[SS-01]

The Effect of Sexual Health Education and Counseling on Sexual Function and Quality of Life in Postpartum Patients with Vaginal and Cesarean Delivery

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Aim: The postpartum period is characterized by significant physical and psychological changes, with sexual health issues being common and negatively affecting women's quality of life. This study aimed to compare the effects of vaginal and cesarean delivery on women's sexual health and physical recovery.[1]

Material and Methods: A prospective, comparative, quasi-experimental study included 332 patients at their 6-week postpartum check-up between April and August 2025. The sample included 145 patients with vaginal deliveries and 187 with cesarean deliveries. Participants received personalized counseling and education on postpartum sexual health from a specialized professional. The education was supported by face-to-face sessions and digital health technologies. The female sexual function index and the World Health Organization-quality of life scale were used to evaluate their sexual function and quality of life.

Results: There was no statistically significant difference in the demographic characteristics of the two groups. A statistically significant increase in sexual function scores was observed in both groups after the sexual health education and counseling ($p<0.05$). However, this increase was more pronounced in the vaginal delivery group compared to the cesarean delivery group. After the intervention, 72% of vaginal delivery patients and 65% of cesarean patients reported a positive impact on their sexual life. Episiotomy and perineal trauma were the most common causes of sexual dysfunction in the vaginal delivery group, while pain and wound healing were the primary factors in the cesarean group.

Conclusion(s): This study demonstrates that sexual health education and counseling provided at the 6-week postpartum mark are an effective method for improving women's sexual function and overall quality of life, regardless of the mode of delivery.[2] The findings suggest that women who have had a vaginal delivery may benefit more rapidly and significantly from this education. It is therefore recommended that personalized and mode-of-delivery-specific sexual health counseling programs be integrated into routine postpartum care for all women.

Keywords: Normal delivery; cesarean section; sexual health education; postpartum; sexual dysfunction

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[SS-02]

A Forgotten But Valuable Surgical Technique: The Manchester-Fothergill Operation in the Management of Isolated Cervical Elongation

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Aim: To present a case of isolated cervical elongation without uterine prolapse successfully managed with the Manchester-Fothergill (MF) operation, emphasizing the importance of uterinepreserving surgical techniques in selected patients.

Case: A 40-year-old woman, gravida 4, para 4 (vaginal delivery), presented with complaints of a sensation of pelvic heaviness. She had no history of any surgery. Speculum examination revealed marked cervical elongation. The cervix extended beyond the hymenal ring. Bimanual examination confirmed the absence of uterine descent. POPQ assessment demonstrated grade 3-4 cervical elongation without uterine prolapse. No other symptoms were reported. Transvaginal ultrasonography showed a normal anatomical appearance. Pap smear was negative. Considering the isolated cervical elongation and the patient's strong preference to preserve her uterus, a MF operation was performed. The surgical steps included cervical amputation, anterior plication of the uterosacral ligaments for additional support. Histopathology of the excised cervix revealed benign. In 6-months-follow-up, she remained symptom-free and expressed high satisfaction with both the outcome and the recovery process.

Discussion: The MF operation, first described over a century ago, has regained clinical interest in the context of uterus-preserving pelvic reconstructive surgery. Archibald Donald from Manchester, England, was the first to combine the components of this operation for the treatment of genital prolapse in 1888. Pelvic organ prolapse refers to the descent of one or more pelvic organs beyond their normal anatomical positions due to weakening of the pelvic floor support structures. It may involve the anterior, apical, or posterior vaginal compartments.[1] While hysterectomy remains a standard surgical option for uterine prolapse, cervical elongation without uterine descent represents a distinct clinical entity. In these cases, uterine support is preserved, and the pathology is limited to hypertrophy or elongation of the cervix. Performing a hysterectomy in such cases may represent overtreatment, especially in women who wish to preserve the uterus for reproductive, psychological, or cultural reasons. The MF procedure combines cervical amputation with uterosacral ligament plication, effectively restoring apical support while maintaining uterine integrity. This approach provides excellent anatomical correction and functional outcomes, with shorter operative time and fewer complications compared with vaginal hysterectomy. Historical data support its efficacy: Conger and Keettel[1] reported favorable long-term outcomes in over 960 patients, and subsequent studies by Marquini et al.[2] and Enklaar et al.[3] demonstrated low recurrence rates and high patient satisfaction. In our case, the MF operation achieved complete resolution of the patient's symptoms. Therefore, in well-selected patients with confirmed cervical elongation but intact uterine support, the MF operation remains a reliable, safe, and effective surgical option.[4]

Conclusion(s): The MF operation represents a valuable uteruspreserving technique for the management of cervical elongation without uterine prolapse. Accurate differentiation between cervical elongation and true uterine descent is essential to avoid unnecessary hysterectomy and to offer a conservative, functionally effective surgical alternative for women desiring uterine preservation.

Keywords: Cervical elongation; pelvic organ prolapse; uterus-preserving surgery; Manchester-Fothergill operation MR before surgery

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[SS-03]

A Rare Case of Laparoscopic Excision and Mesh Repair of A Canal of Nuck Cyst

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Aim: Canal of Nuck cysts are rare conditions in adult women and are often misdiagnosed as inguinal hernias or adnexal masses.[1] We report a rare case of a canal of Nuck cyst presenting with pelvic pain and successfully managed using a laparoscopic approach with mesh repair.

Case: A 47-year-old multiparous woman presented with pelvic pain. Radiological evaluation revealed a cystic lesion located in the right inguinal canal. Ultrasonography and magnetic resonance imaging findings were suggestive of a canal of Nuck cyst. Based on these findings, laparoscopic excision followed by mesh repair was performed (Figure 1).

Results: The cyst was completely excised laparoscopically without intraoperative or postoperative complications. Histopathological examination confirmed a benign canal of Nuck cyst. The patient had an uneventful postoperative recovery.

