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OTHER

- CONGENITAL HEART BLOCK IN AN ANTI-SSA POSITIVE MOTHER: A CASE REPORT
Katrina Therese Nartatez, *Philippines*
- EFFECT OF THE COVID-19 PANDEMIC ON THE PHILIPPINE GENERAL HOSPITAL - OBSTETRICS AND GYNECOLOGY RESIDENCY TRAINING PROGRAM
Marth Louie Tarroza, *Philippines*
- DETERMINATION OF OBSTETRIC VIOLENCE AND AFFECTING FACTORS: A SAMPLE OF TURKEY
Evsen Nazik, *Turkiye*
- THE EFFECT OF ENHANCED RECOVERY AFTER CAESAREAN SECTION (ERACS) ON THE MATERNAL AND NEONATAL OUTCOMES IN SOEROJO HOSPITAL MAGELANG
Rahmalina Rahmalina, *Indonesia*
- A GIANT BILATERAL OVARIAN SEROUS CYSTADENOMA IN YOUNG PREGNANT GIRL: DOCUMENT TYPE: A CASE REPORT
Parveen Abbas, *UK*
- TANDEM BREASTFEEDING AND NURSING
Pinar Kara, *Turkiye*
- CALM DOWN - THE NEW ALGORITHM FOR CLINICAL MANAGEMENT OF SEVERE PREECLAMPSIA
Dmytro Konkov, *Ukraine*
- THE MODERN FEATURES OF THE OPTIMAL INFUSION THERAPY OF HYPEREMESIS GRAVIDARUM
Dmytro Konkov, *Ukraine*
- ACUTE MASTITIS AS A TRIGGER FOR THE DIAGNOSIS OF ACUTE MYELOID LEUKEMIA
Maria Teresa Castillo, *Spain*
- RETINAL FINDINGS AND RISK FACTORS OF PREECLAMPSIA-ASSOCIATED RETINOPATHY: A RETROSPECTIVE COHORT STUDY
Seokyung Kim, *South Korea*
- AVAILABILITY AND ACCESSIBILITY OF TRANSLATOR SERVICES IN MATERNITY CARE AT A LONDON TERTIARY CENTRE
Aimee-Louise Chambault, *UK*
- EFFECT OF OLANZAPINE ON PROLACTIN LEVELS OF FEMALE PATIENTS WITH SCHIZOPHRENIA TREATED WITH RISPERIDONE
Won-Myong Bahk, *South Korea*
- A PLACEBO-CONTROLLED, DOUBLE-BLIND TRIAL OF GINKGO BILOBA FOR ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION
Moon-Doo Kim, *South Korea*
- FACTORS ASSOCIATED WITH ANTENATAL DEPRESSION IN PREGNANT KOREAN FEMALES: THE EFFECT OF BIPOLARITY ON DEPRESSIVE SYMPTOMS
Moon-Doo Kim, *South Korea*
- OBESITY AND ITS POTENTIAL EFFECTS ON ANTIDEPRESSANT TREATMENT OUTCOMES IN PATIENTS WITH DEPRESSIVE DISORDERS: A LITERATURE REVIEW
Young-Joon Kwon, *South Korea*
- AUDIT OF THE OUTCOME OF POST DATE PREGNANCY AFTER INDUCTION OF LABOR
Eyman Mohammed Hizam Al-Ansi, *UK*
- COMPARATIVE STUDY OF COMPLICATIONS FOLLOWING POST-PLACENTAL INTRA UTERINE CONTRACEPTIVE DEVICE INSERTION AFTER VAGINAL DELIVERY VERSUS CESAREAN SECTION
Shalini Gainder, *India*





