



مرکز تحقیقات پیشگیری از بیماری های زنان
Preventative Gynecology Research Center (PGRCC)



Shahid Beheshti
University of Medical Sciences

چکیده سخنرانی ها

پنجمین کنگره بین المللی
چالش های بالینی در مامایی، زنان و نازایی

۲۷-۲۵ بهمن ماه ۱۴۰۲

تهران، مرکز همایش های بین المللی دانشگاه شهید بهشتی، تالار ابوریحان

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Choice of Method for Treatment of Apical Prolapse

Dr Khadijeh Adabi

Associate professor of FPMRS, Tehran university of medical sciences

Downward movement of the tip of the vagina (defined as either the cervix or the vaginal cuff) after a total hysterectomy is called apical prolapse.

Apical prolapse can be repaired through the vagina or abdomen. Vaginal route of administration includes sacrospinous ligament suspension (SSLS) or uterosacral ligament suspension (ULS). SSLS can be performed with the uterus in place (sacrospinous hysteropexy) or in a patient who has had a hysterectomy. ULS is mostly performed in conjunction with a vaginal hysterectomy to access the uterosacral ligaments. Abdominal sacrocolpopexy (ASC) has better objective anatomical results than vaginal apical support procedures. For patients who choose to avoid mesh, native vaginal tissue repairs such as SSLS and ULS are good alternatives to sacrocolpopexy because they have fewer postoperative side effects and reoperations compared to ASC. Transvaginal surgery is performed in almost 80-90 percent of prolapse surgeries. The minimally invasive nature of the procedure and the ease of anterior and posterior repair during surgery were possible explanations for the preference for transvaginal surgery. Shorter operating time and recovery from vaginal surgery are other advantages for women with increased surgical risk or who wish to avoid abdominal surgery. The laparoscopic route may be useful for patients who absolutely require evaluation pelvic cavity or removal of the adnexa. Considering the age and sexual activity of the patient can also be an important part, because SSLS deviates the vaginal axis more than ULS. Because there is no clearly superior vaginal approach, the choice of procedure must focus on patient factors and goals. As always, the training and preference of the surgeon is a strong factor in choosing surgical procedure.

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Clinical Key points of early stage ovarian cancer

Maliheh Arab

Professor of Gyneco- Oncology, Imam Hossein Medical Center, Shahid Beheshti University of Medical Sciences & Health Services

Abstract

Early stage of ovarian cancer is defined as stage 1 (limited to ovary) and stage 2 (limited to pelvis). Ovarian cancer is diagnosed in early stage just in 25% of cases.

The best prognosis and survival is obtained by management of ovarian cancer in Gyneco-Oncology setting .

In surgery of ovarian cancer careful avoidance of rupture is very critical and if occur , would upstage the patient from 1A or B towards 1c1, which is the treshould of starting adjuvant chemotherapy.

Route of surgery is laparotomy as standard, and laparoscopy is accepted in early stage .

There are 3 concers in laparoscopy of ovarian cancer:

- 1 more chance of rupture resulting in upstage
- 2 limitation of inspection of entire abdomen including intestine and mesentrial parts
- 3 low probability of port site metastasis

Surgical staging of early stage ovarian cancer include:

- 1 peritoneal cytology of existant ascites or peritoneal washing
- 2 inspection of entire abdomen and organs
- 3 TAHBSO
- 4 pelvic and para Aortic lymphadenectomy
- 5 Infracolic or Infragastric omentectomy

Fertility preservation in young cases is possible by unilateral salpingo-oophorectomy instead of TAHBSO. In the case of conservation of uterus, endometrial biopsy is done to rule out coexistent endometrial cancer.

Chance of recurrence in fertility sparing cases is not completely investigated. Hysterectomy and oophorectomy of remaining ovary is recommended after completion of childbearing or in 35 years old age.

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W/up:

Soheila Amini Moghadam

1. Evaluation in hydatidiform mole and GTN In addition to the history and examination and lab tests, screen imaging with transvaginal doppler ultrasound of the pelvis and a CXRay, which in case of lung metastasis, need further investigation in the form of chest/abd/pelvic ct with contrast & brain MRI.

2. In treatment At the time of drug resistance or relapse after the initial response and every time the patient candidate to receive a new drug, the extent of the disease must be re-evaluated for Restaging and considering the role of surgery in treatment.

3. The primary treatment in case of fertility preservation in hydatidiform mole is suction curettage under ultrasound guidance, and to reduce bleeding, the use of uterotonics such as misoprostol and metergen during the procedure and the next few hours after surgery, also, if necessary, tranexamic acid can be given during uterine evacuation. The role of oxytocin is faint Due to the possibility of negative oxytocin receptors.

4. In after treatment follow up, it is necessary to repeat the history and physical examination one month after the treatment and hcg monitoring

Every one to two weeks until normal hcg

(which is measured 3 times in a row, Normal is less than 5)

And then every 3 to 6 months.

also ocp use At least

6 months for contraception.

5. In a new study of complete hydatidiform mol

that up to 56 days after uterine evacuation still hcg

Not normalized increased risk of GTN has been reported.

4 6. after Prophylactic hysterectomy: in hydatidiform mole with complete family and age over 4050- years, the risk of postmolar Gtn rate is reduced by 80%, but still need hcg monitoring.

7. Adjuvant hysterectomy in cases of low risk gtn

who have complete fertility can reduce the number of chemotherapy cycles necessary for recovery. And In uterine confined chemoresistant tumors or in cases of bleeding requiring repeated transfusions

Or sepsis control is also considered.

8. In cases of invasive molar pregnancy who require fertility preservation, partial uterine resection and Resection of pulmonary metastatic lesion that can be the source of chemoresistance may increase recovery rate .