Conclusion(s): Although rare, canal of Nuck cysts should be considered in the differential diagnosis of pelvic pain and inguinal cystic lesions in women. Imaging modalities, particularly ultrasonography and magnetic resonance imaging, play a key role in accurate diagnosis.[2,3] Laparoscopic excision with mesh repair is a safe and effective minimally invasive treatment option with low morbidity and recurrence risk.[4]

Keywords: Canal of Nuck cyst; laparoscopy; pelvic pain; inguinal mass; minimally invasive surgery

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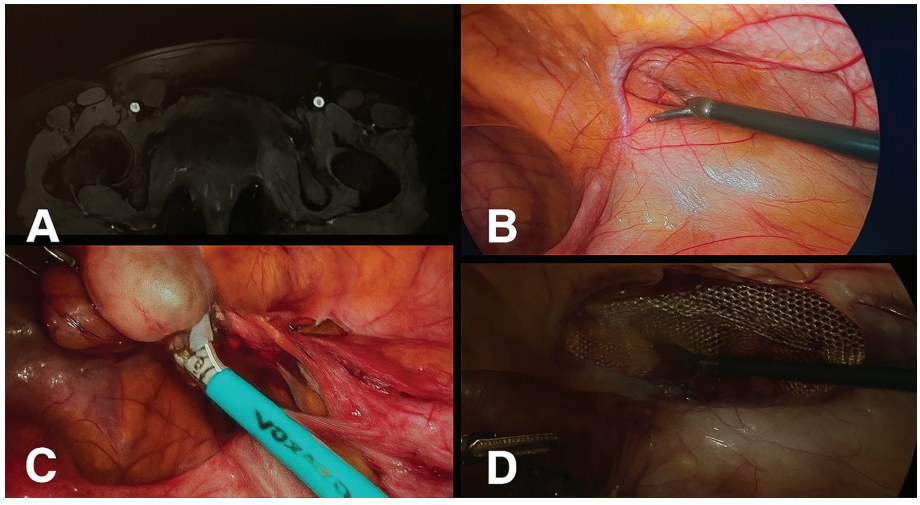

Figure 1. (**A**) Pelvic magnetic resonance imaging showing a thin-septated cystic lesion in the right inguinal canal consistent with a canal of Nuck cyst. (**B**) Laparoscopic view demonstrating dissection of the canal of Nuck cyst in the right inguinal region. (**C**) Intraoperative appearance during cyst excision. (**D**) Placement of mesh over the defect following cyst excision

[SS-04]

Vaginal Approach in Advanced Uterine Pro- Lapse Associated with A Large Uterus and Pelvic Kidney: A Rare Case Report

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Aim: Pelvic organ prolapse is a prevalent condition among multiparous women and may lead to significant urinary, sexual, and pelvic floor symptoms that negatively affect quality of life. Vaginal surgical approaches remain the cornerstone of treatment for advanced prolapse due to their effectiveness and favorable recovery profile.[1] The coexistence of uterine prolapse with a pelvic ectopic kidney is extremely rare and may increase the complexity of surgical planning.[2-5]

Case: A 45-year-old woman (G3P2A1) presented with a sensation of a vaginal mass and pelvic discomfort. Gynecological examination revealed stage 4 uterine prolapse and stage 3 cystocele. The patient had a history of levonorgestrel-releasing intrauterine device insertion for abnormal uterine bleeding. She had no systemic comorbidities. A pelvic ectopic kidney had been identified previously during abdominal imaging performed for unrelated reasons. The patient underwent vaginal hysterectomy, anterior colporrhaphy, and sacrospinous ligament fixation under combined general and spinal anesthesia. The intraoperative course was uneventful, and no anatomical injury or excessive bleeding was observed.

Discussion: Vaginal hysterectomy with concomitant pelvic floor repair is a well-established and effective treatment for advanced uterine prolapse. The presence of rare anatomical variations, such as a pelvic ectopic kidney, necessitates careful preoperative evaluation to avoid intraoperative complications. Despite these challenges, vaginal surgery remains a safe option when meticulous surgical planning is applied.[2-5]

Conclusion(s): This case highlights that vaginal hysterectomy combined with anterior colporrhaphy and sacrospinous fixation can be safely performed in patients with advanced uterine prolapse and rare pelvic anatomical variations. Thorough preoperative assessment is essential for individualized surgical planning and optimal outcomes.

Keywords: Uterine prolapse; cystocele; vaginal hysterectomy; sacrospinous fixation; pelvic kidney

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[SS-05]

Management of Pyometra Complicated by Pelvic Abscess Following Le Fort Colpocleisis: A Case Report

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Aim: Le Fort colpocleisis is a safe and effective obliterative surgical procedure for the treatment of advanced pelvic organ prolapse in elderly and sexually inactive women. Although postoperative complications are uncommon, infectious conditions such as pyometra and pelvic abscess may rarely occur and can lead to serious clinical outcomes. Due to the limited number of reports in the literature, optimal management strategies for these complications are not well established.[1-3] We present a rare case of pyometra complicated by pelvic abscess following Le Fort colpocleisis, successfully managed with a conservative approach.

Material and Methods: A 73-year-old postmenopausal, sexually inactive woman (G3P3) with multiple comorbidities underwent Le Fort colpocleisis for stage 3 pelvic organ prolapse. The postoperative course was initially uneventful, and the patient was discharged on postoperative day 2. On postoperative day 8, she presented with fever, abdominal pain, inability to pass gas or stool, and foul-smelling vaginal discharge. Laboratory evaluation revealed leukocytosis and elevated inflammatory markers. Computed tomography demonstrated a loculated fluid collection originating from the uterine cavity, extending posteriorly to the cervix and compressing the rectum. Broad-spectrum intravenous antibiotic therapy was initiated (Figures 1 and 2).

Results: Due to clinical and laboratory deterioration during follow-up, vaginal incision and drainage were performed. Purulent material was evacuated through the cervical canal under ultrasound guidance, and a posteriorly extending pelvic abscess was drained using a pediatric catheter. The surgical field was irrigated, and a vaginal drain was placed. Abscess culture yielded ESBL-producing *Escherichia coli*. After targeted intravenous antibiotic therapy, inflammatory markers normalized, and the patient showed marked clinical improvement. She was discharged with oral antibiotics according to the antibiogram. No recurrence of prolapse or infectious complications was observed at the three-month follow-up.

Conclusion(s): Pyometra complicated by pelvic abscess after Le Fort colpocleisis is an extremely rare but potentially serious complication.[2] Early recognition, appropriate antibiotic therapy, and timely vaginal drainage using a conservative approach may provide safe and effective outcomes.[3,4] This case supports conservative management as a viable alternative to extensive surgical intervention in selected patients with infectious complications following Le Fort colpocleisis.

