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EP43.24
Sonographic characteristics of ovarian sex cord stromal tumours

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Objectives: To study the epidemiological and clinical characteristics and the sonographic findings of ovarian sex cord stromal tumours (OSCSTs).

Methods: This is a retrospective, monocentric and descriptive study that included 34 cases of histologically confirmed OSCSTs. Patients' characteristics, clinical and sonographic features were analysed and compared according to the histopathological type.

Results: The mean age of the patients included was 48.47 years [27-70 years]. 52.9% of them were postmenopausal. The main symptom was pelvic pain that was chronic in 64.5% of the cases and acute in 23.07% of them followed by irregular vaginal bleeding (46.15%). Only one patient experienced abnormal body hair. Among our 34 patients, 16 had an ovarian thecoma-fibroma (OTF), 14 had a granulosa cell tumour (GCT), two had a Sertoli cell tumour (SCT), one patient had a Leydig cell tumour (LCT) and a lipoma was found in one case. The mean ovarian tumour size was 10.6 cm [4-35 cm] at primary diagnosis. The mass was bilateral in only one case. Various ultrasonographic signs were found. The multilocular solid aspect was predominant (60.71%). It was present in 81.8% of the GCTs and in 53.3% of the OTF group. The unilocular hyperechoic aspect was found in 20.59% of the cases. Septations were found in 7 cases and showed an abundant Doppler flow signal in only one mass (OTF). All of the tumours had clear boundaries. Fluid was found in the Douglas pouch in 19,35% of the cases. Finally, endometrial hypertrophy was detected in 20% of the cases. Four of these patients had an OTF and two of them had a GCT.

Conclusions: Ultrasound remains the first-line exam to suspect ovarian sex cord stromal tumours. These masses have generally a solid aspect but this sign lacks specificity. Larger samples are necessary to establish a diagnosis pattern for these tumours.

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EP44: BLEEDING, ENDOMETRIAL AND MYOMETRIAL PATHOLOGY

EP44.01
Retained placenta after Caesarean section: is it just technique dependent?

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Retained placenta and postpartum hemorrhage after vaginal delivery is a known subject in obstetrics. It was thought that placenta is not

extracted properly or accessory lobe is missed. But now there are cases in which retained placenta were seen also after Caesarean section. Case 1, A 32 years old, 19 days after repeat Caesarean section and fetal growth restriction came with bleeding, stable vital signs, Hb=10.2, and an echogenic area in upper part of uterine cavity measuring 4-5 cm in pelvic scan. Case 2, A 35 years old, 35 days after repeat Caesarean section came with bleeding, stable vital signs, Hb=11.5, and echogenic area in upper part of uterine cavity measuring 3 cm in pelvic scan. Case 3, A 24 years old, 15 days after Caesarean section because of severe pre-eclampsia at 37 weeks 2 days came with fever, temperature was 39 degrees. There was echogenic area in upper part of uterine cavity measuring 3 cm in pelvic scan. All sent to OR and retained placenta was extracted. In all of these three cases the surgeon was sure that after removal of placenta, cavity was properly checked and there was not any placental tissue in uterine cavity. After placental formation and invasive nature of trophoblasts, some parts of placental tissue are in deep locations of endometrial-myometrial zone. Like a note written on a balloon, after balloon evacuation the note became more prominent. Rarely in some cases after birth and subsequent reduction of uterine size, placental tissue deep in endometrial-myometrial zone, expel into uterine cavity.

Supporting information can be found in the online version of this abstract

EP44.02
Ultrasound assessment of endometrial thickness in women with endometrial bleeding

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Objectives: Dysfunctional endometrial bleeding is often during the menopausal transition as a result of hormonal changes during this period. In postmenopaus, there should be no uterine bleeding. Postmenopausal bleeding occurs in approximately 90% of patients with endometrial cancer, but only 9% of women with postmenopausal bleeding have endometrial cancer. The aim of this study is to determine the histopathological changes of the endometrium that occur in women with perimenopausal and postmenopausal bleeding and the association with endometrial thickness and anteroposterior diameter of the uterus.

Methods: This study involved 120 patients with fractionated explorative curettage due to abnormal uterine bleeding. The examined group was divided in two subgroups: 60 women in perimenopausis and 60 women in postmenopausis. Anamnestic data were taken from all respondents. Ultrasound measurement of anteroposterior diameter of uterus and endometrial thickness were made with endovaginal ultrasound probe.

Results: The most common pathological change of the endometrium was an endometrial polyp (in 45% of the respondents). 26.7% of perimenopausal women had dysfunctional uterine bleeding. Endometrial adenocarcinoma was present in 3% of perimenopausal and in 5% of postmenopausal women. The average value of the anteroposterior diameter of the uterus was 50.7 mm in perimenopausal, 37.3 mm in postmenopausal group, and the difference of 13.4 mm was statistically significant ($p < 0.0001$). The average thickness of the endometrium was 13.6 mm in perimenopausal, 10.3 mm in postmenopausal group, and the difference of 3.3 mm was statistically significant ($p = 0.00011$).

