/D	1.82±0.35	1.58±0.50	1.67±0.37	1.83±0.58
UA PI	0.95±0.34$^{\beta}$	0.97±0.2$^{\mu}$	1.01±0.35	1.28±0.67
UA RI	0.57±0.08$^{\gamma}$	0.58±0.08$^{\lambda}$	0.57±0.08$^{\phi}$	0.67±0.23
UA S/D	2.43±0.51	2.56±0.52	2.50±0.71	2.50±0.55
MCA PI	1.26±0.43	1.24±0.41	1.22±0.55	1.44±0.38
MCA RI	0.72±0.06*	0.69±0.09$^{\epsilon}$	0.74±0.16^{+}	0.91±0.44
MCA S/D	3.46±0.87$^{\#}$	3.57±1.37$^{\&}$	3.82±1.79	4.46±1.60

UA: Umbilical artery, MCA: Middle cerebral artery, UtA: Uterine artery
*p=0.003, $^{\alpha}$p=0.005, $^{\infty}$p=0.002, $^{\beta}$p=0.013, $^{\mu}$p=0.029, $^{\gamma}$p=0.007, $^{\lambda}$p=0.023, $^{\phi}$p=0.014, $^{\epsilon}$p=0.001, $^{+}$p=0.012, $^{\#}$p=0.015, $^{\&}$p=0.042; compared with obese with additional disease patients

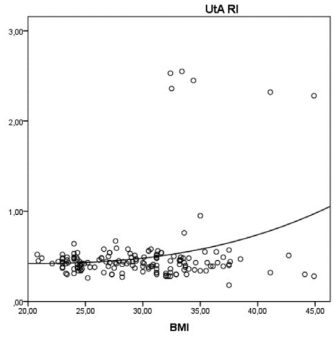


Figure 1. Correlation between Ut-A RI and maternal BMI

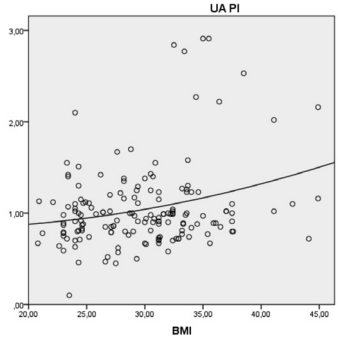


Figure 2. Association of UA-PI with maternal BMI

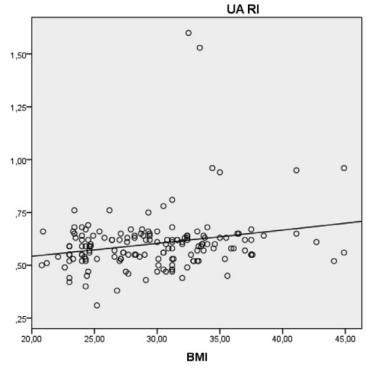


Figure 3. Association of UA-RI with maternal BMI

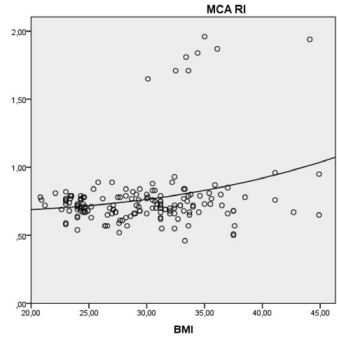


Figure 4. Correlation between MCA-RI values and maternal BMI

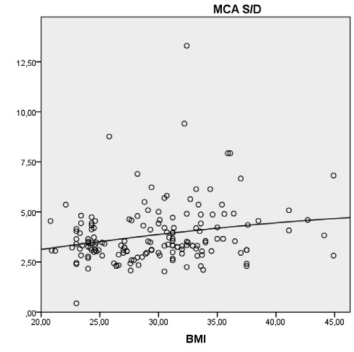


Figure 5. Correlation between MCA-S/D values and maternal BMI

[PP-034]

The effect care to episiotomy pain of lavender oil and ıce used in episiotomy

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Objective: This study was performed to investigate the effects of lavender oil and ice application to episiotomy pain and wound healing.
Material and Methods: This study was performed between in May 2015 and September 2015 in Nazilli State Hospital Obstetrics service. Patients, who applied episiotomy at birth and who criteria included to the study. In this study there were 3 groups; lavender group (n=32), ice group (n=31) and control group (n=33) with a total 96 women's who were agree with experiment. This study was carried out quasi-randomized controlled study. Patient identification form, the visual analog scale and Redness, Oedema, Ecchymosis, Discharge, Approximation (REEDA) scale used for as data collection tools. To analyze the data; number, percentage, chi-square test, Kruskal-Wallis test, Mann-Whitney U test and Wilcoxon signed-ranks test were used.
Results: After application there were statistically significant difference between study and control groups in perineal pain level ($p<0.05$). There were a statistically significant difference between the mean scores of the REEDA scale between study and control groups ($p<0.05$). While the difference between lavender oil and ice group were not statistically significant ($p>0.05$), there were difference between ice-control and lavender-control groups ($p<0.05$). According to the results; lavender oil and ice application reduce episiotomy pain and accelerate the healing.
Conclusion: According to the results of this study, postpartum lavender oil and ice application reduces perineal pain and accelerates wound healing. If non-pharmacological methods as lavender oil and ice application supported by the health providers it will have an important part in the postpartum period is considered.
Keywords: Episiotomy pain, lavender oil, ice application

[PP-035]

Recurrent ectopic pregnancy

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Ectopic pregnancy is a pregnancy implanted outside the main cavity of the uterus. It is seen in 1-2% of all pregnancies in the world (1). Cervical pregnancy is a rare form of ectopic pregnancy accounts for less than 1% of ectopic pregnancies with an incidence of 1:9.000 deliveries (2). The trophoblast implant into the cervical tissue and become a potentially dangerous site of torrential haemorrhage. In this article, recurrent ectopic pregnancy is presented.
Keywords: Cervical, ectopic, recurrent, pregnancy

[PP-036]

Recurrent pregnancy loss with neuropathy as a delayed presentation of Hashimoto's disease: Case report

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Hashimoto's thyroiditis is the most common autoimmune cause of hypothyroidism. Hypothyroidism affects 3-5% of pregnant women and is associated with multiple adverse outcomes, including spontaneous abortion. Diagnosis of hypothyroidism can not depend on the patient's symptoms only, because these are often non-specific. But some of rare symptoms like neuropathy suggest that the underlying cause may be autoimmune. Although it is well known that hypothyroidism may be associated with neuropathy, the occurrence of a progresive but reversible neuropathy is not well documented in pregnancy and do not attract the attention of obstetricians when questioning the symptoms of hypothyroidism. In this case report, we present a comorbidity of marked neuropathy with Hashimoto's thyroiditis in a euthyroid woman with a history of recurrent early pregnancy loss. The patient aged 33 presented to clinic with a desire of a baby. She had complaint about progressively worsening paresthesias affecting all four limbs in a glove and stocking fashion last

three months. Her obstetric history was remarkable with two unexplained fetal miscarriage at 6 and 8 weeks of gestation in the past six months. The patient body mass index was normal and did not have any chronic diseases. Physical examination was unremarkable. Trombophilia and CMV infections were excluded. The serum hormone, glucose level and thyroid stimulating hormone (TSH) level was normal (2.36 uIU/mL). Thyroid peroxidase antibody (TPO-Ab) was 27.78 IU/mL (Normal: 0-5.61) and thyroglobulin autoantibody (Tg-Ab) was 3.36 IU/mL (Normal: 0-4.11). In neurological examination, a sensory and motor neuropathy was detected in the upper and lower extremities. Magnetic resonance imaging of the head and neck, antibodies, vitamin B12 levels, and chemistry tests were normal. Electromyography confirmed the presence of polyneuropathy but there were no reason to explain it in the tests. After endocrinological evaluation, her thyroid founctions were found normal, but serum TPO-Ab returned as marked elevated. Thyroid replacement with levothyroxine 25 mg po was begun despite the low normal TSH. After levothyroxine treatment, all symptoms had disappeared. Following retreatment of the symptoms, she got pregnant again and now her pregnancy is progressing healthy. In this case, the appearance of Hashimoto's thyroiditis without excessive hypothyroidism occurred along a similar time line as the occurrence of the neuropathy and pregnancy loss. The all process may have been autoimmune and the neuropathy developed because of Hashimoto's disease. It is not certain, but probably pregnancy loss is also associated with thyroid dysfunction. Previous reports have identified similer cases but not in pregnant women. In conclusion, an obstetrician should keep in mind that the neuropathy can be a rare symptom of "Autoimmune Thyroid Disease". As far as we know, this is the first case report that shows the benefits of levothyroxine administration, to euthyroid women not only to correct maternal thyroid function and neuropathy symptoms but also to decrease the risk of pregnancy loss. Women with early recurrent pregnancy loss should be screened for TPO-Ab and thyroid functions. Levothyroxine should be administered to women who have a high TSH value and/or a titer of thyroid antibodies.

Keywords: Hashimoto's disease, misscariage, neuropathy, pregnancy

[PP-037]

Cough-related rectus sheath hematoma at pregnancy

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Rectus sheath hematoma caused by the spontaneous bleeding of the inferior epigastric artery into the rectus abdominis sheath. It is rarely seen at the pregnancy. Generally patients approach by the sudden onset of the abdominal pain and it is difficult to differentiate them from the acute pathologies. The risc factors of developing rectus sheath hemaroma are pregnancy, anticoagulation therapy, prior abdominal surgery, infections such as influenza and typhoid fever and trauma from extreme exercise or cough. Acute paroxysmal coughing, asthmatic attacks, bronchitis or influenza is the precipitating event in 56% of the cases. It is important to be aware of this condition since it is often misdiagnosed and outcome of the condition could be mortal. Twenty eight week pregnant woman approached to our clinic with the complaint of ecchymose on her belly. At the physical examination ecchymosed area at abdomen lesion around umbilicus is seen and 28 week pregnancy observed at the transabdominal ultrasonography. Ecchymosed area was seen at the 2/3 lower part of the umbilikus. At transabdominal ultrasonography, 18*9*7 cm sized hematoma was seen. From the anamnesis it is understood that the rectus hematoma is sekonder to the coughing. The patient do not smoke, had no anamnesis of the tuberculosis and asthma. Coughing causes intense contraction of the rectus muscle with tearing and bleeding from the perforating branches of the inferior epigastric artery. The hemoglobin level was 7.7 g/dL and hematocrite value was 23.3%. Two unit of eritrocyte suspansion and 2 unit of fresh frozen plasma were transferred and after the transfusion the hemoglobin level was 9.4 and hematocrite value was 28.2%. Department of thoracic disease evaluated the patient and thought it as a gribal infection with roncus at the every zone of the lungs. Antibiyotics and nebule inhalers are given to the patient. At the second day of the hospital stay there was no difference at the ecchymosed lesion. At the 8th day of the hospital stay the rectus hematoma sized is measured as 16*6*3 cm sized; patient had no symptom of coughing. Patient is discharged from the hospital at the 8th day. At her polyclinic controls the regression of the hematoma is observed at the examinations. The rectus sheath hematoma seen less at the recent years; this is probably because of the advent of antitussives and antibiotics, a decrease in the incidence of influenza and a decrease in the occurrence of grand multiparity. Mortality rates are approximately 4% in the general population and as high as 13% in pregnancy. Imaging is often necessary for the diagnosis. In our case the superficial ultrasound imaging was enough for the diagnosis. Computer tomography (CT scan) is 100% sensitive for the diagnosis but both of the mother and fetus are exposed to the radiation. Rectus sheath hematomas' incidence of misdiagnosis is as high as 93%4. If the rectus sheath hematoma is small and limited, nonoperative treatment can be choosen. Non operative treatment consist of rest, analgesia, discontinuation of any anticoagulation therapy and blood products transfusions if needed. If there is rupture into the peritoneum, if infection is present, or if the patient is hemodynamically unstable; operation should be preformed. The operation consist of evacuation of the hematoma and ligation of bleeding vessels. Cesarean-section delivery should be performed only for fetal indications.

Keywords: Rectus sheath hematoma, pregnancy, cough



Figure 1. Rectus sheath hematoma. 28 week pregnant woman with cough-related rectus sheath hematoma

[PP-038]

Vaginal delivery in a patient with Klippel-Trenaunay syndrome with vulvar edema

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Klippel-Trenaunay syndrome (KTS) is a congenital disease characterised by vascular malformations, cutaneous hemangiomas and localised disturbed growth of bone or soft tissue (1). The etiology of the syndrome is unknown. The normal physiological changes of pregnancy such as increase in venous pressure, leg edema, venous stasis and increased cardiac output, exacerbate the problems of this syndrome resulting in an increased risk of thrombo-embolic disease and hemorrhage (2). During pregnancy and labour, women with KTS could therefore be particularly at risk of venous thromboembolism and postpartum haemorrhage, resulting from vascular anomalies in the pelvic area (3). Pregnant women diagnosed with KTS should be followed up by a multidisciplinary team, contain cardiovascular surgeon, anesthetist and obstetrician. In this case, we aimed to describe the management of pregnant women with KTS. Thirty-year-old, nulliparous pregnant woman admitted to our hospital in 16th week of gestation. The diagnosis of KTS was made when she was two years old. She had port-wine stains in abdomen, hypertrophy of the left leg and vulvar edema (Figure 1). The circumferences of the left leg was 6 cm larger than the right one. The laboratory tests; coagulation profile, blood count and biochemical parameters were normal. After cardiovascular surgery consultation, low-molecular-weight heparine treatment was started. Lower etremity venous Doppler ultrasonographic examination demonstrated no thrombosis. There were no problems about the patient and the fetüs during the pregnancy follow-ups. A 2900 gr female baby was born by vaginal delivery with APGAR scores of 9/10 at the 40th week of the gestation. Vaginal lasseration or dystocia did not ocur. Oxytocin infusion started in the postpartum period. Elastic compressive stockings and low-molecular-weight heparin was administered for 10 postpartum days. On the 2nd postpartum day, the patient was discharged. Postpartum controls were normal. KTS is a rare condition and there is little information available to discuss and counsel the patients regarding effects on maternal physiology and fetal outcome. Early identification is important and the diagnosis is based on clinical evidence. Extensive cutaneous hemangiomas and abnormal venous vessels are characteristic features of KTS. Abnormal vessels near the birth canal or abdominal wall is also problematic during vaginal delivery. To prevent these complications, MRI should be used to determine the existence of abnormal vessels in the pelvis, birth canal, spinal cord and bronchial tube before delivery (4). If neuraxial vascular anomalies cannot be ruled out radio graphically, regional anesthesia should be avoided. The literature also recommends avoidance of epidural or spinal analgesia because of the risk of spinal hematoma (5). Patients with KTS have an increased risk of thromboembolic disease; 8% patients had pulmonary embolism or deep vein thrombosis (2). Anticoagulant therapy with aspirin or heparin calcium during pregnancy could effectively prevent thromboembolic disease (3,4). As there is currently no cure for KTS, treatment aims to relieve symptoms and prevent disabilities. In mild forms of the disease, elastic stockings are advised to prevent oedema (6). We advised our patient for elastic compression stockings and gave her prophylactic low molecular weight heparin.

Keywords: Klippel-Trenaunay syndrome, pregnancy, delivery



Figure 1. Port-wine stains in the left side of the abdomen, hypertrophy of the left leg and vulvar edema

[PP-041]

Application of cervical suturation for Bakri Balloon fixation in case of postpartum bleeding following Plasenta Accreata

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Plasenta previa which is encountered once in 150- 250 births is a serious obstetrical problem also seen together with plasenta accreata with a ratio of 2/3. Plasenta adherence anomalies caused by previous uterine surgeries are known as important causes of postpartum bleeding. In this case, application of Bakri balloon and the usage of cervical suturation technique for the fixation of the balloon in order to control the postpartum bleeding because of following plasenta previa with accreata is defined. The patient of age 37, G4P3, previous 2 cesarean section operation was shown to have plasenta previa totalis associated with accreata in 2nd stage ultrasonographic examination. The patient who had bleedings in various intervals undergone cesarean section at the time of 38 weeks and 2 days in elective conditions. An alive male baby was delivered with APGAR scores 8-9. After placenta and its accessories were delivered, a profuse bleeding was observed in the inferior segments. Although the cavity was sutured and uterine arteries were ligated bilaterally, the bleeding insisted. Then the cavity was filled with a Bakri Balloon inflated to 220 cc. After control of bleeding uterus was fixed with sutures properly. Approximately 4 hours later a profound vaginal bleeding was seen and a completely dilated cervix with luxation of balloon in to the vagina was observed in vaginal examination.

In the operating room conditions the balloon was replaced in the cavity again and suture was applied to the cervix like cerclage. The operation was ended after fixation of balloon and the control of bleeding. In the follow up period since no active vaginal bleeding was observed, the balloon was progressively deflated and completely removed after 24 hours. In the postoperative follow up no vaginal bleeding was observed and uterus was contracted. The patient was discharged at 48 hours postoperatively. Bakri Balloons which are used in control of postpartum bleeding may luxate out of the cavity by causing cervical dilatation. In such cases, cervical suturation is a safe and reliable method for the fixation and prevention of luxation of the Bakri balloon.

Keywords: Placenta previa, balloon tamponade, postpartum bleeding

[PP-047]

Jejunal fistula complicating ovarian serous carcinoma: A rare phenomenon

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Invasion of the wall of the digestive system by ovarian cancer cells isn't so rare. On the other hand, fistula formation between the tumor and digestive system is an uncommon status. We described a patient with ovarian serous carcinoma that was fistulized into jejenum and formed a region composed of stool and tumor surrounded and limited by small intestines recognized during surgery. Seventy-two years old multiparous woman admitted to emergengy with abdominal pain. Extensive ascites, thickening of the peritoneal surfaces, bilateral adnexial masses were detected in computed tomography (CT) scan. Ca-125 was 1002. She was operated and total hysterectomy, bilateral salphingo-oopherectomy, total omentectomy, pelvic peritonectomy, appendectomy, ileal resection, low anterior resection, primary ileal anastomosis, primary colo-rectal anastomosis and loop ileostomy opening were performed. In exploration, uterus, 6-7 cm tumoral masses in the both ovaries, sigmoid colon and small intestine formed a conglomerate mass in the pelvis. During the dissection of small intestine from the mass, a loop of jejenum was detected to fistulize in to the left ovarian tumoral mass and a hidden zone composed of left ovarian tumoral mass and stool behind the left side of the uterus with strong odor that was limited by small intestine and sigmoid colon was observed. After dissecting the fistulized loop of jejenum, the conglomerate mass was removed en-bloc with some part of sigmoid colon and rectum (Figure 1). Frozen section revealed serous malign tumor. The loop of jejenum with the fistula tract (Figure 2) was removed and primary ileal anastomosis was performed. Primary colo-rectal anastomosis was done. A loop ileostomy 30 cm proximal to the ileocecal valve was created. Her pathology report showed high grade serous carcinoma in the both ovaries, omentum, resected small intestine, myometrium, pelvic periton. She completed 6 cycles of chemotherapy without trouble. Following the last cycle of chemotherapy, Ca-125 level was 21 and PET-CT revealed no pathological finding. Fistulization into digestive tract increases the risk of morbidity by increasing the duration of the procedure and by increasing the risk of postoperative complications. This diagnosis should be kept in mind while preparing a patient for ovarian cancer surgery if the patient has acute abdomen or abdominal pain incompatible with the extent of the tumor.

Keywords: Ovarian cancer, fistula, surgery

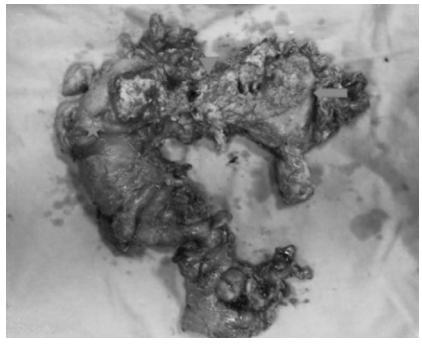


Figure 1. Part of the left tumoral mass (arrowhead) invading myometrium (arrow) and sigmoid colon (star) removed en-bloc

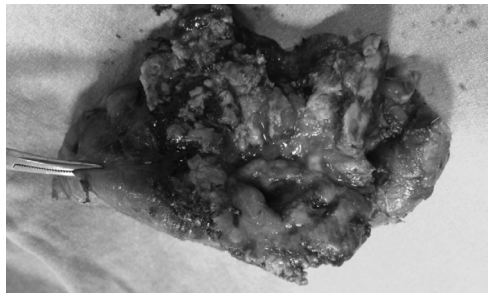


Figure 2. Part of jejenum with the tumor forming the fistula tract

[PP-048]

Hormone therapy following surgery in low grade endometrial stromal sarcoma: Is it related with decrease in recurrence rate?

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Objective: Low-grade endometrial stromal sarcoma (LGESS) is, in most cases, a slow-growing malignancy, however it is related with high recurrence rates. Although LGESS is associated with a higher survival rate than other sarcomas, it has been reported that 37%-50% of patients have recurrence during the late period of the disease. The aim of this study is to determine which factors may be associated with the recurrence rate of LGESS.

Material and Methods: Data for 61 patients treated for histopathologically proven ESS between January 1985 and March 2016 at the gynecologic oncology clinic of our institution were obtained from an electronic database and patient files. Among the patients, 6 with unspecified grade sarcomas, 17 with high-grade or undifferentiated sarcomas, and 1 patient with follow-up <3 months were excluded. The study was completed with 37 patients with LGESS.

Results: Median age at the time of diagnosis was 47 years (range: 34-61 years) and 78% of the patients were premenopausal. All patients underwent hysterectomy and bilateral salpingo-oophorectomy. Additionally, lymphadenectomy was performed in 56.8% (n=21) of the patients. Among the patients who underwent lymphadenectomy, 14.3% (n=3) had lymph node metastasis. Disease was limited to the uterus in 75.7% (n=28) of patients. Tumor diameter was ≤5 cm in 40.5% (n=15) of the patients. In total, 4 patients had stage 2 disease, versus 5 with stage 3 disease. None of the patients had stage 4 disease. Treatment following surgery was radiotherapy in 3 patients, chemotherapy in 7 patients, hormone therapy in 12 patients, and chemotherapy plus hormone therapy in 1. Megestrol acetate was used in all patients that received hormone therapy. Median follow-up time was 96 months. The 5-year disease-free and disease-specific survival were 72% and 97%, respectively. The recurrence rate was 27% (n=10). Only hormone therapy following surgery was significantly associated with a lower recurrence rate, even in patients with stage 1 disease. There was not a significant difference in the distribution of disease stage between the patients treated with and without hormone therapy (p=0.432). None of the patients treated with hormone therapy following surgery had recurrence, whereas recurrence occurred in 38.5% of the patients that underwent surgery only (p=0.039).

Conclusion: Hormone therapy post-surgery should be considered a viable option for decreasing the LGESS recurrence rate, regardless of disease stage.

Keywords: Endometrial stromal sarcoma, low grade, megestrol acetate, lymphadenectomy

Table 1. Association between clinicopathological features and recurrence in all cohort

Factors		**Recurrence status**		
Clinicopathological features		**Absent n (%)**	**Present n (%)**	**p value**
Age	≤50 years	18 (75.0)	6 (25.0)	0.700
	>50 years	8 (66.7)	4 (33.3)	
Menopause status	Premenopausal	22 (75.9)	7 (24.1)	0.322
	Postmenopausal	3 (50.0)	3 (50.0)	
Stage	1	20 (74.1)	7 (25.9)	0.686
	2 and 3	6 (66.7)	3 (33.3)	
Tumor diameter	≤5 cm	10 (66.7)	5 (33.3)	0.061
	>5 cm	10 (100.0)	0 (0.0)	
Uterine serosal involvement	Absent	18 (85.7)	3 (14.3)	0.099
	Present	1 (33.3)	2 (66.7)	
Cervical involvement	Absent	24 (80.0)	6 (20.0)	0.523
	Present	2 (66.7)	1 (33.3)	
Adnexal involvement	Absent	24 (72.7)	9 (27.3)	1.000
	Present	2 (66.7)	1 (33.3)	
Abdominal involvement	Absent	24 (70.6)	10 (29.4)	1.000
	Present	2 (100.0)	0 (0.0)	
Lymph node metastasis	Absent	16 (88.9)	2 (11.1)	0.386
	Present	2 (66.7)	1 (33.3)	
M: Month * p<0.05 is statistically significant				

Table 2. Association between treatment options and recurrence in all cohort

Initial treatment options				
Initial surgery type	TAH + BSO	8 (53.3)	7 (46.7)	0.058
	TAH + BSO + Lymphadenectomy	18 (85.7)	3 (14.3)	
Only surgery and surgery with adjuvant therapy	Only surgery	8 (61.5)	5 (38.5)	0.440
	Surgery with adjuvant therapy	18 (85.7)	5 (21.7)	
Only surgery and surgery with adjuvant radiotherapy	Only surgery	8 (61.5)	5 (38.5)	0.200
	Surgery with only adjuvant radiotherapy	0 (0.0)	3 (100)	
Only surgery and surgery with adjuvant chemotherapy	Only surgery	8 (61.5)	5 (38.5)	1.000
	Surgery with only adjuvant chemotherapy	5 (71.4)	2 (28.6)	
Only surgery and surgery with adjuvant hormone therapy	Only surgery	8 (61.5)	5 (38.5)	0.039*
	Surgery with only adjuvant hormone therapy	12 (100.0)	0 (0.0)	
TAH: Total abdominal hysterectomy, BSO: Bilateral salpingo-oophorectomy, m: month *p<0.05 is statistically significant				

[PP-049]

A giant fibrothecoma in the left ovary: A case report

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We aimed to present a giant fibrothecoma of the left ovary. A 30-year-old multiparous woman admitted to our clinic with the complaint of vaginal discharge. A mobile, solid left adnexial mass was found during the bimanuel examination. While the uterus and the right ovary were normal on ultrasonographic imaging, a tumour having solid -cystic areas and reguler contours was detected in the left adnexial area. The average diameter of the tumour was measured as 29 cm. Additionally, there was ascite in the abdomen. Serum CA-125 level was 52 IU/mL. Exploration of the abdominopelvic area during the laparotomy revealed ascites in the abdomen and a 30 cm diametered mutilobulated solid tumour which had an intact capsule with no papillary projections (Figure 1). Uterus, the right ovary and peritoneal surfaces were observed to be in normal apperarance. Intraoperative frozen section which was performed following the cystectomy from the left ovary and the final pathologic sections were reported as fibrothecoma (Figure 2). The postoperative period was uneventful and the patient was discharged on the second postoperative day. Fibrothecomas are classified within the ovarian sex cord stromal tumours which constitude 1-4% of all ovarian tumours. Albeit the peak detection in postmenapausal period, these tumours make a second peak in woman aged between 20-40 years. They are mostly unilateral having an average diameter of 6 cm. However, there are rare cases which had reached huge diameters as the one reported in the current case report (1,2). Due to the presence of cystic denegeration areas in the tumour, to its solid nature and to the coexistance of abdominal ascites in 10% of the cases, fibrothecomas may lead to a dilemma in putting the clinical diagnosis of malign ovarian tumours (3). Even if there have been a few publications reporting CA-125 levels measured as high as 600 IU/mL, CA-125 levels have been usually in normal ranges in fibrothecoma cases. In the current case report, CA-125 level was mildly elevated. Although mostly detected in postmenopausal period, fibrothecomas should be considered in differential diagnosis of solid ovarian tumours dedected in premanopausal woman.