Keywords: Le Fort colpocleisis; pelvic organ prolapse; pyometra; pelvic abscess; conservative management

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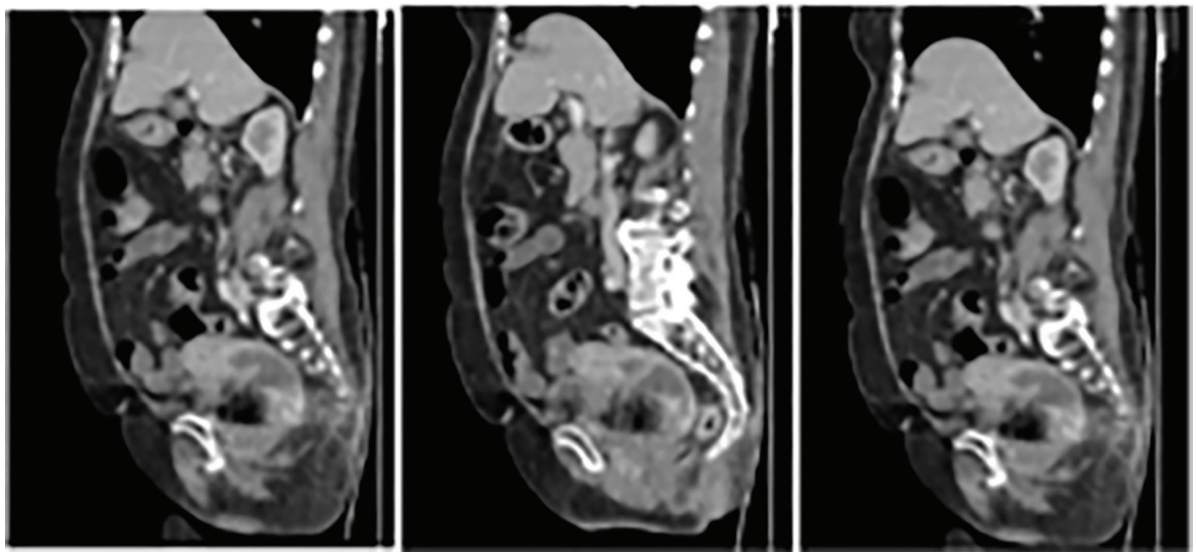

Figure 1. Sagittal CT: A 46×45×50 mm loculated fluid collection associated with the uterine cavity
CT: Computed tomography

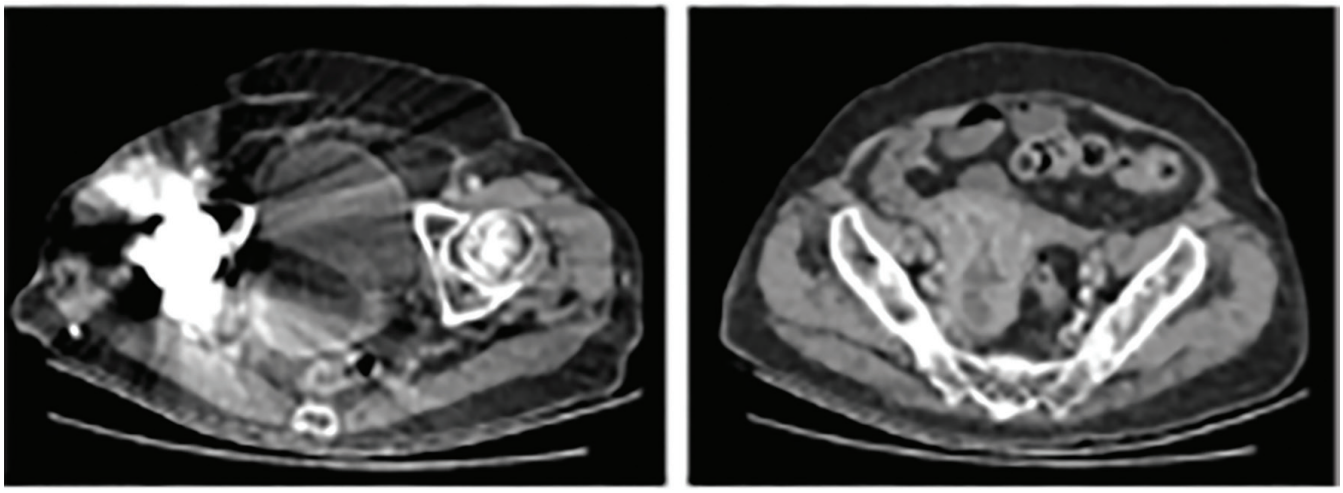

Figure 2. Axial CT: A 46×45×50 mm loculated fluid collection associated with the uterine cavit
CT: Computed tomography

[SS-06]

Late-onset Small Bowel Evisceration Due to Vaginal Cuff Dehiscence: A Rare Case Following Laparoscopic Hysterectomy

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Aim: Hysterectomy has been performed through vaginal and abdominal approaches since the 19th century. After 1989, laparoscopic hysterectomy was introduced into surgical practice and has become widely used today. Compared to the abdominal approach, laparoscopic hysterectomy is preferred in suitable cases due to its lower morbidity, shorter hospital stay, and faster recovery.[1,2] Vaginal cuff dehiscence (VCD), although rare, is a serious complication associated with high morbidity and mortality.[3] Following dehiscence, severe complications such as peritonitis, bowel injury, necrosis, and sepsis may occur. In this report, we present a late-onset case of VCD that developed six months after a total laparoscopic hysterectomy (TLH) performed at an external center.

Case: A 49-year-old woman with known hypothyroidism, heart failure, and a history of three cesarean sections, who had undergone TLH for treatment-resistant abnormal uterine bleeding at an external center six months earlier, presented to our emergency department with a complaint of a mass protruding from the vagina. On examination, ileal loops were observed prolapsing through the introitus, maintaining both vascularization and peristalsis. The patient underwent emergency laparotomy, which revealed a full-thickness dehiscence at the vaginal cuff line (Figure 1 and Figure 2). The prolapsed ileal loops were replaced into the abdominal cavity, and evaluation by the General Surgery team revealed no necrosis, infection, or need for bowel resection in either the small intestine or colon. Approximately 1 cm of tissue was excised from the cuff margins, and the defect was closed continuously using delayed-absorbable sutures (polydioxanone). The postoperative period was uneventful, and the patient was discharged on postoperative day 5 without complications.

Discussion: VCD is a rare but potentially life-threatening complication that may occur at any time following hysterectomy. In premenopausal women, it most commonly appears in the early postoperative period, typically within 2-5 months after surgery. According to the literature, the incidence is highest after robotic surgery (0.7%), followed by laparoscopic hysterectomy (0.5%), and is lower after abdominal (0.3%) and vaginal approaches (0.12%). The most commonly reported precipitating factor is vaginal sexual intercourse; however, heavy physical activity, constipation, smoking, and low body mass index have also been identified as risk factors. Early diagnosis and a multidisciplinary surgical approach are crucial for preventing serious complications such as bowel necrosis, peritonitis, and sepsis. In this case, timely intervention and collaboration with the general surgery team allowed for successful management without the need for bowel resection.