Abstracts



study is to determine experiences of obstetric violence and the affecting factors among women who had childbirth. **Methods:** This descriptive study included 200 women who had vaginal delivery. Data were collected within the first 24 hours following childbirth using the Personal Information Form, the Labor-related Characteristics Form, and the Obstetric Violence Identification Form. Data analysis was performed using descriptive statistics and chi-square tests. Statistical significance was accepted $p < 0.05$. **Results:** Results showed that 25,5% of participating women who had vaginal delivery were exposed to verbal violence, 37,2 % were exposed to psycho-emotional violence, and all of them were exposed to physical violence. Only the place of living among socio-demographic characteristics showed a statistically significant difference with the type of obstetric violence ($p < 0,05$). As for the obstetric characteristics, only receiving information before labor demonstrated a statistically significant difference with exposure to verbal obstetric violence ($p < 0,05$). Of all the participants, 42,5% were slightly satisfied with their childbirth experience. **Conclusion:** This study found that women were exposed to obstetric violence in Turkey and had low levels of satisfaction with their childbirth experience. In line with these conclusions; to determine the extent of obstetric violence and identify the factors contributing to it, research studies can be conducted using qualitative and quantitative methods. Once the factors contributing to obstetric violence have been identified, interventions can be developed to address them.

THE EFFECT OF ENHANCED RECOVERY AFTER CAESAREAN SECTION (ERACS) ON THE MATERNAL AND NEONATAL OUTCOMES IN SOEROJO HOSPITAL MAGELANG

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Problem Statement: Recently, caesarean section (c-section) with Enhanced Recovery After Caesarean Surgery or ERACS is becoming more popular in obstetric surgery, positively impacting maternal and neonatal outcomes. Besides caring for patients with mental disorders, Soerojo Hospital also holistically serves regular patients, including maternity services implementing enhanced recovery cesarean section. The ERACS method has been implemented for more than one year, but evaluation of maternal and neonatal outcomes is still needed so that service standards can be determined to improve service quality and patient satisfaction. The aims of this study are to determine the effect and factors that influence maternal and neonatal outcomes in the ERACS method. **Methods:** This study was a retrospective study. The data was taken from the electronic medical record of Soerojo Hospital from 1st January 2022 until 31st December 2022. The inclusion criteria were all patients who elective ERACS Method during this study period. The exclusion criteria were covid-19 patients and no history of amniotic rupture and signs of labor. The variables were obtained from the medical record. The researchers identified maternal and neonatal outcomes. Descriptive analysis was used to determine the central tendency and variability of the data. Results: From 48 eligible patients, 8 (16.6%) had mental disorders. The average post-ERACS length of stay was 1.92 days. Forty-one patients (85.42%) had mild pain and a mean NRS pain score (1.83). The average time of removal of the catheter was 18.54 hours. Twenty-three patients (47.92%) could sit, and 4 (8.33%) were readmitted. Regarding the neonatal outcomes, 43 babies (89.58%) had breastfeed. The average time for breastfeeding was 11 hours. Four babies (8.33%) had moderate asphyxia, and 8 (16.67%) needed readmission. Factors influencing maternal and neonatal outcomes were antenatal care, knowledge, skills (position and latching), and family support. **Conclusion:** ERACS Method had a positive impact on maternal and neonatal outcomes, especially on the baby's ability to breastfeed which is influenced by various factors.

Keywords: caesarean section, enhanced recovery, maternal and neonatal outcomes

A GIANT BILATERAL OVARIAN SEROUS CYSTADENOMA IN YOUNG PREGNANT GIRL: DOCUMENT TYPE: A CASE REPORT

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PROBLEM: 17 years old otherwise low risk normal BMI Primigravida former smoker was booked into consultant clinic after diagnosis of bilateral ovarian masses on early pregnancy scan with no significant past medial surgical allergy medication history. **ON SCAN:** large cystic structures within the pelvis/abdomen? origin, first located superior to the uterus measuring 18cm x 7.5cm x 17cm and the second located in the POD measuring 8cm x 6cm x 10cm. No increased vascularity Nor ovary identified. **METHODS:** Managed conservatively throughout pregnancy. She underwent ELLSCS +BILATERAL CYSTECTOMY. Peroperatively 20 and 15 cm biltaeral par ovarian clear cysts removed. **RESULTS:** Histology conclusion: para-ovarian cyst - fluid cytology: Slides virtually. RIGHT & LEFT OVARIES: BENIGN SEROUS CYSTADENOMAS. Procedure went uncomplicated. Patient cancelled, followup arranged. **CONCLUSION:** Pregnancy with a huge ovarian cyst is a rare. Most ovarian cysts are asymptomatic, detected accidentally. Management is determined by the gestational age, symptoms, and nature of the cyst. Asymptomatic/small-size/benign featured cyst is managed conservatively. In the larger/symptomatic/malignant cyst surgical intervention is contemplated in the second or third trimester or an emergency if required. In this case patient remained asymptomatic throughout pregnancy and was managed electively after informed decision making.