Keywords: Ascite, fibrothecoma, ovary

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Figure 1. Macroscopic view of the giant ovarian fibrothecoma

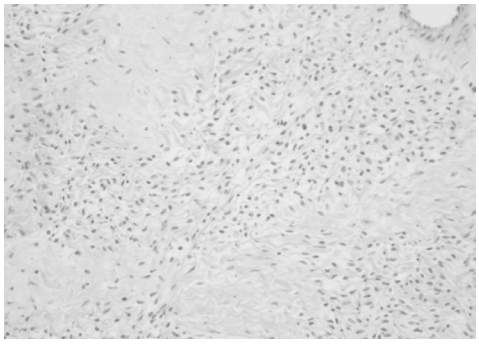


Figure 2. The tumour showed a prominent hyalinized fibrous stroma with a scanty spindle cell component (Hematoxylin-eosin staining 200x original magnification)

[PP-050]

The risk factors predicting recurrence and survival in geriatric patients with endometrium cancer

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Objective: To investigate the risk factors predicting recurrence and survival in geriatric patients diagnosed with endometrium cancer (EC).

Material and Methods: Three hundreds and six geriatric (≥65 years) patients who were treated and followed-up due to epithelial endometrium cancer between January 1993 and May 2013 in a single center were evaluated retrospectively. Geriatric patients were categorized into two groups (65-69 vs ≥70 years). All patients were staged according to FIGO 2009 staging system. Disease-free survival (DFS) was defined as the period from initial surgery to disease failure or the date of the last contact. The period from initial surgery to death because of the disease or last follow-up visit was defined as cancer-specific survival (CSS). The Kaplan-Meier method was used for the assessment of survival outcomes. Survival curves were compared using the log-rank test. Multivariate analysis was performed using a Cox proportional hazards model. The level of statistical significance was set at $p<0.05$.

Results: The median age of all cohort was 70 years (range; 65-92). Median follow-up time was 35 (range, 1-168) months. There were 176 (57.5%) patients and 130 (42.5%) patients in groups including patients with 65-69 years and ≥70 years, respectively. There were no difference among geriatric age groups in the demographical, clinical, surgical and pathological factors. Oncological outcome were similar in both age groups (65-69 vs ≥70 years). The 5-year DFS was 70% and 77%, respectively ($p=0.501$). The 5-year CSS was 85% and 83%, respectively ($p=0.904$). Non-endometrioid type, advanced stage, high grade, presence of cervical invasion, positive cytology, presence of lympho-vascular space invasion, lymph node metastasis and non-nodal extra-uterine spread were worst prognostic factors for oncologic outcomes in the entire cohort (Table 1). Although there was no significant relation between depth of myometrial invasion and oncologic outcomes, it was significantly related to increase in recurrence rates in endometrioid type EC ($p=0.039$). But no significant relation was found between the presence of cervical invasion and recurrence and survival in endometrioid type. Independent prognostic factors were FIGO grade only for recurrence and preoperative CA-125 level for mortality rate (Table 2).

Conclusion: Accepted prognostic factors in endometrium cancer continue their effects in geriatric patient group. The poor prognostic factors and survival rates did not change with the increase in age.

Keywords: Endometrial cancer, geriatrics, prognostic factors, recurrence, survival

Table 1. Prognostic factors predicting disease free survival and cancer spesific survival

		DFS		CSS	
Factors		**5 year (%)**	**p**	**5 year (%)**	**p**
Age	65-69	70	0.501	85	0.904
	≥70	77		83	
Histologic type	Endometrioid	77	0.013	86	0.055
	Non-endometrioid	50		74	
Stage	1	86	0.001	97	0.001
	2	63		80	
	3	56		68	
	4	26		30	
FIGO grade	1 and 2	81	0.001	92	0.001
	3	57		65	
Tumor size (mm)	<20	75	0.859	75	0.263
	≥20	66		78	
Peritoneal cytology	Negative	76	0.001	89	0.001
	Positive	51		52	
Myometrial invasian	<1/2	78	0.222	88	0.294
	≥1/2 ^	71		83	
Cervical invasion	Absent	77	0.001	89	0.001
	Present	55		57	
Adenexial involvement	Absent	77	0.001	90	0.001
	Present	34		38	
LVSI	Absent	81	0.012	94	0.001
	Present	70		75	
Lymph node metastasis	Absent	81	0.001	91	0.001
	Present	49		58	
Non-nodal ekstrauterin spread	Absent	78	0.001	91	0.001
	Present	20		21	

^ : Uterine serosal involvement was excluded, LVSI: lymphovascular invasion

Table 2. The multivariate analysis for prognostic fartors related to recurrence and death

Factors		Recurrence			Death		
		HR	95% CI	p	HR	95% CI	p
FIGO grade	1 and 2	1	-	0.049	1	-	0.032
	3	2.08	1.002-4.347		3.12	1.103-8.828	
Preoperative CA-125 level	≤35 IU/mL	1	-	0.111	1	-	0.05
	>35 IU/mL	1.83	0.871-3.857		2.71	0.976-7.560	
Variables including to model after performing the Backward elemination; HR: Hazard ratio; CI: Confidence inteval, p<0.05 statistically sigificance							

[PP-051]

Determining the probability of subsequent development of premalignant/malignant lesions in cases of the cervical cytology with atypical squamous cells

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Objective: This study has been planned to determine the probability of subsequent development of premalignant/malignant lesions in cases of the cervical cytology with ASC (atypical squamous cells), and to investigate how such cases were managed.

Material and Methods: This retrospective study has been conducted in Clinic of Obstetrics and Gynecology, İzmir Katip Çelebi University, Atatürk Training and Research Hospital between the dates of 30th of September 2010 and 30th of September 2015. The study groups included the patients whose smear tests comprised ASC. These were divided into two groups, the first group included patients presenting with ASC-US (atypical squamous cells of undetermined significance) and, the second group consisted of the patients presenting with ASC-H (atypical squamous cells in which high-grade squamous intraepithelial lesions cannot be excluded). Hospital records of the patients were re-evaluated regarding the diagnostic and therapeutic procedures and follow-up.

Results: The prevalence of ASC-US and ASC-H were 15.4% and 4.8%, respectively. The mean ASC age was 41. Biopsy was performed to 21.4% of ASC-US patients, and 60.6% of ASC-H patients. Premalignant/malignant lesions were found 12.7% of the ASC population. Premalignant lesions comprised 4.7% of ASCUS group, while they were 28.7% in ASC-H group. Malignant lesions were 9% in ASC-H group. Malignancy were not encountered in the group of ASC-US patients. The results of our study revealed that 79.5% of patients with ASC-US, and 63.6% of patients with ASC-H didn't comply to follow up requirement.

Conclusion: The prevalence of ASCUS and ASC-H was found to be higher in our study compared to pertinent literature. We found that malignancy was more prevalent in the patient with ASC-H. Diagnostic and therapeutic approach was insufficient and the patient compliance was low. Since the significance of ASC diagnosis were underestimated, their potential for subsequent development of cervical malignant lesions is mostly ignored and missed by the physicians and the patients.

Keywords: Atypical squamous cells in which high-grade, atypical squamous cells of undetermined significance, atypical squamous cells, cervical cytology

[PP-052]

Acute urinary retention caused by a large impacted leiomyosarcoma

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Acute urinary retention is a rare condition in women. We report a case of urinary retention (UR) caused by impaction of pelvic mass that was finally detected to be uterine leiomyosarcoma. A 61-years old women applied to the urology department for an intermittent urine failure. The symtoms of the patient who did not benefit from the treatment increased and the patient was directed to the obstetrics and gynocology department for further investigation. The patient who could not urinate for 24 hours, stated that she had difficulty in urinating for about three months. The symptoms of the patient got worse in the morning. She had to go to the toilet several times to emty her bladder some mornings. The patient who did not need to strain to start and maintain the first urination needed to urinate again after walking for a few minutes in the house. It was not possible to completely empty the bladder. It took about 3 hours to emty her bladder in such mornings. Physical examination showed distanded bladder. A foley catheter was inserted and 850 cc urine was drained. Transvaginal ultrasonography showed a rectovesical mass pushing the bladder into the abdominal wall. This rectovesical mass was a myoma of approximately 10 cm, originating from the posterior part of the uterus. Bilateral ovaries

were normal. Pelvic magnetic resonance imaging (MRI) showed a solid mass with cystic septal degenarations about 10 cm in the uterine corpus, similarly several myomas observed with the largest diameter of 6.5 cm. MRI also reported that the appearence was compatible with myomatosis uteri but malign degeneration could not be ruled out. Laboratory findings were normal. The neurological examination of the patient was normal. Operation was planned in the same week after evaluation. An abdominal total hysterectomy and bilateral salpingo-oophorectomy were performed (Figure 1). Intraoperative findings were compatible with myomatosis uteri. On the day after surgery, she was able to obtain a normal voiding ability without any difficulty and the postoperative course was normal. The final pathology report revealed leiomyomasarcoma of the uterus. Positron emission tomography-computed tomography (PET-CT) did not show any residual tumour. Medical oncology did not recommend adjuvant therapy. She has been followed-up for 5 months after surgery without any evidence of disease. Impaction of a malign pelvic mass should be kept in mind while evaluating women with UR.

Keywords: Pelvic mass, impaction, urinary retention, leiomyosarcoma



Figure 1. Hysterectomy material, clamps holding the tubes. Uterine fundus (Arrowhead), Myoma uteri impacted in the pelvis (star)

[PP-053]

Two cases of appendiceal neuroendocrine tumours incidentally found and diagnosed during elective gynaecological operations

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Neuroendocrine tumours (NETs) arise from sub-epithelial neuroendocrine cells of appendix. Among gastroenterohepatic neuroendocrine tumours, from 2.1% to 20% are appendiceal NETs (A-NETs). Through recent endoscopic methods and advanced imaging techniques, diagnosis of NETs has shifted to earlier stages. To the best of our knowledge, this is the first case report in the literature on their incidental diagnosis by gynaecologists without signs or symptoms of either acute appendicitis or metastasis and also sent to frozen section analysis due to suspicion of neoplasia. Here, we present two diagnosed cases of A-NETs from a total of 250 gynaecological procedures performed by one gynaecologist either via laparatomy or laparoscopy over two years. A 32-year-old multiparous woman was referred to the gynaecological oncology outpatient clinic with a complaint of abdominal swelling and a right-sided adnexal mass. According to routine query in the outpatient clinic, the patient had no additional signs or symptoms requiring to further investigation. The ultrasonografic, clinical and laboratory results resulted in a prediagnosis of a 10-centimetre (cm) mucinous cystadenoma. The patient underwent a midline laparatomy. During examination of the abdominal cavity, the tip of the appendix was firm, consisting of a 10-millimetre (mm) pearl-like, regular lesion that would have remained undiagnosed if it had not been palpated (Figure 1). There were no additional findings within either the pelvic or the abdominal cavity. As a result of an oral gastroenterological surgery consultation, an appendectomy with a frozen section analysis was recommended and performed. The frozen section analysis revealed a neuroendocrine tumour of the appendix and mucinous cystadenoma of the right ovary. The final pathology demonstrated a Stage 1a, Grade 2 NET of the appendix with clear margins and muscularis propria invasion (Figure 2). Postoperative imaging showed no signs of metastasis. The patient underwent follow-up by the gastroenterological surgery unit and has been disease-free for 16 months now. A 45-year-old woman with a complaint of abnormal uterine bleeding was admitted to the outpatient clinic. On ultrasonography, myoma uteri was diagnosed and no additional signs or symptoms were encountered. The patient underwent laparotomy via a pfannenstiel incision. During abdominal cavity examination, a similar lesion to the first one, 1.5 cm in diameter, was observed and the patient underwent appendectomy with hysterectomy and unilateral salpingo-oopherectomy. The frozen section of the appendix revealed a NET. The final pathological report presented a Stage 1b, Grade 2 NET of the appendix with clear margins and serosal invasion (Figure 3). Additional postoperative imaging exposed no signs of metastatic disease. A right hemicolectomy was recommended by the gastroenterological surgery, but the patient refused to undergo a second operation and underwent follow-up with a disease-free period of nine months. Abdominal cavity exploration may help to reveal other pathologies than the one which the surgeon is interested in. A-NETs indicate a promising outcome and prognosis. Surgical management with a simple appendectomy seems to be curative for the majority of cases, especially for tumours of less than 1 cm.

Keywords: Appendectomy, appendix, gynecology, neuro endocrine tumors



Figure 1. Intraoperative view of appendix

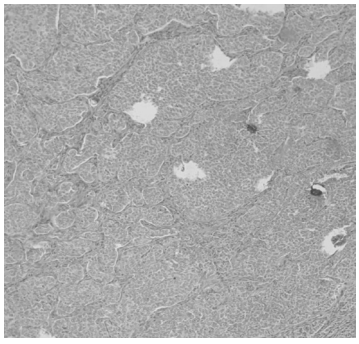


Figure 2. Pathological view of appendix on hematoxylin&eosin x10

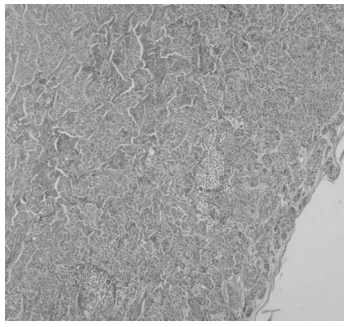


Figure 3. Pathological view of appendix on hematoxylin&eosin x10

[PP-054]

Tunnel cluster cysts of the endocervical canal presenting in imaging as malignancy of the uterine cervix

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Tunnel cluster cells (TCCs) are pseudoneoplastic glandular lesions of the uterine cervix. They are defined as a specific type of nabothian cyst, characterized by complex multicystic dilatation of the endocervical glands. They occur in about 8% of multiparous women over the age of 30. These lesions are possibly caused by the subinvolution of previous episodes of hyperplastic endocervical mucosa associated with previous pregnancies. Adenoma malignum is the malignant version of the differential diagnosis for pseudoneoplastic glandular lesions, and radiography is sometimes insufficient to identify these entities. Furthermore, histopathological diagnosis can sometimes be challenging. There are limited reports about the misdiagnosed imaging features of TTCs in the literature. Here, we present a case of tunnel cluster cells of the endocervix, which presented a cervical imaging conundrum and was believed to be malignant until the histopathological diagnosis. A 52-year-old multiparous woman was admitted to the gynecologic oncology outpatient clinic with a magnetic resonance imaging (MRI) report indicating an 18x19 millimeter, irregular-bordered, heterogeneous-enhancing and diffusion-limiting cervical mass, presenting as hyperintense on T2-weighted images with non-enhancing cystic-necrotic spaces (Figure 1, 2). The lesion had been reported as under suspicion of malignancy. On pelvic examination, no trace of an apparent cervical tumor was present. On transvaginal ultrasonography, a 30-millimeter hypoechoic multicystic cervical mass with internal vascularity was revealed. The cervical screening with a conventional Pap smear test revealed negativity for intraepithelial neoplasia and malignancy. The patient underwent colposcopy with a cervical biopsy and endocervical curettage. An endometrial biopsy was also performed to determine the reason for the abnormal uterine bleeding that the patient had been experiencing for two years. The colposcopic findings indicated features of low-grade intraepithelial neoplasia. On the pathological examination, the biopsies and curettage reports revealed koilocytosis, but no clear indication of malignancy, which led to the decision to perform conization. From the endometrial biopsy specimen, a secretory endometrial pattern was obtained. The results of this conization showed cystic TCCs with low-grade cervical intraepithelial neoplasia (Figure 3). On the patient's first postoperative follow-up examination one month later, a ten-millimeter lesion was found to be persisting in the endocervical canal. Because of this, as well as additional indications, such as adenomyosis and abnormal uterine bleeding, the patient underwent a hysterectomy. The final pathology of the uterine cervix was again found to be cystic TCCs of the endocervix (Figure 4). The imaging features of benign cystic cervical lesions may mistakenly indicate malignancy of the uterine cervix. Histopathology is the cornerstone of diagnosis, but it is sometimes difficult to exclude the suspicion of malignancy. It is important for radiologists and clinicians to be familiar with a broad spectrum of types of cystic lesions of the uterine cervix to prevent overtreatment due to an incorrect histopathological diagnosis of malignancy.

Keywords: Cervical cancer, imaging, tunnel cluster cysts

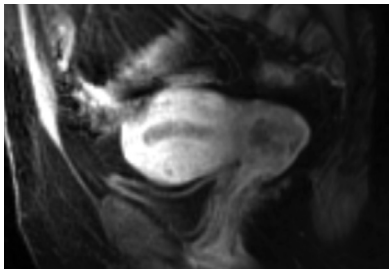


Figure 1. T1 weighted image of the lesion with heterogeneous enhancing

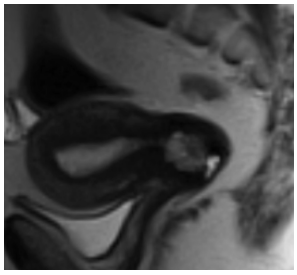


Figure 2. T2 weighted image of the lesion with high signal intensity

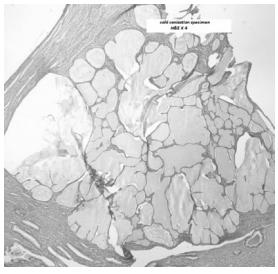


Figure 3. Conization specimen of cervix on hematoxylin & eosin x4

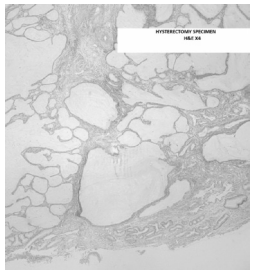


Figure 4. Hysterectomy specimen of cervix on hematoxylin&eosin x4

[PP-055]

Vanishing endometrial cancer

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Endometrial carcinoma is the most commonly seen gynecologic malignancy in women, affecting particularly the postmenopausal stage. In many cases, the diagnosis of endometrial cancer is made upon endometrial biopsy and then confirmed on the hysterectomy specimen. In very rare occasions, no residual carcinoma is found in the hysterectomy specimen, even in the absence of any neoadjuvant treatment (chemotherapy or radiation) and despite thorough evaluation of the pathologic specimen. This scenario has been referred to in the literature as the "vanishing carcinoma phenomenon" that was first reported in radical prostatectomy specimens. The real incidence of this entity has not been clearly identified. In this report, we presented a case of vanishing endometrial carcinoma. A 52-year-old postmenopausal woman with unremarkable history presented with a recent onset of postmenopausal bleeding. She was not receiving hormone replacement theraphy. Ultrasonographic examinations revealed a 1 cm mass within the endometrial cavity consistent with the diagnosis of an endometrial polyp without increase in adjacent endometrium thickness. A dilation and curettage procedure was performed. Histological examination revealed a polyp comprising moderately differentiated endometrioid adenocarcinoma admixed with clear cell carcinoma (Figure 1). Two weeks later, the patient underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy, omental biopsy, and bilateral pelvic and paraaortic lymphatic dissection. The histological examination of the hysterectomy specimen showed no residual tumor, neither malignancy in omental biopsy and lymph nodes. The previous slides were reviewed to exclude possible misdiagnosis, clarifying the presence of the mixed type endometrial cancer while the hysterectomy specimen again showed no residual tumor. The patient is stil alive, living with no apparent evidence of disease and neither receiving any adjuvant therapy for 4 years after hysterectomy. Hysterectomy specimens with no residual cancer after endometrial cancer diagnosis made by endometrial biopsy may be a problem from the medico-legal perspective. The recognition of this phenemenon might be a useful for gynecologic pathologist and gynecologic oncologist in order to prevent mismanagement and medico-legal ligitation.

Keywords: Endometrial carcinoma, hysterectomy, vanishing cancer phenomenon

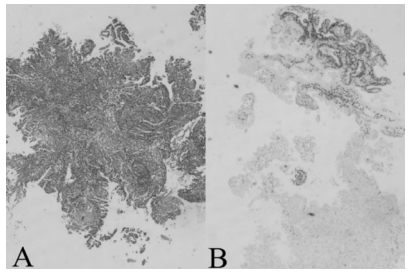


Figure 1. Neoplastic proliferation in the solid-micropapillary pattern with a large clear cytoplasm and hyperchromatic nucleus, as well as stratum corneum cells in the villoglandular pattern in adenocarcinoma morphology were observed (Figure A; hematoxylin-eosin, original magnification x100). Immunohistochemical examination revealed strong nuclear expression of ER and PR and absent of CEA expression in adenocarcinoma areas. The expression of CEA and p53 with absent of ER and PR expression in clear cell areas (Figure B; original magnification x200)

[PP-057]

Laparoscopic surgery in endometrial cancer treatment

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Objective: The aim of this study is to compare surgical outcomes and perioperative complications of laparoscopic surgery and laparotomy in the treatment of early Stage 1A-2B endometrioid endometrial cancer patients.

Material and Methods: We retrospectively reviewed patients who underwent surgery due to endometrial cancer at our institution between 2014-2017. Patient's medical records, operation notes, and pathology files were obtained from hospital database system. Only early stage (Stage 1) endometrioid endometrial cancer patients were included in the study. Other stages and histologic types were excluded. Operation times, length of hospital stay, extracted pelvic lymph nodes, perioperative complications and blood loss were compared.

Results: Two hundred seventy-two patients were treated for endometrial cancer between 2014-2017. One hundred nine of them were Stage 1 endometrioid endometrial cancer. While 47 patient (43.1%) underwent laparoscopic surgery, 62 patient (56.8%) underwent laparotomy. One patient was converted from laparoscopy to laparotomy due to anatomical reasons related to past operations. There were no differences between operation times and extracted pelvic lymph nodes. The length of hospital stay and estimated blood loss were lower in the laparoscopic surgery group. Perioperative complication rate was 8.5% (1 bladder perforation, 1 bowel injury, 1 obturator nerve injury, 1 trocar site hernia) in the laparoscopic surgery group, 14.5% (4 surgical site infection, 2 bowel injury, 3 postoperative incisional hernia) in the laparotomy group. The laparoscopic surgery group had lower perioperative complication rate.

Conclusion: Laparoscopic surgery is a safe and effective technique for treatment of early stage endometrial cancer. Its complication rate was lower than laparotomy. Laparoscopic surgery is an alternative treatment method and should be supported in endometrial cancer treatment.

Keywords: Endometrial cancer, laparoscopy, laparotomy

[PP-059]

Case report of high stage cervical cancer in pregnancy

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Cervical cancer is third most common malignancy in women. 1-3% of cervical cancers will be diagnosed in pregnant-peripartum women; optimal management in the setting of pregnancy is unclear. Cervical cancer management in pregnancy is a clinical challenge. There is a noticeable absence of such data to recommend definitive treatment guidelines. Course of disease and prognosis of cervical cancer in pregnant patients are similar to those of nonpregnant patients. A multidisciplinary team approach is required. Aims of this case were to summarize current recommendations for treatment of cervical cancers in pregnancy and to review updates on existing knowledge regarding safety of treatments in pregnancy, including both oncologic and fetal outcomes. Thirty-nine-year-old woman, gravida 1 para 0 was referred at 28 weeks of gestation with vaginal bleeding, visual impairement, weight loss. Her previous pap smear result was normal. The patient was found to have 3 cm exophytic cervical mass, with parametrial or vaginal involvement. Cervical biopsy revealed cervical high grade invasive squamous cell carcinoma. Abdominal, pelvic and cranial magnetic resonance imaging evaluation showed muliple site distant metastasis. This case was compatible with the clinical cervical carcinoma FIGO stage IVb (see Figure 1-5). Patient wished to preserve pregnancy, elective cesarean section performed at 34 weeks of gestation, after antenatal corticosteroids were administered. Female newborn delivered, 1895 g and APGAR index of 9/10. This patient was under 2 years of follow-up. The baby at 2 years of follow-up has normal neurodevelopment. Our patient had undergone concomitant chemoradiotherapy after delivery. Before and after chemoradiotherapy FDG PET scan was performed. After treatment cervical tumor mass, right frontal, right surrenal, liver, thoracic and mediastinal lymph node metastasis were regressed. She died of sepsis after 2 years. Choice of treatment must be individualized according to gestational age, stage of disease and chioce of mother. If mother chooses to continue pregnancy, decisions regarding timing of treatment and delivery require careful consideration of disease stage and trimester in which diagnosis is made. In addition to assessment of extent of cancer, initial evaluation of pregnant patient with cervical cancer should include an accurate fetal outcome assesment. Once the diagnosis, stage, and extent of invasive cervical cancer have been established, a multidisciplinary meeting should be arranged. Owing to lack of prospective randomized trials of cervical cancer treatment in pregnancy there is a noticeable absence of treatment guidelines. During the second half of the pregnancy, a delay of 6 to 8 weeks to reach fetal lung maturity is acceptable. However, during the first half of pregnancy, when delivery is remote, women are advised to be treated as soon

as possible, relinquishing their pregnancy. Alternatively, neoadjuvant chemotherapy during pregnancy can be used to stabilize or reduce cervical cancer. It is difficult to draw definite treatment guideline in cervical cancer of pregnancy. There are limited number of systematic case series in the literature comparing the treatment of cervical cancer in both pregnant and nonpregnant women. However, these women have survival profile that closely approximates nonpregnant population, when adjusted for stage. The effect of cervical cancer on pregnancy outcome is less clear.

Keywords: Cervical cancer, pregnancy, high stage

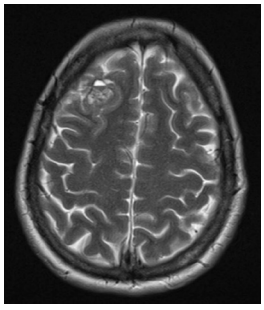


Figure 1.

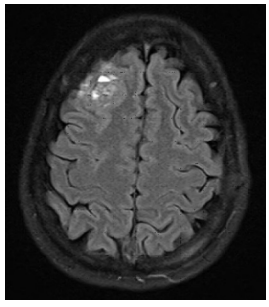


Figure 2.

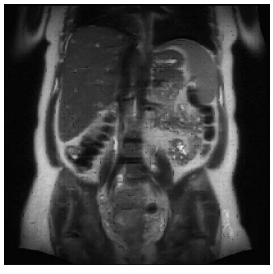


Figure 3.

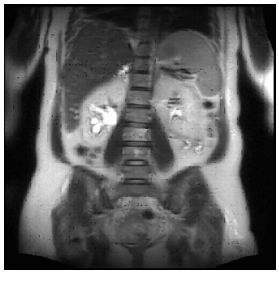


Figure 4.



Figure 5.

