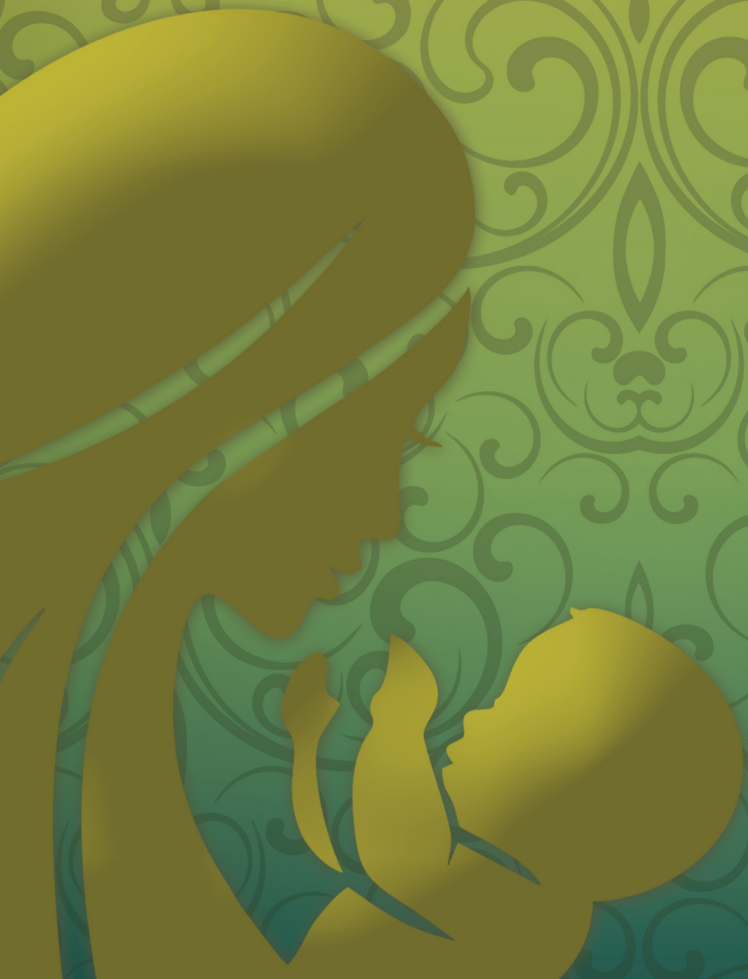
In the name of God



National Association of Iranian
Gynecologist & Obstetricians

کنگره بین المللی
انجمن علمی متخصصین زنان و زایمان ایران

۵-۲ خرداد ۱۴۰۲

تهران، مرکز همایش های رازی

naigo2023.ir

برگزارکننده:

انجمن علمی متخصصین زنان و زایمان ایــران

با همکاری:

- انجمن علمی سرطان های زنان ایران
- انجمن علمی تخصصی باروری و ناباروری ایران
- انجمن علمی پریناتولوژی ایران
- دپارتمان اختلالات کف لگن زنان
- انجمن علمی جراحی های کم تهاجمی زنان ایران

دبیرخانه علمی

انجمن علمی متخصصین زنان و زایمان ایران تلفن: ۶-۸۸۳۰۹۵۶۴-۰۲۱

دبیرخانه اجرایی

مرکز همایش های مهناد تلفن: ۸۸۲۴۹۷۷۵ (۱۰ خط)
info@naigo2023.ir

دکتر سودابه کاظمی اسکی

رئیس کنگره

بنام خداوند علم و قلم

اساتید عزیز، همکاران گرانقدر

خداوند منان را شکرگزاریم که این توفیق را به ما داده است تا یک بار دیگر درکنگره بزرگ بین المللی سالیانه انجمن متخصصین زنان وزایمان ایران NAIGO درتاریخ ۲ تا ۵ خرداد ۱۴۰۲درخدمت همه شما همکاران گرانقدر هستیم.

این کنگره که مهمترین گردهمایی علمی تخصصی زنان وزایمان کشور است باحضور اساتید برجسته از داخل و خارج کشور برای بیش از ۶۰۰۰ متخصص و دستیار رشته زنان وزایمان برگزار می شود.

همکاری ارزشمند اساتید وگروه های علمی از کلیه دانشگاه های علوم پزشکی و انجمن های فلوشیپی و شاخه های استانی انجمن و نیز همکاران شاغل در مراکز تخصصی زنان و زایمان در واحدهای دولتی، خصوصی و.... در پربارترکردن و وزین تر نمودن این رخداد علمی نقش بسزایی داشته است.

دراین کنگره آخرین و بروزترین دستاوردهای علمی دنیا در زمینه تخصصی زنان و زایمان و مامایی در قالب پانل، کنفرانس، سخنرانی و میزگرد و کارگاه در اختیار شرکت کنندگان محترم قرار می گیرد.

حضور شرکت های دارو و تجهیزات امکان آشنایی شما همکاران عزیز را با آخرین دستاوردهای تکنولوژی و محصولات مصرفی فراهم می کند.

همچنین باتوجه به چالش جمعیتی کشور و چاله جمعیتی که بحران پیش روی جامعه ماست در محوریت کنگره اشاره بر جوانی جمعیت و فرزندآوری و سلامت مادران تاکید داشته ایم تاهم به سیاست گزاران و تصمیم سازان این حوزه یادآور شویم متخصصین زنان و زایمان متولیان اصلی سلامت مادران و مقوله بارداری و فرزندآوری هستند و هم با خودمان تجدید پیمان کنیم چونان گذشته، با تمام وجود دانش و مهارت تخصصی مان را برای ارتقای سلامت مادران، زنان وخانواده های این دیار و نیز اعتلای کشورعزیزمان ایران بکار گیریم.

تلاش زیادی داشتیم تا این کنگره بسیار پربار و مفید و قابل استفاده برای همکاران باشد.

از حضور همه شما همکاران ارجمند به خاطر حضور گرمتان کمال تشکر و امتنان را دارم بدیهی است حضور پرشور شما و استقبال گسترده شما، به ما و همه دست اندرکاران برگزاری این رخداد بزرگ انرژی مضاعف داده و ما را در ادامه راه مصمم تر و پرانگیزه تر می‌کند.

ما به آن مقصد اعلا نتوانیم رسید
مگرش پیش نهد لطف شما گامی چند

با احترام

دکتر مریم کاشانیان

دبیر علمی کنگره

اساتید ارجمند، دوستان، همکاران محترم و خانواده بزرگ متخصصین زنان و زایمان ایران

با احترام و افتخار حضور شما در کنگره علمی بین المللی انجمن متخصصین زنان و زایمان ایران را خوش آمد می گویم. این کنگره پذیرای بیش از ۱۸۰۰ همکار از سرتاسر ایران بزرگ می باشد.

ارائه برنامه در سه سالن تدارک دیده شده و تلاش گردیده سخنرانان به روزترین شیوه های بالینی و اطلاعاتی را که آینده رشته ما را شکل می دهد و استانداردهای مراقبت را بهبود می بخشد به اشتراک بگذارند. همچنین تلاش گردیده برنامه علمی به گونه ای برنامه ریزی شود که نیازهای بالینی همکارانی که در شهرهای مختلف با منابع محدود کار می کنند را تا حد امکان مرتفع سازد.

برنامه کنگره شامل سخنرانی، پنل و بحث ها، جلسات دستورالعمل و بحث های هیئت مدیره انجمن خواهد بود. علاوه بر این، کارگاه‌هایی طراحی شده که به مدیریت مشکلات بالینی متخصصین زنان و زایمان می‌پردازند. همچنین جلساتی در طول کنگره برای ارائه بهترین چکیده های مقالات ارسالی فراهم شده است.

کنگره فرصتی ذیقیمت و مناسب برای دیدار دوستان و همکاران و به اشتراک گذاشتن تجربیات و تحقیقات است. مجددا حضورتان را خیر مقدم گفته و از شما تقاضا می کنم به ما کمک کنید تا آینده این رشته را یک گام به جلو ببریم. بیایید و به ما در رفع مشکلات علمی متخصصین زنان و زایمان ایران کمک کنید و در برنامه ریزی و اجرای کنگره برای سالهای بعد انجمن را یاری فرمایید.

مشتاقانه منتظر دیدار مجدد شما هستم!

با ارادت و احترام

اعضای کمیته اجرایی

دکتر مریم کاشانیان
دبیر علمی کنگره

دکتر سودابه کاظمی اسکی
رئیس کنگره

دکترمریم میرپور
دبیر اجرایی کنگره

دکتر فاطمه محمدنجار	نائب رئیس انجمن
دکتر سوسن عزیز محمدی	خزانه دار انجمن
دکتر آزاده مهدیان	عضو هیئت مدیره
دکتر رقیه پورعلی	روابط عمومی
دکتر محبوبه قدم زاده	روابط عمومی
دکتر منوچهر مجد	بازرس انجمن
دکتر نفیسه ثقفی	رییس انجمن متخصصین زنان وزایمان شاخه خراسان
دکتر پیمانه دهقانی	رییس انجمن متخصصین زنان وزایمان شاخه فارس

همکاران اجرایی

دکتر سیدجواد امامی زاده	سحر رضوانی
یاسر قهرمانی	مریم ناظری
مریم گل دوست	لیلا سلامی
شیرین آقایی	مرجان درخشنده
آرزو گل جامجو	خدیجه قربانی

اعضای کمیته علمی

دکتر فاطمه رحیمی شعرباف	دکتر شهرزاد شیخ حسنی	دکتر مرضیه فریمانی
دکتر مینو رجائی	دکتر محبوبه شیرازی	دکتر مینو قارونی
دکتر ثمانه رخگیره	دکتر بهرخ صاحبدل	دکتر افسانه قاسمی
دکتر مریم رسولیان	دکتر ساغر صالحپور	دکتر هتاو قاسمی تهرانی
دکتر صفورا روح الامین	دکتر ثریا صالح گرگری	دکتر فاطمه قائم مقامی
دکتر شهره روزمه	دکتر نسرین صوفی زاده	دکتر مرجان قائمی
دکتر فیروزه رییسی	دکتر کبری طاهرمنش	دکتر فهیمه قطبی زاده
دکتر الهه زارعان	دکتر ربابه طاهری پناه	دکتر فاطمه قلمبر دزفولی
دکتر نسرین سحرخیز	دکتر زهرا طاولی	دکتر زینت قنبری
دکتر فرشته سربازی	دکتر محمدامین طباطبایی فر	دکتر مریم کاشانیان
دکتر نجمیه سعادتی	دکتر رضیه السادات طباطبائی	دکتر سودابه کاظمی
دکتر محمود سعیدی	دکتر آزاده طرفداری	دکتر مریم کاظمی
دکتر محمود سعیدیان	دکتر زیبا ظهیری	دکتر عاطفه کاظمی رباطی
دکتر زهرا سلیمانی	دکتر سهیلا عارفی	دکتر مانیا کاوه
دکتر زهرا سنایی	دکتر آمنه عبیری	دکتر رویا کبود مهری
دکتر نسیم سنجری	دکتر سوسن عزیزمحمدی	دکتر مریم کرمعلی
دکتر ناهید سهرابی عراقی	دکتر زهرا عسگری	دکتر مژگان کریمی زارچی
دکتر بهناز سوییزی	دکتر مینا عطایی	دکتر فاطمه گلشاهی
دکتر شعله شاه غیبی	دکتر شیما علیزاده دوغی کلا	دکتر سیده کیانا لاری بقال
دکتر انسیه شاهرخ نهرانی نژاد	دکتر محبوبه غریب لکی	دکتر مهتاب متوسلیان
دکتر زهرا شاهواری	دکتر شهرزاد فتحی	دکتر منوچهر مجد
دکتر شهناز شایان فر	دکتر فرحناز فرزانه	دکتر فاطمه محمد نجار
دکتر آزاده شعبانی	دکتر فرح فرزانه	دکتر مهدیس محمدیان امیری
دکتر نسیم شکوهی	دکتر لعیا فرزدی	دکتر صلاح الدین محمودی آذر
دکتر رویا شهریاری پور	دکتر داریوش فرهود	دکتر مژگان مختاری

اعضای کمیته علمی

دکتر شهناز احمدی	دکتر اشرف آلیاسین	دکتر اشرف السادات جمال
دکتر مرجان احمدی	دکتر رقیه آهنگری	دکتر شاهرخ جمالی جم
دکتر خدیجه ادبی	دکتر مینا بخشعلی بختیاری	دکتر کبری جودکی
دکتر نسرین اسدی	دکتر صدیقه برنا	دکتر شهلا چایچیان
دکتر لاله اسلامیان	دکتر فاطمه بهادری	دکتر نسرین چنگیزی
دکتر غزاله اسلامیان	دکتر میترا بهمن پور	دکتر مریم حاج هاشمی
دکتر نوشین اشراقی	دکتر بابک بهنام	دکتر نازنین حاجی زاده
دکتر طاهره اشرف گنجویی	دکتر فریبا بهنام فر	دکتر مریم حافظی
دکتر مهناز اشرفی	دکتر محمد ابراهیم پارسانژاد	دکتر صدیقه حسینی
دکتر احسان اطرج	دکتر دکتر زهرا پناهی	دکتر الناز حسینی
دکتر تهمینه اعزازی بجنوردی	دکتر پریچهر پورانصاری	دکتر مریم سادات حسینی
دکتر طاهره افتخار	دکتر نسیم پوردامغان	دکتر صدیقه حسینی موسی
دکتر الهام اکبری	دکتر رقیه پورعلی دوگاهه	دکتر صدیقه حنطوش زاده
دکتر راضیه اکبری	دکتر ریحانه پیرجانی	دکتر سمیه خانجانی
دکتر عبدالرسول اکبریان	دکتر سوزان پیروان	دکتر صغری خضردوست
دکتر آرزو اسماعیل زاده	دکتر سولماز پیری	دکتر لیلا خلیلی
دکتر سعید البرزی	دکتر فاطمه تارا	دکتر سلمه دادگر
دکتر فریبا الماس گنج	دکتر فرحناز ترکستانی	دکتر رویا درخشان
دکتر مریم امامی	دکتر افسانه تهرانیان	دکتر سودابه درویش نارنج بن
دکتر سید عمران امامی	دکتر سحر توکلی	دکتر صلاح الدین دلشاد
دکتر اعظم امیری	دکتر نسترن تیموری	دکتر مریم دلدار
دکتر سهیلا امینی مقدم	دکتر نفیسه ثقفی	دکتر مریم دهقان
دکتر لادن آجری	دکتر مژگان جاودانی	دکتر ناهید رادنیا
دکتر شیده آریانا	دکتر فرهاد جباری	دکتر اطهر راسخ جهرمی
دکتر حسین آصف جاه	دکتر امیرمنصور جلالی	دکتر مریم ربیعی

اعضای کمیته علمی

دکتر وجیهه مرصوصی	دکتر مریم میرپور	دکتر ندا هاشمی
دکتر مریم مژده ذبیحی	دکتر معصومه میرزا مرادی	دکتر سیده راضیه هاشمی
دکتر فاطمه مستعان	دکتر سارا میرزائیان	دکتر فیروزه سادات هاشمی
دکتر مهری مشایخی	دکتر مهسا ناعمی	دکتر مریم هاشمی
دکتر مریم مشفقی	دکتر زهرا نائیجی	دکتر هما همام
دکتر اشرف معینی	دکتر مهین نجفیان	دکتر زینب همتی
دکتر مریم مکتبی	دکتر رضا نصر	دکتر شبنم وظیفه خواه
دکتر عطیه منصوری	دکتر ستاره نصیری	دکتر حمیرا وفایی
دکتر آزاده مهدیان	دکتر فرزانه نظری	دکتر فریبا یارندی
دکتر مهری مهراد	دکتر میثاء نقدی پور	دکتر فخرالملوک یاسایی
دکتر مینو موحدی	دکتر نرگس نهاوندی	دکتر منصوره یراقی
دکتر مژگان مودودی	دکتر مریم نورزاده	دکتر وحید یزدی
دکتر اعظم السادات موسوی	دکتر شیرین نیرومنش	دکتر مینو یغمائی
دکتر لیلا موسوی سرشت	دکتر ندا هادی پور	دکتر آویده نژاد
دکتر سکینه موید محسنی	دکتر مریم هاشم نژاد	

همکاران

حامیان

PLATINUM

GOLD

SILVER

National Association of Iranian
Gynecologist & Obstetricians

Speakers Mini Biography

Shahnaz Ahmadi

Dr. Shahnaz Ahmadi
Date of birth ; 1970
Specialist in obstetric & gynecology from Mashhad university of medical science (1998-2002). Fellowship of infertility &IVF from Shahid Sadoughi of Yazd university of medical science (2007-2009). Professor of Iran university of medical science
Head of OB & Gyn of Firouzabadi hospital
Deputy of education and Research of Akbarabadi hospital
Member of scientific committee of mortality &morbidity , Iran university of medical science
Author of the Fertility and infertility Book
Author of more than 40 articles in valid domestic & foreign journal .

Shideh Aryana

دکتر شیده آریانا
متخصص زنان و زایمان.
فلوشیپ پریناتولوژی،فارغ التحصیل دانشگاه تهران.
عضو هییت علمی دانشگاه علوم پزشکی شهید بهشتی.
استادیار شاغل در بیمارستان امام حسین.
ویراستار ترجمه کتاب ویلیامز چاپ ۲۰۲۲ انتشارات گلبان .
سخنرانی در سمینار ها و وبینار های مختلف مثل سخنرانی در وبینار تازه های ناباروری
سخنران وبینار زایمان زودرس
سخنران وبینار نقش مکملها در باروری و ناباروری
سخنران در وبینار پره ترم لیبر
سخنرانی در کنگره بین آلمللی زنان و زایمان آندومتریوز
سخنران کنفرانس زایمان بدون درد
سخنران کنفرانس شوک و خونریزی
سخنران وبینار HPV
سخنران سمینار چگونگی تفسیر خون بند ناف
سخنران کنگره بزرگ زنان و زایمان دانشگاه شهید بهشتی با عنوان ERA
سخنران در ۲۴ امین کنگره بین المللی نگاهی جامع بر ناباروری از تشخیص تا تولد نوزاد سالم.
سخنران کنفرانس سزارین اسکار پرگننسی.
دارنده مقالات متعدد، به طور خلاصه

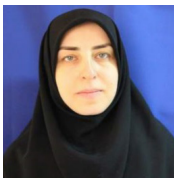
1)Maternal death due to covid 19 disease.
2)evaluation of vascularity and colour Doppler blood flow in uterine myometrium after deliver
3) the impact of laparoscopic cystectomy on ovarian reserve in patients with unilateral and bilateral endometrioma.

Soheila Aminimoghaddam

Gynecologist Oncologist
Associate Professor, Iran University of Medical Sciences, Tehran, Iran
Education: Fellowship of Gynecology Oncology
Tehran University of Medical Sciences, Tehran, Iran
Resident of Obstetrics and Gynecology
Shahid Beheshti University of Medical Sciences, Tehran, Iran
General Physician
Shahid Beheshti University of Medical Sciences, Tehran, Iran
Work experience: Director of Obstetric and Gynecology Ward, Firoozgar Hospital, Tehran, Iran
Director of Gynecology Oncology Department, Firoozgar Hospital, Tehran, Iran
Professional activity and research Interests: GTN and Molar pregnancy, Ovarian Cancer, Cervical Cancer, Endometrial Cancer, Vulvar Cancer, Vaginal
Cancer, Pre-invasive disease of genital tract

Tahereh Ashrafganjoei

- Associate Professor of the Obstetrics and Gynecology, Department of Obstetrics and Gynecology Emam Hossein Hospital, Shahid Beheshti University of Medical Sciences. Tehran-Iran(Since Oct 2011)
- 29 years as clinician in Obstetrics &Gynecology
- 18 years as Gynecologist Oncologist
- Mentor of medical students, Emam Hosein Hospital, Shahid Beheshti University ot medical sciences since 2017 till now.
- Active Member of the Supreme Council for PGRC(Mar 2015 till now)
- Member of the OB & Gyn Preboard Evaluation Committee scince 2015
- -Active Member of the Iranian Society of the Gynecology Oncology (2004 till now)
- Teaching in gynecologic oncology courses, Shahid Beheshti University of Medical Sciences, Tehran/Iran,2011 till now.
- Teaching in gynecologic oncology surgery courses, Shahid Beheshti University of Medical Sciences, Tehran/Iran,2011 till now.
- Teaching in gynecologic oncology fellowship, Shahid Beheshti University of Medical Sciences, Tehran/Iran,2012 till now.



Ameneh Abiri

I am Dr. Ameneh Abiri. I specialize in obstetrics and gynecology and perinatology fellowship. I have studied general medicine, specialty and fellowship at Tehran University of Medical Sciences. Now, It is about two years that I work as an assistant professor in Arash hospital which is a university hospital of Tehran University of Medical sciences and practice medicine in perinatology section.