9. Craniotomy can be considered in cases of brain metastases that cause brain

- bleeding or increased ICP And in cases of imminent brain herniation.
10. Pstt/Ett: originate from intermediate trophoblasts and often months to years after normal pregnancy.
11. There is often involvement of the lower uterine segment and endocervix in ETT and it can be misdiagnosed with scc.
12. PSTT/ETT are metastatic in 30-50% and in contrast of other Gtn may have pelvic lymph nodes involvement.
13. In examining the samples with IHC, Mel-CAM and hPL markers have diffuse pattern in Pstt. Ett has P63 strong expression and Cyclin E occurrence.
14. In these intermediate trophoblastic tumors Figo prognosis scoring is not correlate well with prognosis and the factors associated with worse prognosis include:
Advanced stage,
increased interval from last pregnancy,
Deep myometrial invasion, higher mitotic index, large tumor size and presence of necrosis.
15. Survival is 50-60% in metastatic cases and 100% in non-metastatic cases in ITTs.
and Treatment in the non-metastatic group is hysterectomy, bilateral salpingectomy, and especially in larger tumors or deep invasions, pelvic lymph node biopsy.
And If there are risk factors such as more than 24- years interval from last pregnancy or the number of mitosis is more than 5 in 10 hpf or the presence of necrosis or deep invasion, adjuvant combined chemotherapy is needed.
16. Treatment in the metastatic group include hysterectomy, bilateral salpingectomy plus combined chemotherapy with platinum-based regimens such as EMA-EP and TP/TE.
Also, metastasectomy is in the form of resection of lesions, especially pulmonary isolated lesion.
17. In the follow-up of ITTs after treatment due to lower hcg, should be monitored with imaging like PET/CT every 6 months to 3 years and after that longterm follow-up is recommended.
18. Also, in many cases of ITTs treatment with pembrolizumab, cure has been reported.

Approach to Episiotomy and Related Complications

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Episiotomy is an incision to the posterior perineum to enlarge the birth outlet and facilitate delivery of the baby; however, it is not recommended routinely because of some adverse outcomes such as excessive blood loss, third- and fourth-degree tears, infection, dehiscence, vulvovaginal hematoma, and severe obstetric laceration in a subsequent vaginal delivery.

Currently, there is no specific situation in which episiotomy is essential, and it is considered when expedited or operative vaginal delivery is necessary. Also, it is helpful in shoulder dystocia to provide much space to complete maneuvers for delivering the posterior shoulder; however, the decision to perform episiotomy is made on a case-by-case.

There are two common types of episiotomy, median and mediolateral. Other less common incisions include J-type and T-shape. In mediolateral episiotomies, blood loss, pain, and dyspareunia are more, while the risk of anal sphincter laceration is higher in median episiotomies.

Although the incidence of obstetrical anal sphincter injuries (OASIS) is not high, it may cause long issues for women because of fecal incontinence, so it is important to identify and repair it appropriately. In other words, hemostasis and anatomic reapproximation of all disrupted tissue layers are the key principles for preventing complications and restoring fecal competence. The risk factors for OASIS include operative vaginal delivery, episiotomy, fetal macrosomia, prolonged second stage of labor, fetal occiput posterior presentation, increasing maternal age, primiparity, and prior OASIS. Asymptomatic women with one prior OASIS can have a vaginal delivery, unlike asymptomatic women with two or more prior OASIS or symptomatic women with any prior OASIS that are scheduled for cesarean delivery.

Overall, perineal care, hygiene control, pain killers, sitz bath, and stool softeners have benefits for all individuals undergoing episiotomy to experience less discomfort through the puerperium.

References:

- 1-Uptodate 2023
- 2-Postnatal care. NICE guideline, 2022
- 3-The Management of Third and Fourth-degree Perineal Tears, RCOG, London 2007

Clinical Key points of laparoscopy in adnexal mass and ovarian cancer

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Abstract

Indications of surgery in premenopausal patients with adnexal mass:

1 Sonographic findings are suspicious for malignancy (ORADs5 /risk of malignancy more than 50%) including Ascitis, peritoneal mass, enlarged lymph nodes.

2 acute symptoms such as acute pain / torsion

3 intermediate sonographic findings (ORADs4 /risk of malignancy 10- 50%) besides CA125 of more than 200

Indications of surgery in menopausal patients with adnexal mass:

1 Sonographic findings are suspicious for malignancy (ORADs5 /risk of malignancy more than 50%) including Ascitis, peritoneal mass, enlarged lymph nodes

2 intermediate sonographic findings (ORADs4 /risk of malignancy 10- 50%) besides symptoms such as .abdominal, GI ,pain , urinary , pelvic

3 intermediate sonographic findings (ORADs4 /risk of malignancy 10- 50%) besides being high risk for ovarian cancer

4 rised tumor markers including CA125 of more than 35

5 size of adnexal mass more than 10 cm

Endometrioma is assessed for surgery in 2 points of view: first malignancy concerns , second for patient symptoms.

Indications of surgical approach in endometrioma due to malignancy concerns:

1 significant increase in size

2 nodularity , complex pattern

3 genetic mutations such as BRCA

4 family history of ovarian cancer

5 age above 50 years old

6 suspicious mass pattern

Malignancy transformation in endometriosis is possible and most common histopathologic types are clear cell and endometrioid.

Laparoscopy is the choice approach in adnexal mass due to less bleeding, better recovery, less hospital stay, and cosmetic points.

laparoscopy is accepted in surgical staging of early stage ovarian cancer .

There are 4 concerns in laparoscopy of ovarian cancer:

1 more chance of rupture resulting in upstage

2 limitation of inspection of entire abdomen including intestine and mesentrial parts

3 low probability of port site metastasis

4 more risk of rupture which might make chemotherapy necessary , and worsen survival



Protraction and arrest disorders:

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Approximately 20% of all labors ending in a live birth involve a protraction and /or arrest disorder.

the risk is highest in nulliparous wemon with term pregnancies.

protraction or arrest of labor is the most common reason for primary cesarean delivery.