[PP-060]

Retroperitoneal extraskeleteal mesenchymal chondrosarcoma in a neurofibromatosis patient: An extremely rare case report

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Mesenchymal chondrosarcoma (MC) is not clearly known etiopathogenesis, but it is often originated from primitive mesenchymal cells and, less frequently, from immature cartilaginous tissue 1. MK accounts for 1% of all chondrosarcomas and is very aggressive 2. Non-Skeletal Mesenchymal Chondrosarcomas (NSMC) are rarely seen in the retroperitoneal region, although they are usually observed in the lower extremity 2, 3, 4, 5. Here, we planned to present a 65-year-old case of NSMC with retroperitoneal placement and neurofibromatosis Type 1 (NF1). A 65-years-old female patient applied to obstetrics and gynecology clinic with complaints of incontinence and constipation. The patient's resume feature not seen outside of NF1. The probe curettage could not be performed because of cervical os due to mass pressure. Pelvic MR revealed a heterogeneous mass lesion with a pseudocapsule and a pelvic incision, extending to the pelvic floor and measuring 11x9x13 cm, with cystic necrotic areas. Tumor marcers were negative in the blood tests of the patient. A mass of 16x13 cm was observed in the back of the uterus filling the douglas at the laparatomy. The patient underwent total abdominal hysterectomy and bilateral salpingohoferectomy. It was observed that the clavicle passed through the douglas cavity and proceeded to the rectovaginal plane and reached the pelvic floor. The mass was partially removed with the pseudocapsule completely. Frozen result came as a malign mesenchymal myxoid tumor. Rectum was entered during the operation. Approximately 20 cm of rectum and sigmoid colon

were resected by general surgery. The operation was terminated by performing endwise anastomosis and protective iliostomy. Pathology was assessed as a result of ESMC (FNCLLC Grade 3). In the immunohistochemical staining performed, Vimentin was positive in both areas; SMA, Desmin, CD34, CD117, Cytokeratin AE1/AE3, EMA were negative. S100 is only well differentiated in chondroid tissue, whereas CD99 is only positively in immune cell areas. The Ki67 proliferation index was estimated to be approximately 20% in immature areas. While MC is seen in young adults and adolescents, ESMC is usually seen after 40 years of age 6. Our case was 65 years old in accordance with the literature. ESMC rarely occur in mediastinum, retroperitoneum, abdominal wall and kidney 2, 4, 5, 7. When we perform a literature review, we are the first occurrence in the literature with NF1 association originating from the rectovaginal region. Imaging methods such as USG and MR can be used in patients with ESMC 3, 8, 9, 10. Although radiological methods were useful in our present case, there were nonspecific findings and histopathological evaluation was needed to make a diagnosis. Staining of mesenchymal cells with CD99 and Vimentin and staining of cartilage sites with S-100 may guide ESMCs to distinguish them from other similar tumors 11. In our case histopathologic and immunohistochemical findings were compatible with the literature. ESMC are mostly aggressive tumors that are not diagnosed early. Radical surgery is the primary treatment for the disease 12. However, in cases where surgery cannot be performed, the patient cannot be fully resected or recurrence develops, treatment radiotherapy and chemotherapy should be added 11.

Keywords: Mesenchymal chondrosarcoma, extraskeleteal, neurofibromatosis, immunohistochemical, retroperitoneal



Figure 1. Common neurofibromas in the body

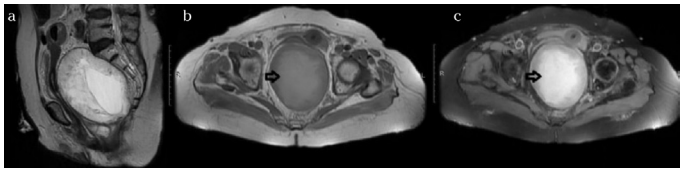


Figure 2. a) Sagittal T2A MR examination; A mass lesion with pseudocapsule multiloculated haemorrhagic areas is seen posterior to the pelvic uterus. b) Axial T1A c) Axial T1A Oil-imprinted MR examination; The hemorrhagic areas (arrow mark) in the kilt are monitored

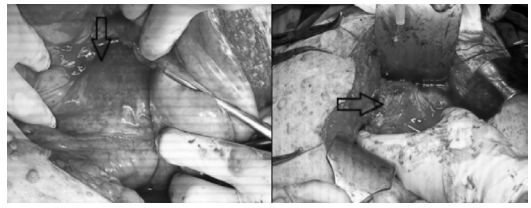


Figure 3. Intraoperative imaging of ESMC with retroperitoneal placement of pelvis

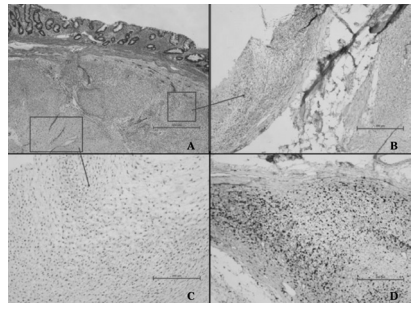


Figure 4. The tumor filling rectum serosa consists of well differentiated chondrosarcoma areas surrounded by hypercellular immune cell clusters at the periphery. A) Hematoxylin-eosin, 4x objective examination. B) The immature cells (small squares) in the hypersaline areas are positive with CD99. C) Immunohistochemistry 10x objective examination; Good differentiation is observed in the S100 positive in the chondrosarcoma areas (large quadrilateral). D) Immunohistochemistry 10x objective examination; Ki67 proliferation index is very high in immature cells

[PP-061]

Is preoperative neutrophil: Lymphocyte ratio a predictor to determine locally advanced endometrioid endometrial cancer?

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Objective: To investigate the predictive value of preoperative neutrophil: lymphocyte ratio (NLR) in staging of patients with endometrioid endometrial cancer.

Material and Methods: The study was conducted retrospectively in a university hospital between 2010 and 2014. Patients with any stage of disease who underwent staging surgery for endometrioid endometrial cancer were included in the study. Exclusion criterias were patients with hematologic disease, patients who received neoadjuvant chemotheraphy and patients using any type of drug

that could influence hematologic parameters. Preoperative NLR was compared with postoperative surgical staging parameters in means of grade, myometrial invasion, cervical stromal invasion, serosal and/or adnexial invasion, vaginal and/or parametrial invasion, positive lymph node localization, bladder and/or bowel invasion, distant metastasis and definitive surgical stage.

Results: The mean age of the patients was 63.1±10.9 years. The mean NLR was 2.7±1.6. The distribution of grades was 23%, 55.3% and 21.7% respectively. Eightysix percent of the patients was diagnosed in early stage (Stage 1-2). There was no statistically significance between NLR and grade, myometrial invasion, vaginal and/or parametrial invasion, positive lymph node localization, bladder and/or bowel invasion, distant metastasis and definitive surgical stage (p>0.05). However, NLR was correlated with cervical stromal and serosal/adnexial involvement (p=0.0, p=0.01, respectively).

Conclusion: NLR may be evaluated alone or with preoperative imaging to determine the patients with endometrioid endometrial cancer confined to uterine body or adnexa.

Keywords: Endometrial cancer, lymphocyte, neutrophil, staging

[PP-062]

Rare situation in extremely rare tumor of uterus; recurrence in uterine tumors resembling ovarian sex-cord tumor: Case report and systematic review

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Objective: To evaluate the prognostic factors of recurrence in UTROSCT and to determine clinical-pathological characteristics, treatment options and outcome.

Material and Methods: The literature electronic search was conducted from 1976 to 2018 (Figure 1). After the comprehensive evaluation and conjunction with our case, the study included 79 cases. A 61 years old patient who underwent total abdominal hysterectomy (TAH) and bilateral salpingo-oophorectomy (BSO) referred our gynecologic-oncology clinic because of diagnosis of UTROSCT. The microscopic evaluation of specimen reviewed by expertise pathologists in gynecologic oncology. The pathologic result showed that the tumor was limited to the endometrium but in some areas myometrial invasion couldn't be excluded. The sections had solid appearance with trabecular formation in patches and included cells with clear, vacuolated cytoplasm. The stromal cells had mild pleiomorphism and no necrosis. The mitotic index was 1 to 2 per 10 high power fields. According to the immunohistochemical results; it was positive for calretinin, CD56, ER (estrogen receptor), PR (progesterone receptor), vimentin, WT1, synaptophysin and chromogranin, but negative for CD10, EMA, desmin, CD99 and inhibin. A 50 mm pelvic mass was determined incidentally with ultrasonography and magnetic resonance imaging in due course of follow-up at 60th months after initial diagnosis. She underwent cytoreductive surgery with performing pelvic mass excision, omentectomy and tumoral implant resection from spleen; and maximal debulking was provided. Pathologic evaluation of reported as a recurrence of UTROSCT. She received adjuvant hormone therapy during one year as megestrol acetate (ceased because of the side effects) and letrozole, respectively. Three months after therapy completed, she underwent cytoreductive surgery because of the secondary recurrence in pelvis and abdomen. There were a pelvic mass behind the bladder, tumoral implants on anterior surface of abdominal wall. Maximal debulking was provided. According to medical oncologist's suggestion adjuvant chemotherapy was planned, but she refused. She is alive and disease free during 7 months after secondary surgery. Her follow up time was 83 months.

Results: The median age at initial diagnosis was 49 years (range; 16-86). The age was under 40 years in 21 (26.6%) patients. Whereas 68 patients underwent at least hysterectomy, 9 patients had organ sparing surgery. There were necrosis in 4 (5.1%) patients, atypia in 16 (20.3%) patients, mitosis in 36 (45.5%) patients and infiltrative tumor border in 34 (43%) of patients. Tumor involved at least part of the myometrium in 54 (68.3%) patients. Median follow-up time was 30 months (range; 3-296). Recurrence was determined in 5 (6.3%) patients (Table 1). The only surgery type was significantly related with disease free survival (DFS). None of the pathologic features were related with DFS. 5-year DFS was 86% and 96% in patients who underwent organ sparing surgery or not, respectively (p=0.039) (Table 2).

Conclusion: Correct pathologic diagnosis of UTROSCT has an important value on shaping the surgical management and follow-up period. The organ sparing surgery was related with lower DFS. Although recurrence is rare, it should be kept in mind for patients with UTROSCT especially in those managed conservatively because of fertility desire.

Keywords: Uterine tumor, sex cord tumors, recurrence, UTROSCT, organ sparing surgery

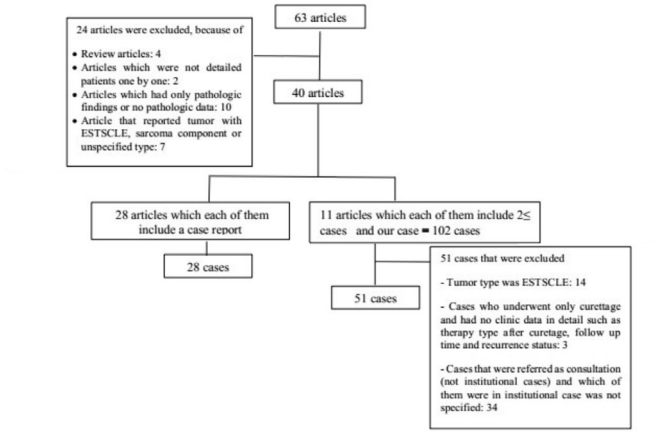


Figure 1. Chart of the literature electronic search of UTROSCT
ESTSCLE: Endometrial stromal tumors with sex cord-like elements

Table 1. Clinical-pathological factors of recurrent patients with UTROSCT

No	Author/ year	Age	Initial therapy	Size of tm (mm)	Localization of tumor	Extra-uterine spread	DFI (m)	Symptom in recurrence	Recurrence site	Therapy of rec	FU- time (m)	Status
1	Biermann et al. 2007 (1)	68	TAH+BSO	45	Uterine	no	48	Intestinal obstruction	Abdominal (Gastric serosa and intestinal wall)	Cytoreductive surgery	48	NR
2	O'meara et al. 2009 (2)	35	TAH	99	Uterine	no	36	Galactorrhoea +palpable mass	Abdominal + pelvis + subcutaneous	Cytoreductive surgery and chemotherapy (BEP protocol)	48	NED
3	Liu et al. 2015 (3)	50	Submucous myomectomy	45	Uterine + cervix	no	10	Pelvic mass	Pelvis (uterine mass)	Surgery (TAH)	60	NED
4	Endo et al. 2016 (4)	62	TAH	NR	Uterine	no	276	Pelvic mass	Pelvis (pelvic lymph node +pelvic wall infiltration)	Hormonal therapy$^{\infty}$ + tumoral arterial embolization+ cytoreductive surgery (incomplete resection	296	Stabile disease
5	Presented case 2017	61	TAH+BSO	NA	Uterine	No	60	Pelvic mass	Abdomen (omentum and splenic hilum) + pelvis	Cytoreductive surgery + adjuvant hormone therapy$^{¥}$ (1 year)$^{◊}$after 3 months without therapy$^{◊}$seconder pelvic recurrence$^{◊}$ cytoreductive surgery	83	NED

UTROSCT: Uterine tumors resembling ovarian sex-cord tumor, TAH: Total abdominal hysterectomy, BSO: Bilateral salpingo-oophorectomy, m: Month, NR: Not reported, NA: Not available, DFI: Disease Free Interval, BEP: Bleomycin+etoposid+cisplatin, FU-time: Follow up time, NED: No evidence of disease $^{\infty}$ Letrozole (aromatase inhibitor) and medroxyprogesterone acetate during 3 months $^{¥}$Megestrol acetate and Letrozole

Table 2. Association between clinic-surgical-pathologic factors and disease-free survival

Paramaters		5 year DFS (%)	p value
Age	<49	90	0.651
	49≤	81	
Menopausal status	Premenopausal	86	0.810
	Postmenopausal	76	
Tumor diameter (mm)	<50	82	0.441
	50≤	93	
Number of lesion	Single	98	0.841
	Multiple (2≤)	100	
Involved layers of uterus	Confined to endometrium	83	0.792
	At least part of the myometrium but no serosa	96	
	All layers (serosa incl.)	100	
Border type of tumor	Pushing or well circumscribed	89	0.269
	Infiltrative	100	
Presence of atypia	Absent	100	0.480
	Present	83	
Presence of mitosis	Absent	80	0.653
	Present	66	
Presence of necrosis	Absent	67	0.414
	Present	100	
Cervical involvement	Absent	98	0.649
	Present	100	
Presence of extra-uterine spread	Absent	98	0.360
	Present	100	
Categorization of surgery according to extension	Hysterectomy Hysterectomy with BSO	87.5 82	0.969
	Hysterectomy ± BSO Hysterectomy with BSO Lymphadenectomy	84 100	0.681
Organ preserving surgery$^{¥}$	Yes	86	0.038*
	No	96	

BSO: Bilateral salpingo-oophorectomy, $^{¥}$organ preserving surgery included patient underwent myomectomy, hysteroscopy, uterine mass excision and transvaginal mass extirpation *p<0.05 is statistically significance

[PP-063]

Synchronous clear cell carcinoma in ovary and endometrium: A case report

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We aimed to present synchronous clear cell carcinoma in ovary and endometrium. A sixty-eight-year-old gravida: 8, parity: 8 posmenopausal women admitted to our clinic with the complaint of vaginal bleeding. She had been operated for breast cancer 17 years ago and had used tamoxifen for 5 years following operation. Transvaginal ultrasonographic examination revealed an endometrial thickness of 14 mm and a multiseptated 10 cm diametered cyst with solid areas in the left ovary. Additionally, omental thickening and metastatic nodules in the bilateral lungs and liver were detected in the computed tomography imaging. Serum CA-15-3 and CA-125 levels were measured 253 IU/mL and 44.5 IU/mL respectively. Endometrial biopsy was reported as clear cell carcinoma. Laparatomy was performed using supraumbilical and infraumbilical midline vertical incision. An uterus with a size of 16-week gestation and dark coloured lobulated left adnexial mass with 15 cm diameter was observed (Figure 1). Hysterectomy and left salphingooopherectomy were performed. Frozen section of adnexial mass was reported as ovarian serous carcinoma. Pelvic-paraaortic lymphadenectomy and omentectomy were undertaken. The final pathologic sectioning was reported as the synchronous clear cell carcinoma of the ovary and endometrium and as tumor infiltration in lymph nodes and omentum (Figure 2, 3). Simultaneous malignancies of the female genital tract is an uncommon event with an incidance of 1-2%. Synchronous genital tumors mostly involve ovaries and endometrium and account for 10% of ovarian cancers and 5% of endometrial cancers (1). They tend to occur 10-15 year earlier than primary tumors of ovary or endometrium alone (2). Albeit difficulties in differential diagnosis of metastatic and primary tumors of ovary and endometrium, it is important to differentiate synchronous tumors since it would effect staging and prognosis. Synchronous ovarian and endometrial tumors have better prognosis than metastatic tumors of these organs to each other. Scully criteria have been used by pathologists for the distiction of metastatic and synchronous tumors of ovary-endometrium (2). Similar to the current case report, abnormal uterine bleeding is present in 80-86% of the cases (3). Synchronous primary carcinomas of ovary-endometrium were most frequently high grade and of endometrioid cell type. However, in the present case report, we present clear cell carcinoma, a very rare type of synchronous ovarian-endometrial tumor, having a worse prognosis compared to endometriod cell type (1,3). Primary surgical staging is the cornerstone in the management for the patients of synchronous endometria land ovarian cancers. However, the adjuvant treatment for these patients is still controversial (2). Synchronous clear cell carcinoma in ovary and endometrium is a rare event which should be discriminated from primary metastatic tumors of ovary and endometrium.

Keywords: Endometrial clear cell carcinoma, ovarian clear cell carcinoma, postmenopausal bleeding, synchronous genital tumors

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Figure 1. Intraoperative view of solid dark coloured ovarian tumor

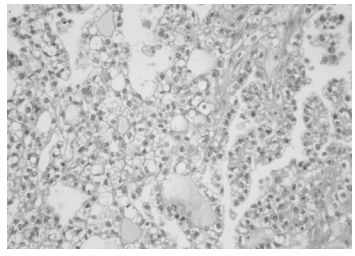


Figure 2. Solid and tubulocystic patterns in endometrium formed by atypical cells with clear cytoplasm and prominent nucleolus (x200 magnification, Hematotoxylin-eosin staining)

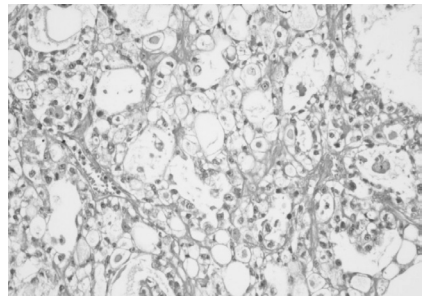


Figure 3. Atypical cells in the ovarian tissue with clear cytoplasm and big vesicular nucleus (x200 magnification, Hematotoxylin-eosin staining)

[PP-064]

Blood vessel invasion is a spread mechanism of endometrial cancer to the cervix

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Objective: To evaluate the association between type of invaded vessels (blood or lymphatic) and cervical involvement in endometrial cancer (EC).

Material and Methods: Pathological slides of 93 patients with EC who had vascular space invasion in hematoxylin-eosin staining underwent immunohistochemical assay with CD31 and podoplanin. CD31 and podoplanin were used to identify blood and lymphatic invaded vessels, respectively. The IHC assay was performed by an automated Ventana Benchmark XT (Ventana™, Tucson, AZ) machine staining technique. Antibody features were as follows: for CD31: JC70; Cell Marque; Antigen Retrieval (AR): ethylenediaminetetraacetic acid (EDTA), 1/50 dilution, 95 °C, 64 mins; Roche®, and for podoplanin: D2-40; cell Marque; AR: EDTA, 1/50 dilution, 95 °C, 64 mins; Roche®. Slides that did not stain with both CD31 and podoplanin were excluded (n=23). The level of statistical significance was set at $p<0.05$.

Results: The pathologic slides exhibited immunoreactivity with CD31 only in 20 (28.6%) patients, with podoplanin only in 37 (52.9%) patients and with both CD31 and podoplanin in 13 (18.6%) patients. Cervical stromal invasion (CSI) was determined in 21 (30%) patients. Two patients had only cervical glandular involvement. CD31 and podoplanin immunostaining were significantly associated with the status of cervical invasion only. Age (<59 vs ≥59 years), histologic type (endometrioid vs non-endometrioid EC), Stage (1 vs ≥2), status of lymph node metastasis (negative vs positive), Grade (1 vs 2&3), myometrial invasion (<1/2 vs ≥1/2), adnexal involvement (negative vs positive), uterine serosal involvement (negative vs positive) and omental spread (negative vs positive) were not significantly associated with CD31 or podoplanin immunostaining (Table 1). The rate of CD31-positive immunostaining was significantly higher in patients with CSI than without (76.2 and 34.7%, p=0.001; respectively). Positive podoplanin immunostaining was determined in 47.6% and 81.6% of patients with and without CSI, respectively (p=0.005) (Table 2). In multivariate analysis, age, myometrial invasion and the combination of CD31 positivity with podoplanin negativity were found as independent predictors for CSI (Table 3).

Conclusion: Blood vessel invasion is an important factor for CSI in EC. Blood vessel invasion rather than lymphatic vessel invasion is one of the predominant ways by which EC spreads to the cervix.

Keywords: Lympho-vascular invasion, podoplanin, CD31, Blood vessel, endometrial cancer

Table 1. Association between clinical-pathological findings and CD31 immunostaining, and podoplanin immunostaining in endometrial cancer

			CD31 immunostaining			Podoplanin immunostaining		
Clinical-pathologic findings		**n**	**n (%)**	**p (%)**	**p value**	**n (%)**	**p (%)**	**p value**
Age	<59 years ≥59 years	34 36	52.9 52.8	47.1 47.2	0.989	32.4 25	67.6 75	0.496
Histologic type	Endometrioid Non-endometrioid	57 13	54.4 46.2	45.6 53.8	0.592	28.1 30.8	71.9 69.2	0.847
Stage	1 ≥2	33 37	57.6 48.6	42.4 51.4	0.455	21.2 35.1	78.8 64.9	0.195
Status of lymph node metastasis	Absent Present	45 25	51.1 56	48.9 44	0.694	31.1 24	68.9 76	0.525
Grade	1 2&3	17 53	58.8 50.9	41.2 49.1	0.570	29.4 28.3	70.6 71.7	0.930
Myometrial invasion	<1/2 ≥1/2	20 50	55 52	45 48	0.820	25 30	75 70	0.673
Uterine serosal involvement	Absent Present	66 4	51.5 75	48.5 25	0.616	28.8 25	71.2 75	1
Cervical invasion	Absent Present	49 21	65.3 23.8	34.7 76.2	0.001*	18.4 52.4	81.6 47.6	0.005*
Adnexal involvement	Absent Present	60 10	55 40	45 60	0.379	26.7 40	73.3 60	0.400
Omental spread	Absent Present	64 5	53.1 40	46.9 60	0.665	28.1 40	71.9 60	0.623

N: Negative, p: positive, n: number, *p<0.05 is statistically significant

Table 2. Univariate analysis of association between pathologic features and cervical involvement

		Cervical involvement		
Pathologic features		**n (%)**	**p (%)**	**p value**
Age	<59 years ≥59 years	58.8 80.6	41.2 19.4	0.046*
Histologic type	Endometrioid Non-endometrioid	73.7 53.8	26.3 46.2	0.188
Grade	1 2&3	64.7 71.7	35.3 28.3	0.762
Myometrial invasion	<1/2 ≥1/2	95 60	5 40	0.004*
Diameter of tumor	<4 cm ≥4 cm	85.7 62.5	14.3 37.5	0.054
Uterine serosal involvement	Absent Present	72.7 25	27.3 75	0.078
CD31 immunostaining	Negative Positive	86.5 51.5	13.5 48.5	0.001*
Podoplanin immunostaining	Negative Positive	45 80	55 20	0.005*

N: Negative, p: positive, n: number, *p<0.05 is statistically significant

Table 3. Multi-variant analysis for prediction of cervical stromal invasion

	Hazard ratio (95% CI)	**p value**
Age	5.2 (1.08-25.4)	0.04*
Combination of CD31 positivity with podoplanin negativity	10 (2.15-48.2)	0.003*
Histologic type	5.8 (0.99-34.5)	0.051
Myometrial invasion	21 (2.09-219)	0.01*
Diameter of tumor	4.3 (0.886-21.1)	0.07

CI: Confidence interval, *p<0.05 is statistically significant

[PP-066]

First trimester fetal karyotyping results from single center

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Objective: Evaluation of first-trimester fetal karyotype outcomes reported in the department of medical genetics between 2010 to 2016.

Material and Methods: Fetal karyotype results of the fetuses with nuchal translucency (NT) measurement above 2 mm (n=239) with or without major sonographic findings (MSF) were assessed retrospectively.

Results: Overall chromosomal abnormality detection rate was 28% (67/239). Frequencies of trisomy 21, Turner's syndrome, trisomy 18, trisomy 13, and triploidy were observed 10.9%, 6.3%, 4.6%, 2.1%, and 1.3%, respectively. A substantial number of scarce chromosomal abnormalities were noted with an overall frequency of 2.9%. Chromosomal aberration rate was 5%, 24.2%, 21.9%, 39.6%, and 37.5% for NT measurements between 2-2.99 mm, 3-3.99 mm, 4-4.99 mm, >5 mm, and MSF, respectively. Figure 1 shows the distribution of aberrant vs normal karyotypes for corresponding NT ranges.

Conclusion: Fetuses with aberrant karyotype demonstrated significantly higher NT measurements with respect to the fetuses with normal karyotypes (mean: 6.5 vs 4.5 mm; median: 4.5 vs 4 mm). Increasing NT is associated with increased risk of associating with a chromosomal aberration (Odds ratios: 1.140 for univariate analysis, 1.126 for multivariate analysis controlled for maternal age). Increased NT is a major predictor for chromosomal aberrations in the first trimester; however, rare chromosomal aberrations may not manifest high NT thickness, such as uncommon trisomies. Coexisting major sonographic marker in fetus increases the yield of detecting an aberrant karyotype, raising from 26.8% to 37.5%.

Keywords: Fetal aneuploidy, nuchal translucency, major sonographic marker

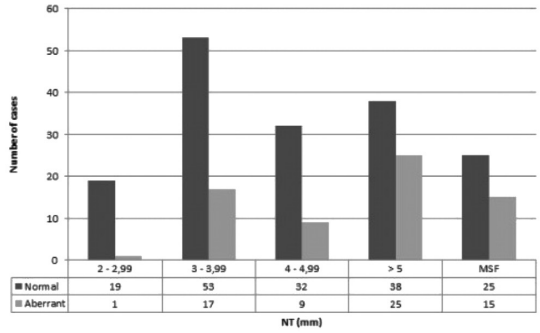


Figure 1. Distribution of normal vs aberrant karyotypes for corresponding NT ranges

[PP-068]

Thiol-disulphide homoestasis in pregnancies with fetal growth restriction

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Objective: To investigate the role of dynamic thiol-disulphide homeoastasis in preeclamptic and idiopathic fetal growth restricted (FGR) pregnancies.

Material and Methods: In this prospective case-control study, a total of 110 singleton pregnancies with FGR (study group) (51 preeclamptic and 59 idiopathic FGR's cases) were compared with 68 healthy pregnant controls at the same gestational weeks (control group). For serum disulphide-thiol homeostasis, a newly used method described by Erel and Neselioglu was used.

Results: Serum native thiol and total thiol levels were lower in FGR pregnancies (285.63±55.92 micromol/L, 324.41±44.18 micromol/L respectively) than control group (324.41±44.18 micromol/L, 362.98±51.43 micromol/L, p<0.001, p=0.004 respectively). In subgroup analysis, only preeclamptic FGR's have lower native and total thiol levels (254.41±59.55, 324.41±44.18 micromol/L, respectively) compare to both idiopathic FGR's and control's. There was no difference in native and total thiol levels with idiopathic FGR's with controls. Idiopathic FGR's have higher levels of disulphide than preeclamptic FGR's (21.72±17.72 vs 16.80±11.20 micromol/L). The serum albumin and total protein levels were positively and spot urine

protein/creatinine ratio, 24-h urine protein levels were negatively correlated with native thiol and total thiol levels.

