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Rixos Sungate, Antalya



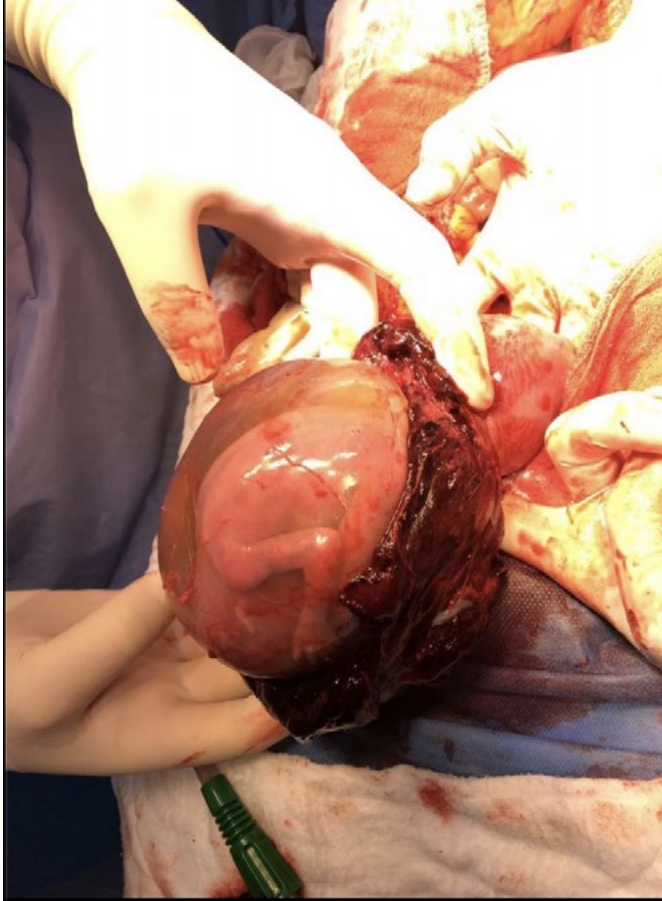
BİLİMSEL PROGRAM ve
BİLDİRİ ÖZETLERİ KİTABI



with this rare ectopic subtype.

Keywords: Cornual pregnancy, Interstitial pregnancy, Ectopic pregnancy rupture, Cornuostomy, Fertility-sparing surgery

Figure 1



Intraoperative view of a ruptured left interstitial pregnancy at 11 weeks of gestation. The image demonstrates a fetus entirely encased within an intact amniotic sac, having been expelled through a transmural myometrial defect. Significant local hemorrhage and a hypervascular cornual region are visible at the rupture site.

SS-118

Postoperative Diagnosis of Leiomyosarcoma Following an Initial Ectopic Pregnancy Assessment: A Case Highlighting Diagnostic Challenges

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INTRODUCTION: Uterine leiomyosarcoma (LMS) is a rare but highly aggressive malignancy arising from the smooth muscle of the uterine wall and is associated with higher recurrence and mortality rates compared to other uterine cancers.¹ Because clinical and radiological findings are often nonspecific, preoperative diagnosis is difficult, and the definitive diagnosis is frequently made after pathological examination following surgery performed with a preliminary diagnosis of leiomyoma.^{2,3} The reported incidence of LMS in surgeries for presumed leiomyoma is approximately 1/350–1/500.⁴ Therefore, careful treatment planning is essential. Retrospective studies have shown that patients diagnosed with LMS after morcellation have an increased risk of sarcomatosis and poorer survival outcomes.^{6–7}

Treatment depends on stage. In early-stage disease (Stage I–II), surgery followed by observation is generally sufficient, and total hysterectomy is recommended for disease confined to the uterus. A National Cancer Database analysis reported no survival difference between premenopausal patients who underwent bilateral salpingo-oophorectomy and those who did not.⁸ In advanced stages (Stage III–IV), adjuvant chemotherapy is recommended after surgery. Prognosis remains poor regardless of stage, with reported five-year overall survival rates of 76%, 60%, 45%, and 29% for stages I–IV, respectively.^{9,10}

CASE REPORT: A 38-year-old patient, gravida 4, para 3 (all cesarean section), abortus 1, was admitted to our clinic after revision curettage was recommended due to suspected retained material following dilation and curettage performed 15 days earlier for nonviable pregnancy. The patient presented with abnormal uterine bleeding and abdominal pain. Ultrasound revealed a 9 cm mass filling the uterine cavity compatible with myoma and a 7 cm cystic anechoic lesion in the left adnexa. Laboratory evaluation showed a β -hCG level of 71 IU/L.