Risk factors that have been associated with abnormal labor progress:

1-hypocontractile uterine activity

2-older maternal age

3-long cervical length at mid pregnancy

4-pregnancy complication

5-non reassuring fetal heart rate pattern

6-bandl's ring

7-neuroaxial anesthesia

8-macrosomia

9-pelvic contraction

10-non-occiput anterior position

11-nulliparity

12-short stature(less than 150cm)

13-high station at full dilation

14-chorioamnionitis

8 15-post term pregnancy

16-obesity

17-fetal anomaly resulting in cephalopelvic dystocia

18-uterine abnormality.

The diagnosis of a protracted active phase is made in women at more than 6 cm dilation who are dilating less than approximately 12- cm/hour.

Women with cervical dilation less than 6 cm are considered to be in latent phase.

Management of latent phase that extends for many hours or days can be physically and emotionally exhausting for the parturient.

In addition to education ,support, hydration and comfort measures, management options for spontaneously labouring women who are not tolerating latent phase

include:

1-Therapeutic rest

2-uterotonic drugs

3-amniotomy

Active phase arrest is diagnosed at cervical dilation more than 6 cm in a patient with ruptured membranes and :

- No cervical change for more than 4 hours despite adequate contractions
- No cervical changes for more than 6 hours with inadequate contractions.

For patients in the active phase (cervix more than 6 cm) who dilated less than 1cm over two hours,we administer oxytocin and proceed with amniotomy if there has been adequate fetal descent to a safe fetal station for amniotomy.

Women with labor arrest in the active phase of the first stage are managed by cesarean delivery.

many studies showed that oxytocin augmentation for at least four hours, rather than the historical standard of two hours,before diagnosing arrest is safe for mother and fetus and increases the chances of achieving a vaginal delivery.

Prolonged second stage:

For nulliparous women , allow three hours of pushing and for multiparous women,allow two hours of pushing prior to diagnosing arrest of labor, when maternal and fetal conditions permit.

A specific absolute maximum length of time that should be allowed in the second stage of labor has not been identified.

Management of prolonged second stage:

After 6090- minutes of pushing ,we begin oxytocin augmentation if descent is minimal or absent and uterine contractions are less frequent than every 3 minutes.

Timing of operative delivery in prolonged second stage:

In the absence of epidural anesthesia we allow nulliparous women to push for at least three hours and multiparous women to push for at least two hours prior to considering operative intervention.

In women who have epidural anesthesia we allow an additional hour of pushing on a case -by-case basis before considering operative intervention for a prolonged second stage.

HPV in pregnancy

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During pregnancy, changing hormone levels can make grow faster than usual. Vertical transmission can be divided into three categories according to the time of HPV infection:

1-peri conceptual: HPV DNA has been detected in different sites of the male reproductive tract, sperm cells, semen, endometrium, and ovaries.

2-prenatal : HPV DNA has been detected in amniotic fluid, placenta, and the umbilical cord. placenta can be infected through the hematogenous route and ascending route.

3-perinatal transmission : it will be considered as the result of the fetus coming into contact with infected cells of the vagina and cervix during birth.

HPV treatment in pregnancy :

1-Bi- And Tri- chloroacetic acid (BCA-TCA)

2-Cryoablation

3-Laser ablation

4-Electrocauterization

5-Small excision surgery

Elective cesarean delivery for women with anogenital warts for the sole indication of preventing JRP or vertical transmission.

Cesarean delivery is indicated if vulvar or vaginal warts obstruct the birth canal, as the lesions may avulse- hemorrhage- cause dystocia during vaginal delivery.

HPV vaccination is not recommended during pregnancy. if a person is found to be pregnant after starting the HPV vaccine series, second and third doses should be delayed until they are no longer pregnant.

If a person receives HPV vaccine and later learns that they are pregnant, there is no reason to be alarmed.

Cervical Elongation

Maryam Deldar

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The normal length of an adult non-pregnant cervix is about 2.5 cm to 3.0 cm. Isolated cervical descent with a normally positioned uterus is found in the case of true cervical elongation, which is a form of congenital elongation of the cervix .

Most of the patients had cervical length between 3.1- 4cm (62.4%). There was no patient with cervical length less than 2 cm.

Cervical elongation is frequently associated with uterine prolapse but not always . It is possible to resuspend the cervix and uterus the uterosacral – cardinal ligament complex (UCC) while leaving the cervix intact.

The Manchester repair (MR) involves the clamping and mobilization of the UCC and their reattachment to the partially amputated cervix , usually with anterior colporrhaphy.

This would appropriate if fertility was important and further pregnancies desired.

Cervical amputation would significantly decrease the likelihood of a woman conceiving and potentially cause cervical incompetence and preterm delivery. There are potential long term risks with uterine conservation including the development of cancer. Hematometra or pyometra can result from cervical stenosis.

Ovarian Rejuvenation

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Premature ovarian failure can be found in 1% of woman at the age of 3540-, mostly due to unknown causes.

Female gametes are extremely sensitive cells in the human body, which decrease in number from fetal period to the prepuberty when they count about 300,000.

Pregnancy and healthy fetal birth in POI and advanced age women with low AFC and low AMH indicate exist functional oocyte in the ovary that cannot be evaluated by ovarian reserve markers such as AFC and AMH.

We talk about the effect of autologous in vitro ovarian activation with stem cells and autologous growth factors on reproductive and endocrine function in patients with ovarian impairment.

We will explain PRP method, use of stem cell, physical changes in the ovaries for hippo signaling disruption and medical methods to suppress increased gonadotropin level which results in some changes in the ovary to reduce its harmful effect on the remaining follicles for rescue of already existing follicles.