Conclusion(s): Although laparoscopic and robotic surgeries offer lower comorbidity and higher patient satisfaction compared to abdominal and vaginal approaches, the incidence of VCD has been reported to be higher with these minimally invasive techniques.[1,2] When evisceration accompanies dehiscence, it constitutes a surgical emergency that can be potentially life-threatening. Therefore, early recognition, prompt surgical repair, and multidisciplinary collaboration play a decisive role in reducing morbidity and mortality.

Keywords: Vaginal cuff dehiscence; laparoscopic hysterectomy; emergency laparotomy

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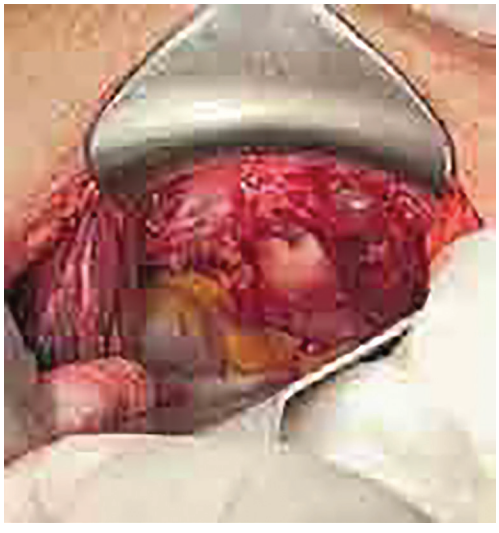

Figure 1. Ileal loops protruding from the vagina

Figure 2. Dehiscence at the vaginal cuff

[SS-08]

Relationship Between Treatment Satisfaction and Clinical Variables Among Pessary Users for More than Two Years

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Aim: Pelvic organ prolapse is a common condition mostly among elderly women. Although surgical treatment exists, also there are options to reduce prolapse with non-surgical treatments including pessaries. Pessary is an effective non-surgical treatment for the ones who wish not to under- go surgery or who are not recommended. We aimed to find out the patient satisfaction of pessary users longer than two years.

Material and Methods: The urogynecology repository was scanned to find the pessary users more than two years duration. Pessary users solely for urinary incontinence and users less than two- year period were excluded. The volunteers asked for fill out the P-QOL and PGI-I questionnaires and demographic and clinical variables were obtained. The data were analyzed by SPSS 27.0 statistical program. The value of $p \leq 0.05$ deemed statistically significant.

Results: The mean age of the pessary users was 74±14.7, and the median was 78.5 (min: 42-max: 98). One patient was premenopausal (6.25%) and 15 were postmenopausal (93.75%). All patients were using 1 mg/g estriol topically. The mean duration of pessary use was 3.625±2.2 years (min: 2-max: 10). Whole study population had normal vaginal delivery and the mean of birth number was 5.25±2.08. Of the study population, six patients (37.5%) had cuff pro- lapse, eight patients (50%) had uterine prolapse, one patient (6.25%) had cystocele, and one patient (6.25%) had rectocele indications for pessary treatment. Four patients who used pessaries for uterine descent opted for vaginal hysterectomy within the past year. While two of these patients were satis- fied with the pessary, they opt to undergo surgery maybe due to their relatively young age (min: 42 -max: 49). Patients who use pessary longer than 2 years appear to have high satisfaction with the treatment. 62.5% of patients re- ported being satisfied with the treatment, subjectively. Using the PGI-I score 1-2 as threshold, satisfaction rate was signifi- cantly higher in the group reporting improvement ($p<0.05$). PGI-I 1-2 threshold is discriminatory in terms of satisfaction (Table 1). The mean of P-QOL total score is 20.71±17.03 for all pessary users. P-QOL strongly discriminates against overall satisfac- tion (area under the curve=0.93). Best threshold value for P-QOL ≤17.45; sensitivity 0.80 [95% confidence interval (CI) 0.49-0.94], specificity 1.00 (95% CI 0.61-1.00); PPV 1.00 (95% CI 0.68-1.00), NPV 0.75 (95% CI 0.41-0.93). A 10 point increase in total score on the P-QOL tended to decrease the likelihood of satisfaction (Figure 1, Table 2). There was no statistical significant association between sat- isfaction and age, obesity, indications, or new-onset vaginal discharge ($p>0.05$) (Table 3). There were no complaints of de-novo urinary incontinence after pessary treatment. P-QOL and PGI-I scores are the primary measure reflecting patient satisfaction in pessary treatment; lower P-QOL scores and PGI-I score 1-2 are associated with higher satisfaction. Demographic and clinical variables (age, obesity, indication, and new onset of posttreatment discharge) were not found to be associated with satisfaction (Figure 1). Among behavioral indicators, desire for surgery correlates more strongly with dissatisfaction (83.3%), while undergoing surgery, being multi-factorial, is a weaker predictor of dissatisfaction ($p=0.604$). The findings are exploratory due to the small sample size and should be confirmed with larger series.

Conclusion(s): P-QOL and PGI-I scores are the primary measure reflecting patient satisfaction in pessary treatment; lower P-QOL scores and PGI-I score 1-2 are associated with higher satisfaction. Demographic and clinical variables (age, obesity, indication, and post-treatment new onset discharge) were not found to be associated with satisfaction. Our find- ings are consistent with recent literature reporting positive effects of pessary treatment on quality of life and symptoms. A retrospective cohort study of premenopausal Thai patients reported 90.1% symptom improvement in the surgical group and 82.63% in the pessary group at 2-year follow-up.[1] In our patients, P-QOL-based discriminability was high, con- sistent with low satisfaction scores. A recent study indicating that pain is the primary reason for discontinuation supports our findings that pessary treatment improves long-term quality of life.[2] In conclusion, pessary treatment for pelvic organ prolapse is an effective, non-surgical treatment with a high subjective satisfaction rate, regardless of indication.