Roghayeh Ahangari

Roghaye Ahangari
Personal details: Date of birth: 03/09/1965
Place of birth: Mazandaran(Qaemshahr)
Citizenship: Iranian
Specialty: Gynecologist (Iranian national Board)
Languages spoken: Farsi, English.
Email: r_ahangari_46@yahoo.com
سمت: عضو هیات علمی گروه زنان زایمان دانشگاه علوم پزشکی قم

Elham Akbari

Dr Elham Akbari
* Graduated from Iran medical university in 1997
* Specialist degree in OB-GYN from Tehran university in 2005 as a board certified specialist
* Diploma in minimally access surgery from minimally invasive center of Tehran university
*Interest in Gynecologic Laparascopy and attending specialized courses in Iran and other countries
* Expert in field of forensic medicine since 2019
* Translation of some Gynecologic articles
* Many lectures in Gynecologic conferences
* Some public articles in endometriosis
* Work in Farmanieh Hospital
* Chief of operating room of Farmanieh Hospital since 2010

Dr. Khadijeh Adabi
Specialised in obstetrics and gynecology from Tehran University of Medical Sciences, 2009-2013
Third place in the board of obstetrics and gynecology in 2013
Fellowship of female pelvic medicine and reconstructive surgery from Tehran University of Medical Sciences 2014-2015
Associated professor of Tehran University of Medical Sciences since 2013 until now

Khadijeh Adabi

دانشیار فلوشیپ‌ناباروری دانشیار پژوهشگاه ابن سینا
چاپ بیش از ۶۵ مقاله در مجلات بین المللی

Soheila Arefi

My name is Dr. Nasrin Asadi. I am an obstetrician and gynecologist with a degree in perinatology. I am also a faculty member at Shiraz univeristy of medical sciences .

I'm currently employed as the Vice Chancellor for Academic Affairs of medical students at Shiraz University.

Nasrin Asadi

Date of birth : 21 March 1967
Medical Doctor : Iran university of medical science 1993
Obstetric & Gynecology: Iran university of medical science 1997
Address : Hajar hospital , Tehran , Iran
Email : dr.azizmohamadi@gmail.com

Susan Azizmohammadi

Saeed Alborzi

Professor Saeed Alborzi was born in 1956 in Tehran, Iran. He graduated from Shiraz University of Medical Sciences(SUMS) in 1987 as a specialist in the field of Obstetrics and Gynecology .

He started working at the same university as an assistant professor, until 2000 when he was promoted to associate professor.

In the year 2005 he became full professor of Obstetrics and Gynecology and has held the same position ever since at Shiraz Universiy of Medical Sciences (SUMS) . Professor Alborzi received his fellowship in the filed of infertility and gynecology endoscopy from Imperial College of London in UK. Amongst the many different positions professor Alborzi has held at Shiraz University of Medical Sciences (SUMS). He is currently professor and chair of obstetrics and Gynecology Ward and the head of the Gyneclogy Endoscopy division. Also he is vice president of Iranian Society of Minimally Invasive Gynecology. Professor Alborzi's major field of interest is endometriosis and gynecologic laparoscopic surgery.

He is the winner of the 11th Razi Research Festival (2005) and the 3rd and 9th Royan International Congress awards (2002 and 2008). He introduced many innovative laparoscopic and hysteroscopic surgeries for the first time in Iran. Moreover, he was the first to use a graft of the peritoneum for treating cervical aplasia and laparoscopic metroplasty for didelphic uterus in the world. Professor Alborzi has published many articles in high ranking related journals and has presented his works in several international conferences. He is a board member of Asian Society of Endometriosis and Adenomyosis, and president of the sixth ACE which was held in Shiraz, Iran on 22-24 November 2017. He is also a scientific committee member of some endometriosis congresses such as SEUD and EEC.


Mahnaz Ashrafi

Name: Mahnaz Ashrafi
Address: Bani Hashem Street, East Hafez Alley, Royan Alley, Royan Research Institute
(1985-1989)
Iran University of Medical Science; Tehran; Iran
- Obstetrics & Gynecology
(1977 -1984)
Tehran University of Medical Science; Tehran; Iran
- General Physician


Zahra Asgri

Dr Zahra Asgri Professor & head of laparoscopic fellowship ward of Tehran University of Medical Sciences


Fariba Behnamfar

Personal Status:
Last name: Behnamfar
First name: Fariba
Date of birth: jun 28, 1967 / Nationality: Iranian / Gender: Female
E-mail: f_behnamfar@yahoo.com
Current Academic Rank: Professor of Esfahan University of Medical Sciences, Department of Obstetrics & Gynecology Alzahra University Hospital.
MD Esfahan University of Medical Sciences, 23 Sept 1985-Feb 1992
Gyn-Obstetrics Board Esfahan University of Medical Sciences, Sep 1996
Gyn-Oncology Fellowship Tehran University of Medical Sciences, Feb 2007
Chair of Gynecology Department Esfahan University of Medical Sciences, Feb 2014- Feb 2020
Iranian Gynecology Board Member, Feb 2015-Continues

Babak Behnam

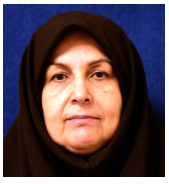
Babak Behnam, M.D., Ph.D.
ABMGG Board, Clinical Biochemical Genetics
• Maryland, USA • (407) 920 -4420 • Babak.behnam@gmail.com
Citizenship: USA
2018: ABMGG-accredited Fellow, Clinical Biochemical Genetics, NHGRI, NIH, Bethesda, MD
2005: Ph.D., Human Genetics, University College London (UCL), London, U.K.
2001 :M.Sc., Molecular Medicine, University of Sheffield, Sheffield, U.K.
1997 :M.D., Medicine, Iran University of Medical Sciences (IUMS), Tehran, Iran

Fatemeh Bahadori

Dr. Fatemeh Bahadori
I am Associate Professor at Urmia University of Medical Sciences .I work at Kosar Hospital. ,Which is the only tertiary center of OB/GYN at West Azarbayjan State.
my Academic Qualifications Education :
Fellowship of perinatology Training at Tehran University of Medical Sciences.fromoctober 2007-2008 , Obstetricians & Gynecologist Residency Training, at Behashti university Medical Sciences .from 1993-1996 AND Medical School at Shahid Behashti University of Medical Sciences frim 1987-1993

Nasrin Changizi

Nasrin Changizi
Language spoken : Farsi , English
Fellowship of Female Pelvic Floor Dysfunction
Research Associate Professor ,Ministry Of Health & Medical Education
- Member of Maternal,Fetal & Neonatal Health Research Center (2008 till Now)
Member of National Center for health Vocational and education Training
- Member of Specialty/Subspecialty Curriculum Development Commission-Deputy Of Education -MOHME May 2023 -present



Sedigheh Borna

Dr. Sedigheh Borna perinatologist .professor in theran medical university .
valiasr hospital. perinatology department

Dr. Soodabeh Darvish
Associated Professor of Obstetrics and Gynecology, Female pelvic medicine and reconstructive surgery, Shahid Beheshti University of Medical Sciences, Tehran, Iran
Email:darvishsudabeh@sbmu.ac.ir,
darvishsudabeh@yahoo.com, darvishsudabeh@gmail.com

Soodabeh Dravish

Dr. Maryam Deldar
OB, GYN. Fellowship of Female Plvic Medicine & Reconstructive Surgery
Assistant Professor of Tehran University of Medical Sciences
Imam Khomeini Hospital

Maryam Deldar

I, Dr. Roya Derakhshan, earned my Doctor of Medicine degree from Isfahan University of Medical Sciences, and completed my residency training in Obstetrics and Gynecology Surgery at Shahid Beheshti University. I graduated from Laparoscopic and Hysteroscopic fellowship program at Iran University of Medical Sciences and Endometriosis Research Center.

Roya Derakhshan

متخصص زنان و زایمان، فلوشیپ پریناتولوزی
دانشیاردانشگاه علوم پزشکی مشهد
متاهل و دارای دو فرزند
دریافت مدرک پزشکی عمومی از دانشگاه آزاد اسلامی واحد مشهد سال ۱۳۸۲
دریافت مدرک تخصص زنان از داشگاه علوم پزشکی مشهد سال ۱۳۸۸
دریافت مدرک فلوشیپ پریناتولوژی از دانشگاه تهران سال ۱۳۹۸
شاغل در بیمارستان امام رضا مشهد وابسته به دانشگاه علوم پزشکی مشهد
کمک سردبیر مجله زنان و مامایی ایران
دارای ۵۰ طرح پژوهشی ، ۱۲ طرح به عنوان مجری و ۳۸ طرح به عنوان همکار طرح
داری ۶۱ مقاله چاپ شده و سه کتاب چاپ شده

Salmeh Dadgar

Maryam Dehghani
Assistant professor of obstetrics and gynecology department at Isfahan university of medical sciences since 2019
Phone – Email: maryamdehghan.1367md@gmail.com

Maryam Dehghani

Laleh Eslamian

Laleh Eslamian MD
Professor of Obstetrics & Gynecology
Maternal Fetal Medicine Specialist, Shariati hospital, Tehran University of Medical Sciences, TUMS
Member of International Society of Ultrasound in Obstetrics & Gynecology
Member of Fetal Medicine Organization, London UK
Member of Iranian Society of Maternal Fetal Medicine
Scientific Secretary of Maternal Mortality & Morbidity Committee of Shariati hospital

Tahereh Eftekhar

Dr. Tahereh Eftekhar is a Full Professor of Obstetrics and Gynecology at the University of Tehran and Imam Khomeini Hospital. She is a 1986 graduate of the University of Tehran Medical School. Eftekhar completed her residency in 1993 at Imam Khomani complex and continues to serve as Assitant Professor at the University of Tehran. She is a certified Gynecology Surgent by the Iranian board of Obstetric Gynecology for the past 25 years. She is also one of the pioneers in pelvic floor dysfunction in Iran who established the first and only pelvic floor dysfunction center in Iran. Her main interest is in urinary incontinence and vaginal reconstruction and Mullerian anomaly, and female sexual dysfunction.
Dr. Eftekhar published over 70 peer-reviewed articles and case reports base on her research over the past years. She conducts over 10 workshops for young Obstetric and Gynecology residence each year and deeply involves in the training of the next generation of students in University of Tehran Medical schools. In addition, she is an active clinician in Imam Khomeini Hospital and currently, she served as a committed member of female middle-age in the ministry of health in Iran.

Dr. Nooshin Eshraghi
Assistant Professor of Perinatology
Iran University of Medical Sciences
Department of Obstetrics and Gynecology, School of Medicine
Shahid Akbar-Abadi Hospital


Nooshin Eshraghi

Prof Farah Farzaneh
Gynecology oncologist
MD. MPhil.
Head of the Preventative Gynecology Research Center,
Shahid Beheshti University of Medical Sciences


Farah Farzaneh

Dr. Laya Farzadi
Obstetrics and Gynecology
Professor of Tabriz University of Medical Sciences
Head of Infertility Department of Alzahra Hospital
Head of Women's Reproductive Health Research Center


Laya Farzadi

*BSc, in Psychology, University of Mainz, Germany (1963)
*MD, University of Erlangen, Germany (1969)
* PhD, in Human Genetics and Anthropology, University of Mainz, Germany (1972)
* MG, Professorship in Medical Genetics, University of Munich, Germany (1991)


Dariush Farhud

Dr. Farahnaz Farzaneh
Infertility Fellowship
Associate Professor
Infertility Fellowship (Grade: Fellowship) :IVI Valencia (Spain)- Tabriz University of Medical Sciences
Obstetrics and Gynecology (Grade: Specialist): Tehran University of Medical Sciences ,Tabriz University of Medical Sciences
General Practitioner(Grade: Doctor) : Tabriz University of Medical Sciences

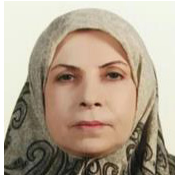

Farahnaz Farzaneh

Marziyeh Farimani

دکتر مرضیه فریمانی
عضو هیات علمی دانشگاه همدان
رئیس مرکز باروری و ناباروری امید همدان

Fahimeh Ghotbizadeh

Fahimeh Ghotbizadeh MD
TEHRAN university physician
academic title; associated proffessor
specialist:ob&gyn
fellowship:perinatalogy
areas of clinical concentration: feto maternal medicine/PLACENTAL ADHESIVE DISORDER surgery
EXPERIANCE:12 YEARS
CONTACT:fghotbi@yahoo.com/00989037154646/
instagram :dr.ghotbizadeh



Fatemeh Ghaemmaghami

Dr. Fatemeh Ghaemmaghami
Gynecologist Oncologist, is a Clinical Professor of Tehran University of Medical Science and one of the founders of IRSGO and served as president of the IRSGO for the fist three years of the organization. Graduated from TUMS, she also chaired in Gynecologist & Oncologist fellowship, and participated in international courses holding in The Royal Marsden, London, UK and MD Anderson, Texas, USA.
She has published about 72 international papers and more than 50 domestic books and papers. She was awarded from Razi Research Academy in 2002, Avesina Festival in 2004.
Dr. Gheammaghami has also received an international award from Eminent Scientist in 2006 for publishing papers in Gynecology Oncology Prevention and Diagnosis and Trophoblastic Disease.

Dr. Afsaneh Ghasemi is an obstetrician and gynecologist who accomplished supplementary infertility courses at Toronto General Hospital in Toronto, Canada, and Royan Institute in Tehran, Iran. Dr. Ghasemi is an associate professor at Iran University of Medical Sciences.

Afsaneh Ghasemi

دکترمحبوبه غریب لکی
جراح و متخصص بیماریهای زنان
دارای بورد تخصصی از دانشگاه شیراز
فلوشیپ فوق تخصصی پریناتولوژی

Mahboubeh Gharib laki

تحصیلات :
پزشک عمومی از دانشگاه اصفهان سال ۸۳-۷۶
تخصص زنان و زایمان از دانشگاه اصفهان سال ۸۹-۸۵
اخذ مدرک فلوشیپ ناباروری زنان از دانشگاه شهیدبهشتی سال ۹۶-۹۴
درجه علمی و موفقیت شغلی :
دانشیار دانشکده پزشکی دانشگاه اصفهان از ۹۹ تاکنون
استادیار دانشکده پزشکی دانشگاه اصفهان از ۸۹ تا ۹۹
ابلاغ های اجرایی :
رییس بخش زنان و مامایی بیمارستان شهید بهشتی اصفهان
مسئول زیرگروه تربیت کننده دستیار فلوشیپ رشته ناباروری گروه زنان و مامایی دانشکده علوم پزشکی اصفهان
مسئول هسته پژوهشی گروه زنان و مامایی دانشکده علوم پزشکی اصفهان
عضو تیم مدیریت آموزش بیمارستان شهید بهشتی اصفهان
عضو کمیته ارتقا کیفیت مستندسازی پرونده های پزشکی بیمارستان بهشتی اصفهان
عضو شورای گروه زنان و مامایی دانشکده علوم پزشکی اصفهان
عضو شورای پژوهشی گروه زنان و مامایی دانشکده علوم پزشکی اصفهان
عضو کمیته رفتارحرفه ای دانشکده علوم پزشکی اصفهان
مسئول برنامه ریزی آموزشی بخش ها

Hatav Ghasemi Tehrani

Fatemeh Ghalambor dezfouli

Specialty: Obs & gyn 1992from ajums
Sub speciality: Infertility &ART 1995 from tums
Birthday:23/sep/1964
Birthplace: Abadan/Iran
High school: Tehran/Iran
General practitioner: Ajums 1988
Member of scientific society of ajums 1992
Pioneer of infertility treatment &ART in ajums 1995& Zakaria institute
Member of speciality &subspeciality validity control of health ministry
Inspector of Iranian ART society for three periods

Marjan Ghaemi

Tehran University of Medical Sciences (TUMS), School of Medicine
Infertility and Endocrinology Fellowship
Tehran University of Medical Sciences (TUMS), School of Medicine
Gynecology and Obstetrics Residency
Top score in OB/GYN national board exam 2019
Thesis: Quality of life evaluation in gynecological cancers, A web-based study
Tehran University of Medical Sciences (TUMS), School of Medicine
Doctorate in Medicine (MD)
Thesis: The prevalence of polycystic ovary (PCO) in adolescents in Tehran

Fatemeh Golshahi

Fellowship of Maternal-Fetal Medicine, perinatologist
Assistant professor of Tehran University of Medical Sciences,
Yas Hospital
Tehran, Iran
fgolshahi@yahoo.com

Neda Hashemi

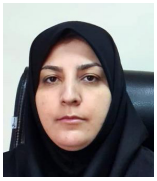
Fellowship of perinatology, Assistant Professor of gynecology and obstetrics, Rasoule-Akram Hospital, Iran University of medical science, Tehran, Iran
Getting the First rank of international Board certification exam (2014)


Zinat Ghanbari

Professor Zinat Ghanbari
Obstetrician & Gynecologist
Fellowship in Female pelvic Floor Medcine &Surgery
Founder of the Fellowship program in Female Pelvic Floor Medcine and Surgery in Iran at Tehran University of Medical Sciences
Director of Obstetrician & Gynecologist group at Tehran University Of Medical Sciences


Maryamsadat Hosseini

MD, Board certification in obstetrics and gynecology (Shahid Beheshti University of Medical Sciences)
Fellowship in Gynecology Oncology (Shahid Beheshti University of Medical Sciences)
Email Address:
hoseiy339@yahoo.com
maryamhosseini@sbmu.ac.ir
Current Positions:
Professor of Obstetrics and Gynecology, Shahid Beheshti University of Medical Science, Tehran, Iran
President of the OB & Gyn Academy Group, Shahid Beheshti University of Medical Sciences (Since July 2014)
Program Manager Fellowship course in gynecology-oncology, Shahid Beheshti University of Medical Sciences (Since July 2011)
Head of the of the Ob&Gyn department, Imam Hosseini Hospital, Shahid Beheshti University of Medical Sciences(since2010)
Tel: +9821 73433000
Site: www.ehmc.ir
Active Member of Preventative Gynecology Research Center (PGRC) Shahid Beheshti University of Medical Sciences; Tehran-Iran Tel: +98 901 921 9200- pgrc@sbmu.ac.ir



Maryam Hashemnejad

Maryam Hashemnejad MD, Assistant professor of obstetrics & gynaecology, Fellowship of perinatology from Tehran University of medical sciences, School of Medicine, Kamala hospital, Alborz University of medical sciences

Sedighe Hosseini

Dr Sedighe Hosseini
Ob, Gyn, IVF fellowship
Assistant professor of
Shahid beheshti university of medical sciences

Maryam Hashemi

Dr Maryam Hashemi is currently assistant professor of obstetrician and gynecology of medical sciences of Isfahan University. She started working at this university since 2013. She received her fellowship in minimally invasive gynecologic surgery (MIGS) from medical sciences of Tehran University. She is training fellowship assistants in the field of MIGS since 2018. Her interest is endometriosis and gynecologic laparoscopic surgery. She has presented lectures in the international congress and has papers in the field of MIGS.

Sedigheh Hosseini Mousa

دکتر صدیقه حسینی موسی
متخصص زنان و زایمان و فلوشیپ نازایی
استادیار دانشگاه علوم پزشکی تهران
دبیر جوانی جمعیت معاونت درمان وزارت بهداشت

Professor, Perinatology -Department & OB/GYN
Tehran University & Medical Sciences
Director, Perinatology Fellowship Program
Tehran University & Medical Sciences
President, Iranian Society & Perinatology

Ashraf Jamal

Gynecologist/Obstetrician and Ph.D. Of Medical Ethics
Researcher of Medical Ethics and History of Medicine Research Center, Tehran University of Medical Sciences

Kobra Joodaki

Maryam Kashanian

Maryam Kashanian is a professor of Obstetrics & Gynecology at the Iran University of Medical Sciences (IUMS) and the ex vice president of The National Association of Iranian Obstetricians & Gynecologists (NAIGO). She is also the Head of the perinatology and high-risk pregnancy unit of Akbarabadi Teaching Hospital in Tehran.

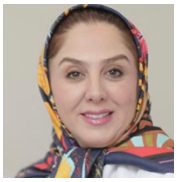
She was thrice elected as the "Head of the Department of Obstetrics & Gynecology at the Iran University of Medical Sciences, between 2007-2018 and was appointed as the Director of the Akbarabadi training hospital in Tehran between 2008-2015, which is the oldest maternity hospital in Iran, with over 50 high risk pregnancies per day. Currently working as a consultant gynecologist and obstetrician at the same hospital, she is focused on fetal-maternal medicine, high risk pregnancies and modern obstetrics.

In her research career, she has published over 150 articles in international journals and more than 100 papers in Iranian journals. She was an invited speaker in numerous conferences and professional societies during her career, for many of which she has won prestigious awards, namely The Razi Festival Prize, the award for best-presented research at the 70th Annual Congress of the Japan Society of Obstetrics & Gynecology 2018 and Hypertension Seoul, 2016 respectively.

Maryam Kazemi

Maryam Kazemi, M.D
OB/GYN - Fellowship of Female Pelvic Floor Disorders
Imam Khomeini Hospital complex

Department of Obstetrics & Gynecology, Faculty of Medicine, Tehran University of Medical Sciences, Tehran, Iran



Maryam Karamali

Maryam Karamali, MD

Associated Professor, School of Medicine, Department of Obstetrics and Gynecology, Iran University of Medical Sciences Workplace Address: firoozgar Medical Training Center.

Email: drmkaramali88@yahoo.com

Qualifications: General Doctor: Iran University of Medical Sciences

Specialized Doctor: Shahid Beheshti University of Medical Sciences

Female Pelvic Medicine and Reconstructive Surgery Fellowship

Tehran University of Medical Sciences

Atefeh Kazemi Robati

Atefeh Kazemi Robati
Iran, Zanjan
Zanajn University of Medical Sciences
Faculty of Medicine
Phone: (024)33130001
Email: atefehkazemi@zums.ac.ir

Experiences:

Obstetrician & Gynecologist

2015- present: Assistant Professor, Zanjan University of Medical sciences

2012- 2014: Assistant Professor, North Khorasan University of Medical sciences

Education:

Isfahan University of Medical Sciences, M.D, May 2004.