TANDEM BREASTFEEDING AND NURSING

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Problem statement: Tandem breastfeeding is defined as the continuation of breastfeeding during pregnancy or after the birth of the mother with her newborn baby, as well as her other baby under the age of two who is still in the breastfeeding period. In this study, it is aimed to give information about the results of tandem breastfeeding related to women, fetus and child health and the responsibilities of nurses. **Methods:** Literature search was carried out in Turkish and English languages, PubMed, and Google Academic electronic databases between 2003-2023. For the literature review, reference keywords were determined for the words "tandem", "breastfeeding" and "nursing" and various combinations of searches were created using these words "AND/OR". **Results:** The results of the research show that the continuation of breastfeeding of the mother who became pregnant while breastfeeding is not harmful for the mother, fetus and other baby. It is reported that as a condition of the continuity of tandem breastfeeding, ensuring adequate and balanced nutrition of the mother. In addition, the importance of closely follow-up the mother, fetus and other baby is emphasized in this process. **Conclusion:** Considering the health benefits both for the infant and the mother, American Academy of Pediatrics (AAP) and World Health Organization (WHO) recommend only mother's milk in the first six months of life and then continuing breastfeeding for at least two years with complementary feeding. In line with the results of the studies, nurses should provide counseling to pregnant women and mothers about tandem breastfeeding and should follow-up closely of pregnant, mother, fetus and baby.

CALM DOWN - THE NEW ALGORITHM FOR CLINICAL MANAGEMENT OF SEVERE PREECLAMPSIA

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Problem statement: Preeclampsia (PE) occurs in 3- 12% of pregnancy and that was no changed during the last century. PE is a leading cause of maternal morbidity and mortality worldwide, accounting for more than 46,000 maternal deaths and approximately 500,000 fetal and newborn deaths annually. According to Ukraine statistic data for 2021: the incidents of hypertension in pregnancy in 20,062 women (68.05 per 1,000 births), including preeclampsia and eclampsia in 10,102 women (37.14 per 1,000 births), of which severe



preeclampsia and cases of eclampsia in 1,324 women (4.96 per 1,000 births). The early multi-disciplinary management are essential to prevent morbidity and mortality associated with preeclampsia. **Material and Methods:** The new version of the Ukrainian National Clinical Guideline (2022) "Hypertensive disorders during pregnancy, childbirth and the postpartum period" covers of the diagnosing and managing pre-eclampsia, during pregnancy, labour and birth. The current algorithm was performed at the National Pirogov Memorial Medical University, Vinnytsya, Ukraine, under budget grant No. 0121 U109141. **Results:** We presented the new algorithm of clinical management for severe pre-eclampsia "CALM DOWN" - the special mnemonic that means "step by step clinical strategy" for the medical teamwork (Table 1).