Keywords: Pelvic organ prolapse; pessary; satisfaction

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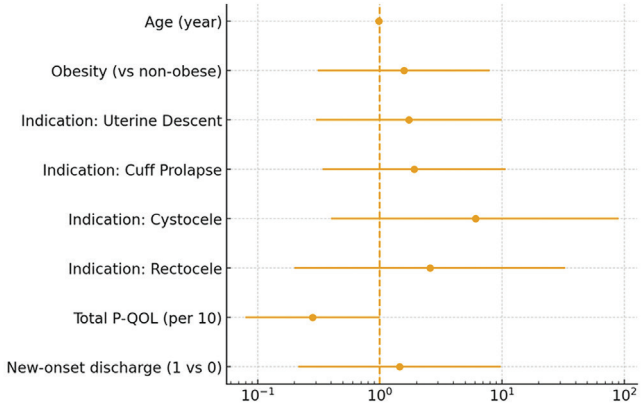

Figure 1. Forest plot – OR and 95% CI
OR: Odds ratio, CI: Confidence interval

Table 1. PGI-I and satisfaction

PGI-I score range		n		%
(1-2)		10		62.5
(3)		4		25
(5-7)		2		12.5
PGI-I scores	Satisfied n	Dissatisfied n	Satisfaction rate	p
1–2	9	1	90%	0.008
3–7	1	5	16.7%	

Table 2. Total P-QOL scores and satisfaction

Satisfied	n	P-QOL total score (mean ± SD)	P-QOL total score (mean ± SD) for whole study population
yes	10	12.1 ± 10.4	20.71±17.03
no	6	35.1 ± 16.7	

Table 3. Logistic regression results

Variable	Coefficient (β)	Odds Ratio (OR)	95% CI	p-value
Age	-0.02	0.98	0.92–1.05	0.62
Obesity	0.45	1.57	0.31–7.89	0.58
Indication: Uterine Prolapse	0.55	1.73	0.30–9.95	0.49
Indication: Cuff Prolapse	0.65	1.91	0.34–10.65	0.45
Indication: Cystocele	1.80	6.05	0.40–90.12	0.19
Indication: Rectocele	0.95	2.58	0.20–32.89	0.48
Total P-QOL Score (per 10-point increase)	-1.27	0.28	0.079–1.000	0.050

[SS-09]

Total Vajinal Necrosis After Transobturator Tape (TOT) Procedure

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Aim: Midurethral slings have been successfully used for the treatment of stress urinary incontinence for more than 20 years and are considered the gold standard surgical method. Although rare complications may occur after transobturator tape (TOT) procedures, total vaginal necrosis has not been previously reported, to our knowledge.[1,2] This presentation demonstrates the management of a case of total vaginal necrosis following TOT surgery with early medical and surgical treatment.

Material and Methods: The patient was a 51-year-old postmenopausal woman (gravida 6, para 4) with a history of two cesarean sections. She had no known systemic disease, was an active smoker (one pack per day), and had a documented allergy to povidone-iodine.

Results: On postoperative day 24 after TOT surgery, the patient presented with vaginal and perineal pain, vaginal discharge, and fever. Physical examination revealed total vaginal necrosis extending from the periurethral region to the anterior and posterior fornices. Laboratory evaluation showed a white blood cell count of 9,100/μL, hemoglobin level of 12.7 g/dL, and a C-reactive protein level of 115 mg/L. Empiric intravenous ceftriaxone and metronidazole were initiated, and surgical debridement of necrotic tissue with complete mesh excision was planned. Postoperatively, intravenous piperacillin–tazobactam was administered for 7 days along with topical antifungal therapy. Histopathological examination revealed extensive necrosis, necrobiosis, and fibrinopurulent exudate. Tissue cultures grew Candida albicans, and systemic antifungal therapy was added. The patient showed clinical improvement by postoperative day 10 and was discharged on day 18. Mild urinary incontinence persisted and was managed with tolterodine. At 8-week follow-up, marked secondary healing with granulation tissue formation was observed. Vaginal stenosis developed in this sexually inactive patient who did not use the recommended vaginal mold.

Conclusion(s): Vaginal necrosis may develop as a result of mesh erosion following midurethral sling procedures. Careful patient selection, individualized surgical planning, and early diagnosis with a multidisciplinary management approach, including appropriate medical therapy and timely surgical intervention, are fundamental determinants of patient outcome.[3-5]

Keywords: Total vaginal necrosis; transobturator tape; stress urinary incontinence

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[SS-11]

Removal of Contralateral Tubal Occlusion with Nelaton Feeding During Surgical Treatment of Ectopic Pregnancy (Salpingectomy)

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Aim: A 33-year-old woman, G2A1, who had been trying to conceive for approximately 2 years, presented to the emergency department with a gestational age of 6 weeks and 2 days based on her last menstrual period and a β-hCG level of 7523 IU/L. Physical examination revealed no defense or rebound; the abdomen was soft, BP: 110/70 mmHg, pulse: 90/min, and the patient was assessed as hemodynamically stable. Transvaginal ultrasound showed a gestational sac and yolk sac in the right tube. A curettage had been performed the day before, and the β-hCG value was 7900 IU/L.

Material and Methods: The patient was informed about medical and surgical treatment options. The patient accepted the risk of salpingectomy and requested evaluation of the other tube, and surgical treatment was preferred.

Results: Diagnostic laparoscopy revealed findings of pelvic inflammatory disease (chlamydial infection). An ectopic focus extending to the mesentery was observed in the proximal part of the right tube. The right tube was clamped with a LigaSure device and dissected stepwise; a right sal- pingectomy was performed to remove the ectopic focus. The adhesions on the side wall of the left tube were opened. A Nelaton feeding catheter was inserted through a 5 mm trocar and advanced from the left tubal fimbria to the ostium, and isotonic irrigation was performed; fluid movement was observed. No passage of methylene blue was observed from the right uterine stump or the left tube. Following the resolution of the tubal occlusion, methylene blue was administered again, and passage of dye through the left tube was subsequently observed. Figures 1-3 demonstrates removal of contralateral tubal occlusion with nelaton feeding methylene blue emerging from the tubal fimbria over the sigmoid colon. The patient was informed. At 3 months postoperatively, the patient became spontaneously pregnant; CRL: 8 weeks 4 days, fetal heartbeat was observed.

Conclusion(s): Medical treatment is usually the first op- tion in ectopic pregnancy.[1] However, the success rate de- creases when β-hCG >5000 IU/L, the focus >3-4 cm, or fetal cardiac activity is present. Multiple doses of methotrexate and salpingostomy show similar efficacy.[2] Surgical treatment (salpingostomy or salpingectomy) is similar in terms of fertility and recurrent ectopic pregnancy rates.[3] Salpingectomy eliminates the risk of residual trophoblastic tissue, thereby reducing the need for additional treatment.[3] In hemody- namically stable cases, evaluation of the contralateral tube during surgery is recommended.