Conclusion: The balance of thiol-disulphide homeostasis was shifted and native and total thiol levels were decreased only in preeclamtic FGR pregnancies. The serum disulfide level was increased in idiopathic FGR pregnancies compare to preeclamtic FGR pregnancies which may be a sign of oxidative stress in idiopathic FGR pregnancies with normal thiol pool.

Keywords: Fetal growth restriction, thiol-disulphide homeostasis, proteinurea

Table 1. Demographic and clinical characteristics of FGR and control group

	FGR (n=110)	Control group (n=68)	P value
Age (mean±SD year)	29.7±5.4	28.6±6.6	0.304
Parity (mean±SD)	2,1±1.5	2,0 ±1.3	0.924
Gestational age (mean ±SD week)	33,3±4,5	34,1±5.4	0.397
BMI (mean±SD kg/m^2)	30,9±5.1	29.7±6.1	0.364
Mean Systolic BP (mm-Hg)	146,3±7,3	112,8±7,8	< 0,001
Mean Diastolic BP (mm-Hg)	92,8±4,2	70,3±6,3	< 0,001

Table 2. Thio-disulphid homeostasis

	FGR (n: 110)		Control group (n:68)		P value
	Mean	SD	Mean	SD	
Native thiol_SH	285,63	55,92	324,41	44,18	< 0,001
Total thiol	324,54	61,89	362,98	51,43	0,004
disulphide_SS	19,45	13,86	19,28	13,86	0,449
SS/SH	7,13	5,0	6,08	4,45	0,127
SS/totalthiol	5,93	3,52	5,16	3,30	0,127
SH/totalthiol	88,012	7,05	89,66	6,61	0,95

Table 3. Thiol-disulphide homeostasis in preeclamptic FGR's, idiopathic FGR's and control groups

N	Preeclamptic FGR (n: 51)		İdiopathic FGR (n: 59)		Control Group (n: 68)		P value
	Mean	SD	Mean	SD	Mean	SD	
Native thiol_SH	254,41	59,55	312,46	35,18	324,41	44,18	< 0,001 < 0,001 0,640 < 0,001
Total thiol	288,02	61,25	355,92	42,40	362,98	51,43	< 0,001 < 0,001 0,473 < 0,001
disulphide_SS	16,80	11,20	21,72	17,72	19,28	13,86	0,105 0,573 0,164 0,026
SS/SH	7,19	5,56	7,08	4,51	6,08	4,45	0,277 0,263 0,136 0,630
SS/totalthiol	5,92	3,84	5,95	3,26	5,16	3,30	0,276 0,262 0,136 0,626
SH/totalthiol	88,15	7,68	88,08	6,52	89,66	6,61	0,276 0,262 0,135 0,626

P values: 1st: comparison of 3 groups . 2nd: preeclampsia and control group, 3rd: idiopathic FGR- and control groups, 4th : preeclamptic FGR and idiopathic FGR groups.

[PP-069]

Does the first trimester thiol-disulphide homeostasis predict the risk of preeclampsia, fetal growth restriction and other adverse pregnancy outcomes?

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Objective: In this study, we aimed to investigate the efficacy of thiol-disulphide homeostasis, a new oxidative stress marker in prediction of preeclampsia and other adverse obstetric outcomes.

Material and Methods: This prospective cohort study was conducted between March 2016 and February 2017 in Obstetric and Gynecology Clinic of Zeynep Kamil Women and Children's Diseases Training and

Research Hospital in İstanbul. A total of 259 singleton pregnancies between 11+0-13+6 weeks gestation admitted for the first trimester aneuploidy screnning test were included in this study. During pregnancy follow up 22 cases were lost from follow-up and 237 cases were included in the analysis. Venous blood samples were obtained, 3 mL for first trimester aneuploidy screening and 3mL for evaluating thiol-disulphide homeostasis. Total thiol was estimated by the sum of existing thiol groups and reduced thiol groups (S-S and -SH). After the native thiols (-SH) and total thiols had been determined, the disulphide (-SS) amounts, disulphide/total thiol percent ratios (-SS/-SH + -SS), disulphide/native thiol percent ratios (-SS/-SH), and native thiol/total thiol percent ratios (-SH/-SH + -SS) were calculated.

Results: Out of 237 cases, in 65 of them, pregnancy resulted in adverse obstetric conditions whereas in 172 cases (control group) there was no adverse obstetric result. There were not any statistically significant differences between the two groups regarding native thiol (-SH), total thiol, disulphide (-SS), disulphide/native thiol percent ratios (-SS/-SH), disulphide/total thiol percent ratios (-SS/-SH + -SS) and native thiol/total thiol percent ratios (-SH/-SH + -SS) ($p>0.05$) between groups with adverse obstretic outcomes and the control group (Table 1). There were not any statistical differences between three groups (control, fetal growth restriction, preeclampsia) in terms of native thiol (-SH), total thiol, disulphide (-SS), disulphide/native thiol percent ratios (-SS/-SH), disulphide/total thiol percent ratios (-SS/-SH + -SS) and native thiol/total thiol percent ratios (-SH/-SH + -SS) ($p>0.05$) (Table 2).

Conclusion: Our preliminary results showed that first trimester maternal serum thiol/disulphide homeostasis did not predict preeclampsia and fetal growth restriction. Placental disulphide measurement may be a good option for preeclampsia and fetal growth restriction prediction in the first trimester.

Keywords: Thiol disulphide homeostasis, preeclampsia, fetal growth retardation

Table 1. Serum thiol-disulphide levels in both groups

	Control group n (172) mean±sd	Adverse obstetric outcome group N(65) Mean ± sd	P value
Native thiol (-SH)	385,8 ± 51,2	383,3 ± 63,67	0,742
Total thiol	434,6 ± 51,02	434,97 ± 58,65	0,962
Disulphide (-SS)	24,20 ± 9,11	24,8 ± 10,07	0,673
Ss/sh(disulphide/native thiol)	6,49 ± 3,03	6,86 ± 3,79	0,904
Ss/total (disulphide/total thiol)	5,63 ± 2,25	5,86 ± 2,63	0,850
Sh/total (native thiol/total thiol)	88,68 ± 4,79	88,08 ± 5,89	0,887

Table 2. Thiol-disulphide levels of control, FGR and preeclamptic groups

	Control group n (172) mean ± sd	FGR group n(22) mean ± sd	P value	Preeclampsia group n(8) mean ± sd	P value
Native thiol (-SH)	385,8 ± 51,2	386,5 ± 44,9	0,951	391,9 ± 34,4	0,740
Total thiol	434,6 ± 51,02	430,9 ± 36,9	0,749	436,7 ± 27,81	0,904
Disulphide (-SS)	24,20 ± 9,11	22,2 ± 11,8	0,332	19,02 ± 7,12	0,109
Ss/Sh (disulphide/native thiol)	6,49 ± 3,03	6,04 ± 4,04	0,159	4,97 ± 2,07	0,110
Ss/total (disulphide/total thiol)	5,63 ± 2,25	5,18 ± 2,85	0,144	4,43 ± 1,74	0,095
Sh/total (native thiol/total thiol)	88,68 ± 4,79	88,74 ± 7,39	0,219	91,02 ± 3,49	0,132

[PP-071]

Differential diagnosis of circumvallate placenta: Two cases analysis of sonographic findings

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This poster presentation aims to draw attention to differential diagnosis of circumvallate placenta from amniotic band, as the antepartum management is different for two cases. A 21-year-old women at 21th week gestation and a 23-year-old women at 19th week gestation were referred to our perinatology clinic for amniotic band. In the ultrasound evaluation, fetal structures and amnions were normal but placental margins were elevated and curled inward to the fetal surface of the placenta. In both cases, a thick band was seen between two edges of the placenta and it was not attached to the fetus. According to these findings, circumvallate placenta was diagnosed in both cases. After informing the patient about the outcomes, patient's follow up was continued. Circumvallate placenta is a placental anomaly that seen between 1% to 7% of deliveries. The chorionic palate is smaller than the placental palate and does not insert to placental edge. A thickened and raised gray-white ring, consisting of chorion, amnion and decidual tissue, is seen on the fetal surface of the placenta. The ring mostly extend through the whole circumference of the placenta. While the cause of the circumvallate placenta is not clearly showed, it could results from deep implantation of blastocyst into the endometrium. Definitive diagnosis of circumvallate placenta have need inspection of delivered placenta and antenatal detection is rare. It has been associated with various adverse pregnancy outcomes such as preterm labor, abruption, antepartum bleeding, perinatal mortality, growth restrictions, congenital malformation and postpartum hemorrhage. Amniotic band, uterine synechiae and septate uterus should be taken in account in the differential diagnosis. In the case of the circumvallate placenta, placental band is attached to placenta, not to fetus or uterine wall. This characteristic is important to make differential diagnosis of circumvallate placenta from amniotic band and synechiae.

Keywords: Circumvallate placenta, amniotic band, differential diagnosis



Figure 1. Case 1



Figure 2. Case 1



Figure 3. Case 2

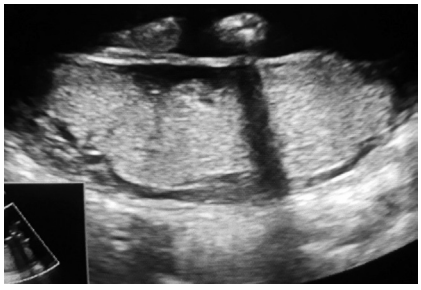


Figure 4. Case 2

[PP-072]

Prenatal diagnosis of body stalk anomaly: Case report

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Body stalk anomaly is a rare, and generally lethal malformation, ranging in prevalence from 0.4 to 3.2 per 100.000 births. It is important to recognize this anomaly earlier. Because early diagnosis can allow safer termination of pregnancy. The 28 year-old primigravide woman who was in 13th gestational weeks presented to our department for routine antenatal assesment. Consanguinity, smoking, and exposure of drug and alcohol were not determined in history. Abdominal wall defect, fetal attachment to the placenta,scoliosis and short umbilical cord were seen on ultrasonografic assesment (Figure 1). The upper fetal body was in the amniotic cavity and the abdominal part of body was in the celomic cavity (Figure 2). Termination of the pregnancy was offered and was done in 14th gestationel weeks. It is characterized by attachment of intrathoracic and abdominal organs directly to the placenta.The umbilical cord may be absent or shortened. Large thoracoabdominal wall defect and commonly limb defects are the important features of body stalk anomaly. In addition, kyphoscoliosis may be present. The pathogenesis of this anomaly includes early amniotic rupture, vascular distruption of embriyo and an abnormality of the germinal disk. The extraembryonic coelomic cavity which lies to the margins of placenta persists. Umbilical vessels embedded in amniotic sheet connect with skin margin of the abdominal wall defect. Oligohydramnios exists in second and third trimestrs. The different diagnoses comprise of amniotic band sequence, pentalogy of cantrell, cloacal exstrophy. This anomaly is not associated with abnormal karyotype. It is a lethal anomaly and termination of the pregnancy is offered.

Keywords: Body stalk anomaly, abdominal defect, limb body wall



Figure 1. Large body wall defect with attachment of fetal vissera to the placenta and short umbilical cord



Figure 2. The boundary between the amniotic cavity and extraembryonic coelomic space

[PP-073]

An early second trimester diagnosed tricuspid valve dysplasia with severe tricuspid regurgitation

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Tricuspid valve dysplasia (TVD) is a rare congenital anomaly that involves thick, nodular, irregular tricuspid valve leaflets. The anatomic insertion of the tricuspid valve leaflets maintains at the normal anulus position. Ultrasound findings include cardiomegaly with right atrial enlargement and thickened valve leaflets which do not close properly in systole. The color doppler images typically show tricuspid regurgitation with the regurgitant jet flow arising from the tricuspid valve annulus. This feature differentiates TVD from Ebstein anomaly. TVD can lead to severe tricuspid regurgitation and hydrops fetalis. It is important to look for associated structural abnormalities (especially for pulmonary stenosis and atresia) and arrhythmias. Associated chromosomal and non chromosomal abnormalities are rare in these cases. If severe regurgitation and hydrops fetalis present, fetal demise is common and outcomes in liveborn infants are very poor. A 23-year-old women at 16th week gestation was referred to our department for fetal cardiomegaly. In the ultrasound evaluation, cardiomegaly with the right atrial and ventricular enlargement was found. Tricuspid valve leaflets were located at normal anatomic position, the level of the tricuspid valve annulus. The color doppler images showed tricuspid regurgitation with regurgitant jet flow arising from the tricuspid valve annulus. It was not observed other associated anomalies. These findings suggest us that it could be the TVD. One week later in control examination, intrauterine fetal demise was detected. TVD is a rare cardiac congenital anomaly. It can be diagnosed as early as second trimester and can be a cause of early fetal death.

Keywords: Tricuspid valve dysplasia, second trimester, tricuspid regurgitation



Figure 1. Ultrasound image: Right atrial and ventricular enlargement



Figure 2. Color Doppler image: Tricuspid regurgitation

[PP-074]

Congenital high airway obstruction syndrome and acrania

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Congenital high airway obstruction syndrome is rare fetal malformation caused by obstruction of fetal airway because of laryngeal or tracheal atresia, subglottic stenosis, laryngeal cyst or laryngeal web. CHAOS is usually caused by atresia or stenosis of the larynx or trachea. The true incidence of CHAOS is unknown. It is important to diagnose it antenatally as it is uniformly lethal. If the syndrome is unrecognized during the prenatal period, it usually results in stillbirth or death shortly after delivery. The prenatal ultrasound findings of CHAOS include large echogenic lungs, flattened or inverted diaphragms, dilated airways distal to the obstruction, and fetal ascites and/or hydrops. Here we present a rare case of CHAOS diagnosed on the antenatal scan. Acrania (exencephaly) is a rare developmental abnormality characterized by partial or complete absence of the cranium with nearly complete development of brain tissue. Thirty-four year old multi-gravida was referred for routine anomaly scan at 17 weeks of gestation. There was no history of consanguinity and the family history was unremarkable. Ultrasound examination revealed a single live intrauterine fetus corresponding to a gestational age of 17 weeks Amniotic fluid was within normal limits. Complete absence of the cranium (Figure 1) was made acrania. Bilateral lungs were echogenic and enlarged with small heart compressed in between the lungs (Figure 1, 2), dilated bronchi and trachea, mild ascites, and flattened diaphragm (Figure 4). Based on these findings, the diagnosis of CHAOS was made. Patient and her family members were counselled regarding the possible unfavourable outcome of the pregnancy. The patient opted for termination of pregnancy (Figure 3, 4). Rare anomalies may coincidentally coexist. we are goal to present a case that has not been reported before.

Keywords: CHAOS, high airway obstruction, acrania



Figure 1. Acrania and bileteral echogenic lungs

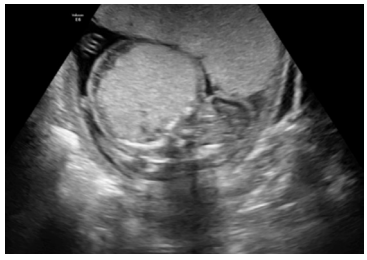


Figure 2.



Figure 3.



Figure 4.

[PP-075]

Nasal bone nasal tip ratio; a new practical marker for trisomy 21: Preliminary report

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Objective: Hypoplastic fetal nasal bone has been proven to be one of the strongest markers in the second trimester ultrasound scan for Down syndrome screening. Although it's a strong marker, any certain length cannot be defined that can be used for every gestational week. So; rather than evaluating the fetal nasal hypoplasia according to the nomogram, it may be possible to evaluate it with a more practical method in bed side setting. To evaluate whether nasal bone nasal tip ratio can be used as a new and practical marker for Down syndrome scanning regardless of gestational week.

Material and Methods: Between 18-22 weeks of gestation, fetal nasal bone length was measured in a strict mid-sagittal view of fetal face, identifying the nasal bone, lips, palate and mandible with an angle between the insonation beam and the nose axis between 45° and 135°. The skin overlying the nasal bone and tip of the nose are identified on this plane. A second measurement was made from the proximal nasal bone to the end of the nasal tip which is the third line in front of the nasal bone and skin (Figure 1). The ratio of nasal bone to nasal tip was calculated. Both groups with 1/3 below and above of this ratio were compared in cases of Down syndrome and euploid fetuses. A total of 9868 patients who were referred to our perinatology unit between the 18-22 weeks of gestation for anatomical screening between 2011-2017 years were retrospectively analyzed. A total of 59 trisomy 21 cases and 2304 fetuses who defined as euploid in the antenatal or postnatal period were analyzed for nasal bone and nasal tip measurements and their ratios to each other.

Results: A total of 103 aneuploid fetuses, in which 59 had Down syndrome, 12 had trisomy 18, 8 had trisomy 13, 17 had turner, 7 had other chromosomal anomalies and 2304 euploid fetuses were included in the study. The ratio of nasal bone to nasal tip 1/3 and below was 21/59 (35.5%) in fetuses with Down syndrome whereas this ratio was 31/2304 (1.3%) in euploid fetuses. This difference is statistically significant ($p<0.001$). Sensitivity, specificity, positive predictive value and negative predictive value of nasal bone/nasal tip ratio ≤1/3 were 35.5%, 98.6%, 40.3% and 98.3% for Down syndrome, respectively.

Conclusion: Nasal bone/nasal tip ratio ≤1/3 may be a new promising and practical sonographic marker in the second trimester ultrasound scan for counseling patients about Down syndrome screening, regardless of gestational week.

Keywords: Down syndrome, fetal anatomical screening, nasal bone, nasal tip

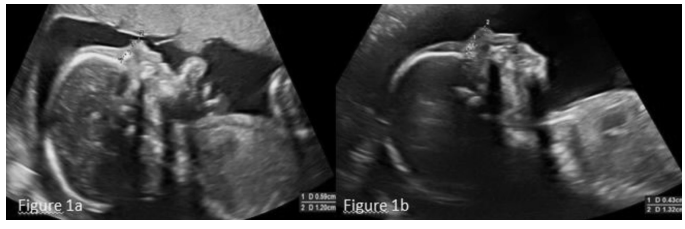


Figure 1. a) Nasal bone/nasal tip ratio>1/3 in euploid fetus, b) Nasal bone/nasal tip ratio ≤1/3 with Down syndrome fetus

[PP-076]

Distribution of fetal cardiac anomalies according to in vitro fertilization indications in pregnancies conceived after assisted reproductive techniques

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Objective: There is no consensus in current practice guidelines on whether fetuses conceived with assisted reproductive technology (ART) are at an increased risk of developing congenital heart defects (CHD) compared with those conceived spontaneously, although previous meta-analyses report an increased risk of all congenital malformations in ART pregnancies. Also, there is poor data evaluating fetal cardiac defects and types that may be related to the underlying cause of infertility during in vitro fertilization (IVF). To present the frequency and distribution of fetal cardiac anomalies according to IVF indications.

Material and Methods: Between April 2008 and September 2017, a total of 2894 IVF babies (2286 pregnancies) were retrospectively analyzed for the frequency of major congenital cardiac anomalies and distribution of CHD according to IVF indications.

Results: The frequency of major congenital heart anomalies was 46/2894 (1.58%) in pregnancies conceived after IVF. The subgroups of IVF indications were similar in terms of age, gravida, parity and BMI. The distribution of CHD according to IVF indications were; 18/1271 (1.4%) in male factor, 14/845 (1.65%) in ovulatory dysfunction, 9/402 (2.2%) in tuboperitoneal factor and endometriosis group and 5/376 (1.3%) in unexplained subfertility group.

Conclusion: Pregnancies conceived by IVF are at increased risk for developing CHD. So, subfertility and IVF applications may be an additional risk factor for fetal CHDs. Especially, CHD risk seems to be higher in IVF pregnancies due to tuboperitoneal factor and endometriosis than the other underlying causes of infertility. However, due to heterogeneity of both ART procedures and cardiac defects, larger, prospective and population-based studies are needed to address questions of etiology so that we can provide more information for counseling prospective patients.

Keywords: Congenital heart defects, fetal echocardiography, in vitro fertilization

[PP-079]

Effects of the transobturator tape surgery on sexual function among women with stress urinary incontinence

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Objective: To investigate the effects of transobturator tape (TOT) procedure on sexual function in women with stress urinary incontinence at preoperative and postoperative sixth months period.

Material and Methods: This is a prospective observational study which was conducted in university affiliated research and training hospital between September 2016 and June 2017. A total of 110 patients who underwent TOT and/or pelvic organ prolapse (POP) surgery were included in the study. The exclusion criteria of the study were as follows; older than 60 years, POP-Q stage >3, had previous incontinence surgery, sexually inactive, no positive stress test, Q-tip test and appropriate follow-up. After excluded, a total of 46 patients were evaluated for the study. Severity Index that developed by Sandvik et al. (1) was used for the assesment of urinary leakage severity, Female Sexual Function Index (FSFI) Turkish validation (2) was performed. FSFI questionnaire includes 19 items, under 6 domains consisting of sexual desire, arousal, lubrication, orgasm, satisfaction and pain. For each individual domain high scores indicate better sexual function. We added one more question to examine incontinence during intercourse. TOT procedures were performed outside-in technique that described by Delorme (3). Statistical analysis was performed with SPSS 21.0. The t-test was used for parametric data and categorical variables were described as percentages. A p value <0.05 was considered as statistically significant.

Results: The mean age of the participants was 48.9±6.8 and 43% of the patients were in postmenopausal period. The mean number of deliveries were 3.39±1.6 and body mass index was 26.4±3.2. The education level was at primary school level in 65.2%, at secondary school in 6.5% and at high school in 28.3% of the patients. Patients who underwent nongynecologic operation were only 15.2% of the patients. A total of 34 patients (73.9%) had no comorbidities while 10.9% had hypertension and 15.2% had diabetes mellitus. According to the severity index scores, 73.9% of the women were reported as cure, 21.7% as improvement and 4.3% as no changes on their urinary incontinence condition. Urinary leakage during sexual intercourse was detected in 18 (39.1%) patients preoperatively and 16 of them reported cure. The comparison of preoperative and postoperative FSFI scores were demonstrated in Table 1. As compared with preoperative FSFI scores, there were significant increment in the arousal and pain domains at postoperative 6 months. Desire, orgasm, satisfaction domains and the total score difference was not statistically significant while there was a significant worsening in the lubrication domain in postoperative period.

Conclusion: Incontinence has unfavorable effects on female sexual life and studies investigated the effect of incontinence surgery on sexual function have conflicting results. Our study demonstrated no remarkable improvement on total score but significant improvement in arousal and pain. The negative effect on lubrication may be due to decreased genital sensation after surgery in our study.

Keywords: Coital incontinence, FSFI, sexual function, TOT, urinary incontinence

Table 1. Comparison of preoperative and postoperative FSFI scores

	Preoperative (mean ± SD)	Postoperative 6 months (mean ± SD)	p value
Desire	3.1±0.63	3.9±0.59	0.153
Arousal	3.4±0.61	3.7±0.60	0.002
Lubrication	4.5±0.93	4.0±1.12	0.013
Orgasm	3.5±0.84	3.7±0.95	0.091
Satisfaction	4.8±1.17	5.0±0.97	0.239
Pain	3.9±0.82	4.4±0.86	0.001
Total score	23.4±3.17	23.8±4.23	0.604

[PP-080]

Le Fort's procedure for pelvic organ prolapse in elderly women with comorbidities: Priliminary results

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Objective: Pelvic organ prolapse (POP) is downward descent of female pelvic organs, or posthysterectomy vaginal cuff, resulting in protrusion of the vagina, uterus, or both. The lifetime prevalence of POP is 3-6% when defined by symptoms, and up to 50% when based upon vaginal examination. The management of POP includes mostly surgical management. Colpocleisis is an obliterative procedure for POP ideal for women who are no longer sexually active or cannot tolerate a more extensive procedure. The 2 most common types are partial and total colpocleisis. Partial colpocleisis (Le Fort) involves surgical creation of a longitudinal vaginal septum by apposition of denuded anterior and posterior vaginal walls. *Le Fort colpocleisis* is the only obliterative option if the uterus is to be preserved. The purpose of this study was to evaluate the results of Le Fort's procedure.

Material and Methods: This was a retrospective study of all consecutive women who underwent *Le Fort colpocleisis*as for POP in a university-affiliated tertiary medical center from February 2015 to July 2017. All of the patients underwent a complete preoperative evaluation that included history, physical examination, and urinalysis.Vaginal ultrasound examination was performed in all patients, including endometrial thickness to exclude pelvic pathology. All of the surgeries were performed by a single surgeon. All of the patients underwent Le Fort's procedure for severe POP.

Results: A total of 10 patients underwent colpocleisis. Mean age at operation was 78.8±5.8 years. Mean parity was 3.2±1.6. Among these 10 patients, 9 (90%) women had at least one medical comorbidity. All of the patients had severe POP (Stage 4). Mean operation time in 10 patients was 54.7±15.5 min. Mean hospital stay was 4.3±2.8 days, and mean postoperative hospital stay was 2.2±1.7 days. No intraoperative complications were observed in the current study. There were few minor postoperative complications of urinary tract infection, and vulvar edema. The total complication rate was 16.8% (2/10) in this study. There is high medical comorbidity and anesthetic risk for the surgical management of POP in elderly women with poor functional status. For elderly patients with significant medical comorbidity who do not desire preservation of the vaginal anatomy for sexual function, obliterative surgery may be an appropriate choice. In cases of severe POP, closure of the vagina by partial colpocleisis (Le Fort's procedure) has long been suggested as suitable for frail or elderly women. Le Fort's procedure is easy to perform, can be done under local anesthesia, has a shorter operating time, decreased morbidity, decreased blood loss, faster recovery, and high anatomic success rates. Ideal candidates for colpocleisis usually have poor functional status with medical comorbidities, rendering them unsuitable for extensive reconstructive procedures.

Keywords: Pelvic organ prolapse, Le Fort's procedure, colpocleisis, comorbidity

[PP-081]

Comparison of surgical technics in pelvic organ prolapsus

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Objective: Pelvic organ prolapse is defined by descending of one or more of anterior vaginal wall, posterior vaginal wall and apex of vagina (cuff after cervix or hysterectomy) at the hymenal level or a lower level. Pelvic organ prolapse is very common problem in female population and surgical methods are used in the exact treatment. The main principle in the pelvic floor surgery is providing support of vaginal apex and fixing the cranio-caudal axle of vagina. In the treatment of prolapse of cuff after uterovaginal or hysterectomy, or in the prophylaxis during vaginal hysterectomy there are some methods and among them; culdoplasty, suspension of uterosacral ligament, fixation of sacrospinous ligament, open/laparoscopic sacrocolpopexy are the most commonly used ones.

Material and Methods: One hundred fifty patients with an average of 54 years that has a complaint of a palpable mass were evaluated in our clinic in the last year period. POP-Q method was used in the evaluation. Vaginal hysterectomy and sacrospinous ligament fixation and McCall culdopasty or uterus protector approached surgery was prefferred. The patients' post opperative treatment success, early and late complications were compared.