Table 1. Clinical management of severe preeclampsia Ukrainian experience

Mnemonic	Definition	Action of personnel	Optimal time
C	Calling for help	Calling on duty doctors, an anesthesiologist at the onset of symptoms of severe preeclampsia, with fixation of actual time.	1-3 min
A	Assessment	Check the airway, auscultation of the lungs, re-measure blood pressure, heart rate, assess the oxygen saturation, fetal heart beats, assess the patient's consciousness.	3-5 min
L	Low blood pressure	Antihypertensive therapy: nifedipine 10 mg p.o., urapidil 10 mg IV	5-10 min
M	Magnesium sulfate	Intravenous therapy is with a loading dose of 4 g of diluted magnesium sulphate (in 50 ml) through perfuser.	10-15 min
	Pause	Evaluate the effectiveness of prescribed medications. Target BP: sBP range of 130 to 150 mmHg; dBP range 80 to 90 mmHg.	5-10 min
D	Decision	Decide about further management. Transfer to the intensive care unit or operating theatre or delivery room, depending on gestational age and patient condition.	5-10 min
O	Oliguria	Women with severe preeclampsia immediately prior to regional anesthesia or immediate delivery: 250 mL bolus. Fluid restriction in pre-eclampsia is recommended no more than 60-80 mL/h of IV fluids.	5-10 min
W	Fetal Well being	Continuous CTG monitoring and Doppler assessment.	10-30 min
N	Parturition	All women with severe pre-eclampsia or eclampsia should be delivered within 24 hours, regardless of gestational age. Recommend vaginal birth unless a caesarean section is required for other obstetric indications. If vaginal birth is planned and the cervix is unfavorable, recommend cervical ripening to increase the chance of successful vaginal birth).	

C" is Calling for help

"A" is Assessment

"L" is Low blood pressure

"M" is Magnesium.

PAUSE is evaluated on the effectiveness of prescribed medications.

D" is Decision (decide about further management).

"O" is Oliguria (fluid restriction in preeclampsia is recommend no more than 60-80 mL/h of IV fluids - 5-10 min.

"W" is fetal Wellbeing (continuous CTG monitoring and Doppler assessment) - 10-30 min.

"N" is parturition, timing of birth is dependent on the severity and the gestational age (prolongation of pregnancy carries no benefit for the woman but may be desirable at early gestations to improve the fetal outcomes and prognosis). **Conclusion:** We have proposed the algorithm "CALM DOWN" for the optimal timing of severe PE, offers to systematize the participation of each member of the team in the provision of emergency care.

Disclosure of Interest: The authors declare no conflict of interest.

THE MODERN FEATURES OF THE OPTIMAL INFUSION THERAPY OF HYPEREMESIS GRAVIDARUM

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Problem statement: Nausea and vomiting in early pregnancy is very common, affecting approximately 80% of pregnancies, hyperemesis gravidarum (HG) is a severe form that complicates up to 2.2% of pregnancies. In addition to the consequences of undernutrition for the mother and fetus, the severity of HG symptoms causes a serious psychosocial burden, leading to depression, anxiety and even the development of perinatal pathology. The aim of the investigation was to examine of the features of infusion therapy of HG and evaluate them based on both subjective and objective measures of efficacy, maternal and fetal safety. **Material and Methods:** A systematic data search was conducted using the databases MEDLINE, PubMed, Cochrane Database of Systematic Reviews and publications in professional publications of Ukraine for 2013–2023. The search was conducted using the terms: pregnancy, hyperemesis, infusion therapy

and the safety profile of medications prescribed during pregnancy in various combinations. The investigation was performed at the National Pirogov Memorial Medical University, Vinnytsya, Ukraine, under budget grant No. 0121 U109141. **Results:** Intravenous fluid and electrolyte replacement is an important part of symptomatic management of nausea and vomiting, as well as for correction of dehydration in women with HG. We presented the analysis of effectiveness and safety of infusion therapy in HG, according to the evidence medicine (Table 1).