Shahid Beheshti University of Medical Sciences, OB &GYN, September 2012.

Skills:

Teaching graduate and under graduate Medical students

Endometriosis management

Low & highrisk pregnancies management

Female gynecologic surgeries

Mojgan Karimi Zarchi

Summary of Dr. Mojgan Karimi Zarchi's resume 1- Birth: 31/6/1353 2- Place of birth: Yazd 3- Married and has 2 children 4- Faculty history: 15 years 5- Full professor of Iran University of Medical Sciences, Tehran and Shahid Sadoughi university of Yazd 6- Surgeon and obstetrician since 2004 7- Women's Oncology Fellowship since 2007 8- Second rank of the National Board of Women, 2004 9- First rank of Iranian Women's Oncology Fellowship, 2005 10- Author of 5 books (1- What women and girls should know 2- Screening for women's cancers 3- Writing articles in simple language 4- Systematic review 5- Summary Williams 2014 Sobhan Publications) 11- Author of more than 258 international articles in the world 12- Six consecutive years of top young university researcher 2016-2017 13- The selected best young researcher of the country in 2010 14- The chosen lady of a country by the esteemed president of the republic in 2013 15-Top selected researcher in Yazd Research and Technology Festival 16- Selected university and national lady in 2009 and 2013 17- The head of the national sample group of the circle of the righteous in 2012 in the meeting of the Basij elites with the Supreme Leader of the Revolution 18- The highest h-index among researchers of Shahid Sadoughi University of Yazd (18) 19- The first person of the scientometric index of the faculty members of Shahid Sadoughi University of Medical Sciences, Yazd 20- Member of the Board of Examiners of the Women's Board 1393-1393 21- Candidate for participation in UNESCO Youngest Female Researcher Festival 22-Member of the International Association of Gynecological Oncologists in Europe and America 23- The author of the audit plan of the Iranian Oncology Association to present to the Office of Presidential Affairs and encouragement from the esteemed Office of the President 24- Member of the board of the Iranian Gynecological Oncology Association in 2015-2011 25- Secretary of the Center for Development and Clinical Research of Shahid Sadoughi Hospital in Yazd and Tehran 26- Member of Maternal Mortality Committee of Shahid Sadoughi University of Medical Sciences, Yazd 27-Head of Tumor Board, Department of Women, Shahid Sadoughi University of Medical Sciences, Yazd 28-Member of Blood, Oncology and Genetics Research Center 29- Active and full time member of the Reproductive Sciences Research Institute 30- Representing the esteemed president of the university in the national plan for screening for women's cancers 31- Winner of the Reproductive Science Festival Award 1390

32- The honor of serving the cases of women's cancers in the south of the country and the repeated encouragement from the esteemed governor of Yazd from 2009-2010 33- Elected member of Omid Festival among Zarch-Yazd elites 34- Participating and presenting speeches and posters in 30 world congresses since 2007 35- Participating and giving speeches in more than 120 national congresses 36- Participating and presenting posters in more than 70 national congresses 37- Author of more than 258 international articles in the world 38- Judging more than 50 international articles and 60 domestic articles 39- Accepting a significant number of articles from more than 30 academic and national scientific research projects 40- First rank of Iranian Women's Oncology Fellowship, 2005 Hope for more efforts and better spiritual honors thanks to God Dr. Mojgan Karimi Zarchi 2021

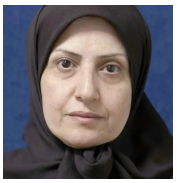
Mania Kaveh

Dr Mania Kaveh
Education and professional Background
Fellowship in minimally invasive surgery in Gynecology
Associate professor of obstetrics & Gynecology Zabol university of Medical sciences.
Head of Department of obsterics& Gynecology ward ,Zabol University.
Member of the international society for Gynecologic Endoscopy
Member of Iranian society for Gynecologic Endoscopy

Soudabeh Kazemi Aski

Dr. Soudabeh Kazemi Aski, OB/GYN, Fellowship in Perinatology, is associate professor of obstetrics and gynecology in Guilan University of Medical Sciences, Rasht, Iran.
President of the Iranian Association of Gynecologists and Obstetricians (NAIGO).
Dr. Kazemi has been a researcher for 8 years working in Reproductive Health Research Center, Department of Obstetrics & Gynecology, Al-zahra Hospital, School of Medicine, Guilan University of Medical Sciences, Rasht, Iran. Her focus areas have been in maternal, fetal, neonatal medicine. She has published several research articles in her area of research.

Dr Soghra Khazardoost
Professor of perinatology
Tehran university of medical scienses
Imam khomeini hospital



Soghra Khazardoost

Gyn & Obs
Mashhad, IRAN / +989151152405/ maryam.mirpour@gmail.com
-NAIGO
Vice president
-Khorasan branch of NAIGO
Vice president from 1395 to now
-IMAM ZAMAN hospital
Chief consultant for woman's surgery and medical issues

Maryam Mirpour

Atieh Mansouri Torshizi
Dr Mansouri Torshizi Atieh
Retired associated proffessor of medical sciences of mashhad university

Atieh Mansouri Torshizi

Dr. Azadeh Mahdian
Obstetrician & Gynecologist
Tehran University of Medical Sciences
Member of the Board of directors of Iranian Association of Obstetricians and Gynecologist(NAIGO)

Azadeh Mahdian

Ashraf Moini

Ashraf Moini , M.D
ashraf.moieni@gmail.com

PERSONAL INFORMATION

Name: Ashraf Moini / Date of birth: 1955 / Sex: Female

Nationality: Iranian

EDUCATIONAL BACKGROUND

(2015)

Tehran University of Medical Science, Tehran, Iran,

Dept. of Endocrinology & Female Infertility,

• Infertility Training Program

(1985- 1989)

Tehran University of Medical Science; Tehran; Iran

• Obstetrics & Gynecology

(1974 -1983)

Iran University of Medical Science

• General Physician

PROMOTION

• Professor, Tehran university of medical science (2013- present).*

• Associate Professor, Tehran university of medical science (2003- 2013).*

• Assisted Professor, Tehran university of medical science (1990-2003).*

• Academic staff & Member of Endocrinology and Female Infertility Department, Royan Institute (1990-present)

EMPLOYMENT

• Professor, Tehran university of medical science (2013- present).*

• Associate Professor, Tehran university of medical science (2003-2013).*

• Academic staff & Member of Endocrinology and Female Infertility Department, Royan

Institute (1990-present)

PROFFESSIONAL EXPERIENCE

(1992-Present)

• Head of OBS & GYN Clinic of Roeen Tan Arash Hospital

Dr. Fatemeh Mostaan
OB & GYN specialist
Fellowship in Female Pelvic Medicine and Reconstructive surgery
Tehran University of medical science

Fatemeh Mostaan

Professor Azamsadat Mousavi M.D
Department of Gynecology Oncology, Tehran University of Medical Sciences

Executive positions:

1. Member of the Research Council of the Obstetrics and Gynecology Group since 1997
2. Director of the Department of Obstetrics and Gynecology since 1997
3. Chief editor of the Iranian Journal of Obstetrics and Gynecology since 2006
4. President of the Iranian Society of Gynecological Oncology from 2011 to 2015
5. Ex President of the Iranian Association of Obstetricians and Gynecologists
6. Chief editor of Iranian Society of Gynecological Oncology Tumor Board Magazine from 2011 to 2015
7. President of the 4th Iranian Society of Gynecological Oncology Congress in 2012
8. President of the 5th Iranian Society of Gynecological Oncology Congress in 2013
9. Member of the board of directors of the Association of Minimally Invasive Surgeries from 2015 to 2018
10. Chief editor of the Official Journal of the Iranian Society of Obstetricians and Gynecologists and the Iranian Society of Gynecological Oncology (JOGCR)
11. Member of chief editors of Iranian Medical Council Journal

Azamsadat Mousavi

Mojgan Mokhtari

Dr Mojgan Mokhtari
Associated professor of Iran University of Medical Sciences

Sara Mirzaeian

Sara Mirzaeian, perinatalogist,assistant proffessor, mashhad univercity of medical sciences

Selahaddin Mahmudi-Azer

Selahaddin Mahmudi-Azer
Dr. Selahaddin Mahmudi-Azer has a dual background in Clinical Medicine and medical research.. He completed his medical degree at the University of Calgary, Canada. Following his M.D., he completed his residency at the University of British Columbia in Vancouver, Canada. Following Residency, he did a Clinical Care Fellowship at the University of Calgary.
He completed his Ph.D. in Medical Immunology at the University of Alberta in Edmonton. Following that, he did a junior Post-Doctoral Fellowship in Respiratory Medicine at the University of Alberta and after this, completed a Parker B. Francis Fellowship from Harvard University.
Currently, he is a senior private practitioner in Western Iran.

Fatemeh Mohammad najar

Dr. Fatemeh Mohammad najar MD

Vice President of The National Association of Iranian Obstetricians & Gynecologists (NAIGO)
Previous Associated Professor of Zahedan University

Vajiheh Marsoosi, M.D
Affiliation: Tehran University of Medical Sciences
Specialty: Obstetrician & Gynecology, fellowship in Perinatology
Experiences:
Fetal ultrasound and intervention, laser fetoscopy
Address: Shariati hospital

Vajiheh Marsoosi

Obstetrics & Gynecology at Iran Medical University,
Fellowship of Infertility at Yazd Medical University
Research and Clinical Center for Infertility,
Bnihashem Sq , Tehran, Iran
e-mail: Dr.Mashayekhy@yahoo.com

Mehri Mashyekhi

Tehran Iran, University of Shahid Beheshti, Mahdiyeh Hospital, Fadaeiyan Eslam Street
Assistant Professor of Obstetric and Gynecology.
Shahid Beheshti University of medical sciences: 2013-2021
Assistant Professor of perinatology
Shahid Beheshti University of medical sciences: 2020-2021

Zahra Naeiji

دکتر شیرین نیرومنش
متخصص زنان و زایمان
فلوشیپ پریناتالوژی
استاد دانشگاه علوم پزشکی تهران
سوابق کاری: ۱۳ سال رئیس بیمارستان
معاون پژوهشی رئیس بخش پریناتولوژی
عضو بورد تخصصی زنان

shirin Niromanesh

Dr. Mahin Najafian Ob & Gyn specialist , Associate professor and head of Ob & Gyn Department .
Fertility, Infertility and Perinatology Research Center; Ahvaz Jundishapur University of Medical Sciences; Ahvaz; Iran

Mahin Najafian

Solmaz Piri

Dr Solmaz Piri is a fetal medicine expert. After receiving her MD from Tehran university of Medical Sciences, she completed her clinical specialty training in Obstetrics & Gynecology at Shahid Beheshti University of Medical Sciences in Tehran. Afterwards, she got a sub-specially diploma in Fetal Medicine from FMF London in 2009.

She has published numerous books and research and review articles in peer-reviewed international and domestic journals with over 130 citations.
Dr Piri is the director of International Affairs in Iranian Association of Gynecologists and Obstetricians (NAIGO).
She is also a member of several national committees including the Ultrasound Committee of NAIGO and Medical Disciplinary Committee of Medical Council of Islamic Republic of Iran and the Guideline Committee for Endocrinologic Disorders in Pregnancy and the Committee of screening for Down Syndrome.
She has won the National Association of Iranian Gynecologist & Obstetricians' Exemplary Practice award in 2016 and has been a virtual mentor of ISUOG since 2019.

She has been elected as the Ambassador of ISUOG in Middle East and North Africa in February 2021.

Zahra Panahi

Assistant professor of TUMS perinatalogy Departman

Reihaneh Pirjani

Name: Reihaneh Pirjani
Asocciate Professor of OB&GYN, Arash Hospital, Tehran University of Medical Sciences
Nationality: Iranian
Email: pirjani@razi.tums.ac.ir
Education
1991-1998: School of Medicine. Tehran University of Medical Sciences
2000-2004: Residency Training(OB& Gyn). Tehran University of Medical Sciences
2004: Second place in Iranian Board of Obstetrics and Gynecology
2009-2011: Post Graduate: Iranian fellowship of Perinatology. Tehran University of Medical Sciences

Mohammad Ebrahim Parsanezhad

M.Ebrahim Parsanezhad M.D, Is currently Professor and Head of Division, Infertility and Reproductive Medicine, department of Gynecology & Obstetrics, SHIRAZ UNIVERSITY, SHIRAZ - IRAN. Professor Parsanezhad obtained his infertility and endoscopy subspeciality from Diako Centre, Gottingen University, Germany in 1990 and an additional course completed in 2003.
Dr. Parsanezhad is a member of several societies, including, American association of Reproductive Medicine(ASRM), European Society for Human Reproduction(ESHRE),
Middle East Fertility Society(MEFS), President of Iranian Society for reproductive Medicine (ISRM).
He is also an editorial member of seve al scientific publications including MEFS Journal, Iranian Journal of Medical Sciences .....
He is a reviewer of many journals, Fertility and Sterility, and many Ntional Iranian Journal.
He has published more than 110 articles in international journals.

Fatemah Rahimi-Sharbaf

Fatemah Rahimi-Sharbaf, M. D. Professor of Obstetrics & Gynecology, Perinatologist, Tehran University of Medical Science, Yas Hospital, Tehran, Iran

Maryam Rabiei

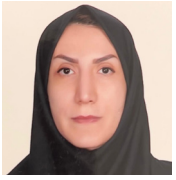
Obstetricians & gynecologist
Prenatologist
Assistant professor
Of tehran university medical sciences

Minoo Rajaei

Dr Minoo Rajaei, Professor of Obstetrics and Gynecology, Fellowship of Prenatology. Faculty member and head of OB&GYN department, of Hormozgan University of Medical sciences.
Member of the regional Board of Examiners and Evaluators in the field of Obstetrics and Gynecology.
Graduated from Shiraz University of Medical Sciences in General medicine and specialty in OB & GYN.
Fellowship of prenatolog in King's College Hospital (London) and Tehran University of Medical Sciences,

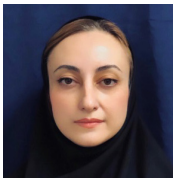
Samaneh Rokhgireh

Dr. Samaneh Rokhgireh
Academic degree: Gynecologist Minimal Invasive Surgery fellowship
Academic Rank: Assistant professor of Iran University of Medical Science
Research Expertise: Endometriosis surgery, minimally invasive surgery



Shohreh Roozmeh

I, Shohreh Roozmeh, was born in Shiraz, IRAN, on 23rd September 1983.I have been working as a registered obstetrician and gynecologist for the past 8 years. I was faculty member of Shiraz university of medical science for 2 years and teaching medical students and residents. Recently, I subspecialized in fetal maternal medicine and start working in Shiraz after I graduated from Shiraz university of medical science under supervision of prof Homaira Vafaiee.
I have experience in advance prenatal care and management of high-risk pregnancies.
I have published several articles in related to maternal and fetal issues and also, passed several courses in advance fetal ultrasound, fetal echocardiography and fetal neurosonography.



Behrokh Sahebdel

Dr Behrokh Sahebdel
Obstetrician and gynecologist
perinatologist.assistant
Professor of Tehran University of medical sciences,Tehran, Iran.

Nahid Radnia

Dr. Nahid Radnia
Obcetric and gynechologist
Fellowship of pelvic floor disorders
Professor assistant of Hamedan university

Fereshteh Sarbazi

Dr. Fereshteh Sarbazi has completed her medical degree in Isfahan University of Medical Science in 1993 and got her specialist degree in Obstetrics and Gynaecology from the same University in 2002 as a board-certified specialist with the highest score in the country. Her interest in gynecologic laparoscopy led to further training by attending specialized courses for laparoscopy at Tehran University. She currently works as a surgeon in the field of advanced laparoscopic gynaecological surgery.

She has translated numerous articles and guidelines in the field of gynecologic laparoscopic surgery for the Journal of the National Association of Iranian Gynecologists & Obstetricians. She has also translated the chapter of Gynecologic Endoscopy of Berek and Novak's Gynecology.

Publications:

Fereshteh Sarbazi; Elham Akbari; Anita Karimi; Behnaz Nouri; Shahla Noori Ardebili. 2021. The Effect of Laparoscopic Surgery of Endometriosis on Women's Pain, Serum Levels of Antimüllerian Hormone, and Cancer Antigen 125 (CA–125); a Two-year study in Farmaniyeh Hospital, Tehran. International Journal of Fertility and Strelity.

kobra shojaei

Dr. Kobra Shojaei, Obstetrician & Gynecologist.
Fellowship of perinatology, Ahvaz Jundishapur of Medical Sciences.

Saghar Salehpour

CURRICULUM VITAE
Personal details : SAGHAR SALEHPOUR
DOB : 28.06.1963 / Place of birth : Tehran - Iran
Primary education . French school , Esfahan , Iran.
Secondary education : in a french school in Esfahan, Iran.
University : Started at 1983 , Esfahan , Iran.
Date of qualification : August 1989 , as a medical
Doctor
Post graduate : - 4 years speciality in obstetrics and Gynecology
,started at September 1989,
finished at September 1993 , Esfahan ,Iran
-1 year fellowship in infertility , IVF in U.K
Family detail :
Foreign language skill :
Present Position:
Married , one daughter
Fluent in English, French language
1- Professor in Obstetrics and Gynecology, Shahid Beheshti University of Medical Sciences.
2- Medical Director IVF Center, Ayatollah Taleghani Hospital, Shahid-Beheshti University of Medical Sciences.
-3 years basic medical science
- 2 years clinical course as a medical student
-18 months internship in internal medicine ,
- 4 years residency in obstetrics
- 1 year fellowship in reproduction , infertility and IVF in Assisted Conception Unit (A.C.U)
Academic unit of obstetrics and gynaecology
University of Birmingham , U.K. Under
Supervision of Mr. M. Afnan , director of A.C.U
- Medical director ob/gyn ward and IVF center- taleghani hospital SBMU
- Member of board of ISRM
(Iranian society of reproduction medicine)

- Medical director Nikan IVF centers.
Publications: More than 50 publication in national and international journals.
Lectures, presentations: More than 100 presentations in national and international seminars, congress and CME.
University Apporved researches: More than 30 university aproned researches.
Publications and awards consultant: 10 Awards, Iranian and international
Responsabilities , honour , success:
1-Elective Researchers, Shaheed Beheshti university of medical sciencs, Nov 2001
2-Member of ESHRE since 1999 (European society of human Reproduction and embryology)
3-Member of MEFS scince 1997 (Middle east fertility society)
4-Member of Iraninan society of Reproductive medicine (ISRM)
5-Member of scientific committee of ISRM (since 2000)
6-Member of organizing commitee of ISRM (since 2002)
7- known Researcher – Shahid Beheshti Medical University (2001)

Nafiseh Saghafi

First name: Nafiseh
Last name: Saghafi
OBGYN, Professor, Head of Obstetrics and gynecology department,
Director of the obstetrics and gynecology group,
Mashhad University of medical Sciences, Mashhad, Iran
President of the Iranian Association of Obstetricians and Gynecologists
Address:
Work (Address for correspondence):
Ghaem
Medical center – mashhad university medical science Mashhad, IRAN
Tel: 00985138417493
E-Mail : saghafiN@mums.ac.ir
Nationality: Iranian
Specialty: Gynecologyst – Laparascopist
Scienticif Level :Full Professor
Research interest: Gynecology, laparascopy

Nasim Sanjari

Dr. Nasim Sanjari MD Ob.Gyn, Health MBA.
Secretory of Iranian Fertility and Infertility Practitioners Society (IFIPS)
Previous secretory and vice president of NAIGO
Executive secretory of daily conferences of NAIGO.
Previous assisted professor in several medical universities.
Deputy Editor of the Journal of Obstetrics, Gynecology and Cancer Research (JOGCR)

Mahboobeh Shirazi

Mahboobeh Shirazi, MaD, perinatologist, Professor of Tehran University of medical sciences. Expert and interested in fetal surgery, fetal intervention for diagnosisand treatments. Manegement of Intra uterine growth restriction, advanced fetal ultrasound. Author and Co Author of more than hundred scientific paper.

Shahrzad Sheikhhasani

Dr. Shahrzad Sheikhhasani MD.
Gynecology- Oncologist from Tehran Unive sity of Medical Sciences. Associated professor of Gynecology-Oncology at Tehran University of Medical Sciences, Valiasr Hospital. Member of Iranian Society of Gynecology Oncology.

Soraya Saleh Gargari

Dr. Soraya Saleh Gargari
Associate Prof. Of Obstetrics and Gynecology at Shahid Beheshti Univ. Of Medical Sciences
She was born in Tabriz. Her medical education and specialty were carried out at Tabriz Univ. Of Medical Sciences. Since she obtained first rank in Obstetrics and Gynecology board exam, she was awarded scholarship to continue her education in the field of perinatology in the United Kingdom of England. She engaged in the managing high risk mother at the Dept. of high risk pregnancy in the university of Leeds and then she continued her fellowship in the Queens Hospital in Nottingham for another year. After passing her exams and defending her thesis in the field of obstetric ultrasound, she became a qualified by standing joint committee of the RCOG&RCR. After returning home she became as an academic member of university and participated in treatment of high risk fetal and mother and teaching medical students, residents and fellowship.