Results: 80% sacrospinous fixation, 15% sacrocolpopexy, 5% culdoplasty has applied to patients. The success rate of the patients who have applied sacrospinous fixation is 85%, no complication intraopperative. In the long term follow-ups dyspareunia seen in 5% of patients, 8% reccurrence rate is determined. In the 15% of the patients, urinary incontinance began. In the patient who have applied McCall culdoplasty, average success rate is 88% and when compared with sacrospinous fixation, there is no meaningful difference in between them about reccurent cuff prolapse rates. The succes rate in the patients who have applied sacrocolpopexy is 92% and there is no intraopperative complication. In the follow-ups the rate of the patients who have an increase in symptoms of urinary incontinance is 10%. In 8% of the patients dyspareunia has determined.

Conclusion: Culdoplasty and sacrospinous fixation are the methods which are applied by vaginal way. When compared with sacrocolpopexy, they are more advantageous in terms of less blood loss, more postopperative comfort, less hospitalization time. These methods also provide that the possibility of intervention of the other pelvic floor surgery methods. They would be preferred in the patients who is old or has any comorbidity, has high risk of surgery. In sacrocolpopexy the long term success rate is more and reccurrent prolapse rate is lower.

Keywords: Prolapsus, sacrocolpopexy, culdoplasty

Table 1. Comprasion of operation rates

Method	Average success rate	Post-op recurrance	Dyspareunia	Hospital-ization
Sacrospinous fixation (120 patient)	85% (102 patient)	8.3% (10 patient)	5% (6 patient)	Median 4 days
McCall culdoplasty (9 patient)	88.8% (7 patient)	11.1% (1 patient)	-	Median 4 days
Sacrocolpopexy (21 patient)	90.4% (19 patient)	-	-	Median 6 days

[PP-086]

Two cases of acute urinary retention caused by huge cervical leiomyoma

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Large uterine or cervical leiomyomas may cause acute urinary retention due to bladder outlet obstruction. We report two cases with acute urinary retention caused by cervical leiomyoma. The patients who are 39 and 41 years old, admitted to our gynecology clinic with complaint of experiencing difficulty in passing urine for nearly 3 months and no urination past few days. Both of their additional complaints were pelvic pain and regular but mild menstrual bleeding. Physical examinations revealed 16 and 18-week-sized uteri with cervical leiomyomas obliterating Douglas pouches and no evidence of pelvic organ prolapse. In ultrasonographic examinations, transabdominal and transvaginal, large and homogeneous masses were located in the retrovesical space, compressing the bladder. They had no neurological symptoms or signs, so we excluded any neurologic etiology. Pre-operative endometrial sampling could not be performed due to mass bulging through the vagina. In intraoperative observations, normal size uteri and large cervical leiomyomas, 14 cm and 12 cm diameters originated from posterior and anterior cervix, respectively. Then, myomectomies were performed due to their desire of fertility and frozen-section examinations were reported as benign leiomyomas in both cases. The urinary symptoms completely resolved in two patients following myomectomies. In patients who are admitted with the complaint of acute urinary retention, cervical leiomyomas should be considered in differential diagnosis.

Keywords: Leiomyoma, myomectomy, urinary retention



Figure 1.

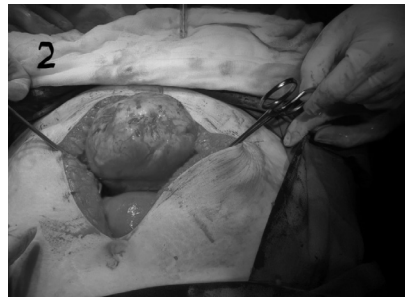


Figure 2.

[PP-087]

Fibroepithelial polyp of vulva, a rare case

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Fibroepithelial polyps are a type of mesenchymal lesion that typically occurs in women of reproductive age. These lesions can be polypoid or pedunculated and are usually solitary growth pattern. They are typically asymptomatic and do not grow larger than 5 cm in diameter and are found incidentally during routine gynecologic exams. FEP are connective-tissue benign tumors and they are so called as naevus molluscum, acrochordon, templeton skin tag, and fibroma. FEP can occur in a wide variety of sites of skin, less commonly on lower female genital tract such as more commonly in the vagina, and less common in the vulva and are rarely present in the cervix. An infected FEP of the vulva is a rare occurrence, for this reason we reported this case. A 48-year-old woman para 3, living 3 presented with a mass in the right side of vulva which was first noticed 3 years ago. Especially in last 3 months, the increase in dimensions of the mass was significantly more. She reported a history of regular menstrual cycles. She had no history of sexually transmitted disease or gynecology related operation. She had diabetes mellitus, hypertension and asthma. She didn't use any drugs for those diseases. The patient's body mass index was 32.4 kg/m^2. Physical examination revealed a 6*5 cm pedunculated mass connected to the right labia majora by 1*2 cm pedincle. The skin over mass was ulcerated with signs of inflammation (Figure 1). And also there was bad smell coming from mass. No lymph nodes were palpable in the vulvar and inguinal regions. Among laboratory test results there were leukocytosis (WBC: 17690x103/uL) and CRP: 55 mg/L. Other laboratory test results were normal. Antibiotherapy was also given to the patient due to the infection of the vulvar mass. The mass was totally excised at the base of pedincle under local anesthesia. The cut surface was dirty white-pink coloured, gelatinous and solid. The histopathological diagnosis revealed a fibroepithelial polyp of vulva. There was no evidence of malignancy. The patient was called for control visites in order to follow-up recurrence situation. In summary, we report a new case of a FEP of vulva in women complicated by ulceration and infection. More case reports of these rare tumors may lead illumination about understanding of their morphological and epidemiological characteristics.

Keywords: Fibroepithelial polyp, vulva, fibroma



Figure 1. Fibroepithelial polyp complicated with ulceration and infection

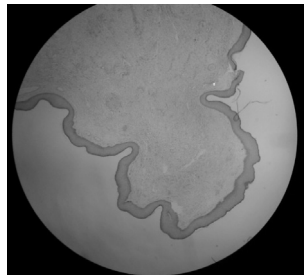


Figure 2. Fibrocollagenous stroma covered by stratified squamous epithelium

[PP-088]

A rare case managed with misdiagnosis in third trimester: Ovarian torsion

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Ovarian torsion (OT) is one of the real gynecological emergencies. Up to one-fifth of OT cases develop during pregnancy. OT in the third trimester of pregnancy is a rare condition that can lead to midline laparotomy and birth of a preterm baby with caesarean section (CS). It is associated with nonspecific symptoms and is often misdiagnosed as appendicitis or preterm labor. Clinical suspicion and rapid intervention consisting of laparotomy/laparoscopy for preventing ovarian necrosis resulted in favorable outcomes. The gravida 2, parity 0, abortion 1 pregnant woman, aged 21 was referred to the emergency room from another hospital with the complaint of right lower quadrant pain. The patient's anamnesis showed a right lower quadrant pain which started suddenly and had been ongoing for three days, accompanied by nausea and vomiting. At another hospital, urinary tract infection was considered and antibiotic treatment was given to the patient. Physical examination revealed rebound and guarding in the lower right quadrant. Vital findings were stable.Her blood count showed hemoglobin (Hb) levels 10.8 g/dL, white blood cells 11.3 103/uL. There were no abnormalities in the blood biochemistry values and urine analysis.Ultrasonography showed intrauterine fetal heart rate positive singleton pregnancy compatible with 36 weeks. In addition, the right adnexal area showed a 97x78 mm solid, non-blooded, torsion compatible image (Figure 1). As a result of the patient's symptoms, acute abdomen and primarily right OT was assumed. Considering the possibility of preterm delivery, laparotomy and CS (because the patient was 36 weeks pregnant) were applied to the patient. The right ovary was twisted around itself twice and the approximate dimensions were 10x10 cm. The left ovary was polycystic. The right ovary was detorsed in operation (Figure 2). OT is rare in the third trimester due to the restriction of the movement of the ovarian pedicle with the growing uterus, but should be considered in the differential diagnosis of pregnant patients with acute abdomen. Ultrasonography is the preferred imaging method for the diagnosis of OT. An ultrasound is also valuable for assessing the fetus, as well as showing the affected ovary. The most common ultrasonographic

finding in the case of OT is ovarian enlargement. Doppler flow cytometry may increase diagnostic efficiency by adding ultrasonography. The management option depends on the gestational week as far as the size of the affected ovary, its position and the presence of an adnexial mass are concerned. Due to the fact that gestational weeks were advanced (36 w) and surgery could start preterm labor, a CS was planned and open surgery (laparotomy) was decided upon at the same session in our case. OT during pregnancy is difficult to diagnose due to its nonspecific symptoms. The low prevalence of OT and the focus on fetal structures rather than adnexa during routine ultrasonographies performed especially in the third trimester increase the frequency of this diagnosis being missed. OT should be kept in mind in pregnant patients with acute abdominal pain and with ovarian enlargement in the sonography. The examination of adnexa during routine sonography is important to avoid misdiagnosis of OT in all trimesters.

Keywords: Acute abdomen, ovarian torsion, pregnancy, ultrasonography

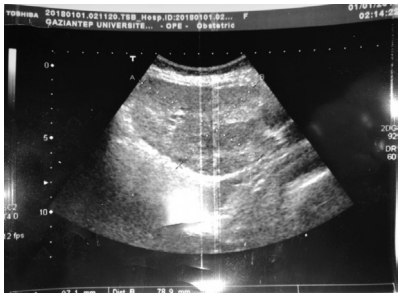


Figure 1. Transvaginal ultrasonography shows the right adnex with an enlarged ovary



Figure 2. Intraoperative image of right ovarian torsion and left polycystic ovary

[PP-089]

Rupture pregnancy in a noncommunicating rudimentery horn of an uterus: A case report

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Pregnancy in the rudimentary horn is a very rare clinical condition. This case report describes a 17th week ruptured pregnancy in a rudimentary horn patient. In this patient, emergency laparotomy was performed because of widespread hemorrhage and peritoneal irritation sign. Ruptured pregnancy in a rudimentary horn removed with excission. Post operative follow up period was uneventful. Afterwards the patient was discharged with suggestions at 7th days. Early diagnosis and timely surgery can reduce mortality and morbidity in such patients. Mullerian duct anomalies in female results from defective fusion or resorption during embryonic life.Congenital anomalies of the müllerian duct in women are seen in the frequency of 0.1-3.8%. Unicornuat uterus is the least common müllerian anomaly,the frequency is 4.4% (1,2). Unicornuat uterus is contains 4 group; 1) Communican rudimentery horn, 2) Non communican rudimentery horn with endometrial cavity, 3) Non communican rudimentery horn without endometrial cavity, 4) Unicornuat uterus. About 90% of unicornuat uterus is with noncommunican type rudimenter horn. 40% of these patients are joint with the urinary system anomalies. The pregnancy with the rudimentary horn is carries high risk for the uterine rupture because of the thin myometrium. In such cases sometimes differenital diagnosis can be diffuclt. A 24 year old primigravida patient admitted to our hospital with abdominal pain and syncope. Patient at usg with live fetus at 17th week of gestation was hospitalized hematology service for due to deep anemi. Patient consulted with general surgery and obstetric departments on the 2nd day of abdominal pain.Transabdominal USG at Radiology department reported diffüse hemorrhagia in abdomen and a single intrauterine pregnancy without cardiac activity having 17 weeks maturity. Laparotomy was decided due to the acute abdomen table and widespread hemoraji in the patient. In laparotomy there was ruptured noncommunican rudimentary horn pregnancy. Right side non communicating horn excised from main uterus and defect was repaired. Left horn of uterus with left fallopian tube and ovary were normal. Postoperative course was uneventful and patient was discharged. She was counselled about need for antenatal care and elective caesarean section for any future pregnancy. These pregnancies can be confused with cornual, istmik and other ectopic pregnancies.uterine anomaly diagnosis is ideal before pregnancy.the exact diagnosis is made with l/s or MRI. USG's sensitivity is around 26%, the sensitivity decreases as the gestational week progresses (3). USG image can sometimes give clues. Thick myometrium around the gestational sac is one of the main diagnostic criteria. So it is important to examine the wall thickness of myometrium. Classical treatment consist of removing the rudimenter horn, but some researchers suggest removing the fallopian tube to prevent ectopic pregnancy that may develop on the same side.

Keywords: Rudimentary horn, rupture, pregnancy

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Figure 1. Pregnant rudimentary horn attached to the uterus. The rudimentary horn has been clamped and cut from the uterus

[PP-090]

Obstetric outcomes of endometriosis: Case report

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By the help of the progress in endometriosis surgery and in vitro fertilisation technics currently patients with diagnose of endometriosis are able to conceive more often. In this case report we aimed to pay attention of the birth complications of the patients who have endometriosis anamnesis with the help of the literature. Our case is 30 years old, G1P0, 39th weeks of pregnancy, she came to the labor ward with her water breaking. During her pregnancy follow up period she had no special risk factors. The only significant information about her was 8 cm endometrioma cyst operation and just seven months after the surgery she has conceived naturally. During the delivery the progress was failed and she had intrapartum hemorragia so the fetal heart rate decreased when the cervics was fully dilatated. We performed vacuum assisted vaginal delivery because of the obstructed labor and fetal distress. In post partum period her uterus was soft, hypotonic and postpartum hemoragia occured just after the forced delivery of the placenta. After the conservative medical treatment post partum hemorragia was under control. Her uterine structure was in sponge like appearance seems as if adenomyosis on high resolution transvaginal sonography evaluation. Two months later we examined her uterine structure on MRI and she had adenomyosis like appereance. We questionared our patient more detailed and learned that her mother and grandmother had also the same PPH anamnesis. We decided to check the medical litreature about the assosiation between adenomyosis and endometriosis, and also be aware of the complications of this pathologies during delivery as we probably faced in our case which maybe the reason of intra/postpartum heamorrhage. Endometriosis is a complex gynecolgical condition and it's impact on pregnancy is realtively unexplored. We checked the medical litreture for endometriosis related pregncy and birth complications. Patients with endometriosis had more increased risk of miscarriage, ectopic pregnancy, uterine rupture, placenta displacement, unexplained antepartum heamorrhage, preterm birth, stillbirth, instrumental delivery, increased cesarean section rates and postpartum hemorrhage so we aimed to highlight endometriosis associated pregnancy complications. The number of pregnant women diagnosed with endometriosis are increasing day by day with the help of improvements in medical treatments and sucsessful surgical technics of endometriosis in our medical approaches. Pelvic endometriosis and adenomyosis are significantly assosciated. On the other hand clinicans do not have optimised awareness of the impact of endometriosis on pregnancy and birth complications. Clinicians should know women with diagnose of endometriosis are at risk of wide range of poor pregnancy outcomes and birth complications so preventative approaches could take place to minimise such life threatening birth complications of mom to be patients with endometriosis.

Keywords: Adenomyosis, endometriosis, heamorragia, obstetrics, pregnancy

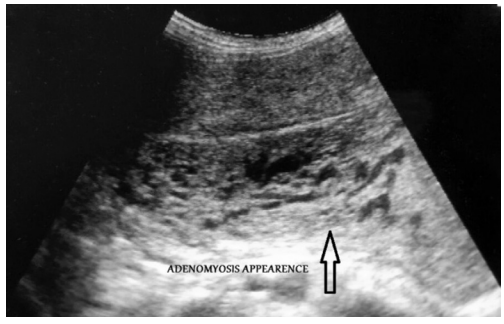


Figure 1. Adenomyosis appearance on TVUSG
TVUSG: Which can improve spatial resolution with its higher frequency, is known to be accurate in diagnosing adenomyosis, but it actually has limitations

[PP-091]

Non-puerperal uterine inversion: A rare case

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Uterine inversion is a medical emergency and most frequently (15-50%) occurs in the third part of the delivery (1). However, we here report, a case of non-puerperal uterine invasion, a rare condition. Possible preceding factors are; uterovaginal prolapsus, endometrial polyps and carcinoma, cervical carcinoma, uterine leiomyoma, leiomyosarcoma.

However, uterine inversion is usually tumour associated with the commonest tumour being prolapsed myoma and leiomyosarcoma (2). A 77 year-old, multiparous, postmenopausal woman was admitted the hospital coplaining of a painful mass exteriorized by the vulva. She was menopausal since 32 years and had no history of systemic disease and abdominal surgery. Gynecological examination revealed a mass protruding through the vajinal introitus and the broadest leading part of mass measured 8 cm. There was no active bleeding and cervical os could not be identified. The mass was felt floopy which bled on touch and could not be reducted. On bimanuel examination, uterus could not be felt and a strong tenderness was felt on posterior vaginal wall. A hard and tight ring like tissue was also palpated behind the mass. Because of insufficient evidence on pelvic ultrosonograpy; magnetic resonance imaging (MRI) also done to establish a diagnose. MRI report was point out a probably malignant cervical mass measured approximately 45x55 mm. Intraopertive findings and pathological examination of the specimen revealed diagnosis of "uterine inversion caused by myoma". Vaginal approach was tried to reinvert uterus but had failed. Abdomen was opened by making a phannenstiel incision under general anesthesia. Intraoperative examination revealed an U-shaped depressed uterus and dimpling at fundus with seperation of uterine walls. Bilateral tubes and ovaries were been drawn into the canal that made by reversed uterus. We grasped round ligaments and uterus from the area below the inversion and pulled up step by step until the uterus was reinverted. Hysterectomy and bilaterally salpingoooferectomy had been done. Patient had no clinical symptoms at postoperative period and the sixth month of outpatient control. Diagnosis of uterine inversion requires a high index of suspicion when gynecologic examination detects a protruding mass in the vagina and the uterine fundus cannot be felt by bimanual examination with an empty bladder (2). Sonographic characteristics are the poor delineation of the endometrial stripe on longitudinal scanning, which instead of being linear takes on a Y-shaped configuration (3). Treatment of uterine inversion depends upon patient's fertility, possible etiology and stage of inversion (4). Kustner and Spinelli procedures are done by vaginal route to reinvert uterus to its anatomic position by a vertical incision on the cervicoisthmic constriction ring. On the other hand, surgery can be done by abdominal approach with Huntington and Haultain procedures to reduce the uterin incision to a minimum (5). In patients with benign disease, where these procedures are not successful, abdominal or vaginal hysterectomy is recommended.

Keywords: Inversion, surgery, vaginal mass

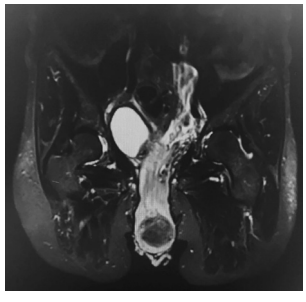


Figure 1. Abdomen- pelvis computed tomography image

[PP-092]

A rare cause of encapsulating peritonitis: Familial mediterranean fever

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Familial mediterranean fever (FMF) is a hereditary autoinflammatory disorder characterized by acute attacks of serosal inflammation and fever. Peritoneal fluid collection and bowel encapsulation are caused by chronic sterile inflammation subsequent to the upregulation of several cytokines. Encapsulating peritonitis is regarded primarily as a complication of peritoneal dialysis and rarely associated with inflammatory diseases. We hereby report two cases of FMF, in the presence of fibrocollagenous peritoneal cystic formations, encapsulating bowel loops, and an unusual form of ascites. A 19-year-old woman presented with acute pain in the right lower abdominal quadrant, associated with nausea and vomiting. She had a history of FMF and colchicine treatment during 3 years. Transvaginal ultrasonography detected a right exophytic ovarian cyst of 62x55 mm, with multiple septations and a paraovarian anechogenic cystic formation of 91x45x54 mm surrounded by approximately 300 mL of intraabdominal fluid. Exploratory laparotomy revealed thickening of the peritoneum and cystic formations retaining ascites. A 6-cm ovarian cyst and other cystic formations were drained. Intra-abdominal free fluid was aspirated. The histological examination results of peritoneal biopsies were compatible with chronic peritonitis and omental, and ovarian biopsies were negative for malignancy and tuberculosis. Histopathologic examination of intra-abdominal free fluid also showed benign cytological findings. During an 8-year follow-up period, colchicine was continued after surgery and no further ascites collection or cystic formations were observed. A 27-year-old female patient was referred to our hospital with acute abdominal pain. Without any history of chronic disease. She had history of a cesarean section two years earlier. An ultrasound examination and computed tomography scan revealed the presence of multiple cystic formations with septations between the intestinal tract and abdominal wall, with loculated ascites. An emergency laparotomy was performed. Multiple cystic formations retaining ascites all over the pelvic area and small bowel loops encapsulated by a fibrous peritoneal membrane were observed during the procedure. Capsules were ablated, fibrous intestinal adhesions were decorticated, and intra-abdominal free fluid was aspirated. Additionally, peritoneal, omental, and ovarian biopsies are taken to rule out the differential diagnosis. Biopsies were negative for malignancy. Histologically, the peritoneum showed mononuclear inflammatory infiltrates with proliferation of fibro-connective tissue and dilated lymphatics. At the 1-month postoperative follow-up, she presented to the hospital with abdominal pain, but no intra-

abdominal findings were found during her examination. After multidisciplinary evaluation, the patient was diagnosed with FMF and began colchicine treatment. After a 4-year treatment with colchicine, no further cystic formations or ascites collection was observed. Additionally, her abdominal pain attacks did not recur. Encapsulating peritonitis mimick malignancy or can cause ineffective emergency laparotomies. Operators must be aware of this entity and should be considered whenever a patient reports recurrent abdominal pain, nausea and vomiting. Diagnostic modalities like ultrasonography and computerized tomography can also be useful and may prevent radical surgery. Apart from other etiologies, FMF also should be considered as part of the differential diagnosis, especially where hereditary inflammatory disease is endemic. Further, molecular genetic research should be done.

Keywords: Familial mediterranean fever, peritonitis, encapsulating peritoneal sclerosis

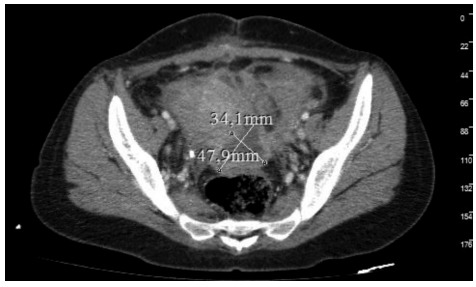


Figure 1. Abdominal computed tomography showed a complex predominately fluid density adnexal mass in the pouch of Douglas

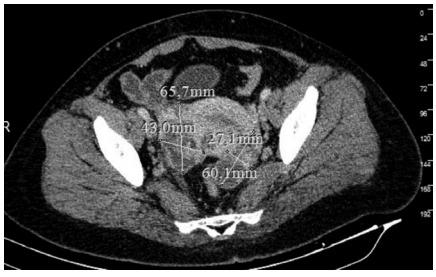


Figure 2. Transaxial computed tomography showed abscesses that contrasting thick walls and internal septations in the bilateral adnexal areas

[PP-095]

Vaginitis emphysematosa: Clinic, ultrasonography and pathology

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Vaginitis Emphysematosa is a rare, benign, self-limited condition characterized by presence of multiple, discrete, gas-filled cycts in vaginal or ectocervikal mucosa. Vaginal discharge and pruritus are the most common symptoms. Etiology of Vaginitis Emphysematosa haven't been completely elucidated, it can be a rare manifestation of common infectious organism in the vagina. This entity is especially associated with compromised immunsystem and pregnancy. A 51-year-old postmenopausal woman was referred to our outpatient clinic due to a history of vaginal discharge and vulvar pruritus for 2-months. The patient underwent total hysterectomy with unilateral salpingo-oophorectomy for myoma uteri and benign ovarian lesion 8 years ago. She had been hospitalized for 10 days, 1 month ago due to a severe depressive episode of bipolar disorder which was diagnosed a long time ago. Gynecological examination disclosed a normal vulva, perineum and perianal area. Speculum examination showed multiple discrete cystic lesions, 3 to 7 mm, occupying the vaginal cuff and posterior vaginal wall (Figure 1). There was an abnormal purulent discharge, sample had taken by the help of a swab over the cystic lesions for wet mount (saline microscopy of vaginal discharge) and culture. Bimanuel examination showed perception of spumy, soft, roughness area at vaginal cuff plane, paravaginal areas were normal. Transvaginal ultrasonographic examination showed multiple submucosal structures appearing as echogenic dots or lineer echogenicities spread uniformly throughout the lesion that was previously described (Figure 2). Because of concerns of possible malignancy, biopsy for histologic examination was obtained. The patient treated with Metronidazole 2*500 mg according to vaginal wet mount showing flagellated protozoas spesific for Trichomonas vaginalis. Vaginal culture was negative. Histopathologic examination of the biopsy specimen demonstrated normal squamous mucosa underlying cysts surrounded by multinucleated giant cells, consistent with a diagnosis of emphysematous vaginitis (Figure 3). There were no additional diagnostic testing or additional medical therapy. At her 2- week follow up the patient was almost asymptomatic, and speculum examination denoted a considerable reduction of the lesions (Figure 4). Since Zweifel had identified emphysematous vaginitis in 1877, approximately 200 cases have been described in the literature (1). It is a benign, self- limited condition characterized bygas-filled cycts in the vagina and on the exocervix. Although it has been proposed to be a rare manifestation of common infectious organisms in the vagina, the exact pathogenesis remanis obscure. It is seen particularly in patients with compromised immune system (2,3). Except of vaginal discharge and vulvar pruritus and less commonly crepitus during intercourse, most patients are free from symptoms. These gas-filled, different sized mucosal cysts can mimic cervikalcarsinoma, Akang et al,emphasizing the importance of an inclusive differential diagnosis on their case report (4). Histopathologic examination is crucial for exclution of malignancy and definitive diagnosis. There are two treatment options: expectant management or metronidazole (5). In this case medical treatment was chosen according to wet mount result. In conclusion, emphysematous vaginitis is a benign, poorly understood, malignancy mimicing condition. It is important for physicians, radiologists and pathologists to recognize its characteristics to avoid unnecessary examinations and treatments.