Type of fluid	Quantity/rate	Comments
Hartmann's	1-2 L. Initial rate 1L/ 2 hours, and then 5L/4 hours.	May be used for slow hydration (over 6-8 hours).
0.9% sodium chloride	1-2 L. Initial rate 1L/ 4 hours, and then 500 ml every 4-6 hours.	Avoid rapid administration (can lead to the development of central pontine myelinolysis). In case of hyponatremia (K ⁺ < 3.5 mmol/L) – 1000 ml of 0.9% sodium chloride with 20 mmol of potassium is administered over 4 hours.
4% dextrose and 0.18% sodium chloride or 5% dextrose	1 L. Initial rate 1L/ 2 hours.	Consider as an option if minimal oral intake, starvation or uncontrolled nausea and only after correction of thiamine deficiency (thiamine 200-300 mg should be added to the infusion) and exclusion of hypokalemia. Avoid usage for fluid replacement as can precipitate Wernick's encephalopathy.
Potassium chloride	30-40 mmol/L. Maximum infusion rate 10mmol over 1 hour	Administer with caution as per local protocol. Preferred product is premixed 30mmol potassium chloride in 1 L. bags of 0.9% sodium chloride. Use large peripheral vein or central venous access only.
Magnesium sulphate	10-20 mmol/day over 20-40 minutes	Oral with 100ml 0.9% sodium chloride. Use large peripheral vein or central venous access only.
Xylitol	4-8 ml/kg of weight	Duration of therapy is 3-5 days. Does not affect the level of blood glucose and does not contribute to the secretion of endogenous insulin.

Conclusion: Emergency management of HG should focus on correction of dehydration and/or electrolyte disturbances, control of nausea and vomiting, to ensure optimal enteral nutrition. Women presenting to the emergency department require infusion therapy based on the severity of HG. The optimal addition to the generally accepted treatment regimens for HG, especially relapses, is the inclusion of the polyatomic alcohol xylitol in the treatment regimen. Xylitol reduces ketogenic intoxication and reduces the synthesis of ketone bodies by accelerating the oxidation of acetyl-CoA in the Krebs cycle, accelerates the removal of ketone bodies from the body and corrects metabolic acidosis, and the balanced composition of electrolytes restores their balance.

Disclosure of Interest: The authors declare no conflict of interest.

ACUTE MASTITIS AS A TRIGGER FOR THE DIAGNOSIS OF ACUTE MYELOID LEUKEMIA.

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Acute myeloid leukemia (AML) refers to a diverse group of aggressive hematologic malignancies involving the proliferation of myeloid blasts committed to granulocytic, monocytic, erythroid, or megakaryocytic lineages. AML is the most common acute leukemia in adults, accounting for approximately 80% of cases in this age group. Patients with AML usually present with symptoms associated with complications of pancytopenia (eg, anemia, neutropenia, and thrombocytopenia), including weakness and easy fatigability, infections of variable severity, and/or bleeding findings such as gingival bleeding, ecchymosis, epistaxis, or menorrhagia. Combinations of these symptoms are common. **Clinical case:** 34-year-old woman with no relevant history, who came to the emergency room due to right mastalgia together with a breast lump of about 3 days of evolution. In emergency analysis, the following is observed: significant elevation of CRP 35.89 mg/dL and procalcitonin 0.65 ng/dL, anemia with hemoglobin of 9.2g/dL, leukocytosis of 16,750 u/mL, with 5% atypical cells, 74% of segmented (hypogranulated) neutrophils, 9% lymphocytes and 12% monocytes and they recommend a consultation with hematology. A bone marrow study was started confirming the presence of 6% lymphocytes, 4% of the erythroid series, 13% neutrophils, 1% mature monocytes and 62% blasts. It is oriented with the diagnosis of acute myelomonocytic leukemia (M4). **Discussion:** The clinical case makes us think about the importance of performing an analysis when the patient went to the emergency room for the first time, the diagnosis of an infectious process was made and the analysis was rejected. Evidently, the evolutionary symptoms of leukemia, with feverish spikes led her to consult a second time, where she performed the analysis with which I suspect the diagnosis of hematological disease. The discrepancy between the symptoms and local examination of the right breast with the fever spikes, which in our opinion were not justified, was also striking. The rapid diagnostic suspicion on the part of the laboratory and the services involved in monitoring and treatment led to the fact that 24 hours after admission to the hospital due to mastitis, it was oriented as possible acute leukemia and transferred to the hematology service where it was confirmed. The diagnosis of AML.