Roya Shahriyaripour

Dr. Roya Shahriyaripour
Board certified Obstetrician & Gynecologist from Iran medical university (IUMS) Assistant professor of Shahrood medical university (2016 to 2019) Gynecologist minimal invasive surgery fellowship from Iran medical university (IUMS)

Azadeh Shabani

Azadeh Shabani,Obstetrics and gynecologist,fellowship of perinatology,assistant professor, Shahid Beheshti university of medical sciences

Najmiyeh saadati

دکتر نجمیه سعادتی پریناتولوژیست
دانشیار دانشگاه علوم پزشکی جندی‌شاپور اهواز

Najmieh Saadati MD.
Perinatologist
Associate professor
AJUMS

Zahra Soleimani, Perinatologist
Baqiyatallah University of Medical Sciences,Tehran, Iran
Faculty Member
Baqiyatallah Hospital Tehran, Iran
Perinatologist (Professional in High-Risk Pregnancy)
Hope Generation Institute Tehran, Iran
Perinatologist (Professional in Fetal Medicine), Obstetrician and Gynecologist
Tehran University of Medical Sciences, Tehran, Iran:
General Practitioner
Obstetrics Maternal & Fetal Medicine Fellowship (Perinatology)
Shahid Beheshti University of Medical Sciences, Tehran, Iran:
Obstetrics and Gynecology Surgeon

Zahra Soleimani

- Obstetrician and Gynecologist.
-Associate professor of Iran University of Medical Sciences, Tehran, Iran.
- Certificate of Ultra-Sonography in Gynecologic-Obstetric: Iran University of Medical Sciences, Tehran, Iran.
- Iranian Board of Obstetrics and Gynecology: Shahid Beheshti University of Medical Sciences, Tehran, Iran.
- MD: Shahid Beheshti University of Medical Sciences, Tehran, Iran.
- Currently working at Laleh and Sasan Private Hospitals, Tehran, Iran.
- Experience: 30 years

Nahid Sohrabi

Dr. Razieh Sadat Tabatabai
Gynecologist and Perinatology Fellow and Assistant Professor of Shahid Sadoughi University of Medical Sciences, Yazd

Razieh Sadat Tabatabai

MD, OB & GYN, Fellowship in IVF & Infertility

Associate professor, Tehran University of Medical Sciences, Imam khomeini Hospital Complex

Azadeh Tarafdari

Afsaneh Tehranian

Dr. Afsaneh Tehranian, the fellowship of gynecologic oncology, is an associate professor at Tehran University of Medical Sciences (TUMS). She obtained her fellowship degree in 2001.
She is vice-chancellor of research and head of the clinical research development center of Arash Women's Hospital. Also, she has been the head of the gynecology ward of Arash Women's hospital since 2005. She has published 7 books and 49 research and review articles in peer-reviewed international and domestic journals with over 403 citations. Dr. Tehranian have different administrative and scientific positions; as a member of the board manager of Iranian Society of Gynecological Oncology from 2008, member of the Obstetrics and Gynecology Commission of Iranian Legal Medicine Organization, member the National Committee for Cancer Prevention and Control, member of the Obstetrics and Gynecology Commission of Medical Council of the Islamic Republic of Iran. Also, she corporate with Iranian reputable journals, as she is one of the editorial board members of the Iranian Journal of Gynecology Oncology and Journal of Obstetrics, Gynecology & Cancer Research (JOGCR).

Kobra Tahermanesh

Dr. Kobra Tahermanesh M.D
FMIGS, has completed her medical degree from Shiraz University of Medical Sciences (SUMS) and got her specialist degree in Obstetrics and Gynecology from Shahid Beheshti University of Medical Sciences (SBMU).
Dr. Tahermanesh also has Fellowship in Minimally Invasive Gynecology Surgery from Tehran University of Medical Sciences (TUMS), Iran.
She is an assistant professor of Obstetrics and Gynecology at Iran University of Medical Sciences (IUMS) and currently working at Rasool-e Akram Tertiary Hospital. Dr. Tahermanesh trains Minimally Invasive Gynecology Fellowships and also coordinating the Endometriosis Research Center.
She is interested in working on advanced Ob & Gyn Laparoscopy and Hysteroscopy.

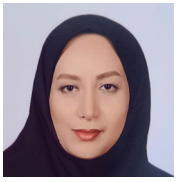
Professor of obstetrics and Gynecology, Fellowship of Maternal-fetal medicine from tums, Faculty of Medicine, Mashhad University of Medical Sciences

Fatemeh Tara

Farahnaz Torkestani associate professor of Shahed Univercity
OB & GYN

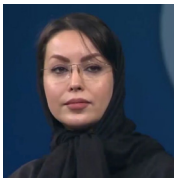
Farahnaz Torkestani

Dr Nastaran Teimoory
Obstetrician and gynecologist, fellowship of perinatology from tehran university of medical sciences.
Assistant professor in Iran university of medical sciences
Expert in performing various obstetric ultrasound scans to detect different fetal structural and genetic abnormalities.



Nastaran Teimoory

دکتر سحر توکلی شیرازی
فوق تخصص خون و سرطان بالغین
عضو هیئت علمی دانشگاه تهران
مشغول به کار در بیمارستان دکتر شریعتی



Sahar Tavakoli Shirazi

Fakhrolmolouk Yassaee

Fakhrolmolouk Yassaee
Obstetrician& Gynecologist
Perinatologist
Professor in Shahid Beheshti University of Medical Sciences, Tehran,Iran

Homeira Vafaei

Dr. Homeira Vafaei, Associate Professor of Obstetrics and gynecology at Shiraz University of Medical Sciences, Fellowship in Maternal and Fetal Medicine from king's College of London. She is a Member of Shiraz Fetal Surgery Team , participating and performing several fetal surgery procedures including FETENDo, correction of spina bifida, laser photocoagulation for TTTS, microwave ablation of umblical cord, bipolar cord coagulation via fetoscope and etc.

she is also Head of Perinatology division and Director of the Maternal and Fetal Research Center and has been Scientific director of several national and international congresses, Organizer of various training courses and workshops, attending more than 40 internal and international congresses as a guest speaker and several congresses as a member of scientific committee. She is a Member of Perinatology Association and Chairman of the IRAN Perinatology Education Committee, member of FMF and ISUOG, Member of the Committee for Promoting Maternal and Newborn Health of Health Ministry, Member of the Assembly of the Medical System of the country and member of supreme council of medical council of Iran .

Sha had been president of medical council of Shiraz and Fars province for 8 years . She has Published many articles in prestigious journals and also Translated 11 to 14 weeks ultrasound book , 18-23 weeks uktrasound book and several educational courses which are available at ISOUG and FMF website and also organized several online courses in IRAN.

Dr. Minoo Yaghmaei
Graduate of Obstetrics and Gynecology from Iran University of Medical Sciences, in 1996

Faculty member of Zahedan University of Medical Sciences from 1996 to 2012
Faculty member of Shahid Beheshti University of Medical Sciences since 2013


Minoo Yaghmaei

Dr. Fariba Yarandi has been a gynecology oncology professor at Tehran University of Medical Sciences(TUMS) for over two decades and is currently head of gynecology oncology department at Yas women hospital.


Fariba Yarandi

Dr. Vahid Yazdi MD, Obstetrician, Gynecologist.
Former associate professor at Hamedan University of Medical Science.


Vahid Yazdi

Elahe Zarean received MD and Specialty in Obstetrics and Gynecology from Isfahan University of Medical Sciences in 1998, and 2006, respectively. She also received fellowship of fetomaternal from Tehran University of Medical Sciences in 2012. She is now an associate professor with Isfahan University of Medical Sciences where she joined as a faculty staff in 1998.


Elahe Zarean

Maryam Mozhdeh Zabihi yeganeh

Associate Professor of Rheumatology, Iran University of Medical Sciences

2003-2005: Subspeciality in Rheumatology. Shahid Beheshti University of Medical Sciences

1998-2002: Residency in Internal Medicine. Iran University of Medical Sciences

1989-1997: Undergraduate Tehran University of Medical Sciences

Ziba Zahiri

Dr. Ziba Zahiri

Graduated from Shiraz University of Medical Sciences in 1994 in the field of general medicine. She was then admitted to the field of obstetrics and gynecology at Guilan University of Medical Sciences and she achieved the first place in the board exam in 1999. In 2000, she accepted in the exam of fellowship of infertility and IVF and get the first rank. She studied at Tehran University of Medical Sciences, and returned to Guilan university as a faculty member after graduation . In 2015, she achieved the degree of full professor of GUMS. She passed the course of advanced laparoscopy, hysteroscopy and endometriosis in Shiraz with supervision of Professor Saeed Alborzi for three years .She has published more than forty articles in English and a large number of articles in Persian. She was the director of the gynecology and obstetrics department of Guilan University of Medical Sciences for 6 years and is currently working as the head of the infertility and IVF department and the educational deputy of Al-Zahra Hospital in Rasht. In addition to infertility, her favorite field is laparoscopic and especially advanced endometriosis surgeries.

National Association of Iranian
Gynecologist & Obstetricians

Speaker's Abstracts

Misoprostol:the essentials by trimester of pregnancy

raziye akbari

میزوپروستول یک داروی صناعی و آنالوگ پروستاگلاندین E۱ می باشد.این دارو در درمان و پیشگیری از زخم های گوارشی گاستروِدئودنال ناشی از مصرف ضد التهاب های غیر استروئیدی (NSAID) استفاده می شود. در حال حاضر این دارو برای مصارف مختلفی در رشته زنان و زایمان قابل استفاده است .این مصارف عبارتند از:القای سقط ،درمان سقط ناکامل، القای زایمان، آماده سازی سرویکس قبل از اقدامات جراحی بر روی سرویکس و در پیشگیری و درمان خونریزی های بعد از زایمان.

از فواید میزوپروستول نسبت به سایر داروهای هم گروه خود می توان به ارزان بودن،عدم نیاز به محیط خنک، در دسترس بودن در کل دنیا وماندگاری طولانی دارو پس از تولید نام برد.

این دارو به اشکال واژینال،زیر زبانی،بوکال، خوراکی و رکتال قابل استفاده است.

اثرات و عوارض میزوپزوستول وابسته به دوز بوده و شامل بازو نرم کردن سرویکس،ایجاد انقباضات رحمی،تهوع،استفراغ،اسهال،تب و لرز می باشد.

این دارو تراتوژن بوده و عوارضی نظیر نقص جمجمه،اکستروفی مثانه،آرتروگریپوزیس،نقایص اندام ها و مافورماسیون در صورت را ایجاد میکند. تنها کنتراندیکاسیون مصرف آن در موارد الزام،حساسیت قبلی به این دارو می باشد.

Management of ovarian cysts from fetal period to menopause

Dr. Atefeh Kazemi

Ovarian cysts occur from the embryonic period to menopause in females, with or without symptoms. During the fetal period, the best management is to monitor the fetus with ultrasounds every 3-4 weeks. If the cyst size increases, aspiration can be performed under ultrasound guidance. During the newborn period, at birth, and then every 4-6 weeks, ultrasound It is repeated. If the sonographic features of the cyst change or the cyst is larger than 6 cm, aspiration or surgical procedures can be used. If acute abdomen occurred from birth to menopause, surgery is recommended. In children, treatment methods are selected based on clinical symptoms and sonographic features of the cyst. Usually, cysts below 9 cm will revolute. If they are not disappear or sonographic features appear in favor of malignancy, surgery is necessary. Most of the cysts during adolescence are follicular and corpus luteum. Pregnancy should always be considered. Simple cysts below 6 cm can be monitored every 2-4 weeks, OCPs can also be prescribed. If the cyst›s sonographic features change or if it persists for more than 3 months, cyst aspiration or surgery is recommended. Before menopause and in menopause, decision will be on The basis of the clinical symptoms and sonographic characteristics of the cyst. In case of O-RADS5 or the presence of metastatic disease, surgery is necessary. In O-RADS4, CA-125 levels are helpful. surgery is recommended when A-125 is above 200 U/ml before and above 35 U/ml after menopause.

One size does not fit all زمان زایمان

دکتر اشرف جمال- پریناتولوژیست- دانشگاه علوم پزشکی تهران

در مورد سزارین الکتیو در ۳۹ هفته و بعد از آن بحثی نیست. اما این زمان بستگی به فاکتورهای متعدد مثل رشد مناسب، وزن مناسب، حجم مایع آمنیوتیک طبیعی، حرکت جنین و پروفایل بیوفیزیکی و فاکتورهای زمینه ای مادر مثل فشار خون بالا، دیابت، سابقه FGR و سابقه مایع کم و سایر بیماری های مدیکال مادر بستگی دارد.

در FGR یک قلو با داپلر نرمال ۳۷-۳۸ هفته باید زایمان انجام شود ولی در FGR با داپلرِ غیرطبیعی بندناف باید ریسک های پرماچوریتی در مقابل عاقبت حاملگی سبک و سنگین شده و معمولاً ۳۴-۳۵ هفته سن مناسبی است. زایمان زودتر از اینها وقتی ریسک Still birth سه برابر باشد باید انجام شود. بنابراین داپلر شریان نافی که عملکرد جفت را نشان می دهد فاکتور پروگنوستیک مهمی در FGR پری ترم است و داپلر داکتوس ونوزوس (DV) فقط برای FGR زودرس که در ریسک Stillbirth هستند مشخص می کند که میزان مرگ جنین چقدر است.

زمان زایمان زودتر در مواردی که وزن نرمال ولی نارسایی جفتی وجود دارد یکی از مشکلات رشته مامایی است بدین معنی که جنین به وزن طبیعی رسیده و با سونوگرافی این موارد جنین AGA است. اما به پتانسیل رشد خود نرسیده است. مثلا جنین باید وزن ۳.۵kg براساس پروگرام اولیه می بود ولی وزن ۳kg دارد وقتی همین جنین با وزن نرمال دفع مکونیوم و هیپوکسی داشته باشد که تشخیص آن کار مشکلی است و بررسی Cerebroplacental ratio را می طلبد که اگر کمتر از ۵٪ بود بکارگیری تست های سلامت جنین و تغییر زمان زایمان را می طلبد.

تعیین سن دقیق حاملگی براساس سونوگرافی سه ماهه اول جهت انتخاب صحیح زمان زایمان مهمترین فاکتور در عاقبت بارداری است.

در مورد فرصت دادن برای زایمان طبیعی از ۴۰-۳۹ هفته به بعد باید خیلی دقیق و با استفاده از تست های سلامت جنین و وضع دهانه رحم، حاملگی مدیریت شود.

Cardiopulmonary Resuscitation in Maternal Patient (Advanced Cardiac Life Support in Maternal Patients)

Dr. Saren Azer, MD/PhD, FRCPC, Director of Critical Care Department, Mojibian Hospital, Yazd, Islamic Republic of Iran,

Cardiac arrest in pregnancy is known to be a very challenging clinical scenario. While, resuscitation of pregnant women shares major similarities with non-pregnant women, there are aspects of pregnancy and certain physiological adaptations, which make resuscitation of maternal patient particularly challenging. Furthermore, having two lives, that of the mother and that of the fetus, hanging in the balance, is an additional layer of difficulty. Maternal mortality has been defined as the death of a woman during pregnancy and up to 42 days after delivery or termination, provided that the cause of death is either related to, or aggravated by the pregnancy or its management. Global statistics show that 800 maternal death accrues daily, with rather devastating implications. Yet, maternal mortality rates are only a small representation of critical events in pregnancy and one needs to also consider maternal near-miss data as well. A comprehensive knowledge, in important factors related to maternal cardiac arrest, including maternal physiology as it relates to resuscitation, pre-event preparation for critically ill pregnant patient, risk stratification during pregnancy, management of the unstable maternal patient, basic as well as advanced cardiovascular life support (ACLS) in pregnancy, perhaps can lead to a better outcome in maternal resuscitation.

Prelabor rupture of membranes (PROM) management:

DR Amene Abiri, perinatologist, TUMS

The management of women with (PPROM) is based upon consideration of several factors, including gestational age, the availability of an appropriate level of neonatal care, the presence or absence of maternal/fetal infection, the presence or absence of labor or placental abruption, the stability of the fetal presentation, the FHR pattern, and cervical status.

* unstable patients: Expeditious delivery of women with PPROM is indicated if intrauterine infection, placental abruption, nonreassuring fetal testing, or a high risk of cord prolapse is present or suspected.

* Stable patients <34 weeks: <34 weeks, we suggest expectant management:

o administering a course of antenatal corticosteroids . this reduce the morbidity and mortality of prematurity if preterm delivery occurs.

o administering a course of prophylactic antibiotics . ampicillin 2 grams IV every 6 hours for 48 hours, followed by amoxicillin 875 mg orally twice daily for an additional five days. In addition, one dose of azithromycin 1 gram orally at the time of admission.

o hospitalize during the entire period of expectant management .

* Stable patients ≥34 week:suggest delivery rather than expectant management. If gestational dating is suboptimal, suggest expectant management with delivery when our best estimate of gestational age is 36 to 37 .

Future pregnancy :A history of PPROM is a strong risk factor for recurrence. Monitoring cervical length in future pregnancies and treating patients with a short cervix with vaginal progesterone or cerclage may improve pregnancy outcome

The impact of BRCA and Other Genetic Testing for Cancer and Updated Screening Guidelines

سخنران: پرفسور داریوش فرهود

جهش های بیماریزا در ژن های مستعد کننده به سرطان یعنی BRCA1 و BRCA2 با خطر افزایش سرطان سینه، تخمدان، لوله های فالوپ و صفاق در خانم ها، سرطان سینه و به میزان کمتر سرطان لوزالمعده و پروستات با شروع زودرس در آقایان در ارتباط است، البته جهش های ژن BRCA2 با ملانوم نیز مرتبط است. جهش های 2/BRCA1 در خانواده ها خوشه ای هستند و الگوی توارثی اتوزومال غالب را نشان می دهد. خطر ابتلا به سرطان سینه در طول زندگی برای زنان دارای جهش در ژنهای BRCA2، BRCA1 بیش از ٪۷۰ میباشد، با این وجود جایگاه و نوع جهش در این ژنها، واریانت های رایج در ژنوم، سابقه خانوادگی، عوامل مرتبط با سبک زندگی و سن همگی برخطر ابتلا به سرطان در ناقلان جهش های فردی موثر هستند، از این رو گایدلاین های جدید غربالگری خانم ها با سابقه خانوادگی بالقوه مرتبط با بدخیمی BRCA، ارجاع به مشاور ژنتیک را توصیه می کنند.
سطوح جمعیتی آنالیز شده در سال ۲۰۱۸ توسط National Health Interview Survey و گایدلاین USPSTF پیشنهاد می کنند که میزان نیاز به ارجاع به مشاوره ژنتیک به میزان قابل توجه بالا می باشد. دستاوردها برای آزمایش های ژنتیک، از آزمایش های تک ژنی تا پنل های سرطان پیشرفت چشمگیری داشته است. در بعضی از کشورها از جمله ایران، علاوه بر ژن های 2/BRCA1 سایر ژن های موثر در ایجاد سرطان سینه شامل TP53، RAD51D,CDH1 ،RAD51C ،ATM ،PALB2 CHEK2 و برخی ژن های دیگر مورد بررسی قرار می گیرند.
مشاوره ژنتیک شامل شناسایی و مشاوره به افراد در معرض خطر ابتلا به سرطان ارثی، قبل و بعد از انجام آزمایش ژنتیک جهش های BRCA و سایر ژن های شناسایی شده می باشد. شناسایی به موقع افراد دارای ژن های بیماری زا سرطان مهم است زیرا دستیابی به گزینه های درمانی از جمله درمان هدفمند و اختصاصی (Personalizes Medicine) و بکارگیری استراتژی های تشخیص و درمان زودهنگام را امکان پذیر می سازد.
واژگان کلیدی: سرطان سینه، پنل سرطان، آزمایش ژنتیک، مشاوره ژنتیک، جهش ژن های BRCA1,2

Infertility Aspect of PCOD

Parsanezhad.M.Ebrahim,M.D., Professor & Head of Division, Infertility & Reproductive Medicine, Shiraz University of Medical Sciences. SHIRAZ – IRAN
Parsanezhad Maryam, M.D., Hospitalist physician, Brockville General Hospital. BROCKVILLE – CANADA
F.Hajibagheri, M.D. Obstetrician & Gynecologist, Dena hospital SHIRAZ – IRAN

Polycystic ovary syndrome (PCOS) is one of the most common causes of anovulatory infertility and affects 5%–10% of women of reproductive age. Women with this syndrome of chronic anovulation and hyperandrogenism are at increased risk of obesity, diabetes, infertility, and miscarriage.

By virtue of its efficacy, safety and ease of administration, Clomiphene Citrate(CC) is the first line of therapy for ovulation induction. Unfortunately, 25% of these women do not respond to CC. CC resistance is defined when ovulation and NL luteal phase were not achieved in patients treated with the highest dose of CC for 5 days and at least for 5 cycles. Patients most likely to not respond to CC are those who are hyperandrogenic, overweight and insulin resistant.

What can be done for the patient who fails to ovulate at maximal doses of clomiphene? Does anything predict which patients will respond to clomiphene? Although many options are available for ovulation induction in PCOD patients, there is currently no evidence-based algorithm to guide the initial and subsequent choices of ovulation induction methods.

Physiopathology of CC Resistance; The effects of excessive LH in the follicular phase, The dysfunctional effects of untimely LH surge, Excessive local concentration of androgens may yield: Impaired Folliculogenesis, Increased Atresia, Poor Oocyte Quality,. Precocious or Impaired Oocyte Maturation, Low fertilization rate, variable implantation rate and deficient corpus leuteum function.