Keywords: Ectopic pregnancy; infertility; salpingectomy

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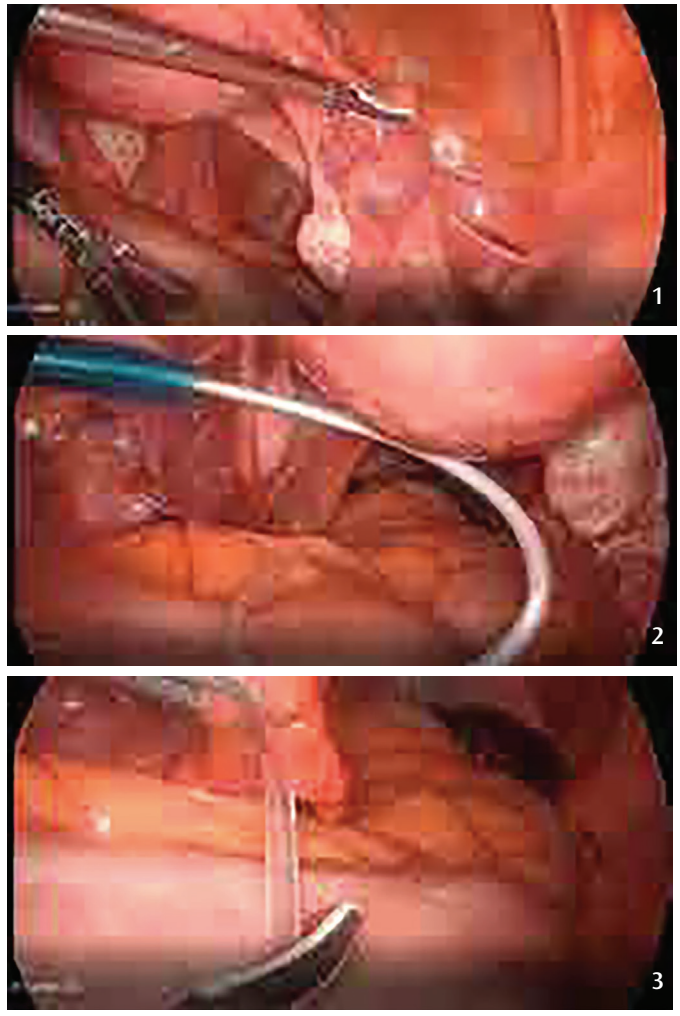

Figures 1-3. Removal of contralateral tubal occlusion with nelaton feeding

[SS-21]

From Symptoms to Solutions: Outcomes of Surgical Techniques for Genital Prolapse Correction

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Aim: Pelvic organs prolapse (POP) is a pathological condition resulting from impaired anatomical support of the pelvic organs, leading to their descent or protrusion. This disorder is highly prevalent among women of all ages and is associated with a significant reduction in quality of life.[1]

Material and Methods: Between January 2019 and December 2024, a total of 1.324 surgical procedures for genital prolapse correction were performed at a single clinic in Moscow. Indications for surgery included symptomatic genital prolapse of stages II-IV according to the pelvic organ prolapse quantification system. Data were retrospectively collected from 747 patients using validated questionnaires (FPDI-20, PFIQ-7, PISQ-12, FSFI) and postoperative clinical examinations.

Results: The mean follow-up period was 42±12 months. The mean operative time was 70.78±26 minutes, with an average blood loss of 91±62 mL. Patients ranged in age from 27 to 86 years. The distribution of prolapse stages was as follows: stage II – 45%, stage III – 43%, stage IV – 12%. The predominant types of prolapse were cystocele (41%), rectocele (12%), and apical prolapse (47%). Patients were divided into two groups. Group 1 (n=754) underwent site-specific or sling-based procedures, alone or in combination, including transsacrospinous hysteropexy (78%), urethropexy (18%), site-specific repair (54%), and sacrocolpopexy (6%). Group 2 (n=570) underwent traditional surgical techniques, including colporrhaphy (90%), perineolevatoroplasty (52%), urethropexy (27%), McCall culdoplasty (3%), and hysterectomy (57%). Significant symptom improvement was observed in Group 1 (n=754): sensation of vaginal bulge decreased from 68.3% to 3.2%, pelvic pain and dyspareunia from 19.5% to 3.5%, voiding difficulties from 21.7% to 3.4%, urinary frequency from 15.6% to 3.8%, nocturia from 18.6% to 5.7%, stress urinary incontinence from 29.4% to 5.2%, constipation from 8.1% to 2.6%, and fecal incontinence from 3.6% to 2.9%. High patient satisfaction was reported, with 56% willing to repeat the procedure and 51% recommending it to others. In Group 2 (n=570), symptom improvement included reduction in vaginal bulge from 49.8% to 4.9%, pelvic pain and dyspareunia from 22.9% to 15.6%, voiding difficulties from 9.5% to 5.3%, urinary frequency from 11.2% to 7.4%, nocturia from 14.7% to 8.5%, stress urinary incontinence from 33.3% to 9.9%, constipation from 7.3% to 3.3%, and fecal incontinence from 3.6% to 1.4%. High patient satisfaction was reported, with 41% willing to repeat the procedure and 42% recommending it to others. No intraoperative complications were recorded. Early postoperative complications in the two groups (n1=754, n2=570) included pulmonary embolism (0.0% vs. 0.4%), deep vein thrombosis (0.2% vs. 0.3%), peritonitis (0.2% vs. 0.4%), cystitis (1.9% vs. 2.4%), urinary retention (1.3% vs. 1.7%), and blood loss 400-500 mL (1.8% vs. 3.7%). Late postoperative complications included mesh erosion into the bladder (0.1% vs. 0.0%) and vaginal mesh erosion (0.5% vs. 0.0%). Relapse of POP occurred in 8.6% and 16.7% of patients, with repeat surgery required in 4.6% and 6.8%, respectively.

Conclusion(s): Surgical correction of genital prolapse is an effective treatment with minimal risk. Site-specific and sling-based procedures demonstrated superiority over traditional techniques, providing better symptom relief and lower recurrence rates. Modern surgical approaches restore normal pelvic anatomy and significantly improve patients' quality of life.

Keywords: Pelvic organs prolapse; surgical correction; quality of life

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[SS-22]

Long Term Results of Surgeontailored Transobturator tape Operation for Female Stress Urinary Incontinence

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Aim: Stress urinary incontinence (SUI) is on the rise due to longer life expectancy, numerous pregnancies, and obesity.[1] SUI is still undertreated and underdiagnosed. Surgeries with and without mesh can be chosen for treatment. Trans-obturator tape (TOT) operation is a mid-urethral sling surgery. New surgeries are emerging daily because of the occurrence of mesh-related complications.[2] In addition, in TOT surgery has disadvantages as groin pain, bladder injury, and various ranges of success rates for SUI. Our study aimed to evaluate the ten-year outcomes of patients who had TOT surgery for SUI performed by the same surgeon at a single center.