Tranexamic acid and blood transfusion were administered due to persistent bleeding. Within 24 hours, β -hCG decreased to 23 IU/L, but symptoms persisted, and at 48 hours the β -hCG level increased to 87 IU/L. Magnetic resonance imaging demonstrated a uterine mass suggestive of degenerating myoma, a 7 cm left adnexal cyst, and pelvic free fluid. Surgery was planned

with preliminary diagnoses of ectopic pregnancy and degenerated myoma.

Intraoperatively, the left adnexa was edematous with serohemorrhagic intra-abdominal fluid. Total abdominal hysterectomy, left salpingo-oophorectomy, right salpingectomy, and partial omentectomy were performed. The patient was discharged on postoperative day three in stable condition. Histopathological examination revealed an 8 cm spindle-cell leiomyosarcoma with high mitotic activity and extensive necrosis. Tumor implantation was detected in the left adnexa, and staging according to FIGO was T2aNxMx. No histological evidence of ectopic pregnancy was found.

CONCLUSION: Uterine leiomyosarcoma may mimic benign uterine conditions or pregnancy-related disorders because of nonspecific clinical and radiological findings. In this case, elevated β -hCG and adnexal mass suggested ectopic pregnancy, while the uterine mass was considered a degenerated myoma. The postoperative diagnosis of LMS emphasizes that malignancy should be considered in patients with uterine masses and atypical clinical findings. When clinical and laboratory results are inconsistent with benign conditions, surgical planning should follow oncologic principles.

Keywords: β -hCG elevation, diagnostic challenge, ectopic pregnancy, uterine leiomyosarcoma, uterine mass.

Figure 1



Surgical specimen of uterus with leiomyosarcoma and adnexal tissue removed during total abdominal hysterectomy.

SS-119

A case report of an ectopic pregnancy in the ipsilateral distal stump following partial salpingectomy

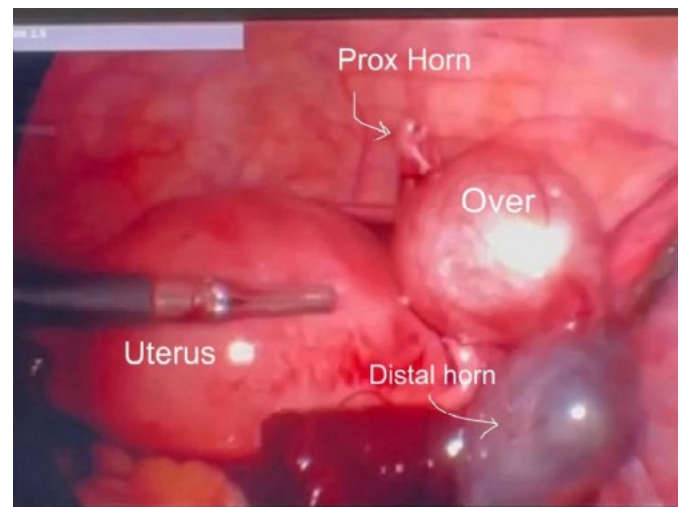
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This case report presents an ipsilateral ectopic pregnancy located in the distal stump (ampullary) of the fallopian tube following partial (isthmus) salpingectomy. A 31-year-old female patient presented with vaginal bleeding and right lower quadrant pain. Her medical history included partial removal of the right fallopian tube (salpingectomy) due to an ectopic pregnancy. Blood tests showed a positive pregnancy result, while ultrasound revealed an empty uterine cavity, a mass in the right adnexal region, and hemorrhagic fluid in the Douglas pouch. Laparoscopically, an ectopic pregnancy was confirmed in the distal stump (ampulla) resulting from a previous partial (isthmusectomy) salpingectomy. Total salpingectomy procedure was performed. This case demonstrates that ipsilateral ectopic pregnancy recurrence is possible in patients with a history of tubal ligation or partial salpingectomy. Therefore, to minimize risks in the surgical treatment of ectopic pregnancy, total salpingectomy is recommended for suitable patients.

Keywords: ectopic pregnancy, distal stump, partial salpingectomy

Picture 1



Laparoscopic view of the uterus, right over, right proximal fallopian tube and ectopic pregnancy within right distal fallopian tube