How to manage clomiphehe Citrate resistance:

1-Extended CC treatment,

2- Treatment of hyperinsulinemia,

3-The addition of Dexamethasone(DEX) to CC,

4-Addition of Bromocriptin to CC for women with normal prolactin,
5-Pretreatment suppression,
6-Gonadotropins,
7-Ovarian Surgical Procedures,
8-Use of aromatase inhibitor.

Key word; PCOD, Clomiphene Citrate, resistant, stimulation

DR h Aryana
Obstetric and gynecologic surgeon
Fellowship of perinatology
Assistant professor
Imam hossein hospital
Shahid beheshti university of medical science

Intrapartum fetal heart rate assessment:
A normal baseline FHR is 110 to 160 bpm, and reflects lack of pathology or pathologic effects from factors that regulate FHR.
FHR variability is the result of integrated activity between the sympathetic and parasympathetic branches of the autonomic nervous system.
FHR accelerations are frequently associated with fetal movement, possibly as a result of stimulation of peripheral proprioceptors, increased catecholamine release, and autonomic stimulation of the heart.
An early deceleration likely represents an autonomic response to changes in intracranial pressure and/or cerebral blood flow caused by intrapartum compression of the fetal head during a uterine contraction and maternal expulsive efforts, although the precise physiologic mechanism is not known.
A late deceleration is a reflex fetal response to transient hypoxemia during a uterine contraction.
A variable deceleration reflects the fetal autonomic reflex response to transient mechanical compression of the umbilical cord
A prolonged deceleration reflects a fall in FHR baseline by ≥15 bpm and lasting ≥2 minutes but <10 minutes
NICHD CLASSIFICATION AND INTERPRETATION OF FHR PATTERNS —
Category I FHR pattern :
A category I pattern has all of the following components:
- A baseline FHR of 110 to 160 bpm
- Moderate FHR variability (6 to 25 bpm)
- Absence of late or variable FHR decelerations
- Early decelerations may or may not be present
- Accelerations may or may not be present

Category III FHR pattern — A category III pattern is abnormal: it is associated with an increased likelihood of severe hypoxia and metabolic acidemia at that

point in time.
A category III tracing has at least one of the following components :
●Absent variability with recurrent late decelerations
●Absent variability with recurrent variable deceleration
●Absent variability with bradycardia
●A sinusoidal pattern
Category II FHR pattern — Category II FHR patterns include all FHR patterns that are not classified as category I (normal) or category III (abnormal)
In utero resuscitation:
1) Reposition the patient onto her left or right side to relieve cord compression and/or improve uteroplacental perfusion.
2) Administer oxygen (eg, 8 to 10 L/min of oxygen via nonrebreather mask).
3) Administer an intravenous (IV) fluid bolus (eg, 500 to 1000 mL of lactated Ringer›s or normal saline solution).
4) Discontinue uterotonic drugs to improve uteroplacental blood flow, which is reduced during contractions.
5) If the FHR pattern persists after discontinuation of uterotonic drugs or in the absence of their use, administer a tocolytic (eg, terbutaline 250 mcg subcutaneously), unless abruption is suspected.
6) Consult the anesthesia team in patients who were recently given neuraxial drugs for labor pain.

Hyperactive Pelvic Floor

Nasrin Changizi
Fellowship of Female Pelvic Floor Medicine and surgery
Research Associate Professor
Ministry of Health and Medical Education

Is Defined as too tense Pelvic floor not able to relax mainly due to the act of holding on pelvic floor muscles and tightening to prevent the loss of control.
Causes
•Spending a lot of time working out and holding onto their core muscles
• history of holding on bladder and/or bowels can also develop tension in their pelvic floor muscles.
• having high levels of stress, fear or anxiety can cause muscles to reflexively tighten, these factors can lead to a hypertonic pelvic floor
•Pelvic health and abdominal Diseases
•Endometriosis
•iIritable bowel syndrome with abdominal pain and cramping
•Interstitial cystitis
•Pudendal neuralgia and
• Vulvodynia.
•Birth trauma and scar tissue
Signs and symptoms of a hypertonic pelvic floor:
•Constipation/incomplete emptying of the bowels/straining when emptying the bowels
•pelvic pain/low back pain/hip pain/coccyx pain/painful sex/vaginismus
•urinary incontinence/incomplete emptying of the bladder/slow flow of urine
•hesitancy or delayed start of urine stream/urinary urgency/urinary frequency / painful urination.
Management :
•Appropriate management of Underlying diseases if any
•Life style modification
•Physiotherapy

Implications for Surgical Management
Psychological Issues and Social Mores in Female Genital Aesthetic Surgery:What Is Normal?

Leila Khalili

• Understanding the anatomy of the female genitalia is fundamental to surgical planning and technique in cosmetic surgery of this area.
• Systematic examination of the mons, labia majora, clitoris, and labia minora (vulval complex) is essential.
• Wide variations exist in the anatomy of the vulval complex.
• In parallel with facial aesthetics and facial harmony, surgeons should consider the concept of genital harmony.
• Newly documented insights into the vascular anatomy of this area may influ- ence choice of technique.
• The degree of labia minora protrusion beyond the labia majora is variable.
• There are variations in the shape and morphology of the labial anatomy that have not been previously documented.
• The clitoral hood–labia minora complex in particular varies widely in appearance and is potentially a problematic area for surgeons.
• Careful documentation of the size and shape of the labia and the labial- clitoral complex is critical.
• No consensus exists regarding what constitutes a normal external appear- ance of the female genitalia.
• The contemporary Western ideal of the "perfect vagina" is often described as hairless and pink with labia minora not projecting beyond the labia majora.
• Studies show a wide range of sizes for each part of the genitalia, making it difficult to describe normal measurements.
• Psychological improvements are well described in women who have under- gone female aesthetic surgical genital procedures for cosmetic and functional reasons.
• The beauty norm is completely subjective for each patient and should help to improve psychological, physical, and sexual states, even in cases of aesthetic genital surgery.
Appropriate patient expectations are essential.
• Patient goals should be realistic for the procedure.
• Informed consent is a process, NOT the signed paper.
• Surgeons should be honest in their disclosure about the effects of new procedures.

Management of surgical wound infection

Dr Mahdiss Mohamadianamiri

surgical site infections (SSIs)

●Among surgical patients, surgical site infections (SSIs) are the most common type of nosocomial infection and

Definitions
•Surgical site infection (SSI) is an infection related to an operative procedure that occurs at or near the surgical incision within 30 days of the procedure (or within 90 days if an implant is left in place).

Diagnosis and treatment
•The diagnosis of SSI is predominantly clinical

Management of Critically Ill Maternal Patient

Dr. Saren Azer, MD/PhD, FRCPC, Director of Critical Care Department, Mojibian Hospital, Yazd, Islamic Republic of Iran,

Although, maternal death seems to be declining globally, it still remains a major health related challenge with wide spread socioeconomic implications, particularly in the majority world. Vast majority of maternal death are known to have limited etiologies. The four major etiologies of maternal death which seems to account for more than eighty percent of maternal death are; Peripartum Hemorrhage, Sepsis, Eclampsia and Pulmonary Thromboembolism. One potential approach to the reduction of maternal death is believed to be focused educational program for those who care for critically ill maternal patients in the evidence based and affective management of major etiologies of maternal death. Over the last 5 years the Iranian Society for obstetrician/gynecologist and Iranian Society of Perinatologists, have organized interactive educational workshops for the perinatologists and obstetrician/gynecologist in the management of critically ill patient with focus on major etiologies of maternal death in Iran. These workshops have focused on evidence-based management of these etiologies and their early diagnosis and intervention. We hope to be able to compare the overall maternal death before and after these educational workshops so that their potential impact on maternal death could be identified.

Urinary incontinence

Maryam Deldar

Urinary incontinence, the involuntary leakage of urine, is common and undertreated . It is estimated that nearly 50 percent of adult women experience urinary incontinence, yet only 25 to 61 percent of symptomatic community-dwelling women seek care.

Women with urgency urinary incontinence experience the urge to void immediately preceding or accompanied by involuntary leakage of urine. «Overactive bladder» is a term that describes a syndrome of urinary urgency with or without incontinence, which is often accompanied by nocturia and urinary frequency. The terms «urgency incontinence» and «overactive bladder with incontinence» are often used interchangeably.

The initial evaluation of urinary incontinence includes characterizing and classifying the type of incontinence, identifying underlying conditions (eg, neurologic disorder or malignancy) that may manifest as urinary incontinence, and identifying potentially reversible causes of incontinence. This evaluation includes a thorough history, urinalysis, and physical examination when appropriate.

Initial treatment of OAB is the same as for SUI and includes pelvic floor muscle training and lifestyle modifications. Additional treatment options include medication, injections of botulinum toxin, and/or sacral neuromodulation.

For patients who elect a trial of pharmacotherapy, we suggest initial treatment with a beta-3 adrenergic agonist rather than an antimuscarinic agent . Efficacy is similar for the two drug classes but antimuscarinic agents have more adverse effects. In addition, case-control and cohort studies have raised concerns for an increased risk of dementia with anticholinergic drugs. Efficacy data appear to be similar for the beta-3 adrenergic drugs mirabegron and vibegron.

For patients who cannot access beta-3 adrenergic agonist medications for reasons of availability or cost, antimuscarinic agents are a reasonable alternative as initial therapy. With any antimuscarinic drug, we start with the lowest drug dose and reassess patient response in two to six weeks. Dose increases are titrated to patient response and development of side effects.

Individuals with persistent symptoms despite exercise and lifestyle therapies followed by a trial of at least two pharmacologic therapies (or inability to tolerate them) warrant referral to a specialist to consider third-line treatment options or surgery.

Maternal near miss

Nafiseh Saghafi

Definition: A Maternal near miss occurs when a woman is on the verge of dying but survives from a life – threatening obstetric complication that occurred during her pregnancy, childbirth , or within 42 days of termination of pregnancy

Specific disorders:

. Obstetric hemorrhage

. Hypertensive disorders

. Pregnancy- related sepsis

. Abortion

. Embolism

.Ruptured uterus

.Other direct causes (complications of delivery, obstructed labor , and all other direct causes)

. Indirect causes (preexisting medical disorders , HIV- related maternal deaths, and all other indirect causes)

Causes

Overviw: circumstances leading to maternal death are both complex and multifactorial , often involing at least four contributing factors and patent / family provider , and /or facility delay . the three Delays model has been widely applied in the global context to medical events contributing to maternal deaths these delays involve :

. Delay in the decision to seek care (eg, lack of knowledge of warning signs, lack of khowledge symptoms requiring health care assessment , unrecognized life –threatening illness, woman needing to seek permission from family members before obtaining care)

. Delay in arrival to an appropriate medical care faclility (eg, poor or no transportation , long distancefrom care facility)

. Delay in receiving adequate care once a patient arrives to the medical facility (eg, lack of assessment resulting in misdiagnosis delayed or ineffective treatment,unrecognized or undertreated life- threatening condition ,inadequate facilities for severity of disease ,lack of patient care coordination Before obtaining care)

. Delay in receiving adequate care once patients arrives to the medical facility (eg , lack of assessment resulting in misdiagnosis , delayed or ineffective treatment

unrecognized or undertreated life – threatening condition , inadequate facilities for severity of disease, lack of patient care coordinationand poor communication between providers)
Example, in the united states, women residing inrural compared mortality due to lack of access to onstetric care or subspecialists (eg, maternal – fetal medicine specialists)

درمان کنسرواتیو پرولاپس ارگانهای لگنی

دکتررادنیا -فلوشیپ اختلالات کف لگن

پرولاپس ارگانهای لگنی وضعیت شایع با شیوع ۲۵ تا ۶۵ درصد میباشد در حالی که جمعیت مسن رو به افزایش است شیوع پرولاپس نیز بیشتر میشود. روشهای ترمیمی جراحی یک روش درمانی است که نزدیک به۲۰۰ هزار زن سالانه برای پرولاپس در ایالات متحده تحت جراحی قرار می گیرند. ۱۱ درصد این زنان که تحت جراحی قرار می گیرند سن ۸۰سال دارندو ۳۰درصد این زنان نیاز به تکرار جراحی دارند ،چون علائم پایدار یا عود کننده پیدا می کنند.پساری واژینال یک درمان جایگزین برای زنان با این شرایط است. از عوامل مستعد کننده میتوان از زایمان واژینال و حاملگی -کاهش کلاژن / منوپوز -افزایش فشار داخل شکم- جراحی لگن وچاقی را نام برد.

اقدامات درمانی کنسرواتیو و جراحی:

اقدامات کنسرواتیو شامل تغییرات سبک زندگی و اقدامات دیگر است.

•از موارد پیشگیری میتوان به حفظ سلامت عمومی- اجتناب از حاملگیهای متعددو پشت سر هم - افزایش فاصله بین دو حاملگی -اطمینان از استراحت کافی در دوره پورپریوم - اجتناب از تلاش زودرس در زور زدن زمان زایمان - مصرف میزان مناسب فیبر و مایعات برای پیشگیری از یبوست -اجتناب از افزایش وزن و چاقی -مدیفیه کردن مشکلات شغلی مثل بلند کردن اجسام سنگین - درمان سرفه مزمن میباشد.

سایر اقدامات:

•ورزش کگل

•فیزیوتراپی کف لگن و بیوفیدبک

•پساری

•اندیکاسیون پساری :

استفاده از پساری را می توان به تمام زنان با پرولاپس ارگانی علیرغم ویژگیهای بیمار پیشنهاد کرد. شرایط کلنیکی که در موارد استفاده از پساری بایدتوجه کرد شامل:

• بیمار درمان غیر جراحی را ترجیح دهد.

•شرایط طبی که بیمار را جهت انجام عمل جراحی نامناسب می سازد.

•نیاز به تاخیر انداختن جراحی برای چند هفته یا ماه باشد

•پرولاپس ارگان لگنی یا بی اختیاری استرس اداری عود کننده

•زخمهای واژینال بدلیل پرولاپس شدید ایجاد می شود .

•در جریان حاملگی ، جهت کنترل پرولاپس ارگان لگنی و نارسایی سرویکس

•تمایل به بچه دارشدن در آینده فواید ترمیم جراحی پرولاپس ارگان لگنی به دنبال حاملگی بعدی و زایمان ممکن است باطل شود.

• در جریان حاملگی ، جهت کنترل پرولاپس ارگان لگنی و نارسایی سرویکس

•انواع پساری:

•پساری های حمایتی

•پساری های فضاگیر

A rare case of ectopic partial molar pregnancy following IVF

Nazanin Hajizadeh

Abstract
A 29 years old female who received assisted reproductive therapy (IVF) in our infertility
clinic, at gestational age of 7w + 2d following embryo transfer presented with a favorable rise
of β-hCG level with no detectable gestational sac in uterine cavity in the vaginal ultrasonogram. First dose of MTX (78) with simultaneous β-hCG titration of 110000 pg/mL
was administered. The patient underwent a second TVS in which a mass in favor of molar
ectopic pregnancy was reported. With the suspicion of molar EP the patient underwent
explorative laparotomy. A 3*4 cm mass which was found adjacent to the right ovary was
resected. Final pathology report was compatible with partial molar pregnancy. In follow up
period after surgical resection the patient recovered completely without any recurrence
Severe early ovarian hyperstimulation syndrome following GnRH agonist trigger and freeze-all strategy in GnRH antagonist protocol; case report and literature review 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.

////////////?

Dr Zahra Soleimani . perinatologist .Baghqiatallah University of Medical Sciences

NIPT

- Prenatal screening for aneuploidies can be performed using next-generation sequencing of cfDNA in the maternal circulation.
- Circulating cfDNA is derived from both the mother and the fetal-placental unit and cleared from the maternal circulation soon after delivery .
- The cfDNA test provides excellent performance (at least 99 percent of trisomy 21 pregnancies are detected with a screen-positive rate of approximately 1 per 1000
- in patients who do not experience a test failure (no call or no result). However, it is still considered a screening test due to infrequent false-positive and false-negative results.

An invasive procedure (amniocentesis or cvs) and subsequent karyotyping or microarray analysis are considered the gold standard diagnostic tests and should be offered to patients who are screen positive by cfDNA testing

- Both the mother and the fetal-placental unit produce cfDNA. The primary is thought to be apoptosis of placental cells (syncytiotrophoblast)
- maternal hematopoietic cells are the source of most maternal cfDNA .
- A lesser source is apoptosis of fetal erythroblasts generating cfDNA

-these fragments can cross the placenta and enter the maternal circulation . Since the fetus and the placenta originate from a single fertilized egg, they are usually genetically identical,

but differences between the placenta and fetus are important sources of discordant cfDNA test results (confined placental mosaicism

Management of Oligohydramnios

Dr Neda Hashemi

Fellowship of Perinatology, Assistant Professor of Obstetrics and Gynecology
Rasoul-Akram Hospital, Iran University of Medical Science

Oligohydramnios refers to amniotic fluid volume (AFV) that is less than the minimum expected for gestational age. It is diagnosed by ultrasound examination, preferably based on an objective measurement such as amniotic fluid index (AFI) ≤5 cm or single deepest pocket (SDP) <2 cm, but a subjective assessment of reduced AFV is also acceptable. Some cases have an identifiable maternal, fetal, or placental cause; the remainder are considered idiopathic.

The fetal prognosis depends on several factors, particularly the underlying cause, severity (reduced versus no amniotic fluid), and gestational age at occurrence.

The diagnosis is based on any of the following:

Amniotic fluid index (AFI) ≤5 cm

Single deepest pocket (SDP) <2 cm

Subjective assessment of oligohydramnios by an experienced ultrasound examiner

Specific disorders associated with oligohydramnios are managed as appropriate for the disorder.

Some experts perform a nonstress test (NST) and evaluate the SDP (or AFI) once or twice weekly until birth, depending upon the maternal and fetal condition. Combined use of the NST and SDP (or AFI) is associated with a low rate of unexpected fetal death. Performing a biophysical profile is a reasonable alternative. Some experts serial sonographic examinations every three to four weeks to monitor fetal growth. Doppler velocimetry is only used to monitor pregnancies with FGR.

In pregnancies with idiopathic oligohydramnios and reassuring fetal testing we suggest delivery at 360+ to 376+ weeks of gestation or at diagnosis if diagnosed later, in accord with the American College of Obstetricians and Gynecologists› guidelines.

The Effects of Vaginal Probiotic Administration on Perinatal Outcomes in Patients with Premature Preterm Rupture of Membrane

Dr. Soufizadeh

Background: Preterm premature rupture of membrane (PPROM) is the rupture of fetal membrane before 37 weeks of gestation. The aim of the current study was to assess the effects of vaginal probiotic administration on perinatal outcomes in patients with PPROM.

Material and Methods: Sixty pregnant women with PPROM were randomly divided into two groups (n= 30). In the first group, in the first 48 hours of hospitalization, 2 gr of intravenous ampicillin and 500-mg amoxicillin capsules were administered for five days. In the second group, the patients received one vaginal probiotic supplement for ten days in addition to receiving an antibiotic treatment similar to the first group. Finally, the perinatal outcomes were examined.

Results: NICU hospitalization was significantly lower in the second group than in the first group ($P< 0.05$). The Apgar scores 1 and 5 minutes after birth and the newborns' weight at birth were higher in the second group than in the first group ($P< 0.05$). Pregnancy duration was longer in the second group than in the first group ($P< 0.05$).

Conclusion: The results of this study showed that the administration of vaginal probiotics in PPROM patients may be effective in delaying childbirth and reducing neonatal complications.

Comparison of the 12-hour and 24-hour Magnesium Sulfate Therapy Regimens after Delivery in Patients with Severe Preeclampsia

Dr. Soufizadeh

Background: Preeclampsia is considered as a major threat to public health in the world that causes complications and mortality of maternal and perinatal. The aim of this study was to compare the effect of 12-hour and 24-hour magnesium sulfate therapy regimens on severe preeclampsia after delivery.
Material and Methods: This clinical trial study was performed on 120 mothers in two groups with a diagnosis of severe preeclampsia. It was performed in Besat Hospital of Kurdistan University of Medical Sciences. In the 12-hour group (intervention group), MgSO4 was administered for 12 hours after delivery. And in the 24-hour group (control groups) MgSO4 was administered four 24 hours after delivery. It was randomly formed by random 4 blocks. Data were analyzed using SPSS software version 24, Chi-square and t-test.
Results: Based on the results of mothers of the two groups, there was not a significant difference according age, BMI, parity, gravidity, type of delivery and the sex of the baby (P> 0.05). Administration of 12-hour magnesium sulfate as much as 22-hour magnesium sulfate was effective and there was no statistically significant relationship between the two groups (P> 0.05).
Conclusion: Administration of 12-hour magnesium sulfate is as effective as 24-hour on severe preeclampsia after delivery.

Screening Across Women's Lifespan

Roya Derakhshan .Endometriosis Research Center,Iran University of Medical Sciences. Tehran.Iran

Roya Derakhshan MD
Obstetrician & Gynecologist
Fellowship of Minimal Invasive Surgery.
Iran University of Medical Sciences, Endometriosis Research Center.