Conclusions: Fractionated explorative curettage is an effective method for timely and effective diagnosis of pathological changes

of the endometrium in women with abnormal uterine bleeding Perimenopausal patients had significantly higher anteroposterior diameter of the uterus and thicker endometrium than those in the postmenopausal period.

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The multidisciplinary view on the uterine junctional zone: explaining discrepancies between MRI and ultrasound images on a microscopic level

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Objectives: To investigate the accordance on the definition of the junctional zone across different diagnostic approaches and examine how the imaging findings can be linked to histological findings in the context of adenomyosis diagnosis.

Methods: A comprehensive literature review was conducted for articles describing the imaging appearance and histological structure of the junctional zone within the uterus.

Results: The junctional zone (JZ) is distinguished from the middle and outer myometrium by gradual changes in smooth muscle cell density, extracellular space, connective tissue, water content, and vascularity. While the signal intensity from JZ to middle myometrium changes abruptly on MRI, the histopathological changes are gradual and its border can be difficult to distinguish on TVUS. The thickness of the junctional zone on MRI was significantly larger than on TVUS. Thus, TVUS and MRI do not reflect exactly the same layer. Although a thickened JZ is often used to diagnose adenomyosis on MRI, the presence of adenomyosis can more accurately be described by interruptions of the JZ represented by direct features, such as subendometrial lines and buds on TVUS or bright foci on MRI.

Conclusions: The junctional zone is not a well-defined entity across and even within different diagnostic disciplines. A better awareness among clinicians is needed that findings on MRI cannot readily be extrapolated to ultrasound. Understanding of these findings is necessary to further investigate the potential relevance of the uterine junctional zone as a functional unit and the association between the visualisation of direct features of adenomyosis in the junctional zone and clinical symptoms.

Supporting information can be found in the online version of this abstract

EP44.05

Laparotomic myomectomy complications

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Objectives: The study objective is to study the intraoperative and postoperative complications of laparotomic myomectomy and patients’ characteristics influencing this risk.

Methods: Retrospective monocentric analytical descriptive study, with a review of the patient records. The incidence and type of complications occurring in laparotomic myomectomies undertaken over a period of 7 years were recorded.

Results: The surgical technique was the same. The age group for this study was 32 years of age. The patients were mainly nulliparous (82%) without any medical history. Single or multiple myomectomies for symptomatic and asymptomatic myomas measuring on average 4 cm in diameter were performed. Most of the leiomyomas were intramural and were located in the fundus. Most patients (55%) had more than 1 myoma, with a maximum of 30 per patient. Total complication rate was 30 % (minor and major). The most serious events were hemorrhages (14 cases, 0.07%) requiring blood transfusions, 6 (0.03%) patients needed a further surgery; 20 (0.1%) patient presented a post operative fever only requiring an empowerment of the antibiotics, 10 (0.05%) postoperative hematomas located in the myomectomy scar; requiring also further surgery; 1 (0.005%) case of deep thrombosis occurred; 1 (0.005%) case of postoperative occlusion of the small bowel with an early flange was re-perforated, needing a revision surgery.

Conclusions: Odds ratio computed to estimate the risk of complications in relation to the patient characteristics showed that the probability of complications significantly rises with an increase in the number (more than 3 myomas) and with the intramural or the intraligamentous location of myomas whereas the myoma size seems to influence particularly the risk of major complications. Patients undergoing myomectomies should be carefully selected, due to the high rate of complications, other alternatives should be also considered such as laparoscopic myomectomy; uterine embolisation.

EP44.06

20 cases of normal and abnormal vaginal bleeding

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Case 1: 20 year old primary infertility.

Cases 2–3: Two patients targeting ovulation.

Case 4: 35 year old with several years hypermenorrhea after tubal ligation, last 4 months 12 days long metrorrhagia.

Case 5: Hx of metrorrhagia.

Cases 6–7: Hx of metrorrhagia.

Case 8: Hx of AUB.

Case 9: Obese, hypertensive with Hx of AUB with 1 episode of metrorrhagia with Provera TTO.

Case 10: 33-year-old/ patient, retroverted uterus with constant spotting for 3 months (AUB).

Have you been thorough? Did you check the cervix? What else should you do? What is the Final Diagnosis NOW?

Case 11: Patient with pelvic pain. Incidental diagnosis.

Case 12: 42-year-old patient, had metrorrhagia last cycle.

What should be done next?

Case 13: Postpartum bleeding with severe pelvic pain. Transabdominal US showed thick endometrial contents and hypervascular uterus. A culture was taken before continuing with the transvaginal exam.

Case 14: Miscarriage with D&C a week before this exam. Transabdominal uterus before and after E-VAC.

Cases 15–16: Iatrogenic post-curettage bleeding. Treatment with Depoprovera. Both ultrasounds were performed 20 and 23 days after the curettage.

Case 17: Abnormal vaginal bleeding for 55 days, endometrial biopsy a year ago showed no malignancy. Endometrial aspect reminds the endometrial images of patients on Tamoxifen. This US showed a subseptal uterus. endometrium located at both cornuas = 17 mm.