Keywords: Histopathology, sonography, vaginitis emphysematosa

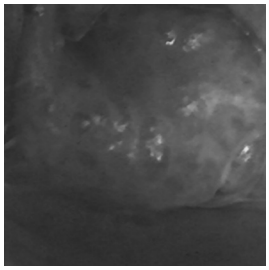


Figure 1. Multiple cystic vaginal lesions

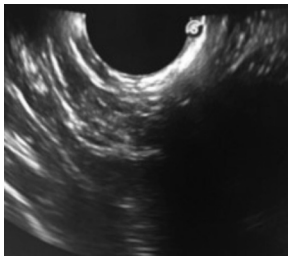


Figure 2. Transvaginal sonography; echogenic dots or linear echogenities spreading throughout the lesion

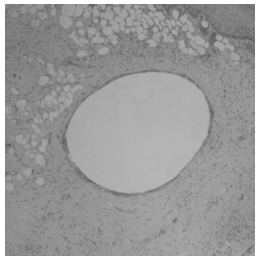


Figure 3. Normal squamous mucosa underlying cysts, surrounded by multinucleated giant cells

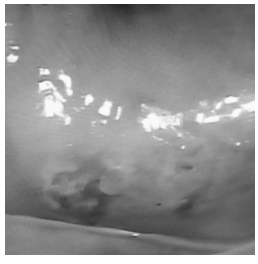


Figure 4. Normal vaginal mucosa after two weeks, cystic lesions disappeared

[PP-096]

Spontaneous heterotopic pregnancy: Case report and review of literature

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Spontaneous heterotopic pregnancy is defined as the simultaneous coexistence of both intrauterine and extrauterine gestation. This rare and potentially dangerous condition has an incidence of only 1 in 30.000 spontaneous pregnancies. Because of its rarity, the diagnosis of this situation is usually challenging. Surgical intervention plays a critical role in the management. The primary aim of the treatment is removing the ectopic pregnancy while not putting on the line the intrauterine one. We would like to present a heterotopic pregnancy with massive intraabdominal bleeding with successful maintenance of the intrauterine pregnancy. Thirty three- year-old G2P0A1 patient with a previously diagnosed pregnancy at 9th week presented to the emergency room with a complaint of abdominal pain and vaginal spotting. Transvaginal ultrasound revealed a single live intrauterine pregnancy of 8 weeks and 4 days and 7 cm x 5 cm hematoma formation was detected at left adnexa with a suspicious ectopic pregnancy appearance inside the hematoma. Minimal fluid was detected in the Douglas pouch. Patient was hospitalized and followed closely. After 24 hours of hospitalization the vital signs of the patient were deteriorated and the massive bleeding appearance in the abdominal ultrasound was detected. Exploratory laparotomy was performed revealing 5 cm x 3 cm ruptured ectopic pregnancy with an intraabdominal coagulum 1500 cc in volume. Left salpingectomy and evacuation of hematoperitoneum was performed. The patient was uneventful postoperatively and the patient was discharged with live intrauterine pregnancy in postoperative 7th day. Vaginal spotting and abdominal pain in a pregnant woman usually indicates ectopic pregnancy in daily practice. Presence of an intrauterine pregnancy makes the differential diagnosis challenging. Including heterotopic pregnancy to the differential diagnosis choices almost always give the practitioner a chance for preventing severe morbidity and mortality for the mother and a chance for ongoing the natural course for the intrauterine pregnancy

Keywords: Heterotopic, pregnancy, obstetric emergency



Figure 1. Intraoperative view of heterotopic pregnancy



Figure 2. Intraoperative view of heterotopic pregnancy



Figure 3. Ultrasonographic view of heterotopic pregnancy



Figure 4. Ultrasonographic view of intrauterine pregnancy postoperatively

[PP-097]

Endometriosis at cesarean section scar

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Term of endometriosis is growth of ectopic endometrial tissue outside of the uterine cavity while extrapelvic endometriosis refers to endometriosis found at body sites other than the pelvis. Abdominal surgery scars following gynecologic abdominal surgical procedures like cesarean section are the extrapelvic sites for the disease. The development of the endometriosis on a surgical scar may have a very late onset after the surgery. Because of this situation the diagnosis of the disease often mistaken for a suture granuloma, incisional hernia, or a strange body this situation often predisposes to incorrect. One of the most accepted theory about cesarean scar endometriosis (CSE) is the mechanical iatrogenic implantation. The term scar endometriosis is used for tumoral lesions, such as non-neoplastic granuloma which formed by whitish fibrous tissue, with thick chocolate- like colored liquid areas. Although CSE has many different clinic presentations, the most common clinical symptoms and signs are swelling, tenderness on local site, and cyclic pain. A 29-year-old woman was presented with a 6-month history of lump on the lateral aspect of a pfannensteil incision and pain during her menstruation at her abdominal scar from a cesarean section three years earlier. Abdominal examination revealed a lump about 2x1 cm, firm, mild and tender (Figure 1, 2). Ultrasound of the abdomen was performed and revealed a bright heteroechoic mass about 21x13 mm at the lateral aspect of the abdominal wall scar. Patient was treated surgically, with removal of the endometriosis with a safety margin, with the aiming of achieving a cure and avoiding regional recurrence. Histopathology showed fibroadipose tissues with interspersed glands and stroma of endometriosis which confirmed diagnosis of endometriosis abdominal wall scar. Abdominal wall endometriosis is largely related to previous history of surgery. Endometriosis implants developing in the subcutaneous tissue of surgical scars occur most frequently after gynecological and obstetrical procedures. The pathogenesis of endometriosis is complex and CSE is believed to be the result of a mechanical iatrogenic implantation, through the direct inoculation of the abdominal fascia and/or subcutaneous tissue with endometrial cells during the surgical intervention. The most evident risk factor for the presence of endometriosis in scar tissue is a previous history of obstetric surgical procedures. Physical examination is essential for an accurate diagnosis. Ultrasound is the most accessible, reliable, and cost-effective procedure for diagnosis. Medical treatment gives only partial relief and with regard to the almost certain recurrence of the condition. Complete wide excision with clear margins is both diagnostic and therapeutic. One of the most important issue to be considered during surgery is nonspreading endometriosis.

Keywords: Endometriosis, cesarean section scar, cyclic pain



Figure 1. Abdominal examination revealed a lump about 2x1 cm, firm, mild and tender

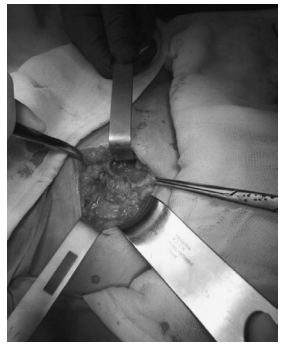


Figure 2. Endometriosis at cesarean section scar

[PP-098]

A case of full-term heterotopic pregnancy after cornual ectopic preganancy excision

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Ectopic pregnancy describes the extra-uterine placement of the gestational sac. Heterotopic pregnancy is a type of ectopic pregnancy associated with at least one intrauterine pregnancy. Its frequency increases with IVF. The termination of ectopic pregnancy in heterotopic pregnancy is a risky situation in terms of intrauterine pregnancy. A healthy, full-term pregnancy after a ruptured cornual pregnancy is presented in this case. A 34-year-old patient with G1P0 was referred to our clinic with an acute abdomen table. A normal intrauterine, 7-week pregnancy was observed was observed in the ultrasonography ectopic pregnancy with a focus in the right uterine cornu. There was copious, unbound liquid in the abdomen. The patient has severe pain and was taken in for an emergency laparotomy with a preliminary diagnosis of ruptured ectopic pregnancy. In the operation, actively bleeding 4x4 cm ectopic focus located the cornual region between the right ovary and oviduct, and a state of hydrosalpinx in the right oviduct were observed in the operation. The ectopic area was double sutured by excising the ectopic focus, and the right salpingectomy was performed. The patient was discharged on the 2nd postoperative day without issue and by determining alive embryo. Progesterone support and sc anticoagulant therapy were administered in the follow-ups. The patient observed normal pregnancy follow-ups and was administered tocolytic treatment with the initiation of uterine contractions in the 35th week. The patient was administered betamethasone for lung maturation, and a cesarean section was performed due to transverse incidence upon the initiation of labor in her 37th week; and a health male baby was delivered at 2940 grams and an 8/9 apgar score. A 4 cm endometrioma cyst observed in the left ovary was excised during the cesarean operation. No complication developed in the post-operative period. The mother and baby were discharged healthily. We are confronted with heterotopic pregnancies, especially in pregnancies attained with IVF. Heterotopic pregnancies should especially be kept in mind in IVF pregnancies referred with acute abdomen. Patients who undergo uterine surgery in the early weeks of pregnancy may be closely monitored with follow-ups until term.

Keywords: Heterotopic pregnancy, ectopic pregnancy, term

[PP-099]

Postpartum urinary retention after cesarean section with general anesthesia: A rare case report

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Postpartum urinary retention (PUR) which is defined as difficulty in emptying the bladder completely after delivery, may be clinically pronounced or silent. It's frequency changes according to the definition. Many risk factors for this disturbance are identified in the literature. Therefore, we present a case report of PUR after cesarean section with general anesthesia. A 34 year old gravida 3 parity 2 patient applied to the clinic during the 38th gestational week due to pelvic pain and vaginal bleeding. Her body mass index (BMI) was 27. She had two cesarean section story and 4 cm 70% cervical effacement and dilation on vaginal examination with regular contractions at fetal non-stress test (NST). Emergency cesarean section was performed with general anesthesia and propofol, sevoflurane, fentanyl was used as agents. The baby was borned with 3450 grams. The urinary 16F nelaton catheter was removed after 8 hours later from the operation with 1000 mL clear urine was drained but the patient was unable to void spontaneously. She had no complaining of abdominal pain or urinary incontinence. On the postoperative first day at the hospital, patient's serum blood urea nitrogen was 75 mg/dL, creatinine value was 2.2 mg/dL, hemogram was normal and urine analysis was clear. Abdominal ultrasonography showed a large (14x10x12 cm) distended bladder. The patient was catheterised immediately and 2000 mL clear urine was drained, but she was unable to void spontaneously again. After consultation with urology and neurology departments, electroneuromyography (EMG) was performed, contractility of the detrusor muscle was normal. Secondary to the using of general anesthesic agents was considered with the patient's urinary retention as a result. Meanwhile, with appropriate hydration, renal function tests returned to the normal range within 24 hours. She was catheterised for a second time for one week and voiding problems were disappeared. Mechanisms of disturbance resulting in PUR have not been fully explained. Some important predisposing risk factors for PUR are nulliparity, instrumental delivery, prolonged labour (>700 minutes), tissue oedema and bladder neck obstruction, detrussor muscle injury, catheterisation during labour, epidural anaesthesia. PUR is also associated with surgical procedure, anesthesia and analgesia type. In the literature, the reported incidence rate for postcesarean urinary retention varies widely between 5% and 33.3%. PUR remains a matter for debate, since the aetiology and management have not been clarified and longitudinal prospective studies to establish its long-term consequences are needed.

Keywords: Postpartum urinary retention, cesarean section, general anesthesia, electroneuromyography

[PP-100]

A big cornual pregnancy treated with single dose methotrexate

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A cornual pregnancy describes a pregnancy in the interstitial segment of the fallopian tube and due to the high myometrial and vascular content value of this segment, a cornual pregnancy has a mortality of about 5%, which is six or seven times higher than that of ectopic pregnancies in general medical treatment of cornual pregnancy is generally multi-dose methotrexate, (resorting to surgical therapy if there is any deterioration in clinical status. With multi-dose methotrexate for interstitial pregnancy, success rates of 66 to 100 percent have been reported. In this case we report a cornual pregnancy treated with single dose methotrexate. A 40 years old gravida 4, parity 2, abortus 1 female patient was admitted to our out patient clinic with a history of 12 weeks amenorrhea. During our examination of the patient her general physical examination was normal. The transvaginal sonography revealed there was an eccentrically located gestational sac about 35x23 mm in the uterine cavity but there was no embryo or yolk sac in the gestational sac (Figure 1). Serum β-HCG level was 3791 IU/mL. The myometrial thinning around the gestational sac was less than 5 mm and it was also separate from the uterine cavity. Single dose methotrexat treatment and 1st, 4th, and weekly β–HCG measurements were applied respectively. At the fourth month of the treatment β-HCG level was 0 IU/mL and there was a 17x18 mm view of the scar tissue (Figure 2). Cornual pregnancy is a rare and dangerous type of ectopic pregnancy that describes an implantation in the upper and lateral uterine cavity. It accounts for 2%-4% of all ectopic pregnancies and it has a higher mortality rate than other ectopic pregnancies, which is about 2%-2.5%. The treatment options for cornual pregnancy are generally surgical treatment or multi-dose methotrexate treatment. We concluded in this case that single dose methotrexate treatment could be a treatment option for well-chosen cases.
Keywords: Cornual, ectopic pregnancy, methotrexate



Figure 1. Gestational sac placed uterin cornu



Figure 2. View of the cornual scar tissue

[PP-101]

A large uterine leiomyoma with hypertrophied omental vessels: A case report

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Uterine leiomyomas are the most common solid benign uterine neoplasms that arise from the overgrowth of smooth muscle and connective tissue in the uterus. It is estimated that 20-40% of women of reproductive age have uterine leiomyoma. The most common presenting symptoms of leiomyomas are menorrhagia, dysmenorrhea, subfertility, pelvic pain, dyspareunia and pressure symptoms from the bowel and bladder, e.g. constipation, frequency, chronic urinary tract infections. Clinical examination (medical history, abdominal palpation, speculum examination, bimanual palpation), utrasonographic examination, computed tomography scanning and magnetic resonance imaging are often to diagnose fibroids. This case represents a successful surgical management of a postmenopausal woman with large uterine leiomyoma accompanying hypertrophied omental vessels. A 52-year-old postmenopausal multiparous woman (gravida 8, para 5, aborta 3) presented with a history of lower abdominal pain and distension for about 10 months. The patient's personal history revealed fatigue, loss of appetite, dyspnea and chronic constipation. She had no history of medical illness or surgical procedures. Her vital signs were all within normal limits. On physical examination, an abdominopelvic mass with a dullness on percussion-a solid mass was palpated. Abdominal tenderness was not present. Gynecologic examination revealed a large, mobile abdominopelvic mass with a normal external genitalia and uterine cervix. The results of routine laboratory testing including serum electrolyte levels, tumor markers, tests of liver and renal function and Pap smear were normal except the hemoglobin level, which was 8 g/dL. Abdominal ultrasonography revealed a large solid mass, approximately 20 cm x 15 cm in size, occupying the abdomen. Ovaries couldn't observed due to the solid mass. Magnetic resonance imaging of pelvic area revealed an

intramural, hypo-intense and homogenous solid uterine mass 200 mm x 150 mm x 150 mm with omental large dilated blood vessels measuring upto 5 mm in diameter (Figure 1a-1c). A possible large leiomyoma was diagnosed and the patient underwent laparotomy. Two units of packed red blood cells were transfused preoperatively. A vertical, midline incision was made 1 cm below the umbilicus extending down to 2 cm above the pubic symphysis. At laparotomy, an enlarged intramural leiomyoma arising from uterus that filled the entire lower abdomen with omental large dilated blood vessels was observed (Figure 2). A total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed. After obtaining hemostasis, a hemovac drain was packed into the pelvis to drain any blood for the first 24 hours postoperatively. The drain was removed on the first postoperative day, and she was discharged on the third postoperative day in excellent condition. Gross pathologic examination revealed a 20 cm x 20 cm x 15 cm, 3600 g intramural, myomatous, cellular leiomyoma and bilateral ovaries and tubes were normal (Figure 3). Histologic signs of malignancy were not found. The final diagnosis was a intramural uterineleiomyoma with degenerative changes. Uterine fibroid tumors are the most common benign neoplasms of the female reproductive tract. A surgical approach is most frequently preferred for management of large leiomyomas. Careful perioperative management and multidisciplinary patient care are essential to prevent morbidity and mortality.

Keywords: Large leiomyoma, surgery, omentum, hypertrophied vessels

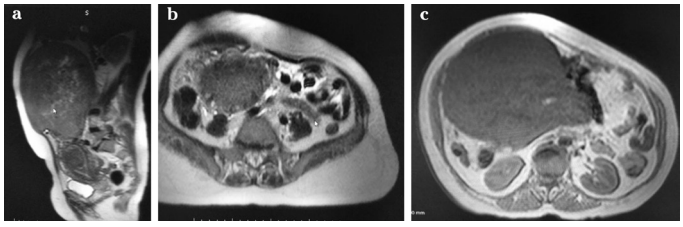


Figure 1a, b, c. Images of MRI in sagittal and axial sections showing the uterine fibroid mass

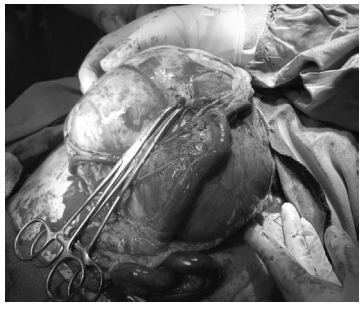


Figure 2. Intraoperative appearance of uterus with large leiomyoma and omental large dilated blood vessels

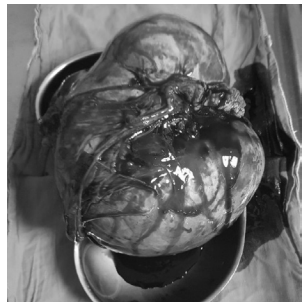


Figure 3. Post-operative specimen showing the uterus with large leiomyoma

[PP-102]

Prenatal diagnosis of X-linked hydrocephalus by ultrasound in the second trimester of pregnancy: Case report

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X-linked congenital hydrocephalus (XLH) is the most common of the inherited forms of hydrocephalus. The prevalence is 0.3/10.000. Hydrocephalus-stenosis of the acqueduct of Sylvius sequence (HSAS) is characterized by hydrocephalus, macrocephaly, mental retardation, bilateral adducted thumbs, and spasticity of upper and lower limbs. The pathogenesis of XLH is mutations in the L1 cell adhesion molecule (L1CAM) gene, coding neural cell. We report a case of HSAS diagnosed prenatally. X-linked hydrocephalus is known to be due to mutations in the gene coding for the neural cell adhesion molecule L1 (L1-CAM) and diagnosis is made by identification of a mutation in the L1-CAM gene. Prenatal diagnosis of HSAS is usually suggested on ultrasound examination showing hydrocephalus in a male fetus associated with bilateral adducted thumbs. Mutation screening of the L1-CAM gene is indicated when neuropathological examination shows hypoplasia of the corticospinal tract associated with aqueductal stenosis. We report here two cases of HSAS diagnosed within the same family by ultrasound examination in the first trimester of pregnancy when bilateral adducted thumbs were the only early ultrasound marker X-linked hydrocephalus is known to be due to mutations in the gene coding for the neural cell adhesion molecule L1 (L1-CAM) and diagnosis is made by identification of a mutation in the L1-CAM gene. Prenatal diagnosis of HSAS is usually suggested on ultrasound examination showing hydrocephalus in a male fetus associated with bilateral adducted thumbs. Mutation screening of the L1-CAM gene is indicated when neuropathological examination shows hypoplasia of the corticospinal tract associated with aqueductal stenosis. We report here two cases of HSAS diagnosed within the same family by ultrasound examination in the first trimester of pregnancy when bilateral adducted thumbs were the only early ultrasound marker A 29-year-old woman, gravida 1, para 0 was referred to our unit at 24 weeks of gestation because of ventriculomegaly. She had a non-

contributive personal history. But her mother had a male baby who died soon after delivery due to a severe hydrocephalus. Significantly enlarged bilateral ventricles, measuring 23.8 mm at the level of the atrium and dilatation of the third ventricle in male fetus were detected. The fetal hands showed the thumbs to be fixed in a flexed-adducted position (Figure 1). Posterior fossa, cerebellum and fourth ventricle were normal. The presence of XLH was considered. After counseling, prenatal diagnosis was performed by chordocentesis which showed a normal 46,XY fetal karyotype and the mother was not immune for CMV nor for toxoplasmosis. Mutation in L1CAM gene was detected in genetic material of both maternal and fetus. The parents were counseled and they requested termination of the pregnancy. Bilateral adducted thumbs were found on direct post-mortem examination (Figure 2). XLH should be considered when prenatal sonographic examination is showed hydrocephalus due to congenital stenosis of the acqueduct of Sylvius in a male fetus affected with bilateral adducted thumbs. If possible, the diagnosis should be made by analysis for the LlCAM gene. Thus, subsequent pregnancies may benefit from early diagnosis or preimplantation of genetic diagnosis.

Keywords: Bilateral adducted thumbs, congenital hydrocephalus, L1CAM gene

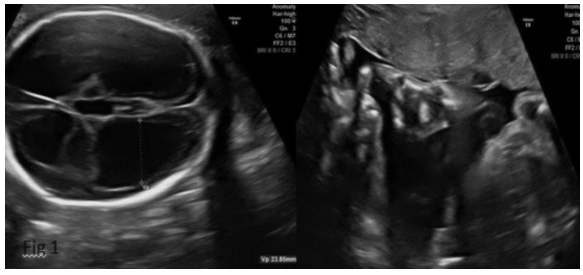


Figure 1. Fetal hydrocephalus and adducted thumbs at 27 weeks gestation



Figure 2. Adducted thumbs in the affected fetus after termination of pregnancy

[PP-103]

Prenatal diagnosis of Miller syndrome by ultrasound in the second trimester of pregnancy: A case report

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Miller syndrome is a quite rare mendelian disorder which is a type of postaxial acrofacial dysostosis that mainly affects the development of the face and limbs. The predominant features of this condition are micrognathia, orofacial clefts, malar hypoplasia, aplasia of the medial lower lid eyelashes, coloboma of the lower eyelid, hearing loss caused by defects in the middle ear, cup-shaped ears combined with various bone abnormalities although the heart, gastrointestinal tract, urinary tract, and skin may also be involved. The most common extremity problem is absent fifth fingers and toes. This condition is inherited in an autosomal recessive pattern. Mutations in the dihydroorotate dehydrogenase (DHODH) gene which is located at chromosome 16q22 and encodes a key enzyme in the pyrimidine de novo biosynthesis pathway and is localized at mitochondria intermembrane space cause Miller syndrome. We report a case of Miller syndrome diagnosed prenatally. A 28-year-old woman, gravida 1, para 0 was referred to our unit at 26 weeks of gestation because of fetal face abnormality. No anomalies were detected during the 12 weeks scan with low risk of aneuploidies. She had non-contributive personal or family history. Also, medical history was negative. Our ultrasound examination revealed a male fetus with bilateral cleft lip. The palate was intact and intact uvula (equal sign) was seen. Additionally, flat forehead, deformed ears that is called a cup-shaped ears and presence of four toes because of absence of fifth postaxial toes and metatarsals in both feet of fetus were recognized during the sonographic scan. Fetal cardiac examination was normal. The amniotic fluid volume was within the normal limits. Fetal face appearance in coronal and oblique views on three-dimensional images confirmed the presence of bilateral cleft lip (Figure 1). Our diagnosis based on the ultrasound findings, was Miller syndrome. After counseling, prenatal diagnosis was performed by chordocentesis which showed a normal 46,XY fetal karyotype. Exome sequencing confirmed the presence of DHODH mutations in genetic material of the fetus. After two weeks of scan, fetus died in utero. Postmortem examination confirmed our sonographic findings (Figure 2). The parents had received genetic counselling and been given a recurrence risk of 25%. Miller syndrome should be considered when prenatal sonographic examination is showed cleft lip and/or palate combined with aplasia of the postaxial elements of the limbs. After diagnosis, cautious genetic counseling is advisable since recurrence cannot be ruled out and careful prenatal surveillance as well as ultrasound evaluation should be made for subsequent pregnancies.

Keywords: Dihydroorotate dehydrogenase gene, miller syndrome, postaxial acrofacial dysostosis



Figure 1. Bilateral cleft lip on 3D image



Figure 2. Postmortem appearance presents bilateral cleft lip, four toes (absent 5th toe) in both feet in male baby

[PP-104]

Pure large cell neuroendocrine carcinoma of ovary: A rare clinical entity

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Neuroendocrine tumours consist a group of neoplasms which derived from the diffuse neuroendocrine cell system. Neuroendocrine tumours are mostly defined in gastrointestinal tract and lung. On the contrary, gynaecological neuroendocrine (NE) tumours not common both for primary and secondary tumours. In the recent times, NE tumours are divided into two groups: poorly differentiated neuroendocrine carcinomas (NECs) and well-differentiated neuroendocrine tumours (NETs). NECs contain small cell carcinoma and large cell neuroendocrine carcinoma. Large cell neuroendocrine carcinoma (LCNEC) of the ovary is a rare tumour. Its pure form without any associated surface epithelial stromal or germ cell component is more rarely seen. Its prognosis is generally very poor even when the diagnosis is made at an early stage. We report a case of pure large cell neuroendocrine tumour of ovary. LCNC has no standard treatment. Generally surgical resection is the clinical management of ovarian neuroendocrine neoplasms. Adjuvant chemotherapy and primary debulking surgery should be done when it is possible. A 73 year old, gravida 8, parity 5, postmenopausal woman visited our clinic with complaint of pelvic pain. On physical examination a firm, irregular, solid mass was felt occupying the right adnexial region measuring 10*9 cm with restricted mobility. The margins of uterus couldn't be differentiated, left adnexial region was mobile and free. Ultrasonography revealed a 117*101 mm heterogeneous, solid with irregular margins mass lesion on the right adnexial region and extended to the left adnexial region. Her Ca-125 level was 31.8, also the other tumour markers like CEA, AFP, CA 19-9 were normal. Her Pap cervical cancer screening was normal. At operation, frozen pelvis was seen, ovarian mass was found to adhere to the uterus, bladder and rectum. The adhesions within mass and its peripheral organs were dissected. During the operation the pathologic result of pelvic mass was malignant however the origin of malignancy was indefinite. This was the reason she only underwent exploratory laparotomy with resection of the pelvic mass, total abdominal hysterectomy and bilateral salpingo-oopherectomy. The cytological evaluation of the abdominopelvic washing fluid showed malignant cells. The definite pathologic diagnosis of the pelvic mass was pure large cell neuroendocrine carcinoma of the ovary. Histological examination showed a pure LCNEC without any associated component confirmed by immunohistochemistry. Immunohistochemical staining was positive for CD56, synaptophysin, pancytoceratine, CAM5.2 but negative for WT-1, EMA, CK7, p16 and p53. After the exact result of pathology, the patient refused to have second surgery. Post-operative chest CT was normal. She was treated with 6 sessions of a combination chemotherapy consisting of etoposide 100 mg/m^2 and cisplatin 25 mg/m^2. She is still healthy after the last chemotherapy. Due to the rarity of the disease, few number of reported cases and the lack of systematic population based studies or registry data, it is very difficult to be sure about the prognosis of the LCNEC of the ovary and there are no reliable guidelines for diagnosis or treatment.

Keywords: Large cell neuroendocrine carcinoma, ovary, pure

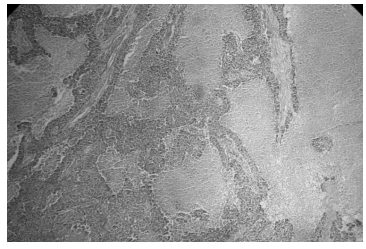


Figure 1. H and E 4X/0.10 Geographic necrosis in a poorly differentiated neuroendocrine carcinoma

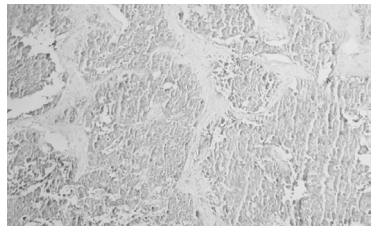


Figure 2. CD56 positivity

[PP-105]

Segonder amenorrhea due to trumatic avulsion of the cervix from uterine corpus

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Twenty five years old nulligravid woman was admitted with a complain of segondary amenorrhea for the last 10 years. In her past history she had menarche at 13 years of age and after she had had an car accident with pelvic ring fracture she had been amenorrheic. At the time of accident no laparatomy was needed and vesical trauma was healed with urinary catheter within 3 days. At physical examination segondary sexual characteristics, external genitaia, vagina and cervix were normal, but the movements of corpus uteri was independent from the movements of cervix uteri. In pelvic ultrasonography and magnetic rezonans imagining (MRI), uterin corpus and cervix were disconnected to each other (Figure 1, 2). At laparascopic exploration there was no dense adhesions in the abdomen, there were a few endometritic focuses on the vezico-uterine peritoneal surface, uterine corpus was completelly separeted from cervix at the ıstmic level (Figure 3). For the uterocervical reanastamosis, phannenstiel insicions was done. A no 8 Hegar buji was passed through the external cervikal os to the endoservical canal and was penetrated to the abdominal cavity. A vertical incision was made through the anterior surface of corpus uteri to enter the endometrial cavity. scatered tissue was exited. Cervix and corpus were approximated at 3.00 and 9.00 positions by separated sutures. A latex tube was inserted through endocervical canal to the endometrial cavity. Reanastamosis was made between anterior and posterior portions of cervix and corpus uteri (Figure 4, 5). Post operative follow up, latex tube was removed at 15th day of operation with the first mensturation and second mensturation was occured after 1 month from the first mensturation. Injury to pelvic organs due to pelvic bone fractures were extremelly rare occasions. In a 10 year experience Niemi reported only 4 vaginal laseration in 114 women with pelvic bone fracture (1). Nelson reported 220 women with exploratory laparatomies due to blunt abdominal trauma and reported only one case with uterino vaginal laseration (2). In the literature Guillotine-type seperation of corpus uteri from cervix after pelvic bone fracutures was described in only 5 cases (Table 1). Hematometra and endometriosis could be seen in the pelvis because of the uterine outflow obstruction. But Toaff and Ballas reported that trauma at the level of cervico-istmic portion without any hematometra. They explained that when the viseral reflexes at the istmic portion of the uterus was interrupted, endometrium became refractory to hormonal stimulus and this causes hypomenorrhea or amenorrhea. In our case we can also explaine few endometriotic focus and no hematometra with this hypothesis. A rare etiologies of segondary amenorrhea is seperation of cervix from the corpus uterus after pelvic bone fratures. Exact diagnosis and successful reanastamosis operation provide the patient reguler menstureal bleeding and succesful pregnancy outcomes. We should also give more attention during pregnancy follow up, because of the increased risks of placental invasion anomalies and previous uterine scar rupture.