Most medical training prepares doctors to identify and manage diseases, while the management of preventable disorders is very important, especially in adolescents. Gynecologists, unlike other subspecialties, are considered primary health care professionals.Preventive services are intended to reduce serious morbidity and premature mortality in adolescence and beyond. Various organizations such as USPSTF, AMA , AAFP have developed guidelines designed to empower clinicians to identify specific health problems and behaviors.Here, recommendations for women clinical prevention services developed by national organizations are presented. A physical exam should be performed every one to two years for adults ages 1949-, and every year for adults ages 50 and older. Weight, Height and BMI Monitoring Annually. women be screened for hypertension (in adults aged 18 years or older); obesity and eating disorders; hyperlipidemia (every 5 years beginning at age 20); tuberculosis (if at risk); physical, sexual, and emotional abuse; substance use; depression and suicide; sexual behavior and STD ,HIV infection; and cervical cancer every 3 years with cervical cytology alone It starts at the age of 21.Screening mammography, every 12- years for women aged 40 and older. Prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity,colorectal cancer in all adults aged 50 to 75 years, Osteoporosis in women ages 65 and older and in younger women whose fracture risk.The USPSTF recommends usage of risk-reducing medications, such as tamoxifen to women who are at increased risk for breast cancer and at low risk for adverse medication effects.

Effect of maternal undernutrition or overnutrition on FGR complications:

Dr.Shohreh Roozmeh
MD, Obstetrician & Gynecologist. Fellowship in Maternal-fetal medicine

Fetal growth restriction (FGR) affects around 5% of pregnancies and is associated with significant short- and long-term adverse outcomes. A number of factors can increase the risk of FGR, one of which is maternal
diet. Maternal nutrition and lifestyle factors can cause placental insufficiency results in chronic fetal hypoxemia, and reduced nutrient availability, altered
amino acid transfer and fetal hypoglycemia. Maternal undernutrition or overnutrition is associated with poor health outcomes in adulthood, including metabolic disease, obesity, cancer, and osteoporosis. In this section we aim to evaluate the effect of micronutrients on FGR complications

Nonhospitalized management of first-trimester abortion during the COVID-19 pandemic

Athar Rasekh Jahromi1, , Farzaneh Alipour 2 ,Zahra Zarei babaarabi3

1 Obstetrics and Gynecology ,Departments of Obstetrics and Gynecology, Jahrom University of Medical Sciences, Jahrom, Iran

2 Internist , Iran University of Medical Sciences, Jahrom, Iran

3(.Midwife) Women›s Health Research Center, Jahrom University of Medical Science, Jahrom, Iran

Corresponding author: Athar Rasekh Jahromi1

Abstract

Objective: comparison was done between the administration of misoprostol with the combined use of misoprostol plus oxytocin and misoprostol plus methylergometrine for full expulsion of retained intrauterine tissues in patients who underwent a miscarriage during the COVID-19 pandemic

Method : In this randomized, double-blind, clinical trial, 90 patients participated with their gestational age being below 12 weeks with recent miscarriage. They were randomly allocated into three groups after being screened for underlying diseases and coagulative blood disorders. For the first group, labeled as the control group, misoprostol was administered alone, while as, the combination of misoprostol plus methylergometrine and misoprostol plus oxytocin was prescribed for the second and third groups, respectively. Data were analyzed by SPSS v.22 software.

Results: Despite no significant statistical difference being observed in the expulsion of retained products of conception (RPOC)by the administration of misoprostol alone or with combined medical therapy of misoprostol with oxytocin or methylergometrine (P-value< 0.329), all of them showed a successful treatment. Additionally, the patients treated with misoprostol and oxytocin showed good results in expelling the RPOC(P=0.013); while as, those treated by misoprostol plus methylergometrine reported controlled pain and hemorrhage after an abortion (P=0.004).

Conclusion: Outpatient abortion managment are cost-effective and have shown lesser side effects. An outpatient approach was deemed more satisfactory against surgical maneuvers and hospitalizations by patients since family support influenced their pain coping mechanism. Additionally, this medical therapy aided in preserving the patients' physical and mental health.

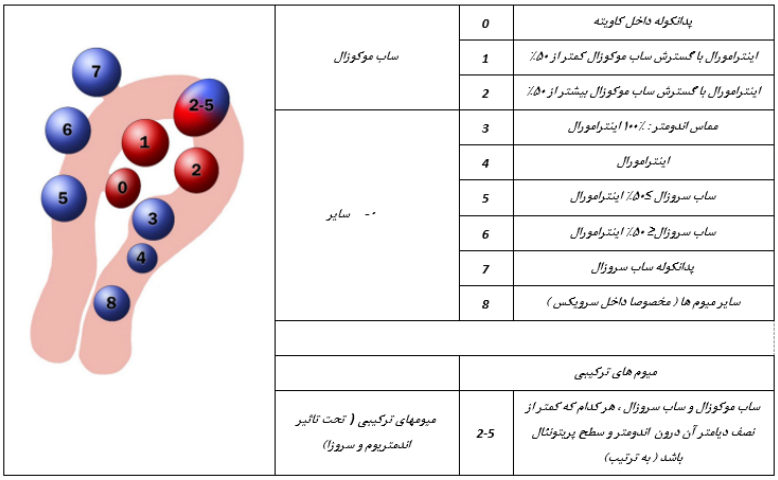
Keywords: Outpatient, treatment, medical, abortion, first trimester,

اداره فیبروم های رحمی

دکتر آزاده طرفداری

متخصص زنان و زایمان ، فلوشیپ ناباروری و IVF
هیات علمی دانشگاه علوم پزشکی تهران

فیبروم های رحمی شایعترین تومورهای لگنی در سنین باروری هستند که با طیف های متفاوتی از علایم بالینی همراه هستند.
مهمترین عوامل خطر بروز فیبروم عبارتند از ضافه وزن و چاقی ،باردار نشدن (افرادی که فرزندان بیشتری به دنیا می‌آورند کمتر در معرض فیبروم رحمی هستند) ،شروع زودرس قاعدگی ،یائسگی دیررس، سابقه خانوادگی ،کمبود ویتامین D، مصرف زیاد گوشت قرمز، کمبود سبزیجات سبز، میوه و لبنیات، مصرف الکل و آبجو و نژاد سیاه.
علائم بالینی فیبروم ها به تعداد همچنین محل و اندازه آنها بستگی دارد. به عنوان مثال، فیبروم‌های رحمی زیر مخاطی ممکن است باعث خونریزی شدید قاعدگی و مشکل در بارداری شوند. علایم فیبروم رحم ممکن است شامل موارد زیر باشد:
خونریزی شدید پریود یا خونریزی بین دوره‌های قاعدگی که شامل لخته‌شدن خون هم می‌شود ،درد در لگن یا کمر ، درد زیر شکمی ،قاعدگی دردناک ، تکرار ادرار، درد هنگام رابطه جنسی ، پریودی‌هایی که بیشتر از حد معمول طول می‌کشند، احساس فشار یا پری در زیر شکم ، تورم یا بزرگ‌شدن شکم و احساس ناراحتی در رکتوم (راست روده).



ساب موکوزال	0	پدانکوله داخل کاویته
	1	اینترامورال با گسترش ساب موکوزال کمتر از ۵۰٪
	2	اینترامورال با گسترش ساب موکوزال بیشتر از ۵۰٪
سایر	3	مماس اندومتر: ٪۱۰۰ اینترامورال
	4	اینترامورال
	5	ساب سروزال ≤۵۰٪ اینترامورال
	6	ساب سروزال ≥ ۵۰٪ اینترامورال
	7	پدانکوله ساب سروزال
	8	سایر میوم ها (مخصوصا داخل سرویکس)
میوم های ترکیبی		
میومهای ترکیبی (تحت تاثیر اندمتریوم و سروزا)	2-5	ساب موکوزال و ساب سروزال ، هر کدام که کمتر از نصف دیامتر آن درون اندومتر و سطح پریتونئال باشد (به ترتیب)

مهمترین سیستم طبقه بندی فیبروم ها سیستم فیگو است نه بر طبق جدول زیر صورت می گیرد:
درمان فیبروم بر اساس علایم بالینی و محل و اندازه آن صورت می گیرد و شامل درمان های دارویی و جراحی می باشد.

The association between food groups and preeclampsia: a case control study

Akram Kooshki a, Behnaz Sovizi b, Rahil Mahmoudi c, Saiedeh Ghezi d, and Elaheh Foroumandi e

a.Nutrition and Biochemistry Department, Non- Communicable Diseases Research Center, sabzevar University of Medical Sciences, Sabzevar, Iran;
b.Department of Obstetrics and Gynecology, Faculty Member of Medicine School, sabzevar University of Medical Sciences, Sabzevar, Iran;
c.Department of Community of Medicine, Faculty Member of Medicine School, sabzevar University of Medical Sciences, Sabzevar, Iran;
d.Department of Midwifery, School of Nursing and Midwifery, sabzevar University of Medical Sciences, Sabzevar, Iran;
e.Nutrition and Biochemistry Department, Cellular and Molecular Research Center, sabzevar University of Medical Sciences, Sabzevar, Iran

ABSTRACT
Purpose: The aim of current study was to investigate the correlation between preeclampsia and
food groups among pregnant women.
Methods: This case-control study was done on pregnant women with a diagnosis of preeclampsia in Sabzevar. The control group was included non-infected postpartum women.
Results: Intake of vegetables (OR = 0.952, CI: 0.724–0.985, $p < 0.001$), fruits (OR = 0.901, CI: 0.852–0.990, $p = 0.012$), nuts and legumes (OR = 0.712, CI: 0.531–0.848, $p = 0.009$), and sugars and sweets (OR = 1.254, CI: 1.112–1.497, $p < 0.001$) were related to the odds of preeclampsia.
Conclusions: Women with preeclampsia had lower intake of vegetables, fruits, milk and products,and also fluids. Intake of sugars and sweets compared with the intake of vegetables, fruits, nuts,and legumes was associated with increasing odds of preeclampsia.
KEYWORDS:Pregnancy; preeclampsia;food group; dietary patterns;

Advanced maternal age & pregnancy

Fatemeh Tara
Professor of Perinatology, Mashhad University of Medical Sciences, Iran

A woman is born with all the eggs she is going to have in her lifetime. Her eggs age with her, decreasing in quality and quantity. Age is the single most important factor affecting a woman›s fertility. Fertility clearly declines with advancing age, especially after the mid-30s, and women who conceive are at greater risk of pregnancy complications. While good health improves the chance of getting pregnant and having a healthy baby, it doesn›t override the effects of age on a woman›s fertility. The increased occurrence of births at older maternal ages: Increased population of women aged 35 to 45, Later marriage, Second marriage, The availability of better contraceptive options, Wider opportunities for further education and Career advancement

The risk of pregnancy complications increases with age too. The risk of miscarriage and chromosomal abnormalities in the fetus increase from age 35. Complications such as gestational diabetes, Multiple gestation, preeclampsia, placenta previa, caesarean section and still birth are also more common among older women than younger women. While maternal mortality is relatively rare, women 40 years or older are at a six fold increased risk of maternal death when compared with women less than 20 years of age

The experience of pregnancy at an advanced maternal age may impact subsequent health as the woman continues to age, both because of changes from the pregnancy itself and because of increased risk of pregnancy-related complications that negatively affect health.

Management: Women should balance the biological advantages of having a child at a younger age against the economic and social advantages of establishing a career. Counsel on the age-related risk of fetal aneuploidy and offer prenatal screening and diagnosis. Offer prenatal screening and diagnosis. Weekly testing from 37 w to drop the risk of fetal death and hospital delivery

Bowel endometriosis

S.Rokhgireh MD
Obstetrician & Gynecologist
Fellowship in Minimally Invasive Gynecology Surgery (FMIGS)
Assistant professor
Iran University of Medical Science(IUMS)
Rasoul- eAkram Tertiary Hospital Tehran, Iran

Endometriosis is an estrogen-dependent inflammatory disease defined by the presence of endometrial glands and stroma at extra-uterine sites. There are three subtypes of endometriosis, including
superficial endometriosis, ovarian endometriotic cyst and deep endometriosis. Bowel endometriosis is diagnosed when the disease is situated inside the bowel wall. The most affected part is the rectosigmoid area in 90%.The prevalence of deep endometriosis involving the bowel has been reported 5.3% - 12% .
Patients with bowel endometriosis may suffer pain and intestinal symptoms, including dyschezia, abdominal bloating, constipation, or diarrhea that may worsen during the menstrual cycle, passage of mucus with the stools, cyclical rectal bleeding and defecation urgency. Large intestinal endometriotic
nodules may cause significant stenosis . Asymptomatic patients do not need treatment. Hormonal therapies may mitigate pain and intestinal symptoms .
Surgery is needed in patients with obstructive or Semi-obstructive symptoms, in those who do not have improvement of symptoms despite the hormonal treatments, in those with contraindications to the use of hormonal therapies and in patients desiring to conceive.
Bowel endometriotic nodules can be treated by different surgical techniques. Shaving technique is
used when the endometriotic nodule could be peeled without opening the intestinal lumen.
Disc excision is used to define a full-thickness resection of the intestinal wall.
Segmental resection is defined as the removal of a bowel segment with subsequent anastomosis.
Segmental resection is usually performed for large, circumferential, obstructive nodules, and multifocal disease. Rectovaginal fistula and anastomotic leakage are two major complications of Segmental Resection. Other complications include pelvic abscess, postoperative bleeding, ureteral damage, and anastomotic
stricture.

احتباس ادرار بعد از زایمان stopsutrap mutrapsotp (RUP) noitneter yraniru

دکتر منصوره یراقی، دکتر نسیم شکوهی

احتباس ادرار بعد از زایمان تعاریف متنوعی دارند و بنابراین شیوع آن متفاوت گزارش می شود.علل متنوعی باعث این اختلال می شوند ولیکن به نظر می رسد مهمترین عامل، اختلال عملکرد عصب پودندال می باشد.از عوامل خطر آن می توان به بی حسی پودندال، پریمی پاریته، زایمان ابزاری و اپی زیوتومی اشاره کرد. احتباس ادرار بعد از زایمان به دو نوع overt و covert تقسیم می شود.

علایم این اختلال از طیف بی علامت تا دفع مقادیر کم ادرار ،تکرر ادرار یا جریان متناوب یا آهسته ادرار، درد یا احساس ناراحتی مثانه، بی اختیاری ادرار، زور زدن یا احساس تخلیه نا کامل می باشد.

اگر چه درمان های دارویی متنوعی گزارش شده اند لیکن هیچ کدام از آنها موثر نیستند و تنها درمان کتتریزاسیون متناوب است. پروتکل استانداردی در این زمینه وجود ندارد با این حال می توان هر ۴ تا ۶ ساعت یا در زمان هایی که بیمار دچار حس ادرار کردن می شود اقدام به کتتریزاسیون نمود. این اقدام را می توان تا زمانی که باقیمانده ادرار به کمتر از ۱۵۰ میلی لیتر برسد و بیمار در ادرار کردن مشکلی نداشته باشد ادامه داد.

Adherence to Mediterranean Diet and Outcomes of Assisted Reproduction Technologies

Ghazaleh Eslamian
Assistant professor, Department of Cellular and Molecular Nutrition, Faculty of Nutrition and Food Technology, National Nutrition and Food Technology Research Institute, Shahid Beheshti University of Medical Sciences, Tehran, Iran

Background and Aim: There is growing acceptance that nutrition may be related to fertility, and specifically to assisted reproductive technologies (ART) success in women; however, there is still no specific dietary guidance. This systematic review aimed to evaluate the relationship between pre-treatment adherence to Mediterranean Diet (MedDiet) and outcomes of ART.

The recognition that nutrition can impact fertility, particularly with regards to assisted reproductive technologies (ART) in women, is growing. However, there is currently no specific dietary guidance available. This systematic review was conducted to assess the relationship between pre-treatment adherence to the Mediterranean Diet (MedDiet) and ART outcomes. The review involved a search of Persian and English language databases, using keywords related to Mediterranean dietary patterns, fertility, infertility, in vitro fertilization, and intra-cytoplasmic sperm injection. Five studies were evaluated, with varying results. Gaskin et al. found that women with higher MedDiet adherence had a greater chance of live birth compared to those with lower adherence. Vujkovic et al. reported a higher probability of pregnancy with high adherence to the Mediterranean diet by the couple. Sun et al. demonstrated that higher MedDiet adherence was associated with a larger number of embryos available. Karayiannis et al. showed that women with the highest MedDietScore had higher rates of clinical pregnancy and live birth compared to those with lower scores. However, Ricci et al. did not find a significant association between the Mediterranean diet score and IVF outcomes. Overall, the systematic review suggests that adherence to the Mediterranean diet during ART treatment may enhance the likelihood of achieving pregnancy. Therefore, it appears that the optimal «fertility diet» is similar to the Mediterranean dietary pattern.

Methods: In the current systematic review, the keywords of Mediterranean dietary patterns, fertility, infertility, in vitro fertilization and intra-cytoplasmic sperm injection in Medline, PubMed, Embase, Science Direct, Magiran, ISD, ISC and Cochrane were searched in Persian and English languages.

Results: In this systematic review, 5 studies were examined. Gaskin et al. showed

that women in the 2nd thru 4th quartiles of MedDiet adherence had significantly higher probability of live birth (0.44 95% CI 0.39, 0.49) compared to women in 1st quartile (0.31 95% 0.25, 0.39). Vujkovic et al indicated that high adherence by the couple to the «Mediterranean» diet increased the probability of pregnancy, odds ratio 1.4 (95% CI 1.01.9-). Sun et al showed that higher MediDiet adherence group showed larger number of embryos available (8.40 ± 5.26 vs 7.40 ± 4.71, P = 0.028). Karayiannis et al showed women in the highest tertile of the MedDietScore, women in the lowest tertile (≤30, n = 79) had significantly lower rates of clinical pregnancy (29.1 vs 50.0%, P = 0.01) and live birth (26.6 vs 48.8%, P = 0.01). However Ricci et al showed Mediterranean diet score was not significantly associated with in vitro fertilization outcomes.

Conclusion: Adherence to Mediterranean diet by couples undergoing ART treatment may contribute to the success of achieving pregnancy. Optimal “fertility diet” is very closely resemble the Mediterranean dietary pattern.

Keywords: Mediterranean dietary patterns, fertility, infertility, IVF, ICSI

Ghazaleh The management of pregnancy in women of advanced age

Maryam Moshfeghi Perinatologist

Department of Endocrinology and Female Infertility, Reproductive Biomedicine Research Center,Royan Institue for Reproductive Biomedicine,ACECR, Tehran , Iran

In many countries, the mean maternal age at first birth is rising. However, fertility declines with advancing age. Thus, many females in more advanced age groups are presenting for fertility evaluation and treatment. The rising mean age of first pregnancy has been further impacted by declining birth rates in younger individuals combined with rising birth rates in individuals of advancing reproductive age. Pregnancy complications that occur with increased frequency in older gravidae include: ectopic pregnancy, spontaneous abortion, fetal chromosomal abnormalities, some congenital anomalies, placenta previa, gestational diabetes, preeclampsia, and cesarean delivery. Such complications may, in turn, result in preterm birth. There is also an increased risk of perinatal mortality. At a time when women are delaying childbearing, the availability of assisted reproductive technologies for older women has allowed women to extend their reproductive options. The risk of pregnancy loss associated with advancing maternal age has been well recognized. For pregnant women ≥35 years of age at the estimated date of delivery, we suggest offering prenatal diagnosis or screening for aneuploidy and a detailed second trimester ultrasound examination to look for significant structural anomalies (particularly cardiac defects . Age and obesity are risk factors for development of type 2 diabetes mellitus, as well as gestational diabetes . Events that occur with increased frequency in older gravidae include hypertensive disease and preeclampsia, placenta previa, gestational diabetes, and abruption. we favor delivery in the 39th week of gestation for women ages 35 years and older because of the increased risk of stillbirth beyond this gestational age, the diminishing reproductive options for women in this age group, and the low risk of neonatal morbidity/mortality at this gestational age. Women who decline induction are managed with twice weekly testing and daily kick counts until spontaneous labor, nonreassuring testing, or 41 weeks of gestation.