- Prolonged suppression of FSH and LH by GnRH analogues for 412- wk in hyper gonadotropic amenorrhea is beneficial for ovulation and improved response to gonadotropin stimulation.

- Administration of autologous PRP can be considered a safe and tolerable alternative approach to the classical ones for ovarian rejuvenation.

- Transplanted sc are located in ovarian tissue and by secreting growth factor and cytokines increase follicular growth, ovarian vascularity, follicular and stromal cell proliferation and reduce apoptosis, stromal fibrosis and improve the environment of follicles and rescue the remaining follicles.

ORAL AND ANAL HPV INFECTION

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Introduction

Human papillomavirus (HPV) infection is a sexually transmitted virus that is associated with condyloma acuminatum, squamous intraepithelial lesions, and malignancy, including anogenital malignancies (cervical, vaginal, vulval, penile, and anal carcinoma) and head and neck squamous cell.

ORAL HPV infection; Two viral oncogenes (E6 and E7), which are expressed as a result of high-risk HPV infection, are mainly responsible for malignant transformation and, ultimately, an HPV associated head and neck cancer with a molecular signature distinct from non-HPV associated head and neck cancer. HPV associated head and neck cancers occur primarily in the tonsils, base of tongue, or soft palate. HPV associated malignancies account for 70 to 80 percent of oropharyngeal cancers in the United States and Western Europe. High-risk HPV infection may also be causative in some cases of other head and neck cancer sites. We routinely use immunohistochemistry (IHC) for p16 as a surrogate for HPV status, as it is highly sensitive for HPV associated tumors. If decision-making hinges on HPV status, this diagnosis can be confirmed with either in situ hybridization or polymerase chain reaction (PCR). HPV associated oropharyngeal cancer typically presents in younger patients without a history of excessive exposure to alcohol and tobacco. HPV associated oropharyngeal cancers tend to present with regional cervical lymph node metastases and smaller primary tumors. HPV associated oropharyngeal cancer has a better prognosis and response to therapy than non-HPV associated disease. Tumor testing for HPV status should be included in the evaluation of patients with oropharyngeal squamous cell carcinoma. The management of HPV associated oropharyngeal cancer follows a similar treatment approach as for non-HPV associated tumors outside the context of a clinical trial, despite the difference in prognosis. Treatment deintensification in patients with HPV associated head and neck cancer.

HPV infection in nonoropharyngeal cancers – HPV positivity is much less common in nonoropharyngeal cancers, and its prognostic implications remain unclear, although similar to oropharyngeal cancer, data suggest a relatively favorable prognosis Anal squamous

intraepithelial lesions (SIL) are preinvasive anal neoplasia caused by human papillomavirus (HPV) infection. Risk factors for anal SIL include sexual behavior, HIV, and iatrogenic immunosuppression (eg, solid organ transplant recipients). Rates of anal neoplasia are substantially higher among males who have sex with males (MSM), and are particularly high in MSM who are living with HIV (MSMLWH).

• For high-risk populations clinicians should discuss the risk of anal SIL and cancer and the symptoms that should lead to a consultation and digital anorectal examination. Anal low-grade SIL (LSIL) is a risk factor for the presence of anal high-grade SIL (HSIL) and/or invasive cancer, rather than a direct precursor. Anal HSIL can progress to invasive anal cancer. No clinical trials have evaluated the risk benefit ratio of screening for anal SIL; support for screening relies on the similarities between the anus and cervix, the established success of cervical cancer screening, and the demonstrated benefit of treating HSIL in reducing the rate of progression to invasive anal cancer. Cytology is used as the initial screening test. Individuals with abnormal cytology are referred for high-resolution anoscopy (HRA) to examine the anal canal and perianus and to biopsy areas of potential HSIL. We suggest screening for anal SIL in all MSMLWH. We also suggest screening for other at-risk groups, even though their risk for anal cancer is likely lower than MSMLWH. We initiate screening after age 25 in people living with HIV (PLWH) and those with other forms of immunosuppression, and after age 40 for at-risk groups without immunosuppression. At-risk individuals without HIV are typically screened every two to three years, while PLWH may be screened annually. HPV vaccination decreases the incidence of infection with the high-risk HPV types associated with cervical and anal cancer. Data from the ANCHOR trial now demonstrate efficacy of treating anal HSIL to reduce the risk of invasive anal cancer in people living with HIV aged 35 and older. The majority of participants in this study were treated with ablative therapy (hyfrecation), however the optimal treatment modality has not been clearly established. The following represents our approach to treatment. For all patients with anal HSIL, we suggest treatment rather than observation of asymptomatic LSIL is optional, given that these are not considered precancerous.

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Empty follicle syndrome following GnRH agonist stimulation, in a patient with PCOS treated with HCG rescue protocol, resulting in 3PN zygote formation: a case report

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Abstract

Empty follicle syndrome is a rare condition characterized by failure to retrieve oocytes despite repeated careful aspiration of mature precursor follicles during controlled ovarian stimulation. This report presents a case of empty follicle syndrome in a patient with polycystic ovary syndrome using a gonadotropin-releasing hormone agonist as a trigger for final oocyte maturation. No oocytes were retrieved from the right ovary and the procedure was discontinued. The patient was administered an injection with 10,000 units of HCG and 3 oocytes were obtained after 24 hours. All oocytes were mature (MII); fertilization was performed with sperm from the patient's husband resulting in 3PN zygotes. The formation of 3PN zygotes from ICSI might be due to oocyte cytoplasmic disorders caused by long-term exposure to gonadotropins and increased duration of stimulation. Although our patient had false empty follicle syndrome and the hCG rescue protocol led to the retrieval of oocytes, the oocytes were not of good quality. As previously described, empty follicle syndrome is not a predictor of success in subsequent cycles. Our patient's next cycle was uneventful.