Keywords: Amenorrhea, seperation of cervix, pelvic fracture



Figure 1. Pelvic ultrasound



Figure 2. Pelvic MRI

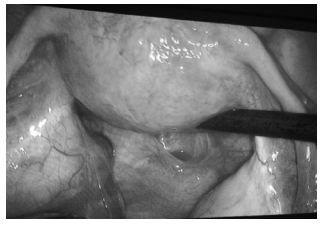


Figure 3. Laparoscopic view of uterine corpus and cervix



Figure 4. After reanastamosis, anterior portion of uterus



Figure 5. After reanastamosis posterior portion of uterus

Table 1. Cervical amputation cases in the literature due to pelvic fracture admitted with amenorrhea

literature	Age at trauma (year)	Age at admision (year)	Symptoms	Findings at surgery
Deırdre et al(3)	2	22	1⁰ amenorrhea	Uterin cervix amputation, hematometra 1cm<, diffuse adhesions
Donner et al (4)	12	18	1⁰ amenorrhea	Cervical seperation, hematometra, endometriosis
Malik et al (5)	3	15	1⁰ amenorrhea	Cervical seperation, hematometra, endometriosis
Kesterson et al (6)	13	15	2⁰ amenorrhea	Cervical separation, lacerated right broad ligament
Zhang (7)	2	16	1⁰ amenorrhea	Cervical seperation, lacerated bilat broad lig and endometrioma

[PP-108]

Listeriosis mimicking hyperemesis gravidarum in a pregnant woman

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Listeriosis is usually related to contaminated processed food, especially fast-food. It is a rather rare infectious disease. Maternal infection may present as a nonspecific, flu-like illness with fever, myalgia, backache, and headache, often preceded by diarrhea or other gastrointestinal symptoms. A 27 years aged multiparous pregnant woman applied to emergency department with complaints of nausea vomiting, headache and modarate fever for 3-4 days. The patient was considered hyperemesis and the treatment get started. The all parameters were deterioated, dispne and confession occured. The patient underwent magnetic resonance imaging (MRI) and it was reported a mass at pons. And her blood culture showed listeria infection. Brain tomography scan was performed and it showed listeria rhombencephalitis. Ampicilin and Meropenem get started after consultation of infectious diseases. The pregnancy terminated on the recommendation of the brain surgery because of existence of increase intracraniel pressure sendrom. Finally she was admitted to intensive care unit and was intubated. After sixty days of treatment, the patient was discharged with clinical healing and regression of the cranial mass. It can be life saving to keep in mind listeriosis in pregnant women admitted to the hospital with nausea, vomiting, headache and unexplained fever.

Keywords: Listeria monocytogenes, pregnancy, cranial mass, hyperemesis

[PP-109]

Giant uterine leiomyoma

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Uterine leiomyom are benign neoplasms arising from uterine smooth muscle. Although their pathogenesis remains unclear, they are the most common tumor of the female reproductive tract, occurring in as many as half of women older than 35 years. By age 50 years, 80% of African American women and nearly 70% of Caucasian women have fibroids. Forty percent of abdominal hysterectomies and 17% of vaginal hysterectomies are performed for fibroids, and 77% of hysterectomy specimens contain fibroids. Although they may cause menorrhagia, dysmenorrhea, and symptoms related to pressure and mass effect, half of women with fibroids are asymptomatic. Most of these patients have small fibroids. On rare occasions, however, fibroids can grow extremely large. It is in these cases that treatment is not standardized because proper management of patients with very large fibroids is complex and requires exceptional skill. We presented a case of a 43-year-old woman who was admitted to the hospital because of giant uterine leiomyomata which mimicking a huge ovarian malignancy. The patient underwent total abdominal hysterectomy and bilateral salpinjectomy without complication. Gravite 2, parity 2, a 12-year-old menarche, hipermenoresi present 43 years old patient; prominent during the last 6 months and increased lower abdominal pain, stiff mass in the abdomen and frequent urination applied to our polyclinic with complaints. Detailed directly; polyuria, sometimes pain during mixing as well as urinary system complaints, and pubic pain, constipation and defecation habits We have found findings like changes. The patient was admitted to our hospital with pelvic mass and malignancy with preliminary diagnosis. On the physical examination of the patient,abdominal and pelvic mass were detected. Pelvic ultrasonography; likely to originate from the uterine anterior/fundus region, 25x23 cm homogenous hypoechoic filling the abdomen and pelviswere reported as mass. The size of the advanced imaging considering the possibility of malignancy submerged by computed tomography (CT) and a pelvis scan was performed. The entire pelvis and abdomen filling, homogeneous hypoechoic appearance, peripheral invasion unobserved and probable origin of the uterus fundus area mass was reported (Figure 1, 2). In malignancy screening and follow-up program tumor markers (AFP, CA-125, CA-19-9, CA-15-3, CEA) were within normal limits. The external genitalia and uterine cervix were normal. Her vital signs were all within normal limits. She had no any other symptoms, there was no history of weight loss and loss of appetite. The patient was treated chronically due to diabetes. She had no surgeries and there was no history of carcinoma in patient family. Blood test and other routine hematological examinations and biochemical tests were within normal limits. Considering the size of the tumor and the possibility of malignancy, a radical abdominal hysterectomy

and bilateral salpinjectomy was performed (Figure 3, 4). The time of surgery was about 120 minutes. Patient after surgery felt good and did not complain of pain. Histopathology examination of a huge tumor showed uterine leiomyoma with cystic degeneration (weight: 6.3 kg). The postoperative period was uncomplicated and the patient left the ward in the 4th day after surgery.

Keywords: Leiyomyoma, pelvic mass, hysterectomy



Figure 1. The computed tomography scan showing mass adherent to the stem of the uterus

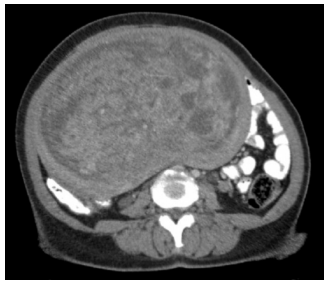


Figure 2. The computed tomography scan showing giant uterine fibroid tumor which the largest transverse dimension at the level of iliac was 250x230 millimeters



Figure 3. Laparotomy material showing giant leiomyoma

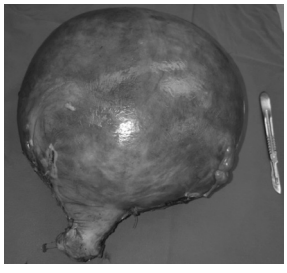


Figure 4. Photo taken during surgery showing giant fibroid uterus

[PP-110]

Vaginal birth after cesarean

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Increasing the number of vaginal birhs after cesarean (VBAC) produces a significant health care cost reduction. The benefits of VBAC include reduced risk of hemorrhage and infection, reduced risk of blood transfusion, accelerated postpartum healing, avoidance of major abdominal surgery, complications that may arise with cesarean. Women with previous cesarean delivery should be informed about the risk of uterine rupture. Furthermore, should be recommended to give birth a hospital which have equipments to provide emergency care for the development of other complications. It is important for the women to have previous vaginal delivery for increasing the success of VBAC. A women aged 33 years old, gravida 5, parity 4 who had undergone labor at 39 weeks gestation. She had 4 children. Her past history revealed that she had 2 vaginal birth (VB), after she had one emergency cesarean section for cephalopelvic disproportion, after three years one VB again. The blood pressure, pulse rate, fetal heart rate were normal. Vaginal examination revealed a fully dilated cervix and the station of the head was at +3. By giving an episiotomy and normal spontaneous vaginal delivery, a live baby boy of 3000 grams, 50 cm and Apgar score of 8-10 at first and fifth minutes was delivered. Postpartum oxytocin intravenous infusion of the patient was followed. In laboratory tests hemoglobin, hematocrit, white blood cell and blood type was found respectively as 11.3 g/dL, 36,5%, 9.8 K/uL, 0 Rh (+). In postpartum follow-ups, it was observed that the uterus was involuted on abdominal examination. Uterus contours were regular in ultrasonography and there was no free fluid in abdomen. On the first postpartum day, hemoglobin was 10.6 g/dl and hematocrit was 28.72%. Having normal vital findings, the woman was discharged from the hospital on the second postpartum day with her baby. In general, 60 to 80 percent of women who are considered candidates to attempt VBAC will have a successful vaginal birth. The benefits of VBAC include the following; shorter length of hospital stay, postpartum recovery, fewer neonatal breathing problems. Factors that increase the chances for a successful VBAC in an individual woman include: a previous vaginal delivery, spontaneous onset of labor, normal progress of labor, only one prior cesarean delivery. VBAC is contraindicated in women with previous a classical or T incision. An intervening vaginal delivery appears to increase the chances of a second vaginal birth after cesarean section. This case report confirms the fact that safe vaginal delivery is possible in some well selected women with scarred uteri. There was a limited number of prospective studies about VBAC. Definitive studies are lacking to identify patients who are at greatest risk. It is thought that it will contribute to the VBAC by increasing its knowledge and awareness with randomized controlled study.

Keywords: Cesarean section, normal vaginal birth, vaginal birth after cesarean

[PP-112]

Ectopic pregnancy occured four years after bilateral tubal ligation

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Objective: Ectopic regnancy is one of the important causes of maternal deaths. Although tubal ligation is known as a permanent method of sterilisation, pregnancy may occur in less than one percent of woman who have a procedure. The risk of ectopic pregnancy after tubal ligation is mostly seen within the first 2 years.

Material and Methods: A 35-year-old multiparous woman presented to emergency department with complaints of 3 days of progressively increasing pelvic pain and vaginal bleeding. The medical history of patient was significant for prior bilateral tubal ligation during cesarean section 4 years ago. A serum hCG level was 78.6 IU/L. We performed a transvaginal sonagraphy and saw that there was no gestational sac in the uterus and bilateral adnexa were normal.

Results: We followed the patient by serial measurement of beta-hCG concentrations in outpatient clinic. Although serum hCG titres were assayed every 2 days, a rise in hCG was slow. Subsequently, beta-hCG titres remains plateau, then decreased spontaneously.

Conclusion: Although pregnancy occurs most frequently within 2 years after tubal ligation, it is still useful to evaluate serum beta-hCG in patients presenting with pelvic pain and vaginal bleeding. Otherwise it could be life-threatining.

Keywords: Ectopic pregnancy, tubal sterilisation, hCG assays

[PP-115]

Hereditary spherocytosis with pregnancy

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Hereditary spherocytosis (HS) is a dsorder of the red blood cell membrane protein that leads to sphere shaped red blood cells. The incidence of HS varies from 1:2000 to 1:5001 in northern Europe and America. The prevalence of hereditary spherocytosis in people of other ethnic backgrounds is unknown. Family studies indicate autosomal dominant inheritance in approximately 75 percent of patients with recessive inheritance occurring in most of the remaining patients. It is a heterogeneous group of disorders with regard to clinical severity, protein defects and mode of inheritance. Diagnosis is made by anemia, increased reticulocyte count, MCHC, spherocytes in peripheral smear, elevated bilirubin and LDH levels, decreased MCV. There is increased osmotic and incubated fragility test. The confirmatory test for this disease is sodium dodecyl sulfate polyacrylamide gel electrophoresis. Atypical cases may require measurement of erythrocyte membrane proteins to clarify the nature of the membrane disorder and in the absence of a family history. The disease may be mild, moderate or severe. Mild disease needs no treatment. Moderate disease is treated with folic acid 5 mg/day, supportive treatment and regular check up. Severe disease warrants frequent hematological supervision and splenectomy. Information regarding the course of HS during pregnancy is limited. We report a case of pregnancy with moderate HS detected during pregnancy. A 22-years old patient who was pregnant for the third time presented at twenty-eighth week of gestation with the complaining of fatigue and jaundice. She had moderate pallor and no hepatosplenomegaly. The Hb was 8.3 g/dL, Htc: 23.9%, MCV: 65 fL, platelet count 252000, WBC: 9300. Serum iron studies, folic acid and Hb electrophoresis were normal. Reticulocyte count was 5%. Serum bilirubin was increased (total bilirubin 2.5 mg/dL and indirect bilirubin: 1.4 mg/dL). LDH was increased (268 U/L) and MCV was decreased. There is spherocytes in peripheral smear and increased osmotic fragility test. Diagnosis of hereditary spherocytosis was confirmed after positive osmotic fragility test and the patient was successfully managed by supportive therapy alone. Management of pregnancy in Hereditary Spherocytosis is challenging and systemic approach should be adopted to ensure best outcome. The disease may be mild, moderate or severe depending on various parameters. The indication for blood transfusion and splenectomy depends on the severity of symptoms. Also we have to consider issues related to haemotological changes during pregnancy, the need for splenectomy, postsplenectomy infections, antibiotic prophylaxis, the need for optimal dose of folate supplementation to prevent megaloblastic crisis during pregnancy and early diagnosis and management of the newborn affected with hereditary spherocytosis.

Keywords: Anemia, hereditary spherocytosis, pregnancy, treatment

[PP-116]

Late postpartum hemorrhage and management in patients with placenta previa: Two cases

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Postpartum hemorrhage (PPH) is one of the most prevalent causes of maternal mortality, involves approximately 25% of pregnancy related deaths. PPH origin is classified according to amount of bleeding, clinical findings; but in conventional time, it is called as early (primary) PPH seen within the first 24 hours and late onset (secondary) PPH between 24 hours and 12 weeks. Late PPH is rare, incidence is 1-3%. Bleeding can be so serious as to be life -threatening,

regardless of postpartum healing process. Placental regional subinvolution, rest, infection, coagulopathy, neovascularization and surgical complications can cause this. In this case report, we aimed to present management of massive hemorrhage in two young mothers on postoperative 29th and 41st days. (Case 1) Thirty three years old, primigravid, referred massive vaginal bleeding with placenta previa totalis, emergency cesarean section (CS) was performed at 36+2 weeks. After placental separation, operation was completed without any intervention or transfusion. She was discharged on second postoperative day. There was no complaints and abnormal examination findings on postpartum controls. Patient was admitted to emergency service with active vaginal bleeding on the 29th postoperative day. While cavity control was performing, peripheral pulse was not available. It was hypovolemic shock and emergency laparotomy was performed on the other hand with replacement. Uterus was soft, large from expected; was bleeding from CS incision line. Cavity was checked, lower segment was removed, the balloon tamponade was applied in cavity and modified B-lynch suture was performed. Chorionic villi or trophoblastic cells weren't observed of pathologycal examination of the sampling of cavity and resected tissues. Postoperative hemoglobin was 8,7 g/dL after three unit erythrocyte suspension and two units fresh frozen plasma transfusion. Tamponade was taken at 36th hours. She was discharged on eleventh day. (Case 2) Thirty six years old, had an abortion and a CS, with total placenta previa underwent elective cesarean section at 37th week. Placenta was hardly separated from lower segment and cervix. Intrauterine haemostasis sutures were placed in bleeding placental side and balloon tamponade was applied to lower segment. Balloon was withdrawn 36th hours. She was discharged on third postoperative day without complications, transfusion requirement. The patient has complaints of spotting but no bleeding in controls; uterine involution, thin endometrium, fluid image below the caesarean incision line and in cervical canal was seen with ultrasound. Forty first postop, the patient was hospitalized for suddenly increased bleeding. The region under the CS incision scar was compressioned by attaching a 22F sterile catheter with ultrasound guidance. Methylergonovine, misoprostol were administered. Patient who partial response to interventional and medical treatments but without satisfactory results, uterine artery embolization was performed, then discharged by healing. The placental region subinvolution and possibility of late post -neovascularization constitute risk for late onset PPH. Patient should be informed about intraoperative and postoperative complications, expectations and emergencies should be evaluated. Although hysterectomy is considered as definitive solution, but due to age of patient, the desire for fertility and the experienced psychological effects, uterus -preserving alternative therapies should be kept in mind first.

Keywords: Cesarean, late postpartum haemorrhage, placenta previa

[PP-117]

A rare case of acute abdomen: Mucinous cystadenoma associated with ruptured mature cystic teratoma in a pregnant woman

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Mature cystic teratoma is the most common ovarian neoplasm. Although mature cystic teratoma is accepted as benign and generally asymptomatic condition, its torsion or perforation which could cause to acute abdomen related to the chemical peritonitis could be reported in literature. On the other hand, mucinous cystadenoma with teratoma has not been reported in literature. In this case we reported a 34-year-old pregnant woman at the 23rd gestational week with a spontaneously ruptured mass called mucinous cyst adenoma with mature cystic teratoma. A 34-year-old pregnant woman at the 23rd week of gestation was admitted to the general surgery outpatient clinic with symptoms of right lower quadrant pain in inflammatory character. Upon reviewing her medical history, she had had right lower quadrant pain and loss of appetite for two days. The patient had no previous surgery and there was tenderness and rebound in right lower quadrant, but there was no defense. The laboratory tests revealed the following: leukocyte: 13100/U, hemoglobin: 10.9 g/dL, hematocrit: 32.9%. The patient was hospitalized in the general surgery clinic with the diagnosis of acute abdomen. Before the surgical intervention, the gynecologist examined the patient by using the ultrasonography, but he did not reveal any obstetric or gynecological pathology. At the laparotomy, a hairy glomus surrounded by purulent fluid was observed in the right ovarian area, and there was ruptured ovarian cyst measuring 3x2 cm in the right ovary (Figure 1a, b). A ruptured cystic lesion and a great number of hairs within the cyst thought the dermoid cyst. The perforated ovarian cyst with its capsule was removed by the gynecologist, and then following the appendectomy the right adnexal region was cleaned and a drainage tube was placed to this surgical area. After the surgical intervention, the patient was transferred to the gynecology clinic. The histopathological investigation revealed that the cyst wall was paved with the squamous epithelium within keratinous material and sebaseous glands (Figure 2a), and the cystic component was paved with single row bening mucinous epithelium in the different areas of the specimen (Figure 2b). These findings were called "mature cystic teratoma with mucinous cystadenoma", histopathologically (Figure 2a, b). Then, on the postoperative fourth day, the general condition of the patient and her surgical incision was observed well, and she was discharged from the hospital. Mature cystic teratoma is the most common ovarian neoplasm among all ovarian tumors. Although it is

observed in all age groups, it is most commonly seen between the ages 20 and 30. This fact makes it the most common tumor during pregnancy (22-40% of all ovarian tumors). During pregnancy, the risk of complications such as rupture, torsion, infection and malignant degeneration significantly increase and when the cyst ruptures, chemical or granulomatous peritonitis could develop. In our best knowledge, this case report described the first report which identified the ruptured mature cystic teratoma with mucinous cystadenoma in a pregnant patient.

Keywords: Mucinous cystadenoma, ruptured mature cystic teratoma, pregnant woman, acute abdomen, ovarian neoplasm, right lower quadrant pain

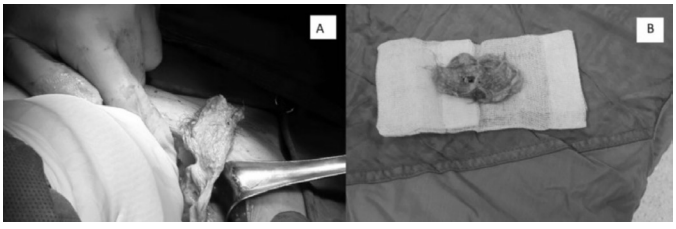


Figure 1. A) The photograph demonstrates the ruptured cystic esion and a great number of hairs within the cyst were seen during the surgical intervention. B) The photograph demonstrates the acroscopic image of the ruptured cystic component

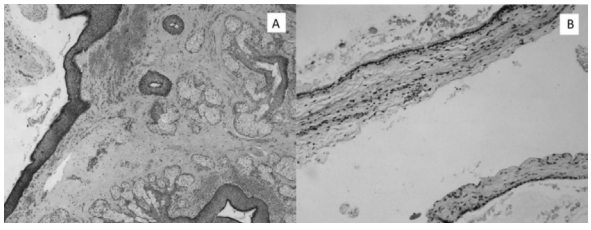


Figure 2. A) The cyst wall paved with the squamous epithelium within keratinous material and sebaseous glands were observed in the histopathological specimen (H and E X40), B) The cystic component paved with bening mucinous epithelium with single row was seen in the specimen (H and E X100)

[PP-118]

Management of aspiration pnomonia case occurred after a serious pstpartum hemorrhage related to anticoagulant treatment during pregnancy

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Although prosthetic thrombosis is a rare complication, it has high mortality and morbidity. In the third trimester and at delivery, the use of warfarin is associated with maternal and neonatal bleeding in approximately 5 to 15% of cases, respectively. Management of this condition has serious difficulties such as wide range of risks, like fetal abortion and toxicity, fetal and maternal bleeding and thrombosis. A 32 years-old woman, gravida 5, parity 1, abortion 4 was referred to our clinic as having 33 weeks' pregnancy with the complaints of premature preterm rupture of the membrane (PPROM) and sudden pelvic pain. In her anamnesis, there was a history of mitral valve replacement (MVR) and usage of coumadin. Under spinal anesthesia, a pfannenstiel incision was made after the administration of 2 units fresh frozen plasma (FFP). A 2400 gr male newborn was delivered with an Apgar score of 9. At the second and sixth hours of the postoperative first day, the Hb values were 10.1 gr/dL and 9.2gr/dL, respectively. Enoxaparin sodium 6000 IU (60 mg)/0.6 mL was started bid. On the third day of her postoperative period, she complained about sudden dizziness, hypotension (90/60 mmHg), tachypnea (20-25/min) and tachycardia (120/min). There wasn't any active bleeding. In the ultrasound, large peritoneal fluid was observed. Blood products preparation was planned promptly due to Hb was 3.1 gr/dL. Blood pressure, pulse, and respiration rate were 70/40 mmHg, 140-150/min, and 20-25/min, respectively. Hb value was measured as 2.4 gr/dL. Furthermore, the patient lost her conscious. She was entubated, and four units of concentrated red blood cells were transfused. When the patient was stabilized in relation with hemodinamically, reoperation was performed. Approximately 4 liters of coagulated blood was drained from the abdomen. During the postoperative period, 1 additional unit of fresh frozen plasma were replaced and Hb values reached 9.9 g/dL. 6000 IU (60 mg)/0.6 mL of enoxaparin sodium was again started every 12 hours. At the tenth hours of reoperation, the patient's oxygen saturations was starting to fall. During the observation, chest X-ray revealed common pneumonic infiltrates. She was diagnosed with aspiration pneumonia involving the bilateral middle and lower zones and parenteral antibiotic therapy (tigecycline) was initiated. In addition, she was successfully treated with high continuous positive airway pressure for 2 days. On the third postoperative day, warfarin was started with the recommendation of the cardiology department. On the sixth postoperative day, the patient was discharged home with almost complete resolution of her symptoms. As demonstrated in our case, gestational management of MVR-treated patients with anticoagulant has serious problems in terms of both bleeding and thrombosis risk. Therefore, it is necessary to give detailed information about the risks of pregnancy to such patients and their relatives before pregnancy. In addition, it is very important to plan the birth of these patients at a convenient center and to prepare blood/blood products in advance.

Keywords: Anticoagulant therapy, postpartum hemorrhage, aspiration pneumonia



Figure 1. Lung graphy showing aspiration pneumonia with bilateral infiltration

[PP-120]

Ovarian ectopic pregnancy after natural conception: Case report

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Objective: Ectopic pregnancy defines an embryo implantation outside of the uterine cavity. After natural conception, the incidence of ovarian ectopic pregnancy is 1/2000-1/60000 deliveries.

Material and Methods: Our patient is a 25-year-old multiparous woman with previous cesarean section who referred to our clinic with abdominal pain and vaginal bleeding for 2 days. Transvaginal sonography revealed a right heterogen adnexal mass, uterus without gestational sac and free fluid in peritoneal cavity with clots.

Results: We detected signs of acute abdomen and decided to emergency laparotomy. We found a ruptured ectopic pregnancy in the right ovary. Approximately, 1000 mL of blood in the abdominal cavity. We performed right salpingo-oophorectomy. Histopathological examination confirmed ovarian ectopic pregnancy.

Conclusion: Primary ovarian ectopic pregnancy is a rare variant of ectopic implantation. It should be diagnosed and treated in its early stages otherwise it could be life-threatening. Histopathological examination is ideal for confirming the diagnosis.

Keywords: Ectopic pregnancy, ovarian pregnancy, laparotomy

[PP-126]

A rare mullerian anomally complete uterocervicovaginal septum: A aginally birth of healthy term baby after surgical correction

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A septate uterus is the most common uterine malformation and it originates from the incomplete resorption of the adjacent walls of the two fused Mullerian ducts. This septum may extend to the cervical canal and can be associated with a vaginal septum which can be partial or can reach the introitus. We present a case of complete uterocervicovaginal septum as a rare mullerian anomaly in a young woman with recurrent pregnancy loss. Twenty three years old woman, presented with recurrent first trimester pregnancy loss. She had history of three abortus. She had regular normal menses. General and systemic examination was normal. On speculum examination, a longitudinal vaginal septum was seen showing two unequal vaginal cavities (right being roomier) and septum extending upto the cervix showing two cervical openings (Figure 1). Ultrasound was suggestive of either bicornuate or a septate uterus. Hysterosalpingography showed two cervices and two uterine cavities (Figure 2). Diagnostic hysterolaparoscopy showed longitudinal vaginal septum with two cervices and a broad single fundus. Our patient does not fit into the American fertility Society (1988) classification but she fits into the ESHRE/ ESGE 2017 classification in class U2b (complete septate uterus and septum fully dividing the uterine cavity up to the level of the internal cervical os), class C1 (septate cervix inclusive of all absorption defects of cervix), V1 (longitudinal non-obstructing vaginal septum). Patients vaginal septum was resected with a blunt tip sealer and divider till cervix was reached. Both cervical os were dilated and tubal patency was checked through each half of the cervix independently. Bilateral free spill was seen. Paediatric Foley's catheter was inserted through the left cervix and inflated with methylene blue. Hysteroscopy was done through the right cervix and uterine septum was resected with Collins monopolar resectoscope till cavity was opened into a single uterine cavity and foleys from the other side was seen (Figure 3). Uterine fundus was rechecked laparoscopically (Figrue 4). The patient was pregnant after 3 months of surgery. A 38-week-old healthy 3150 gr male baby was delivered with vaginal breech presentation. The best surgical treatment is minimally invasive methods to treat uterocervicovaginal septum cases as most rare mullerian anomalies. this minimally invasive approach will reduce morbidity and cost and increase the rate of live birth and vaginal delivery.