Maternal near miss

Nafiseh Saghafi

Definition: A Maternal near miss occurs when a woman is on the verge of dying but survives from a life – threatening obstetric complication that occurred during her pregnancy, childbirth , or within 42 days of termination of pregnancy

Specific disorders:

. Obstetric hemorrhage

. Hypertensive disorders

. Pregnancy- related sepsis

. Abortion

. Embolism

.Ruptured uterus

.Other direct causes (complications of delivery, obstructed labor , and all other direct causes)

. Indirect causes (preexisting medical disorders , HIV- related maternal deaths, and all other indirect causes)

Causes

Overviw: circumstances leading to maternal death are both complex and multifactorial , often involing at least four contributing factors and patent / family provider , and /or facility delay . the three Delays model has been widely applied in the global context to medical events contributing to maternal deaths

these delays involve :

. Delay in the decision to seek care (eg, lack of knowledge of warning signs, lack of khowledge symptoms requiring health care assessment , unrecognized life – threatening illness, woman needing to seek permission from family members before obtaining care)

. Delay in arrival to an appropriate medical care faclility (eg, poor or no transportation , long distancefrom care facility)

. Delay in receiving adequate care once a patient arrives to the medical facility (eg, lack of assessment resulting in misdiagnosis delayed or ineffective treatment,unrecognized or undertreated life- threatening condition ,inadequate facilities for severity of disease ,lack of patient care coordination Before obtaining care)

. Delay in receiving adequate care once patients arrives to the medical facility (eg , lack of assessment resulting in misdiagnosis , delayed or ineffective treatment unrecognized or undertreated life – threatening condition , inadequate facilities

for severity of disease, lack of patient care coordinationand poor communication between providers)Example, in the united states, women residing inrural compared mortality due to lack of access to onstetric care or subspecialists (eg, maternal – fetal medicine specialists

عوارض طولانی مدت سندرم تخمدان پلی کیستیک

دکتر مهناز اشرفی
۱. پژوهشگاه رویان، پژوهشکده زیست شناسی و علوم پزشکی تولید مثل جهاد دانشگاهی، مرکز تحقیقات پزشکی تولیدمثل،گروه اندوکرینولوژی و ناباروری زنان، تهران، ایران
۲. واحد توسعه تحقیقات بالینی شهید اکبرابادی؛ دانشکده پزشکی دانشگاه علوم پزشکی ایران، تهران، ایران

سندرم تخمدان پلی کیستیک از حدود ۸۰ سال قبل تعریف شده است و همواره به عنوان بیماری مزمن در رابطه با اختلالات ژنیکولوژیک و متابولیک همراه بوده است. دو عامل مهم بروز این عوارض مسئله هیپرآندروژنیسم (افزایش آندروژن) و مسئله مقاومت به انسولین می باشد که این عوارض خود باعث بروز بیماریهای کاردیو واسکولار (قلبی عروقی) در این بیماران شده است. از طرف دیگر با افزایش سن خانم ها ,PCOS میزان بروز چاقی، عدم تحمل گلوکز، افزایش فشار خون ، مشکلات در رابطه با متابولیسم چربی (Dyslipidemia) و سندرم متابولیک گزارش شده است. بنابراین شواهد نشان داده است که بیماران PCOD درطول زمان در خطر دیابت نوع دوم و سندرم متابولیت ، آپنه انسدادی حین خواب(Obstructive Sleep Apnea)، کانسر آندومتر و اختلالات رفتاری هستند و مسئله اختلالات کاردیو واسکولار هم برای آنها مطرح شده است. در بررسی های اخیر مشاهده شده است علی رغم یافته های خاص در بیماران PCOD که می تواند آنها را دچار بیماری های متابولیک و کاردیو واسکولار در سنین پایین تر نسبت به افراد غیر PCOS نماید. با افزایش سن بخصوص در زمان پیرامون یائسگی و بعد از آن در بیماران PCOS علائم خاص بیماری مانند افزایش آندروژن ها و اختلالات تولید مثلی آنها نسبتا برطرف شد لذا این مسئله را مطرح نموده است که آیا با این تغییر شرایط بخصوص در فنوتیپ های خاص PCOS باز احتمال بروز بیماری های قلبی و عروقی و متابولیک نسبت به افراد دیگر بیشتر است یا نه. در این رابطه در تحقیقات بسیار طولانی مدت (حدود ۲۰ ساله) که انجام شده به این نتیجه نسبی رسیده اند که با کاهش علائم PCOS مانند هیپرآندروژنیسم ، بیماریهای متابولیک و کاردیو واسکولار نسبت به افراد غیر PCOS تفاوت چندانی ندارد ولی این مسئله خیلی مربوط به نوع فنوتیپ بیمار می باشد. ولی در رابطه با OSA (Obstructive Sleep Apnea) و کانسر و اضطراب و افسردگی نتایج نامعلوم بوده و نیازمند تحقیقات بیشتری می باشد. لذا با توجه به گستردگی فنوتیپ بیماران PCO مسائل در رابطه با عوارض طولانی مدت (Long term complication) در آنها متفاوت می باشد. دراین زمینه تحقیقات کمی وجود دارد که بتواند اثرات فنوتیپ و نژاد را بررسی کند و نیازمند مطالعات بیشتر است.

به نام خدا
با عرض سلام و ارادت حضور محترم استاد گرامی سرکارخانم دکتر کاشانیان :

این مقاله خالصه ای از تجربیات ۴۰ساله اینجانب در بعضی اعمال جراحی و نکاتی در مورد اتاق عمل می باشد.
۱.نکاتی در مورد باز کردن و بستن جدار شکم مثال: هموستات ها را برای باز کردن پرتیوان جداری نزدیک به هم نگرفته و ترجیحا با بیستوری باز کنیم. (ریسک پارگی روده کمتر می شود).
بهترین Exposure انسیزیون فانشتیل باز کردن قسمت باالی آن حتی تا زیر ناف است.
۲.هیسترکتومی شکمی مثال۱: برای Exposeکردن رحم بهتر است فوندوس را با تناکولوم نگیریم (به خصوص در موارد مشکوک به کانسر رحم) بهتر است با کوخر آدنکس را مماس با رحم بگیریم هم خونرسانی به رحم کم می شود هم برای قطع لیگامانها نیاز به کوخر اضافه تر نداریم ، در ضمن اگر کانسر رحم باشد از طریق لوله به داخل لگن پخش نمی شود. در ابتدای هیسترکتومی می توانیم لیگامان های اوتروساکرال را قطع کنیم رحم تحرک بیشتری خواهد داشت.
مثال :۲ اگر تخمدانها را نگه می داریم حتما پدیکول رو به نحوی فیکس کنیم که ۱) احتمال تورسیون کمتر شود . ۲) تخمدان ها به طرف قدام قرار گیرد که هم داخل دوگالس (دیس پارونی) قرار نگیرد و هم اینکه اگر خدای نکرده در آینده سرطان تخمدان ایجاد شود بیمار زودتر متوجه شود ۳) پدیکول تخمدان اگر رها باشد احتمال چسبندگی تخمدان به جدار شکم و متعاقب آن درد شدید جدار موقع اووالسیون اتفاق خواهد افتاد.
مثال:۳ هیسترکتومی ساب توتال حتما با کونیزاسیون بر عکس سرویکس انجام شود.
مثال ۴)در بعضی موارد شاید کالمپ ها را بزنیم سوچور نکنیم رحم را خارج کنیم بعد سوچور کنیم (در موارد خونریزی شدید یا سزارین هیسترکتومی) .
مثال ۵ : گوشه های کاف واژن را به هم نزدیک کنیم به خصوص با عبور از اوتروساکراها (احتمال پروالپس کاف کمتر می شود) (سوچور مجزا).
۳.سزارین : ۱) انسیزیون کوچک ندهیم ۲) قبل از عمل از قرارگیری پشت جنین (معمولا طرف چپ) برای فلکسیون سر در جهت مخالف مطمئن باشیم (هم خروج جنین راحت تر است هم خطر ترومای عضله و عصب در جنین کمتر می شود) ۳)سگمان نازک ترانسیزیون باالتر ۴) سر پک شده بهتر است یک نفر موقع خروج ، سر را از طریق توشه واژینال به باال هدایت کند .
۴. آدنکس ها : مثال: ۱) رگ های مزوسالپنکس تا حد امکان حفظ شود ۲) برش های روی کیست از کنار داده نشود بهتر است روی کیست برش داده شود که بتوانیم نسج تخمدانی بیشتری را حفظ کنیم (به خصوص اگر نسج تخمدان کم باشد) ۳)کیست های مورگاگنی یا کوبلت نزدیک فیمبریا بهتر است برداشته شوند چون احتمال تورسیون آدنکس هست.
۷.سوچورینگ و هموستاز :
-بهترین سوچور Through and Through است.
-بدترین سوچور lock پیوسته است به خصوص اگر روی آن سوچور مجدد هم زده شود !!
- Biteهای بزرگ کال توصیه نمی شود
- همیشه نوک وسیله را اسکراب به طرف باال روی دست جراح قرار دهد
چه موقع سوزن(circle) ۲/۱ استفاده کنیم

چه موقع سوزن ۸/۳ استفاده کنیم .
کال هر چین اضافه احتمال کیست انکلزیونی رابیشتر می کند.
۸. میومکتومی : morcelation بهترین تکنیک برای حفظ آندومتر است .
اولین الیه میوتر را بهتر است تک تک سوچور کنیم.
عمیق ترین میوم ها را اول برداریم که باالئی ها دستگیره باشند.
۹. نکات جراحی واژینال
۱۰. رعایت اصول ارگونومی و...
با سپاس فراوان
دکتر وحید یزدی اسفند ۱۴۰۱

Recurrent Reproductive Failure, immunopathology and immunotherapeutic approaches

Dr. brjis

Human reproduction, as an inefficient process, faces various complications, caused by maternal or embryonic factors. Recurrent reproductive failure (RRF) is a comprehensive phrase, including the complications related to failure in implantation (repeated or recurrent implantation failures (RIF)) or maintenance of pregnancy (recurrent pregnancy loss (RPL), which is also known as recurrent miscarriages (RM), recurrent spontaneous abortion (RSA)). RPL is defined as two or more pregnancy losses, while RIF is >3 failed high quality embryo transfers (ETs). Although several risk factors have been determined for RIF and RPL, including chromosomal and anatomical abnormalities, infections, endocrine disorders, thrombophilia, and lifestyle, nevertheless, the etiology of almost 50% of RRFs remains unclear. Abnormalities in maternal immune system is the other factor, which affects the reproduction outcome.

Human embryo or fetus, similar to a semi-allograft, carries paternal antigens, which are recognized by maternal immune system. In order to protect the fetus from the maternal immune system attack, regulatory or suppressive mechanisms are required to neutralize the responses of immune system. Any disturbance in these regulatory mechanism may lead to pregnancy adverse outcomes. The most studied immunologic aberrations which are involved in the etiopathogenesis of RRF are as following: increased frequency and function of both uterine and peripheral natural killer cells, upregulation of T helper 1 (Th1), Th17, and Th9 cells and associated cytokines, reduced frequency and cytokine secretion of regulatory arm, Th2 and regulatory T cell (Treg). Moreover, over-production of auto-antibodies such as anti-phospholipid antibodies, anti-nuclear antibodies and anti-thyroid antibodies by B lymphocytes, also compromise the pregnancy maintenance by different mechanisms, such as cross-reaction with oocyte, placenta, clot formation, necrosis of trophoblast cells and etc.

Several immunotherapeutic agents have been already introduced to modulate the abnormal immune responses of mother against embryo or fetus, and their efficiency have been investigated in several in-vitro, animal and clinical studies such as heparin, aspirin, corticosteroids, intravenous immunoglobulin G (IVIG), intralipids and lymphocyte immunotherapy. However, there are some novel immunotherapeutic approaches, which still require further investigation, in spite of promising results in improving pregnancy outcome, including immunosuppressive medications

used in inhibition of graft rejection, such as calcineurin inhibitors (Cyclosporine, Tacrolimus) and mammalian target of rapamycin (mTOR) kinase pathway inhibitor (Sirolimus), recombinant cytokines, monoclonal antibodies against cytokines (anti-TNF-α antibodies) and cell therapy (mesenchymal stem cells, human amniotic epithelial cells).

Considering the novelty of immunotherapy in the field of reproductive disorders and the limited number and heterogeneity of available studies (sample size, patients' selection, dose, route, duration), further investigations are required in order to confirm the efficiency and safety of recent approaches. Moreover, due to the involvement of immunologic aberrations in pathogenesis of RRF (excluding other etiologies), evaluation of immunologic abnormalities by immunologic tests and patients' selection based on their immunologic basis, or personalized medicine in other words, would result in be more beneficial effects of immunotherapeutic approach.

انتخاب درمان کانسر پیشرفته تخمدان : جراحی یا شیمی درمانی نئوادجوانت

دکتر فاطمه قائم مقامی
انکولوژیست زنان، استاد دانشگاه علوم پزشکی تهران

چکیده:
کانسر تخمدان یکی از کانسرهای شایع ژنیکولوژیک است، به طوری که در کشورهای در حال توسعه سومین کانسر ژنیکولوژیک بعد از کانسر سرویکس و اندومتر و در کشورهای توسعه یافته دومین کانسر ژنیکولوژیک بعد از کانسر اندومتر است.
از طرفی مرگبارترین کانسر ژنیکولوژیک است زیرا در حالی که ۲/۵ درصد از کانسرهای زنان را در کل بدخیمی ها تشکیل می دهد. علت مرگ ۵درصد بدخیمی های زنان است و از نظر علت مرگ بعد از کانسر ریه، پستان، کولون و پانکراس، پنجمین علت مرگ زنان را تشکیل می دهد.
این مسئله به دلیل عدم وجود مارکر ویژه جهت تشخیص در مراحل اولیه و عدم وجود علائم خاص در مراحل اولیه است. به طوری که در ۷۵درصد موارد در مراحل پیشرفته و Advanced تشخیص داده می شوند.
درمان اصلی کانسر تخمدان پیشرفته جراحی سایتوریداکتیو و کموتراپی ادجوانت بر اساس پلاتینیوم است.
در این جراحی مهمترین فاکتور موثر در سوروایوال حجم تومور باقیمانده است، به طوری که بیشترین پیش آگهی در صورتی که جراحی به صورت complete و no visible تومور باشد، حاصل می گردد. ولی تومور باقیمانده در حد کمتر از ۱۰ میلی متر یا optimal نیز مورد قبول است.
استفاده از کموتراپی نئوادجوانت با ۳ تا ۴ سیکل کموتراپی و سپس جراحی interval Debulking staging می باشد. در موارد Stage III, IV کانسر تخمدان که با Imaging (CT) و لاپاروسکوپی explorative، unresectibility تومور (در حد غیر optimal) داده شود یا بیمار شرایط Poor condition داشته باشد (سن بالا، سابقه ترومبوفلبیت، پلورال وپریکاردیال ایفوژن، ....)، NACT/IDS توصیه می شود. این روش تاثیری در PFS و OS ندارد و نسبت به جراحی اولیه یعنی non inferior ، PDS (Primary Debulking surgery) است.
با این حال برخی مطالعات اخیر احتمال relapse در NACT/IDS نسبت به PDS در مدت زمان کوتاهتر بدلیل chemo resistancy نشان داده است و محل relapse در NACT/IDS نسبت به PDS بیشتر خارج از لگن است.
نرمال شدن CA۱۲۵ قبل از جراحی در روش NACT/IDS و فاصله کمتر از ۵ هفته از آخرین کموتراپی نئوادجوانت پیش آگهی بهتری نشان داده است و سوروایوال بیماران بهتر بوده است.
به طور کلی در صورتی که امکان جراحی با رسیدن به تومور باقیمانده در حد R1-R0 یعنی optimal جراحی اولیه یا PDS انتخاب بهتری است که صلاح است توسط ژنیکولوژیست انکولوژیست در مراکز high quality انجام شود.

National Association of Iranian
Gynecologist & Obstetricians

Oral Presentations

Presentation Type: Oral

The Effect of Metformin in Preventing of Superimposed Preeclampsia: a Randomized Clinical Trial

Submission Author: Shahnaz Ahmadi

Shahnaz Ahmadi[1]

1. iran university of medical science

Background and Aim: Preeclampsia is associated with the release of soluble endoglin (sENG) into the maternal circulation. It inhibits sENG secretion, inhibiting the complex I of the mitochondrial electron transport chain. Therefore, using metformin may be helpful in the prevention of preeclampsia. The aim of this study was to evaluate the effect of metformin in preventing superimposed preeclampsia

Methods: This single-blind randomized clinical trial was conducted on ۶۰ pregnant women ۲۵-۴۰ years old with chronic hypertension before the ۲۰th week of pregnancy. The patients were randomized and divided into two groups (n=۳۰). The first group received ۱۰۰۰ mg metformin (tablet metformin ۵۰۰ mg bid), and the second group received a placebo (۲ tablets daily). Then the incidence of preeclampsia and intrauterine retardation growth of the fetus were compared in the two groups

Results: The metformin consumption significantly reduced the incidence of preeclampsia (P=۰.۰۴) and intrauterine growth restriction (P=۰.۰۳۵) compared to the control group

Conclusion: Metformin effectively reduced the incidence of superimposed preeclampsia and related factors in a pregnant patient with chronic hypertension.

Keywords: Chronic Hypertension ، Metformin ، Pregnancy ، Superimposed Preeclampsia

Presentation Type: Oral

Relationship between serum lead levels (from air pollution) and maternal and fetal outcomes

Submission Author: Mino Movahedi

Mino Movahedi[1]

1. Department of gynecology, Isfahan University of medical Science, Isfahan. Iran

Background and Aim: Air pollution and industrial waste could contribute to different pregnancy complications. In this study, we aimed to compare blood lead levels of mothers with or without pregnancy complications.

Methods: This is a descriptive analytic cross-sectional study that was performed in 20202021- on pregnant women with diagnosis of preterm labor (PTL), pregnancy induced hypertension (PIH) and Intrauterine Growth Restriction (IUGR) and normal pregnant women as control. Demographic information including age, body mass index (BMI) and place of residence, were collected. The blood levels of lead were evaluated for all participant. Data were compared between the four groups.

Results: We evaluated data of 100 pregnant women with no complications during pregnancy, 55 women with complication of IUGR for their neonates, 55 patients with PTL and 56 patients with PIH. Women without complications had significantly lower levels of lead (3.333.12±) compared to women with IUGR (6.831.23±), PTL (7.721.44±) and PIH (6.362.07±) ($P< 0.05$ for all four groups). There were no significant relationships between lead levels and mother's age ($P= 0.450$), BMI ($P= 0.973$) and Apgar score ($P= 0.563$).

Conclusion: The mothers with complications had significantly higher lead levels compared to controls. There were no other significant differences between the evaluated cases and we observed no significant relationships between lead levels and population characteristics (mother's age, BMI and Apgar score).

Keywords: pregnancy, complications, lead.

Presentation Type: Oral

Heart Diseases Frequency in Pregnant Women Referred to Al-Zahra Hospital Joint Clinic of Pregnancy and Heart Disease

Submission Author: Mahmoud Saeidi

Mahmoud Saeidi[1], Minoo Movahedi[2], Parvin Bahrami[3]

1. Department of Cardiac Surgery, Isfahan University of Medical Sciences, Isfahan, Iran
2. Department of Obstetrics and Gynecology, Isfahan University of Medical Sciences, Isfahan, Iran
3. Department of Internal Medicine, Isfahan University of Medical Sciences, Isfahan, Iran

Background and Aim: Pregnancy is a complex process and Cardiovascular disease in pregnancies is the most common cause of maternal death. Pregnancy causes sweeping changes in mothers that can burden the cardiovascular system, leading to new disorders such as preeclampsia and arrhythmia or the activation and exacerbation of existing cardiovascular problems.

Methods: In this retrospective cohort study, we assessed heart disease frequency in pregnant mothers referred to the Joint Clinic of Pregnancy and Heart disease in AlZahra Hospital between March 2017 and March 2021.

Results: A total of 298 pregnant women with heart disease were assessed. Among the principal diagnosis of heart disease during pregnancy was congenital heart disease 24.5%, followed by prosthetic heart valve 15.8% and Mitral Stenosis (MS) 15%

Conclusion: This study demonstrates that congenital heart disease (CHD) is the primary type of heart disease in pregnancy, followed by prosthetic heart valves and MS. More comprehensive studies are recommended.

Keywords: Pregnancy, Heart diseases, Prevalence

Presentation Type: Oral

Pregnancy outcome in women with mechanical prosthetic heart valvesat their first trimester of pregnancy treated with unfractionated heparin (UFH) or enoxaparin: A randomized clinical trial

Submission Author: Mahmoud Saeidi

Mahmoud Saeidi[1], Minoo Movahedi[2], Parvin Bahrami[3]

1. Department of Cardiac Surgery, Isfahan University of Medical Sciences, Isfahan, Iran
2. Department of Obstetrics and Gynecology, Isfahan University of Medical Sciences, Isfahan, Iran
3. Department of Internal Medicine, Isfahan University of Medical Sciences, Isfahan, Iran

Background and Aim: Pregnancy increases the risks of thromboembolism for the mother and fetus in patients with mechanical heart valves. The results of some studies have indicated that low molecular weight heparin (LMWH), in comparison with unfractionated heparin (UFH), leads to a lower incidence rate of thrombocytopenia and a decrease in bleeding.

Methods: The present randomized clinical trial involved 31 pregnant women with mechanical heart valves at their first trimester (014- weeks) of pregnancy. To perform the study, the patients were divided into two groups, i.e. group A (LMWH group-16 patients) and group B (UFH group-15 patients). The birth weight, mode of delivery, and gestational age at birth as well as the maternal and fetal complications were compared between the two groups.

Results: The mean age of mothers in the UFH and LMWH groups was 32.679.11± and 31.505.81±years, respectively (P value > 0.05). Although the rate of maternal and fetal complications was higher in the UFH group as compared with the LMWH group, the observed difference was not significant (P value > 0.05).

Conclusion: LMWH can be regarded as a safer therapy for both the mother and

fetus due to its lower number of refill prescriptions and fewer changes in the blood level.

Keywords: Low Molecular Weight Heparin; Mechanical Heart Valves; Pregnancy; Unfractionated Heparin.

Presentation Type: Oral

Tuboplasty as a reversal macrosurgery for tubal ligation.Is Pregnancy Possible?

Submission Author: Fakhrolmolouk Yassaee

Fakhrolmolouk Yassaee[1]

1. Shahid Beheshti University of Medical Sciences

Background and Aim: : Reversal of tubal ligation is requested by some women for various reasons.The present study aims to determine the rate of pregnancy after tubal ligation reversal.

Methods: From April 1996- April 2012, 15 women who requested reversal of tubal ligation were included in the study and end to end anastomosis of fallopian tubes was carried out.