Keywords: ICSI; empty follicle syndrome; trippronuclear embryo.



مرکز تخصصی پزشکی از زنان و مامایی
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دانشگاه شهید بهشتی
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پنجمین کنگره بین المللی چالش های بالینی در مامایی، زنان و نازایی

۲۷-۲۵ بهمن ماه ۱۴۰۲

تهران، مرکز همایش های بین المللی دانشگاه شهید بهشتی، تالار ابوریحان

Pannel challeng of pcos: prevention of pcos

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Abstract:

Psychological features are common and important components of PCOS that all healthcare professionals should be aware of. Funding bodies should recognize that PCOS is highly prevalent, and has significantly higher psychological disorders which should be prioritized and funded accordingly. Healthcare professionals and women should recognize the adverse impact of PCOS and/or PCOS features on quality of life in adults. Women with PCOS should be asked about their perception of PCOS related-symptoms, impact on quality of life, key concerns, and priorities for management. Healthcare professionals should be aware of the high prevalence of moderate to severe depressive symptoms and depression in adults and adolescents with PCOS and should screen for depression in all adults and adolescents with PCOS, using regionally validated screening tools. If moderate or severe depressive or anxiety symptoms are detected, practitioners should further assess, refer appropriately, or offer treatment. Lifestyle intervention (exercise alone or multicomponent diet combined with exercise and behavioural strategies) should be recommended for all women with PCOS, for improving metabolic health including central adiposity and lipid profile.

Severe early ovarian hyperstimulation syndrome following GnRH agonist trigger and freeze-all strategy in GnRH antagonist protocol; case report and literature review

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Abstract

Ovarian hyperstimulation syndrome (OHSS) is characterized by increased vascular permeability, hemoconcentration and fluid leakage to the third space. The vast majority of OHSS cases occur following ovarian stimulation for IVF. This potentially lethal iatrogenic condition is one of the most serious complications of assisted reproductive technologies. We report one case of severe early OHSS after GnRH agonist trigger in a GnRH antagonist protocol and freeze-all approach without the administration of any hCG for luteal-phase support in a 34-year-old case of PCO with 7 years primary infertility. After oocyte retrieval the patient was seen at the emergency unit of the hospital with abdominal distension, pain, anuria, dyspnea, and OHSS symptoms. The diagnosis was OHSS with severe ascitis. She was admitted to the Intensive care unit (ICU). She was managed with oxygen by mask, intravenous fluids, anticoagulant and albumen, we performed a two-time vaginal ascites puncture, resulting in the removal of 7800mL of clear fluid in Intensive Care Unit with full recovery. This case study presents the clinical manifestations, investigation, progress, management, outcome and preventive measures. The patient was managed with no complications. Clinicians have to be aware that even the sequential approach to ovarian stimulation with a freeze-all approach and GNRH analog triggering does not completely eliminate OHSS in all patients.

Keywords: GnRH agonist triggering; GnRH antagonist; freeze-all; ovarian hyperstimulation syndrome.

Progesterone and Pregnancy

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Progesterone supplementation may reduce the risk of preterm birth by up to one-third in women with a singleton pregnancy who have had a previous spontaneous singleton preterm birth and in women with a short cervix on ultras. For women with a singleton pregnancy who have had a previous spontaneous singleton preterm birth, we suggest providers discuss the option of prophylactic progesterone supplementation in the current pregnancy. We also follow their cervical length with serial ultrasound examinations until 24 weeks of gestation and consider cerclage if cervical length is ≤ 25 mm. For women with midtrimester cervical shortening (defined as ≤ 25 mm before 24 weeks) and no prior spontaneous singleton preterm birth, we suggest daily vaginal progesterone treatment through 36 weeks of gestation. Reasonable options include a vaginal suppository (100 or 200 mg), gel (90 mg), or tablet (100 mg micronized progesterone). For multiple gestations, we recommend not administering progesterone supplementation routinely. Routine progesterone supplementation does not appear to be useful for preventing preterm birth in the setting of preterm premature rupture of membranes or after an episode of arrested preterm labor. The effect in women with a cerclage is unclear.

Trans Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNotes)

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Introduction: vNOTES refers to an emerging field of surgery that allows to access the peritoneal cavity through vaginal incisions. NOTES compared to laparoscopic surgery has reduced post-operative pain, improved cosmesis, reduced physiological and immunological Responses to surgery, and the potential for quicker recovery.

It may also offer better access in patients where factors such as dense adhesions or morbid obesity.

NOTES surgery in gynecology was first used in 2012 with the removal of adnexa for benign pathology. We can use Vnotes surgery for ovarian cystectomy, salpingectomy for ectopic pregnancy, hysterectomy, and cuff suspension procedures.

Technique: Patients were placed in a lithotomy position. A circular incision was made around the cervix. Access to the pouch of Douglas and utero-vesical fold was created. the uterosacral ligaments were transected.

A Gel point device (Applied Medical) was set up and inserted.

A pneumoperitoneum was created and a hysterectomy.

Keywords: Transvaginal NOTES, Gel POINT, hysterectomy



مرکز تحقیقات پیشگیری از سرطان زنان
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تهران، مرکز همایش های بین المللی دانشگاه شهید بهشتی، تالار ابوریحان

MANAGEMENT OF PREMONAUSAL BENIGN ADNEXAL MASSES

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INTRODUCTION: An adnexal mass is a common gynecologic issue and ovarian masses are the most common type (835%-).

Management of nonurgent condition may involved:

Expectant management -when the mass is not suspicious of malignancy and there are no other indications for surgery or surveillance , no further follow-up in needed.

Surveillance – Surgery is performed when ther is a high risk of malignancy is low but has not been completely excluded and includes onr or more pelvic ultrasound and /or measurement of serum tumor markers.