Material and Methods: This prospective study included patients who had TOT surgery at Şanlıurfa Training and Research Hospital. Patients at their tenth postoperative year were examined regarding their latest incontinence status, their use of medication for incontinence, and the development of any complications. This study had included patients who had TOT surgery with surgeon-tailored mesh due to SUI between August 2015 and January 2025. The exclusion criteria for patients were pregnancy, breastfeeding, acute infection, malignancy, TOT with concomitant pelvic floor surgery (anterior or posterior repair, para vaginal repair, Le Fort operation, and vaginal hysterectomy), previous anti-incontinence surgery or a diagnosis of any neurologic disease. This surgeon-tailored polypropylene mesh is a non-absorbable, monofilament, macroporous structure with standard features. This standard mesh measuring 15×15 cm was cut to form a conical shape at the ends of 7.5×1 cm, and a No. 1 polyglactin 910 suture was fixed to both ends of the created mesh. All patients had a standard preoperative evaluation, medical history, gynecological examination, and routine abdominopelvic ultrasonography (US). A previously validated Turkish version of the incontinence impact questionnaire was used in this study for the effect of TOT operation on SUI, which the patient rates from 0 (not at all affected) to 3 (greatly affected). SUI definition was made by tap test positivity, cough test and subjective complaints. All of the patients had conventional TOT (outside-in) operation. The study was approved by the regional Ethics Committee of The Harran University Ethics Committee, decision number: HRU/24.03.08.

Results: The ten-year results of TOT operation of 209 patients were evaluated. The mean age of the patients was 45.95±10.62 (25-72) years. 52.2% of patients were postmenopausal. The cure rate was 89.5% (one hundred eighty-seven patients) at tenth year. Nineteen patients (9.1%) had *de novo* urgency, which was defined as failure either. Three patients (1.4%) had still incontinent as before, which was defined as failure (Figure 1). Leg pain was seen in 2.9%, dyspareunia in 1%, and mesh erosion in 5.3% of patients. Cystoscopy was not routinely used unless hematuria occurred. None of the patients had bladder perforation. The relationship between *de novo* urgency and postmenopausal status or grand multiparity were not statistically significant, with p values of 0.31 and 0.40, respectively. A total of 2.9% of patients had leg pain in the right leg. There was no neurological deficit in any patient. When the mesh was loosened, leg pain disappeared in one patient. The mesh was loosened but not removed at the first postoperative day by local anesthesia, through the interrupted sutures on the incision. Patients were still urinary continent. The advantages of the TOT operations are minimally invasiveness, has lower costs than laparoscopic surgery as Burch colpo-suspension.[3] While DynaMesh® costs approximately 59 US dollars, the surgeon tailored mesh costs about 7.5 US dollars for each surgery. It can be an advantage for low-income countries. In a study comparing traditional mesh and surgeon-tailored mesh,[4] the cure rate was 92.3% for traditional mesh and 100% for the surgeon-tailored mesh. In our study, the cure rate was 89.5%. We followed the patients for ten years, therefore, our results are more realistic than data from other similar studies. In a prospective study,[5] that included five years of follow-up, the objective and subjective cure rates were 91.0% and 82.8%, respectively.

Conclusion(s): Although surgeon-tailored mesh is a cheap and practical method for places that do not have the opportunity to buy traditional mesh, its chance of success in the long term remains lower than that of traditional mesh, and the risk of mesh erosion and the *de novo* urgency it causes should not be ignored.

Keywords: *De novo* urgency, mid-urethral sling, stress incontinence, trans-obturator tape

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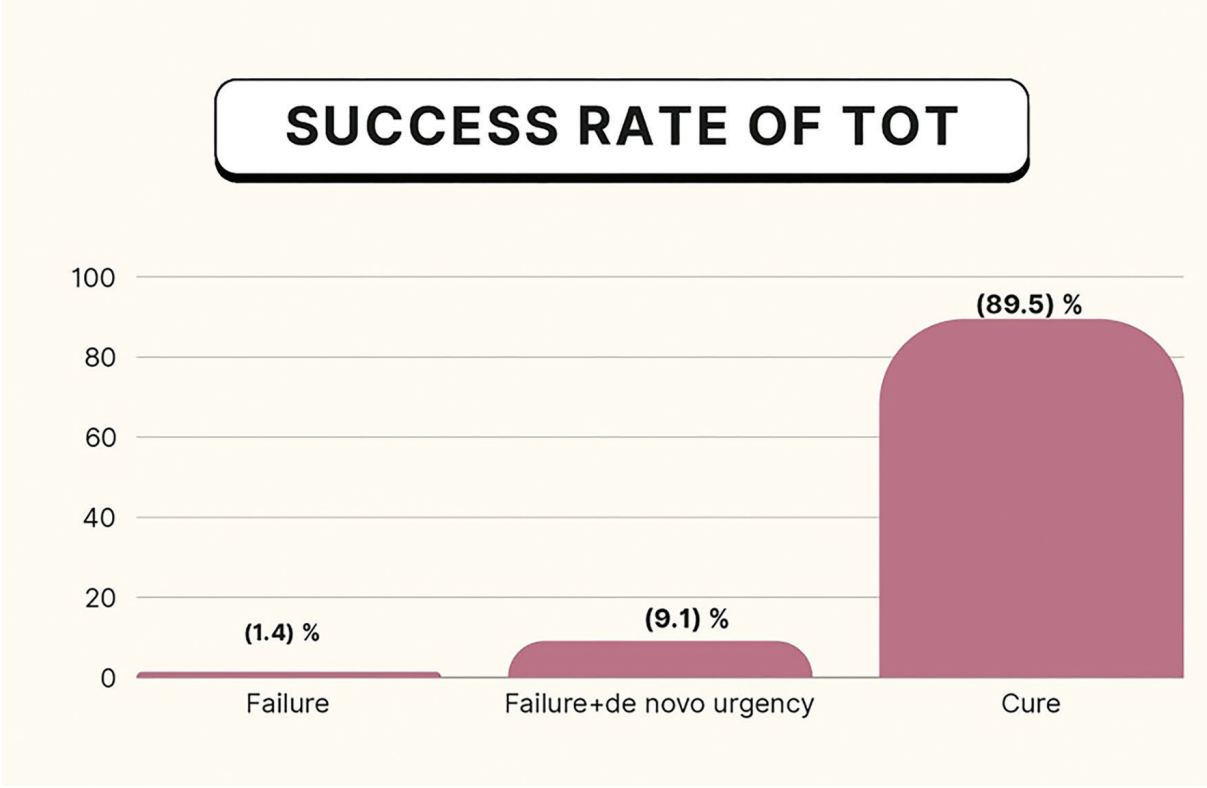

Figure 1. The success rate of surgeon-tailored TOT operation
TOT: Trans-obturator tape operation

[SS-23]

Clinical Significance of Coexistence of HPV Types

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Aim: Cervical cancer is the fourth most common malignancy among women worldwide.[1] Almost all cases are attributed to human papillomavirus (HPV) infection, with approximately 70% caused by HPV types 16 and 18.[2] However, data remain limited regarding whether concurrent infection with HPV 16 and other genotypes further increases cervical cancer risk. This study aimed to evaluate the association between combined HPV infections and the presence of high-grade squamous intraepithelial lesions (HSIL).