Keywords: Mullerian anomally, recurrent pregnancy loss, uterocervicovaginal septum

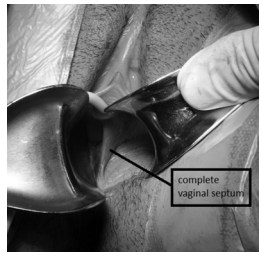


Figure 1. Complete vaginal septum

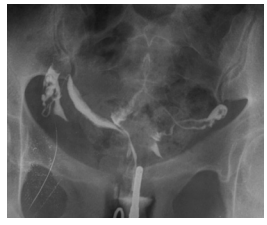


Figure 2. Hysterosalpingography

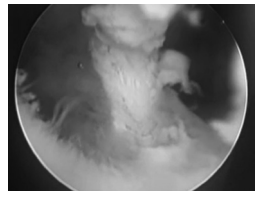


Figure 3. Complete uterine septum

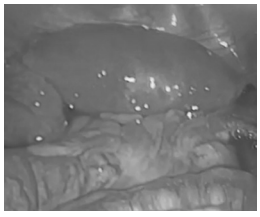


Figure 4. Laparoscopic image of uterine fundus

[PP-132]

Paraovarian borderline tumor during pregnancy

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Paraovarian cysts are a rare pathology, constituting 10-20% of the adnexal masses. These cysts are epithelial lined closed fluid filled cysts in adnexa adjacent to ovary and fallopian tube. Paraovarian simple cyst originates from the embryologic remnants of the urogenital system (mesonephric and paramesonephric ducts). Another origin can be represented by the mesothelium, resulted from the invagination of the tubal serosa. Most are asymptomatic, although patients with large lesions can present with pelvic pain. Paraovarian cysts are generally benign but may, on rare occasions give rise to borderline tumours and malignancy. Malignancy has been reported in 2-3% of cases. Simple, asymptomatic paraovarian cyst can be managed expectantly without further follow-up. Surgical exploration and removal is indicated for these lesions, if they undergo torsion, cause persistent pain, pressure symptoms, or appear neoplastic with suspicious findings by ultrasonography (septations, papillations, fluid, and solid components). These tumors during pregnancy are detected incidentally during routine examination, ultrasound or a cesarean section at term. Here, we report a case of paraovarian serous borderline tumor during pregnancy. An asymptomatic 35-year-old multigravida with a singleton pregnancy after spontaneous conception underwent a routine ultrasound anomaly scan at 20 weeks. At this examination a large (70x67 mm) unilocular cystic adnexal mass with a thin, smooth wall and homogeneous anechoic content was detected. There were no septa, solid elements or mural blood flow in the cyst, and there was no sign of accompanying ascites. The patient was informed about the risks and benefits from conservative management vs cystectomy and a plan for expectant management was initially agreed upon. Cyst diameter was increased to 75x67 mm, 80x70 mm and 90x75 mm at 24, 28 and 34 weeks of gestation, respectively. The patient underwent cesarean section due to fetal malpositioning (breech presentation) at 39 weeks. During cesarean section, the cyst was observed to be located in the mesosalpinx, attached to the fimbriated end of the fallopian tube, its surface was smooth (Figure 1a) and extirpated during the operation. On the microscopic examination, the surface of the cyst was pseudostratified with a single layer columnar epithelium, and most of the sites had edematous stromal papillary structures containing fibrovascular core. Epithelial cells have mild to moderate nuclear atypia with no significant plemorphism and mitosis. Stromal invasion was not seen (Figure 1b, c). Final pathological report concluded a paraovarian serous borderline tumor. The postoperative course was uneventful. The patient has been regularly followed, and there is no clinical evidence of disease, 5 years after diagnosis. Paraovarian borderline tumors are an uncommon type of cystic mass during pregnancy, which should be included in the differential diagnostic workup whenever a growing simple cyst is encountered.

Keywords: Borderline tumor, paraovarian, pregnancy



Figure 1. Intraoperative appearance and microscopic findings of cyst

The surface of the cyst was pseudostratified with a single layer columnar epithelium, and most of the sites had edematous stromal papillary structures containing fibrovascular core. Papillary extensions lay polygonal-cubic cells with extensive eosinophilic cytoplasm, round oval nucleus, and some with nucleol-specificity. Epithelial cells have mild to moderate nuclear atypia with no significant plemorphism and mitosis. Stromal invasion has not been observed

[PP-134]

DiGeorge syndrome associated with absent pulmonary valve

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We report prenatal diagnosis of 22q11.2 deletion syndrome in a pregnancy with absent pulmonary valve in the fetus. Twenty-five year-old, primigravid woman was referred for counseling at 20 weeks of gestation because of abnormal ultrasound findings of fetal congenital heart defects. This cases of “absent pulmonary valve” are described. The level 2 ultrasound [Toshibo Aplio 300] revealed a singleton fetus with heart defects including pulmonary semilunar cusps and is always combined with aneurysmatic dilatation of pulmonary artery cordocentesis was performed. Metaphase fluorescence in situ hybridization on lymphocyte in cord blood confirmed deletion in 22q11.2 region (DiGeorge syndrome). Prenatal ultrasound findings of congenital heart defects indicate that the fetuses are at increased risk for chromosome abnormalities.

Keywords: Absent pulmonary valve, DiGeorge syndrome, 22q11.2 deletion



Figure 1.

[PP-135]

Abnormal uterine bleeding in endometrial cancer detection in reproductive period and postmenopausal period

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Objective: There is an association between AUB (abnormal uterine bleeding) and endometrial pathologies. Full curettage is recommended for patients with AUB over 35 years. Our aim was to compare the rates of endometrial cancer with and without AUB in the reproductive period over 35 years and in postmenopausal period.

Material and Methods: Datas of patients who underwent hysterectomy following full curettage for increased endometrial thickness and/or AUB between 04.29.2014 and 12.04.2017 in Kartal Dr. Lütfi Kırdar Training and Research Hospital were obtained, retrospectively. Seventy one patients included in the study were divided into 2 groups as over 35 years in reproductive period and postmenopause. Subsequently, these groups were divided into two subgroups, one with and without AUB. Subgroups were compared in terms of age, endometrial thickness, and endometrial cancer rates. SPSS 17 was used for comparisons. Student's t-test was used for continuous data and chi-square test was used for categorical data. P<0.05 was considered statistically significant.

Results: Seventy-one patients who underwent total hysterectomy resulting in endometrial hyperplasia or endometrial cancer, following full curettage for reasons such as AUB, endometrial thickness were included in the study. There were 39 postmenopausal patients and 32 patients in the reproductive period over 35 years. There were 20 patients in Group 1 (AUB+) and 19 patients in Group 2 (AUB-). In the reproductive period there were 27 patients in Group 1 (AUB+) and 5 patients in Group 2 (AUB-). The data of postmenopausal patients are shown in Table 1 that shows there are no differences in terms of age, endometrial thickness and endometrial cancer rate between Group 1 and Group 2, but the rate of endometrial cancer is higher in Group 1 than Group 2 (40% and 10.5%, p=0.065; respectively). The comparison between the groups in reproductive period is seen in Table 2 that shows no differences in terms of age, endometrial thickness and endometrial cancer among the groups.

Conclusion: The rate of endometrial cancer in patients with AUB is higher than without AUB in postmenopausal period, although not statistically significant. The rates are similar in reproductive period.

Keywords: Abnormal uterine bleeding, menopause, endometrial cancer

Table 1. Postmenopausal period-abnormal uterine bleeding; datas of age, endometrial thickness and endometrial cancer

Parameters	Grup 1 (AUB+) n=20	Grup 2 (AUB-) n=19	P
Age (year)	57.1±6.9	56.5±10.6	.673[a]
Endometrial thickness (mm)	11.9±5.1	9.7±4.3	.168[a]
Endometrial cancer +/-	8/12 40%	2/17 10.5%	.065[b]

Datas were recorded as mean± SD, % and rate. p <0.05 was statistically significant.
[a]Student t-test [b]Chi square test

Table 2. Reproductive period over 35 years-abnormal uterine bleeding; datas of age, endometrial thickness and endometrial cancer

Parameters	Grup 1 (AUB+) n=27	Grup 2 (AUB-) n=5	P
Age (year)	45.7±5.8	44.4±7.6	.755[a]
Endometrial thickness (mm)	10.6±4.9	10.2±4.5	.897[a]
Endometrial cancer +/-	8/19 29.6%	2/3 40%	.637[b]

Datas were recorded as mean± SD, % and rate. p <0.05 was statistically significant.
[a]Student t-test [b]Chi square test

[PP-139]

Reproductive period labial fusion diagnosis and treatment: A case report

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Labial fusion (LF) is complete or incomplete adhesions of labium major or minor, majority near of clitoris. It is thought that low estrogen level may be causes. LF occurs rarely in reproductive period, often prepubertal, less frequent postmenopausal period. The etiology may include infections, trauma, burns and radiotherapy. Diagnosis can be easily made by clinical examination. LF can cause complications such as frequent urinary infections, hydronephrosis and even amenorrhea. We aimed to present LF and its treatment in reproductive age patient who had any risk factors. Twenty-six year old, virgin patient admitted to urology because of unable to urination. Cystoscopy was planned because of no pathology on ultrasonography. Cystoscopy couldn't be done during operation, so she directed our clinic. From her anamnesis; menarche 13 to 14

years old and simultaneous secondary sex characters developed, menstrual regularity is normal but the amount of bleeding has been more and more decreased. She noted frequent urinary infections and difficulty in urinating gradually. Her mother had no medication during her pregnancy. There was no genital trauma or infection. Gynecologic examination revealed complete fusion in the labium majus, labium minors couldn't seen. Approximately 1 mm of ostium was observed (Figure 1). In laboratory findings; estradiol: 32.7, FSH: 7, LH: 6.7, PRL: 27 and 3+ leukocyte persisting in urinalysis. No additional genitourinary anomalies were seen in ultrasound and MR. Surgery was planned after failure to obtain results from treatment of the current infection and local estrogen cream. With general anesthesia, which thought to be the orifice was dilated in lithotomy position. Labium major were seen sticking to each other with dens adhesions, they were separated in midline from each other by sharp dissections; a pseudo -space viewed where urethra and vaginal entry was found (Figure 2). Hymen was not intact; residues were observed in form of myrintiformis. The incision was extended upwards; urethra and clitoris were removed. Bladder was catheterized and filled with methylene blue, then tissues of the labia minus in entrance of vagina were combined into labium majus skin (Figure 3). The povidoniot and nitrofurantoin buffer were placed between the sutured tissues and operation was terminated. In first postoperative day, external and internal genitalia were anatomically natural (Figure 4). Postoperative second week was complete and patient had no complaints (Figure 5). As is the case in this case, the most important stage of the clinical evaluation is an essential physical examination. Labial adhesions should be considered in patients presenting with urinary complaints despite the fact that in reproductive period, no risk factor in etiology. The treatments can be performed in symptomatic patients are topical estrogen and/or surgery. Generally, the success rate of topical estrogen is high in the prepubertal period, but success of in adults is not always confirmed. Surgical dissection has been reported to be a successful and definitive treatment in retrospective evaluations of case series. It is emphasized that postoperative local estrogen application and hygiene are important for the preservation of the bladder after surgery and prevent from recurrence of LF.

Keywords: Labial fusion, recurrent urinary infections, reproductive age



Figure 1. Complete labial fusion and 1 mm ostium

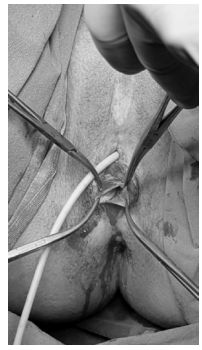


Figure 2. Urethra and vaginal entry



Figure 3. Sutured labial tissues



Figure 4. In first postoperative day

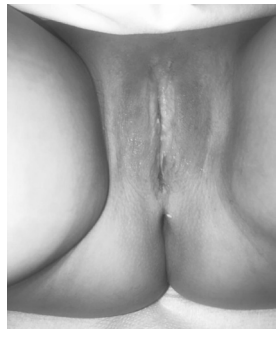


Figure 5. Postoperative second week

[PP-140]

An approach to managing pelvic organ prolapse in gynecologic cancer survivors

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Uterine malignancy coexistent with pelvic organ prolapse (POP) still has no standardized treatment protocol which has been established yet. The first objective of this present case was to highlight the management of endometrial polyp and myomas causing postmenopausal bleeding in association with POP. Another aim of this case was how to add procphylactic bilateral salpingo-ooferectomy to vaginal hysterectomy due to the strong family history related to her mother with overian cancer. A 62-year-old woman in menopausal period with active sex life, gravida 5, para 5 was admitted to the hospital with bleeding for 6 months and bulging mass from vagina for 2 years. In her medical history there was a strong family risk because of her mother related to overian cancer. She has not undergone any operation before except tissue samplings from lung masses which were reported as benign. She had a long history of high blood pressure. Transvaginal ultrasound demonstrated the uterus 90x70x60 mm in size with two myomas fundus located 50 mm in diameter and cervix located 40 mm in diameter. A single polyp 25 mm in diameter was detected by transvaginal ultrasound after the endometrial tissue sampling which was reported as benign endoservical tissues before the operation. All tumor markers were negative. The patient diagnosed with Stage 2 POP according to the Pelvic Organ Quantification System (POP-Q) including anterior vaginal wall prolapse with paravaginal defect, posterior vaginal wall prolapse with rectocele and desensus uteri with elongatio colli. We managed this case by vaginal surgery including procphylactic bilateral salpingo-ooferectomy with no posterior repair in addition to protect from postoperative de novo dyspareunia. The uterus was measured 160x80x70 mm in size, myomas were measured 50 mm and 40 mm in diameter and cervix was measured 100 mm in lenght just before the frozen section evaluation. The frozen section was reported as benign. Postoperative examination was performed in the third month after the operation. Objective cure defined as Stage 0 according to POP-Q and subjective cure defined as negative response to all questions on Pelvic Organ Prolapse Distress Inventory 6. Three different secondary acquisitions were obtained such as no complication, no symptom and high quality of sex life according to Female Sexual Function Index. Pelvic floor disorders are prevalent in gynecologic cancer survivors and this is an important area of clinical concern and future research is urgently required.

Keywords: Postmenopausal bleeding, prolapsus, vaginal bilateral salpingo-ooferectomy

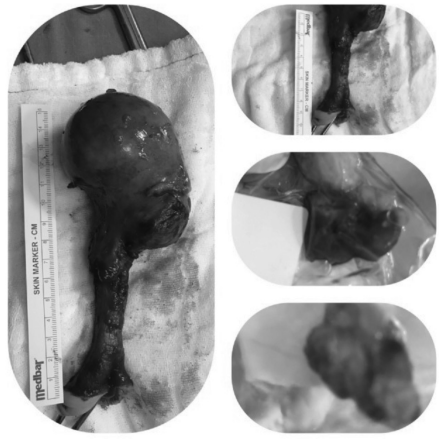


Figure 1. Uterus and ovaries

[PP-141]

A case of huge cutaneous decidualized endometriosis in pregnancy

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Objective: Endometriosis, hormone sensitive ectopic endometrial tissue, is commonly seen during reproductive period. It is most commonly seen on the ovary. However it is rarely found outside of pelvic peritoneal cavity as cutaneous endometriosis. This ectopic endometrium can be decidualized like normal endometrium, especially during pregnancy. We reported a case presented with decidualized cutaneous scar endometriosis during pregnancy. The final diagnosis was made by pathological and immunohistochemical evolution after surgical removal of the cutaneous mass.

Material and Methods: A 38-years-old, 20-weeks pregnant woman applied to our clinic. She had a phannenstiel scar due to cesarean operation performed 2 years ago. On the right corner of the incision scar, approximately 9x5 cm, irregular, pink-purple colored, soft lesion was observed (Figure 1). A 20 weeks, live fetus was detected in obstetric ultrasonography. Superficial tissue ultrasonography was reported a 9x5 cm hypo echoic lesion with punctate mill metric lesions and increased vascularity on color doppler ultrasonography.

Results: Expectant management until delivery and mass excision during cesarean section were decided. During pregnancy, 4 cm increment on length of mass was observed. An alive, healthy fetus was delivered by cesarean section at 39th weeks of pregnancy. The lesion was excised and sent to pathological evolution. The patient and newborn were discharged on the second day of operation. Macroscopic examination of the mass was reported as 9x5x2 cm in size with 2.5 cm depth in compliance with ectopic decidua (Figure 1). Negative staining with pancytokeratin, calretinin, CD31, CD34, SMA, HMB45, CD117, CD68, S100 was obtained on the histochemical analysis.

Conclusion: Cutaneous endometriosis is a rare entity and can be seen on the surgical wound sites. The size of the lesion may change in relation to the menstrual period. In pregnancy, level of ca-125 is not very helpful in diagnosing because it is expected to increase in a normal pregnancy. Color doppler ultrasonography is also not very helpful in diagnosing because malignancy or decidualized tissue may also present increased vascular flow. Decidualized cutaneous endometriosis is rarely seen in non-pregnant patients. That is, cutaneous decidualized endometriosis should be considered in both pregnant and non-pregnant patients.

Keywords: Decidualization, cutaneous endometriosis, pregnancy



Figure 1. Cutaneous decidualized endometriosis on the right corner of the incision scar

[PP-143]

Non-alcoholic fatty liver disease and gallbladder stone frequency of women with Polycystic Ovarian syndrome, preliminary results

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Objective: Non-Alcoholic Fatty Lives Disease (NAFLD) is associated with Polycystic Ovarian syndrome (PCOS) within either obese or non-obese patients. Although screening is recommended to be done in a BMI based stratified manner, many non-obese patients with PCOS are still at high risk of metabolic disorders including NAFLD. Our aim with this study is to evaluate NAFLD and gallbladder stone incidence through obese and non-obese patients with PCOS.

Material and Methods: This is a prospective case-control study conducted in Zekai Tahir Burak PCOS center since September 2018. Fifty-two patients with PCOS underwent hepato-biliary screening through ultrasound. Here we present our preliminary data of the study.

Results: Among 52 patients 28 had normal hepato-biliary screening, 16 had hepatosteatosis, 6 had gallbladderstone and 2 had both. There were no significant differences between screen normal and abnormal women in terms of marital status, education level, occupation, physical activity, sleep apne and hirsutism scores. The incidence of hepatosteatosis and gallbladder stone was correlated with the patients age and BMI. The mean age of patients with PCOS who had normal and abnormal screening were 23 and 26.7 respectively. And their mean BMIs with normal and abnormal screening were 26.2 and 32.2 respectively. Nine patients with abnormal screening were younger than 25 years old and 4 of their BMI were less than 25. Twelve of 24 patients with screen-anomaly were parous.

Conclusion: Our results are indicating that hepato-biliary screening shouldn't be overseen when patient with PCOS has a BMI more than 25 and it should be considered especially for older patients with children. The earlier medication and life style arrangements done in a patients life may be the less metabolic disorder's complications faced.

Keywords: Gallbladder, hepatosteatosis, ovarian, polycystic, stone, syndrome

[PP-144]

Postpartum retroperitoneal hematoma due to presacral venous plexus bleeding

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Retroperitoneal hematoma following vaginal delivery and C-section is a rare occurrence. It is important to understand the etiology and management of this potentially life threatening condition. It was established to progress secondary to lacerations of the uterine artery, ovarian artery, hemorrhoidal artery, vessels of the broad ligament, ruptured splenic or renal artery aneurysm. It is also reported in literature that spontaneously retroperitoneal hemorrhage could occur as a result of heparin anticoagulation in pregnancy. Presacral venous bleeding is an uncommon cause of retroperitoneal hematoma which could have fatal progress if the diagnosis is delayed. It is usually thought to occur in complicated rectal surgery because of incorrect mobilisation of Waldeyer's fascia resulting in uncontrollable bleeding. We present a case of a 23-year-old primipara ginger woman who complaint about acute abdominal, lower flank and severe back pain 6 hours after an uncomplicated vaginal delivery, and was found to have a large retroperitoneal hematoma by ultrasonography. Although Operative versus non-operative approach is dependent on haemodynamic status of the patient we performed an exploratory laparotomy due to severe pain symptoms 10 hours after delivery. The patient was hemodynamically stabile at the time of operation. Subsequently performing an extending dissection of retroperitonal area, ligation of the hypogastric artery and decompression of the ureters bilaterally was performed. We found bleeding vessels on the level of presacral venous plexus. Active bleeding has been managed by ligation of damaged vessels. To our knowledge, this is the first case report presented with retroperitoneal hematoma due to presacral venous plexus bleeding during the post-partum period have been reported in the English-language published work.

Rupture of presacral vessels is a life-threatening emergency condition requiring acute diagnosis and treatment. The possibility of bleeding presacral region should be considered in any postpartum woman with symptoms of an acute abdomen with or without hemorrhagic shock.

Keywords: Postpartum hemorrhage, postpartum retroperitoneal hematoma, presacral venous plexus bleeding

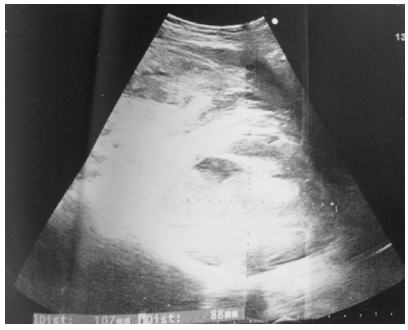


Figure 1. Ultrasonographic image of retroperitoneal hematoma

[PP-145]

Prediction of gestational diabetes mellitus in the first trimester by fasting plasma glucose which cut-off is better?

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Objective: We aimed to predict subsequent gestational diabetes mellitus (GDM) by fasting plasma glucose (FPG) in the first trimester.

Material and Methods: Healthy pregnant women who were screened for GDM at 24-28 gestational weeks and had fasting plasma glucose levels calculated during their first antenatal visit less than 14 gestational weeks were included in this cross-sectional study.

Results: Of the 2601 women who were recruited for the study, 244 (9.4%) were diagnosed with GDM at weeks 24-28. The area under the ROC curve analysis for the prediction of GDM was 0.730 p<0.001 (95% CI 0.695-0.764). For a false positive rate of 5% for the prediction of GDM the cut-off value was 99.5 mg/dL, however the best accuracy according to Youden's index was with the cut-off value of 87.5 mg/dL with a sensitivity 70.1% (95% CI 63.8-75.7) and specificity 66.2% (95% CI 64.2-68.1). Positive and negative predictive values were 17.7% (95% CI 15.3-20.2) and 95.5% (95% CI 94.4-96.5) respectively. The diagnostic odds ratio for FPG predicting GDM was 4.6 (95% CI 3.4-6.1) (p value <0.001) and Number Needed to Diagnose was 2.8 (95% CI 2.4-3.4).

Conclusion: FPG values which are within the normoglycemic range constitute an independent risk factor for the development of GDM. Due to rise in obesity among pregnant women threshold for gestational diabetes diagnosis must be reevaluated.

Keywords: Gestational diabetes mellitus, pregnancy, fasting plasma glucose

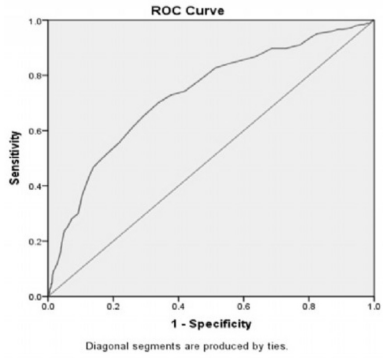


Figure 1. The area under the ROC curve analysis for the prediction of GDM

[PP-147]

Prevalence of gestational diabetes mellitus and results of the screening tests at a tertiary referral center

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Objective: This study aimed to identify the gestational diabetes mellitus (GDM) prevalence of healthy (low risk) pregnant population at a tertiary referral center by different approaches.

Material and Methods: A cross-sectional study using retrospective data of the Zekai Tahir Burak Women's Health Practice and Research Center antenatal outpatient clinic between 2007-2017 was conducted. The data of perinatology outpatient clinic was excluded as our hospital is a tertiary referral center. During this period 77227 patients underwent either two step or one step glucose tolerance tests. A total of 144113 fasting plasma glucose (FPG) values were obtained in the initial visit. Quantitative determinations of blood glucose were done by enzymatic method on Roche automated clinical chemistry analyzer (Hitachi Cobas® 6000 analyzer. Roche Diagnostics GmbH. Germany). Glucose was assayed using a commercial glucose oxidase kit (Glucose HK Gen.3. Roche Diagnostics GmbH. Germany). Measuring range was 2-750 mg/dL (0.11-41.6 mmol/L) and intra- and inter-assay coefficient of variation (CV) values were 0.8 and 1.3% respectively.

Results: The median age of the study population was 27 (15-49). The median FPG level was 83.6 (34-507). The distribution of FPG levels was reported in Table 1. During the study period 74412 women underwent 50 gr glucose challenge test and the results are reported in Table 2. The screening positive patients were sent to 100 gr oral

glucose tolerance test and the results are reported in Table 3. The prevalence of GDM with two-step screening was 5.5%. A total of 2815 patients were screened by 75 gr glucose tolerance test and the results are reported in Table 4. Overall 4684 patients have been diagnosed as gestational diabetes mellitus with the prevalence of 6.07%.

Conclusion: Fasting plasma glucose >92 mg/dL is challenging in our population due to improper fasting. The FPG dependent GDM prevalence is almost four times higher than two-step glucose screening test results (21.8% vs 5.5%). If FPG levels will be used for diagnosing GDM then the values must be checked in a second laboratory analysis.

Keywords: gestaional diabetes mellitus, screening, pregnancy, 50 gr GCT, 75 gr GTT, 100 gr GTT

Table 1. The distribution of FPG levels

FPG mg/dL	n	%
<92	111935	77.67
92-126	30373	21.08
>126	1805	1.25
Total	144113	100

Table 2. 50 gr glucose challenge test results

50 gr GCT results (mg/dL)	n	%
<70	1873	2.4
70-140	56394	73
140-180	13898	18
>180	2247	2.9
Total	74412	100.0

Table 3. 100 gr glucose tolerance test results

100 gr GTT results (n=14515)	n	%
1 value abnormal	5846	40.28
2 value abnormal	1329	9.16
3 value abnormal	418	2.88
4 value abnormal	100	0.69
GDM	1847	12.72

Table 4. 75 gr glucose tolerance test results

75 gr GTT results (n=2815) (mg/dL)	n	(%)
FPG >92	485	17.23
1st hour >180	199	7.07
2nd hour >153	123	4.37
GDM	590	20.96