Surgery is performed when there is a high risk of malignancy , histologic diagnosis is desired, or the patient has persistent pain or other symptoms.

Management of patients requiring prompt intervention because of their potential for causing serious morbidity and /or loss of ovarian function include :Ectopic pregnancy, Adnexal torsion, Tubo-ovarian abscess, Ruptured or hemorrhagic ovarian cyst.

Scope of surgery – The type of surgery (ovarian cystectomy , oophorectomy ,staging) and Surgical approach laparoscopic versus open) is based one many factors, including patient age, desire for future childbearing , degree of suspicion for malignancy , and intraoperative findings.

Key words: Premenopausal adnexal masses; Ovarian benign masses

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HPV and Infertility

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HPV is the most prevalent sexually transmitted infection among men and women of reproductive age worldwide. The role of HPV in cervical cancer is well known. HPV infections are correlated substantially with multiple reproductive system abnormalities. HPV can be a threat to the reproductive health of patients. Reproductive health refers to “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters pertaining to the reproductive system and to its functions and processes.

HPV-positive women identified some reproductive concerns such as worrying about reduced male and female fertility potential, the impact of HPV on fetal health, negative pregnancy outcomes (miscarriage and preterm delivery), and the safety of breastfeeding. HPV-positive women who had abnormal cells in their cervical cytology results were anxious that becoming pregnant or taking hormonal contraception might worsen their health condition. Most participants were reluctant to use a condom in spite of being recommended to use it. Women also asked about the potential reproductive risks of the HPV vaccine. HPV-positive women need to be better understood and informed about the impact of HPV on human reproductive in educational-consulting interventions. Women need to be better understood and informed about the impact of HPV on their reproductive health. Health care providers may lack knowledge about these specific areas, and they could benefit from additional up-to-date information to address women’s reproductive concerns.

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Abstract:

Obliterative surgery treats pelvic organ prolapse (POP) by removing and closing off all or a portion of the vaginal canal (colpocleisis) to reduce the vagina and viscera back into the pelvis.

Obliterative procedures are an effective option for patients who do not want, or cannot tolerate, more extensive surgery and who are not planning future vaginal intercourse.

All colpocleisis procedures remove vaginal epithelium and then appose the anterior and posterior vaginal muscularis.

•**Partial (Le Fort) colpocleisis** – In this procedure, strips of anterior and posterior vaginal epithelium are removed .The remaining lateral portions of epithelium are left in place, providing drainage tracts for uterine bleeding or discharge. Partial colpocleisis is the preferred procedure for patients with a uterus and a reasonable option for patients with vaginal vault prolapse.

•**Total colpocleisis (colpectomy)** – This procedure is typically done for vaginal vault prolapse (ie, cervix and uterus are absent) and involves removal of the majority of the vaginal epithelium.

Concomitant hysterectomy at the time of colpocleisis increases operative duration, morbidity, and complications.

Patients undergoing obliterative POP surgery often have symptomatic or occult stress urinary incontinence. Concomitant midurethral sling is appropriate in some women and does not seem to increase postoperative rates of urinary retention.

Significant postoperative complications of colpocleisis are often related to comorbidities and frailty more than chronological age. The most common complications related to the procedure itself are transfusion and pyelonephritis. Colpocleisis is highly effective for treating prolapse; success rates range from 90 to 100 percent, with long-term success rates of 78 percent. Colpocleisis does not appear to alter body image, and regret after the procedure is uncommon (ranging from 0 to 13 percent).

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Preterm Labor and Birth

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The average duration of a normal human pregnancy is 267 days, counted after conception, or 280 days (40 weeks) from the first day of the last normal menstrual period. Infants born at 39 and 40 weeks of gestation have the lowest rates of adverse outcomes.

A *preterm birth* is commonly defined as one that occurs after 20 weeks' gestation and before the completion of 37 menstrual weeks of gestation regardless of birthweight.

Although advances in neonatal care have led to increased survival and reduced short- and long-term morbidity for infants born preterm, surviving infants have increased risks of visual and hearing impairment, chronic lung disease, cerebral palsy, and delayed development in childhood. Gestational age at birth is strongly correlated with adverse pregnancy outcomes that include stillbirth (fetal death after 20 weeks' gestation), deaths of neonates (<28 days) and infants (<12 months), and long-term physical and intellectual morbidities. *Perinatal mortality* is defined as the sum of stillbirths after 20 weeks' gestation plus neonatal deaths through 28 days of life per 1000 total births (liveborn plus stillborn). Perinatal mortality increases markedly as gestational age and birthweight decline.

Common complications in premature infants include respiratory distress syndrome (RDS), intraventricular hemorrhage (IVH), bronchopulmonary dysplasia (BPD), patent ductus arteriosus (PDA), necrotizing enterocolitis (NEC), sepsis, apnea, and retinopathy of prematurity (ROP). Rates of morbidity vary primarily by gestational age .

pregestational diabetes

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Preexisting diabetes (also called pregestational diabetes) means you have diabetes before you get pregnant. This is different from gestational diabetes, which is a kind of diabetes that some women get during pregnancy. Hyperglycemia is a known teratogen whether occurring from T1DM or T2DM and can result in complex cardiac defects, CNS anomalies such as anencephaly and spina bifida, skeletal malformations, and genitourinary abnormalities. Women with a normal A1c at conception and during the first trimester have no increased risk while women with a A1c of 10-12% or a fasting blood glucose >260 mg/dl have up to a 25% risk of major malformations. There is no evidence that exposure to glyburide or metformin in first trimester are teratogenic, but both do cross the placenta, metformin substantially more than glyburide . It is recommended that women with T2DM who are actively trying to become pregnant should be switched from oral or noninsulin injectable hypoglycemic agents to insulin prior to conception if possible. This rationale is based on the fact that it may take some time to determine the ideal insulin dose prior to the critical time of embryogenesis. However, women who conceive on any oral agents should not stop them until they can be switched effectively to insulin because hyperglycemia is potentially much more dangerous than any of the current available therapies to treat diabetes .