Material and Methods: Medical records of HPV-positive women who underwent colposcopic examination were retrospectively reviewed. Women aged 25-65 years were included, while those with a history of malignancy, autoimmune disease, or immunosuppressive therapy were excluded. Data regarding HPV genotype, colposcopic findings, and histopathological results were collected from medical records.

Results: A total of 107 patients met the inclusion criteria; 69 (64.5%) had HPV 16 alone, and 38 (35.5%) had HPV 16 with other genotypes. Both groups showed similar baseline characteristics. We then evaluated the relationship between HPV 16 infection, alone or combined with other types, and the presence of HSIL lesions. When pathology results were compared according to HPV types, 27 patients (33.8%) without HSIL had combined HPV types, whereas 11 patients (40.7%) with HSIL had both HPV 16 and other types detected (p=0.512).

Conclusion(s): In our study, the combination of HPV 16 with other HPV types was not found to confer an additional risk for the development of HSIL lesions. Khan et al.[3] reported a 17% incidence of HSIL among HPV 16-positive women, compared with 3% for other high-risk types. In another cohort of approximately 20,500 women, isolated HPV 16 infection was associated with a significantly higher 10-year risk of HSIL or cervical cancer.[3] Therefore, colposcopic evaluation should be performed in all patients with HPV 16 positivity, even in the absence of coexisting HPV types.

Keywords: HPV; HSIL; colposcopy; multi-infection

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[SS-24]

Interpretation of the Relationship Between Bladder Neck Descent and Nocturia

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Aim: Transperineal ultrasonography (TPUS) in a non-invasive office procedure sensitive for assessing dynamic changes related with urethral mobility besides from examining pelvic floor structures.[1] Several parameters have been proposed to be related with urinary symptoms.[2] In this study we aimed to compare bladder neck descent measured by TPUS between women with and without nocturia.

Material and Methods: Patient files of women assessed with TPUS were retrospectively analyzed. Bladder neck descent were compared against age, body mass index and D point distance matched women with and without nocturia. Bladder neck descent was measured during resting and maximum valsalva according to a standardized method described previously.[3] Distance of the bladder neck from symphysis were noted in both conditions. Bladder neck descent was calculated by calculating the difference of these distances.

Results: There were total 86 women who met the inclusion criteria. Age and body mass index are matched in two groups. Bladder neck descent measurements in women with nocuria, urge incontinence and stress incontinence symptoms were investigated. Only nocturia was found to be associated with bladder neck descent in this study population (1.51 vs. 2.32, p=0.008).

Discussion: This study suggests that the relationship between anatomical descent and functional symptoms is more nuanced than previously understood. The current body of evidence emphasizes the multifactorial nature of nocturia and highlights the importance of comprehensive assessment including voiding diaries, postvoid residual measurement, and evaluation of sleep, renal, and cardiovascular factors when interpreting this symptom.

Conclusion(s): Further studies with larger sample sizes are warranted to understand the role of perineal ultrasonography in the evaluation of the underlying dynamic anatomical mechanisms linking to specific LUTS profiles.

Keywords: Perineal ultrasonography; nocturia; urinary incontinence

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[SS-25]

Periuretral Amelanotic Malignant Melanoma: A Rare Case Report

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Aim: Primary urethral melanoma is an extremely rare and highly malignant neoplasm, accounting for less than 1% of all melanoma cases.[1] Due to its rarity and non-specific clinical presentation, diagnosis is often delayed, leading to poor prognosis. Amelanotic melanomas, by contrast, are exceedingly rare variants that lack the typical melanin pigmentation seen in conventional melanomas. This absence of pigmentation frequently results in diagnostic challenges, as these tumors may mimic other benign or malignant lesions of the urethra. Early recognition and accurate histopathological evaluation are therefore essential for proper management and improved outcomes

Case: A 67-year-old female patient presented with complaints of groin pain and vaginal bleeding. Gynecological examination revealed a non-pigmented periurethral mass measuring approximately 3×4 cm, almost completely obstructing the urethral orifice. Palpable lymph nodes were also detected in the left inguinal region. Given the tumor's anatomical location, vaginal or urethral squamous cell carcinoma (SCC) was initially considered in the differential diagnosis. However, the macroscopic appearance of the lesion was not compatible with SCC. Biopsy specimens obtained from both the urethral mass and the left inguinal lymph nodes demonstrated histopathological features consistent with malignant melanoma. Positron emission tomography-computed tomography (PET-CT) revealed no additional pathological findings apart from the periurethral mass and the left inguinal lymphadenopathy. Comparison with a PET-CT performed one year earlier showed that these pathological findings had newly developed, consistent with the aggressive biological behavior of malignant melanoma.

Discussion: Primary urethral melanoma is an exceptionally rare malignancy, accounting for less than 1% of all melanomas. It most commonly affects elderly women and is often diagnosed at an advanced stage due to its non-specific symptoms.[3] Amelanotic variants are even rarer and may be easily overlooked because of the absence of the characteristic dark pigmentation, often leading to a delay in diagnosis. In our case, given the tumor's anatomical location, vaginal or urethral SCC was initially considered in the differential diagnosis. However, histopathological and immunohistochemical findings confirmed the diagnosis of malignant melanoma. The presence of inguinal lymph node metastasis and the rapid development of new pathological findings on PET-CT imaging within one year are consistent with the aggressive biological behavior of this tumor type. This case emphasizes the importance of considering malignant melanoma in the differential diagnosis of periurethral masses, even in the absence of pigmentation. Early recognition and accurate histopathological evaluation are essential to improve clinical outcomes in such rare and aggressive malignancies. Considering the biological similarity among melanoma subtypes, immunotherapy may represent a promising adjunctive treatment option for periurethral melanoma cases.[2]

Conclusion(s): Primary amelanotic urethral melanoma is an extremely rare and aggressive malignancy that poses significant diagnostic and therapeutic challenges. The absence of pigmentation often leads to misdiagnosis or delayed diagnosis. This case underscores the importance of considering malignant melanoma in the differential diagnosis of periurethral masses, even when pigmentation is absent. Early diagnosis, histopathological confirmation, and surgical resection whenever feasible are crucial for achieving better clinical outcomes in these patients.

Keywords: Malignant melanoma; urethra, periurethral mass

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