Evaluation of anal cytology and human papillomavirus infection in high-risk women: a cross-sectional study

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BACKGROUND and Aim: Anal cancer incidence has been on the rise over the past few decades. This study aimed to assess anal Papanicolaou (Pap) smear changes in women with high risk for dysplasia and human papillomavirus (HPV) infection.

METHODS This cross-sectional study was conducted in 121 patients referred to the Gynecology Oncology Clinic of Imam Hossein Medical Center between 2020 and 2021 in Tehran, Iran, who had cervical and vulvar dysplasia, cervical HPV infection, and abnormal cervical cytology results and were over 21 years old. Data analysis was performed using SPSS software version 21 (IBM Corp., USA) at a significance level of 0.05.

RESULTS 121 women, with a mean age of 39.69 years, were included in this study. Overall, 23.1% of women had positive anal HPV results, and 35.5% were over 40 years old. Younger age was associated with an increased risk of anal HPV ($p = 0.045$). 33.9% of women were single and had a higher risk of anal HPV. Multiple sexual partnerships and anal sex were the significant risk factors for anal cancer ($p < 0.001$). Women with positive anal HPV results had significantly more genital warts ($p < 0.001$). No significant difference was observed in smoking, educational level, and cervical Pap smear results between women with negative and positive rectal HPV results.

CONCLUSIONS Younger age at diagnosis, being single, multiple sexual partnerships, anal sex, and genital warts were associated with anal HPV infection in women. Abnormal anal cytology was only associated with being single and having multiple sexual partners.

KEYWORDS anal neoplasms, cytology, human papillomavirus, Papanicolaou test, uterine cervical neoplasms

Diagnostic evaluation in female sexual pain

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All women with sexual pain undergo a detailed history and physical examination:

1. The **history** includes a:

comprehensive review of systems,

detailed gynecologic history,

sexual pain history to characterize the patient's pain

identify potential specific causes of FSP

When does the pain occur?

Where is the pain located?

Was the onset of pain associated with a specific event?

What is the character and pattern of the pain?

first sexual experience

relationship with partner(s)?

Additional gynecologic and medical issues:

Urologic, Gastrointestinal, Musculoskeletal, Dermatologic, Vascular

Cultural factors is important.

2. Physical examination :

Patient comfort, to bring a support person or electronic device, a hand mirror

so she can observe the examination,

pressure-point testing, **Visual inspection**, palpation, speculum examination of
the vagina and cervix

Abdominal, bimanual, and rectovaginal examination

3. laboratory evaluation:

vaginal pH, microscopy, and testing for sexually transmitted infections

26 *genital ulcers* are evaluated for herpes simplex virus, syphilis, chancroid,
lymphogranuloma venereum, granuloma inguinale, and erosive vulvar
dermatoses

4. Imaging studies:

to diagnose or exclude specific causes of FSP.

transvaginal ultrasound to evaluate for endometriosis

Computed tomography scan

Lumbosacral MRI

5. DIFFERENTIAL DIAGNOSIS OF FEMALE SEXUAL PAIN:

premenopausal women

postmenopausal women

6. When to refer:

Endometriosis : Refer to a gynecologic specialist

Gastrointestinal pathology : Refer to a gastrointestinal specialist

Idiopathic FSP : Refer to a gynecologic specialist to confirm that no causes for the woman's symptoms can be identified.

Neurologic history or findings : Refer to a neurologist.

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placenta previa' should be used when the placenta lies directly over the internal os. The placenta should be reported as 'low lying' when the placental edge is less than 2 cm from the internal os and as normal when the placental edge is 2 cm or more from the internal os.

The incidence of placenta previa is estimated to be 5 in 1000 deliveries .The recurrence rate of placenta previa in a subsequent birth has been estimated to be around 4.8%.

The second trimester routine fetal anomaly scan should include placental localization in order to identify women at risk of persisting placenta previa.

The possibility of placenta accreta spectrum (PAS) should be excluded in all patients with placenta previa, given the strong association between the two disorders.

After the diagnosis of placenta previa in second trimester, follow-up transvaginal ultrasonography is performed at 32 weeks of gestation. If the placenta is morbidly adherent (placenta accreta spectrum), cesarean birth is planned for 340+ to 356+ weeks of gestation. If the placenta is over or <2 cm from the internal os but not morbidly adherent, transvaginal ultrasound is repeated at 36 weeks. Cesarean birth is performed at 360+ to 376+ weeks of gestation. A course of antenatal corticosteroids ,48 hours before a cesarean birth scheduled before 370+ weeks of gestation, is recommended, if not previously given.

Neurologic Challenges in Eclampsia/Preeclampsia

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Potential cerebral complications of preeclampsia include ischemic stroke, hemorrhagic stroke, cerebral edema, and seizures. Preeclampsia has been associated with posterior reversible encephalopathy syndrome (PRES) and reversible cerebral vasoconstriction syndrome (RCVS).

Eclampsia occurs in 0.05% of all pregnancies, and approximately 30% of seizures occur in the postpartum period in preeclamptic mothers. Neurologic manifestations of eclampsia are similar to those of hypertensive encephalopathy. The condition can be present even in the absence

of hypertension and proteinuria. Neurologic manifestations of eclampsia are similar to

those of hypertensive encephalopathy. The condition can be present even in the absence

of hypertension and proteinuria.

Several hypotheses and pathologic mechanisms have been implicated to explain the pathogenesis of eclamptic seizures.

1. Cerebral autoregulation alterations
2. Blood-brain barrier dysfunction
3. Cerebral overregulation and vasospasm

Lower genital tract lesions (Vulvar LSIL and differentiated VIN)

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Squamous intraepithelial lesions (**SILs**), previously named as vulvar intraepithelial neoplasia (**VIN**), are a group of premalignant diseases with no screening method for them. The new classification system, was published in 2015 by the International Society for the Study of Vulvovaginal Disease (ISSVD), is:

1. **Low-grade SIL (VLSIL)**, previously was referred to VIN1.
2. **High-grade SIL (VHSIL)**, previously was referred to VIN2,3.
3. **Differentiated VIN (dVIN)**, includes lesions are associated with vulvar dermatoses, mainly lichen sclerosus. It was previously referred to VIN simplex type.

VSILs are multifocal and multicentric. So, patients with **VSIL** may also have lower anogenital tract lesions.

The prevalence of HPV in **VLSIL** is 63%, most of them are 6 and 11. However, in a minority of lesions, high risk types (16, 18, 31) can be found. They usually resolve within one to two years and shouldn't be considered as neoplastic lesions.

VLSILs are benign lesions and except in rare cases, don't contribute to the development of carcinoma. Thus, they don't need to be treated unless symptomatic.

Histologic characteristics of **VLSIL** are cytologic atypia in the upper keratinocytes, increased mitotic activity in the basal or parabasal epithelium, and maturation in the upper two-thirds of the epithelium.

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Differentiated VIN (dVIN) is rare and is the precursor of keratinizing squamous cell carcinoma (KSCC) in 80% of cases. The major risk factor for **dVIN** is having an associated vulvar dermatosis, such as lichen sclerosus. It is usually placed adjacent to KSCC or in patients with a history of vulvar cancer. Surgical excision is recommended rather than ablation or medical treatment for **dVIN**.

We must remember that **dVIN** diagnosis means the patient already had vulvar cancer prior to, has it synchronous with, or will get it later at following.

Structural Recurrent Miscarriage

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Structural Recurrent Miscarriage (RM):

Congenital Anomaly (CA) and Acquired uterine anomalies (AUA)

CA: SEPTATE, Bicornate, ARCUATE, DIDELPHUS, UNICORNE

The Commonest Anomalies across all: Septate variety, Bicornate variety Unicornate variety

AUA: Myoma, Endometrial Polyps, Uterine Adhesion

A meta-analysis has shown that the risk of sporadic first trimester miscarriage

Significantly increased risk of RM in Septate & Bicornate

But was not significantly increased miscarriage in Arcuate, Didelphys, Unicornate

Hysteroscopy metroplasty in septate & bicornate reduce RM, RR=0.36 (2023 meta-analysis)

Acquired Uterine Abnormalities: Myoma Figo zero ,I and II (it may be effective in RM) Endometrial polyps there are no data to our knowledge specifically

effect of polyps on sporadic or recurrent miscarriage

intrauterine adhesions: Small Cohort studies showed: intrauterine adhesions

ET less than 5mm have higher sporadic miscarriage rates versus ET more than

5mm (50% versus 8.3%; P<0.001)



مرکز تخصصی زنان و زایمان
Shahid Beheshti Medical University



دانشگاه شهید بهشتی
Shahid Beheshti
University of Medical Sciences

پنجمین کنگره بین المللی چالش های بالینی در مامایی، زنان و نازایی

۲۷-۲۵ بهمن ماه ۱۴۰۲

تهران، مرکز همایش های بین المللی دانشگاه شهید بهشتی، تالار ابوریحان

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INFORMING THE PATIENT OF THE DIAGNOSIS. The most important steps after making the diagnosis of spontaneous primary ovarian insufficiency (POI) are to inform the patient of the diagnosis in a sensitive and caring manner, provide accurate information, and offer referral to appropriate resources for emotional support. **Suggested estrogen regimens** — Theoretically, hormone replacement for young women with POI should mimic normal ovarian function as much as possible. Estradiol (17-beta-estradiol; E2) and micronized progesterone are bioidentical hormones, eg, they have the same molecular structure as the estradiol and progesterone produced by the ovary. **Goals** : Unless there is an absolute contraindication to taking estrogen therapy, all women with primary ovarian insufficiency (POI) should receive estrogen therapy to reduce the risk of osteoporosis and cardiovascular disease.

Uterine didelphys and bicornuate

Dr. Ziba Zahiri

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Congenital anomalies of the female reproductive tract are of special interest because of their association with various reproductive difficulties : impaired possibility of natural or assisted conception, increased rate of first and second trimester miscarriages , preterm birth , placental abruption , lower birth weight and fetal growth retardation , malpresentation at delivery and perinatal mortality.

Congenital malformation of the female genital tract represent a heterogeneous group and have they origin in the abnormal formation , confluence , or resorption of the mullerian duct during fetal development.

Currently , there are various classification systems for the categorization of this anomalies.ASRM classification was the oldest and most commonly used . There are also the ESHRE-ESGE classification.

Anomalies can result from the failure of the mullerian ducts to fuse in the midline. Because fusion begins in the midline and extened cephalad , abnormal results are more common at the fondal portion of the uterus (bicornuate uterus)

Complete lack of fusion of the two mullerian ducts result in duplication of the corpus , cervix and upper vagina (didelphys uterus).

Bicornuate uterus is relatively common . It may be with high rate of early misscarriage , preterm birth , and breech delivery.

Surgical metroplasty is rarely considered . The cervical length shoud be assesed during pregnancy due to association between bicornuate uterus and cervical incompetency.

Adverse obstetrical outcomes in didelphys uterus are similar but less frequent than those seen with unicornuate uterus.

About 1520%- of women with didelphys uterus also have obstructed hemivagina often with unilateral renal agenesis (OHVIRA syndrome).early diagnosis and excision of obstructed vaginal septum will preserve fertility.