Results: Death of a male child was the commonest (26.6%) reason for tubal ligation reversal.Four women(26.6%) conceived after reversal surgery, 2 had term pregnancy and in 2 the fetus was aborted. More than 50% of the women who conceived became pregnant within one year of tuboplasty, all of them had bilateral isthmic- isthmic anastomosis. All those who conceived had residual tubal length of more than 6cm

Conclusion: The success rate of pregnancy after macrosurgical reversal of tubal ligation is good and can be considered before in vitro fertilization. The type of tubal ligation and the procedure used will determine the best procedure for reversal and have a major impact on chances of success for reversal surgery

Keywords: Tubal ligation ,reversal macrosurgery, tuboplasty

Presentation Type: Oral

Predictive role of Doppler indices of cerebral–placental–uterine ratio and umbilico-cerebral ratio for late-onset fetal growth restriction: a prospective cohort study

Submission Author: Fatemeh Golshahi

Fatemeh Golshahi[1], Shirin Niroomanesh[2]

1. Maternal Fetal and Neonatal Research Center, Tehran University of Medical Sciences, Tehran, Iran
2. Maternal, Fetal, and Neonatal Research Center, Yas Complex Hospital, Tehran University of Medical Sciences, Tehran, Iran

Background and Aim: Predicting late-onset fetal growth restriction (FGR) has proven to be rather challenging. In this study, we propose a new parameter, cerebral–placental–uterine (CPU) ratio and umbilico-cerebral (UC) ratio for this matter.

Methods: In this study, we propose a new parameter, cerebral–placental–uterine (CPU) ratio and umbilico-cerebral (UC) ratio for this matter.

Results: results of this study which included a total of 227 nulliparous women showed that an increase in CPU ratio (OR = 0.45; 95% CI: 0.23–0.88; p=.020) was associated with lower odds of fetal weight above the 10th percentile at birth. CPU ratio measured at 35–37 weeks of gestation had an AUC of 0.78 (95% CI: 0.58, 0.98), sensitivity of 0.62 (95% CI: 0.24, 0.91) and specificity of 0.90 (95% CI: 0.79, 0.96) for prediction of late-onset FGR, which showed higher accuracy than UC ratio. Results showed that each unit increase in numeric variables including CP ratio (OR = 0.29, p=.006), and CPU ratio (OR = 0.40, p=.006) was associated with lower odds of the foetal weight above the 10th percentile in the second ultrasound at 35–37 weeks. In other words, CPU ratio can prove to be useful marker in prediction of late-onset FGR.

Conclusion: As some cases of the late-onset FGR are not diagnosed by foetal biometry, it is important to find Doppler parameters that can help us predict these cases and CPU ratio may help physicians in detection of high-risk fetuses that will benefit from earlier intervention.

Keywords: cerebral–placental–uterine (CPU) ratio, umbilico-cerebral (UC) ratio, doppler

Presentation Type: Oral

عوارض مصرف نابجای بتامتازون در بارداری

Submission Author: Somayeh Khanjani

Somayeh Khanjani[1]

1. Somayeh Khanjani Assistant Professor of Perinatology Department of Obstetrics & Gynecology, School of Medicine Isfahan University of Medical Sciences

Background and Aim: باتوجه به مصرف بی رویه ی کورتون در بارداری، و همچنین مصرف دوزهای متعدد آن بدون اندیکاسیون نیاز است که متخصصان زنان جنرال در این زمینه آموزش های لازم را داشته باشند.

Methods: سخنرانی

Results: برای سخنرانی در حوزه سایر موارد پریناتولوژی اعلام آمادگی می نمایم.

Conclusion: برای سخنرانی در حوزه سایر موارد پریناتولوژی اعلام آمادگی می نمایم.

Keywords: سخنرانی

Presentation Type: Oral

Artificial intelligence: A growing topic in obstetric ultrasound

Submission Author: Farzaneh Nazari

Farzaneh Nazari[1]

1. Department of gynecology and obstetrics, Bushehr university of medical sciences, Bushehr, Iran

Background and Aim: Ultrasound is utilized throughout the entire process of pregnancy for providing detailed information on fetal anatomy with high-quality images and improved diagnostic accuracy. Two-dimensional (2D) imaging and three-dimensional (3D) ultrasound are extensively used to measure fetal structures (Biometry, Nuchal Translucency, lateral ventricle), assess organ functions, and diagnose diseases. Access to good quality and standardized obstetric ultrasound imaging is important for accurate diagnosis and treatment. There are many challenges in analysis of ultrasound images such as missing boundaries, speckle noise, acoustic shadows, which are caused by the complex interaction between ultrasound waves and mother and fetal biological tissues. One of the newest methods for better evaluation of ultrasound images is artificial intelligence (AI) that needs more researches. In this review, we explain the benefits of AI technology in obstetric ultrasound diagnosis.

Methods: A literature search was performed for relevant studies Published from 2019. This systematic review was carried out using the PubMed/Medline electronic database. In particular, key words used in the search included ("fetal ultrasound" or "fetal imaging") and ("artificial intelligence "OR "deep learning" OR "radiomics").

Results: Two approaches of artificial intelligence (AI) for interpreting of medical images are feature-based methods such as radiomics and deep learning methods (based on the trial and error). Radiomics is defined as the extraction of information from medical images using advanced feature analysis. Deep learning is a class of machine learning algorithms that uses multiple images to progressively extract higher-level features from the images. It seems if there are many standard data (images) for interpretation, we can use AI for diagnosis of ventriculomegaly, high NT, fetal lung maturity, facial anomalies by decreasing artifacts.

Conclusion: We believe that with the advancement of AI techniques and interdisciplinary integration between sonographers and AI scientists, there will be hopeful future that AI can offer in the field of obstetric ultrasound.

Keywords: Artificial Intelligence, Fetal ultrasound, Deep learning, Radiomics

Presentation Type: Oral

The Effect of Omega-3 in the Prevention of Preeclampsia in Pregnant Women with Hyperlipidemia.

Submission Author: Shole Shahgheibi

Shole Shahgheibi[1], Naghashzargar, Shima Mahdavian[2], Zare, Shamsi[3]

1. Professor of Obstetrics & Gynecology Kurdistan University of Medical Sciences, Sanandaj, Iran Shahgheibi@yahoo.comm
2. Obstetrics & Gynecology
3. Assistant Professor of Obstetrics & Gynecology Kurdistan University of Medical Sciences, Sanandaj, Iran

Background and Aim: Description Introduction: Preeclampsia is one of the most common complications of pregnancy and one of the leading causes of maternal and fetal mortalities. The aim of our study was to evaluate the effect of omega-3 in the prevention of preeclampsia in pregnant women with hyperlipidemia. Methods:

Methods: This single-blind randomized clinical trial study was performed on mothers with hyperlipidemia during 20192021-. The participants of this study were divided into two groups, the placebo receiving group and the omega-3 receiving group, each comprising 36 participants. Mothers in each groups were evaluated for clinical parameters.

Results: age of 72 participants was 32.7 ± 5.1 years. The difference in neonatal weight at birth was statistically significant (P = 0.01). There was a significant relationship between omega 3 consumption and 5-minutes Apgar score of (P <0.05). Complications observed in the omega-3 receiving group were significantly lower than the placebo group (58.3%: placebo and 22.2%: omega 3) (P = 0.02). The frequency of preeclampsia in the omega-3 receiving group was lower than the control group (placebo) and the difference was statistically significant (P <0.05).

Conclusion: Omega-3 has a beneficial effect on preeclampsia and fetal weight during pregnancy, and the prevalence of preeclampsia has decreased significantly in the omega-3 group.

Keywords: Omega-3

Presentation Type: Oral

The effects of vaginal probiotic administration on perinatal outcomes and the levels of pro-inflammatory cytokines in patients with premature preterm rupture of membrane

Submission Author: Nasrin Soufizadeh

Nasrin Soufizadeh[1], Fereshteh Kahvazi[2], Shamsi Zare[3], Fariba Seyedoshohadaei[4]

1. Department of Obstetrics and Gynecology, Faculty of Medicine, Kurdistan University of Medical Sciences, Sanandaj, Iran
2. Department of Obstetrics and Gynecology, Faculty of Medicine, Kurdistan University of Medical Sciences, Sanandaj, Iran
3. Department of Obstetrics and Gynecology, Faculty of Medicine, Kurdistan University of Medical Sciences, Sanandaj, Iran
4. Department of Obstetrics and Gynecology, Faculty of Medicine, Kurdistan University of Medical Sciences, Sanandaj, Iran

Background and Aim: Preterm premature rupture of membrane (PPROM) is the rupture of fetal membrane before 37 weeks of gestation. The aim of the current study was to assess the effects of vaginal probiotic administration on perinatal outcomes in patients with PPROM.

Methods: Sixty pregnant women with PPROM were randomly divided into two groups (n=30). In the first group, in the first 48 hours of hospitalization, 2 gr of intravenous ampicillin and 500-mg amoxicillin capsules were administered for five days. In the second group, the patients received one vaginal probiotic supplement for ten days in addition to receiving an antibiotic treatment similar to the first group. Finally, the perinatal outcomes were examined.

Results: NICU hospitalization was significantly lower in the second group than in the first group ($P<0.05$). The Apgar scores 1 and 5 minutes after birth and the newborns' weight at birth were higher in the second group than in the first group ($P<0.05$). Pregnancy duration was longer in the second group than in the first group ($P<0.05$).

Conclusion: The results of this study showed that the administration of vaginal probiotics in PPROM patients may be effective in delaying childbirth and reducing neonatal complications.

Keywords: Probiotic, Vaginal, Preterm premature rupture of membrane

Presentation Type: Oral

Comparison of the 12-hour and 24-hour Magnesium Sulfate Therapy Regimens after Delivery in Patients with Severe Preeclampsia

Submission Author: Nasrin Soufizadeh

Nasrin Soufizadeh[1], Fatemeh Farahan[2], Shamsi Zare[3], Fariba Seyedoshohadaei[4]

1. Associate Professor of Obstetrics and Gynecology, Department of Obstetrics and Gynecology, School of Medicine, Kurdistan University of Medical Sciences, Sanandaj, Iran.
2. Resident of Obstetrics and Gynecology, Department of Obstetrics and Gynecology, School of Medicine, Kurdistan University of Medical Sciences, Sanandaj, Iran.
3. Assistant Professor of Perinatology, Department of Obstetrics and Gynecology, School of Medicine, Kurdistan University of Medical Sciences, Sanandaj, Iran
4. Associate Professor of Obstetrics and Gynecology, Department of Obstetrics and Gynecology, School of Medicine, Kurdistan University of Medical Sciences, Sanandaj, Iran.

Background and Aim: Preeclampsia is considered as a major threat to public health in the world that causes complications and mortality of maternal and perinatal. The aim of this study was to compare the effect of 12-hour and 24-hour magnesium sulfate therapy regimens on severe preeclampsia after delivery.

Methods: This clinical trial study was performed on 120 mothers in two groups with a diagnosis of severe preeclampsia. It was performed in Besat Hospital of Kurdistan University of Medical Sciences. In the 12-hour group (intervention group), MgSO4 was administered for 12 hours after delivery. And in the 24-hour group (control groups) MgSO4 was administered four 24 hours after delivery . It was randomly formed by random 4 blocks. Data were analyzed using SPSS software version 24, Chi-square and t-test.

Results: Based on the results of mothers of the two groups, there was not a significant difference according age, BMI, parity, gravidity, type of delivery and the sex of the baby (P> 0.05). Administration of 12-hour magnesium sulfate as

much as 22-hour magnesium sulfate was effective and there was no statistically significant relationship between the two groups (P> 0.05).

Conclusion: Administration of 12-hour magnesium sulfate is as effective as 24-hour on severe preeclampsia after delivery.

Keywords: Magnesium Sulfate, Preeclampsia, Childbirth, Eclampsia, Pregnancy.

Presentation Type: Oral

The association between food groups and preeclampsia: a case-control study

Submission Author: Behnaz Souizi

Behnaz Souizi[1], Akram Kooshki[2], Rahil Mahmoudi[3], Saiedeh Ghezi[4], Elaheh Foroumandi[5]

1. Dr. Behnaz Souizi Infertility Fellowship, Assistant Professor, Sabzevar University of Medical Sciences
2. Nutrition and Biochemistry Department, Non- Communicable Diseases Research Center, sabzevar University of Medical Sciences, Sabzevar, Iran;
3. Department of Community of Medicine, Faculty Member of Medicine School, sabzevar University of Medical Sciences, Sabzevar, Iran
4. Department of Midwifery, School of Nursing and Midwifery, sabzevar University of Medical Sciences, Sabzevar, Iran
5. Biochemistry Department, Cellular and Molecular Research Center, sabzevar University of Medical Sciences, Sabzevar, Iran

Background and Aim: The aim of current study was to investigate the correlation between preeclampsia and food groups among pregnant women

Methods: This case-control study was done on pregnant women with a diagnosis of preeclampsia in Sabzevar. The control group was included non-infected postpartum women. The study tools were demographic information ques- tionnaire and semi-quantitative food frequency question- naire (FFQ). In the interview form, anthropometric indices (weight before pregnancy and height), blood pressure, 24- hour urinary protein content, other preeclampsia tests, and gestational age based on ultrasound or last menstrual date were also recorded. Then, dietary information was recorded once before the participants' delivery using a semi-quantitative valid and reliable FFQ with 147 food items. Participants determined how many times they ate the food and how much they ate each time in the past month. Weight of the participants was assessed using a seca digital scale, made in Germany. Blood pressure (BP) was manually measured twice at a distance of 30 seconds using a mercury sphygmomanometer

(richter, made in Germany) and a stethoscope. Finally, the average of the two BP measurements was recorded as BP. To eliminate the individual errors, all the measurements were performed by one person.

Results: Intake of vegetables (OR = 0.952, CI: 0.724–0.985, $p < 0.001$), fruits (OR = 0.901, CI: 0.852– 0.990, $p = 0.012$), nuts and legumes (OR = 0.712, CI: 0.531–0.848, $p = 0.009$), and sugars and sweets (OR = 1.254, CI: 1.112–1.497, $p < 0.001$) were related to the odds of preeclampsia.

Conclusion: Women with preeclampsia had lower intake of vegetables, fruits, milk and products, and also fluids. Intake of sugars and sweets compared with the intake of vegetables, fruits, nuts, and legumes was associated with increasing odds of preeclampsia

Keywords: Pregnancy; preeclampsia; food group; women; blood pressure; dietary patterns; case-control

Presentation Type: Oral

Spinal Analgesia in Labor on Maternal and Neonatal Outcomes: A Retrospective Cross Sectional Study

Submission Author: Shahnaz Ahmadi

Shahnaz Ahmadi[1]

1. iran university of medical science

Background and Aim: Spinal analgesia and Entonox analgesia are used as pain relief methods during labor. This cross-sectional study was conducted to determine the effect of spinal analgesia and Entonox analgesia on the duration of the first, second, and third stages of labor, Apgar score, and maternal and fetal outcome

Methods: Clinical information of 1,000 patients who delivered at Shahid Akbarabadi Hospital and underwent painless delivery with Entonox gas and spinal anesthesia was assessed; then, according to the inclusion criteria, 280 cases were divided into two groups: the spinal analgesia group (n=140) and Entonox analgesia group (n=140). In the spinal analgesia group, 25 µg of fentanyl and 12- mg of bupivacaine were administered. For the Entonox group, Entonox inhalation was administered via a face mask at the initiation of pain at each contraction. The duration of labor, mode of delivery, side effects, and maternal satisfaction were also compared in the two groups

Results: The duration of the first stage was significantly shorter in the spinal analgesia group than in the Entonox analgesia group (P < /em><0.001), but the duration of the second stage in the spinal analgesia group was longer (P < /em><0.001). There were no significant differences in the cesarean section rates, Apgar score, weight, and acidity (PH) and the partial pressure of carbon dioxide (pCO2) between the two groups. Measured pain was significantly lower in the spinal analgesia group (P < /em>=0.01) than in the Entonox analgesia group regarding visual analog scale (VAS) scores

Conclusion: Spinal analgesia is a safe, suitable, and effective method for pain reduction with no adverse effects on the outcome of labor compared to Entonox analgesia.

Keywords: Labor pain Labor stage Nitrous oxide Pregnancy Outcome Spinal

analgesia

Presentation Type: Oral

Standard and delayed remove of urinary catheter after abdominal hysterectomy: a randomized clinical trial

Submission Author: Ladan Ajori

leila nazari[1], ladan ajori[2]

1. 1-Dr Leila nazari,clinical research development unit and department of obstetric and gynecology deparment of Shohada-e Tajrish hospital,school of science of shahid beheshti university of medical science ,Tehran iran nazari@sbmu.ac.ir
2. Corresponder:dr ladan ajori, clinical research development unit and department of obstetric and gynecology deparment of Shohada-e Tajrish hospital,school of science of shahid beheshti university of medical science ,Tehran iran. ajori@sbmu.ac.ir

Background and Aim: Background: The early and delayed removal of urinary catheter after abdominal hysterectomy can influence the prevalence of re-catheterization because of rate of urinary tract infection (UTIs), urinary retention, hospital stay duration and ambulation time.

Methods: he present study as a randomized clinical trial, were done on female cases that referred to Shahada Tajrish Hospital with inclusion criteria and indicated for hysterectomy will be included in the study after informed consent. cases are randomly assigned to two groups: group I cases which catether was removed 8 hours after operation, and group II cases which catether removed 24 hours after the operation. The rate of re-catheterization, the length of hospitalization and the level of patient satisfaction after the operation are recorded.

Results: There was not significant difference between the re-catheterization and the hospitalization duration in patients with premature withdrawal of the urinary catheter in early and late removing of the urinary catheter. However the increase in the satisfaction level of patients in the two groups was statistically significant.

Conclusion: Based on our results, early removal, with lower complication and higher efficacy, can replace the old method as delayed removing of the urinary catheter.

Keywords: Urinary catheter removal, abdominal hysterectomy, re-catheterization, urinary tract infection, Catheter-associated urinary retention

Presentation Type: Oral

The impact of synbiotic supplementation on the health-related quality of life in women with polycystic ovary syndrome. A randomized, triple-blind, placebo-controlled trial

Submission Author: Zahra Hariri

Zahra Hariri[1], Zahra Yari[2], Sedighe Hoseini[3], Khadijeh Abhari [4], Golbon Sohrab[5]

1. Student Research Committee, (Department of Clinical Nutrition and dietetics Department, Faculty of Nutrition Sciences and Food Technology) Shahid Beheshti University of Medical Sciences Tehran, Tehran, Iran.
2. Department of Nutrition Research, National Nutrition and Food Technology Research Institute, Shahid Beheshti University of Medical Sciences, Tehran, Iran
3. Department of Obstetrics and Gynecology, Preventative Gynecology Research Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran.
4. Department of Food Science and Technology, National Nutrition and Food Technology Research Institute, Faculty of Nutrition Sciences and Food Technology, Shahid Beheshti University of Medical Sciences, Tehran, Iran
5. Clinical Nutrition and dietetics Department, Faculty of Nutrition Sciences and Food Technology, National Nutrition and Food Technology Research Institute, Shahid Beheshti University of Medical Sciences Tehran, Tehran, Iran.

Background and Aim: There are intricate mechanisms that links the disruption of the gut microbiome to the symptoms and complications of polycystic ovary syndrome (PCOS). In this study, an attempt was made to measure the effect of synbiotics on the health-related quality of life (HRQoL) among PCOS patients.

Methods: 56 women with PCOS were subjected to a triple-blind controlled

trial for 3 months. They were randomly assigned to receive a daily 2g synbiotic sachets (containing Bacillus coagulans (GBI-30), Lactobacillus rhamnus, Lactobacillus helveticus, and fructooligosaccharide) (n=28) or placebo (n=28). In order to evaluate the impact on the HRQoL, patients were required to fill Polycystic Ovary Syndrome Health-Related Quality of Life Questionnaire (PCOSQ-26), 12-Item Short-Form Health Survey (SF-12) and Perceived Stress Scale (PSS-10) pre and post the intervention.

Results: Ultimately, statistical analyses were performed on 52 patients who finished their intervention. This supplementation improved the emotional (P = 0.044), body hair (P = 0.016), weight (P = 0.033) and infertility domains (P = 0.027) of PCOSQ-26 compared to placebo group. The physical score within SF-12 also had a significant enhancement (P = 0.035). There was no meaningful change in the PSS-10 items by the end of the trial.

Conclusion: This study illustrated the advantageous effects of synbiotics on the health related quality of life domains in PCOS patients. Extensive and more accurate trials are needed in each of the areas investigated in this study.

Keywords: Polycystic ovary syndrome, health-related quality of life, synbiotic, Bacillus coagulans.

Presentation Type: Oral

The prevalence of endometrial polyp in women with tubal factor infertility is higher than male factor infertility: Is PID one of the causes of endometrial polyp?

Submission Author: Roya Kabodmehri

Dr. Seyedeh Hajar Sharami[1], Roya Kabodmehri[2], Dr. Forozan Milani[3], Dr. Zahra Rafiei Sorouri[4], Nasrin Ghanami Gashti[5], Seyedeh Fatemeh Dalil Heirati [6], Habib Eslami-Kenarsari[7]

1. Professor of Obstetric & Gynecology, Reproductive Health Research Center, Department of Obstetrics & Gynecology, Al-zahra Hospital, School of Medicine, Guilan University of Medical Sciences, Rasht, Iran/ sharami@gums.ac.ir/09111500433/ http://orcid.org/0000-0001-3769-7815
2. Assistant Professor of Infertility & IVF, Reproductive Health Research Center, Department of Obstetrics & Gynecology, Al-zahra Hospital, School of Medicine, Guilan University of Medical Sciences, Rasht, Iran /dr.royakabodmehri@gmail.com/09101081502/ http://orcid.org/0000-6846-4162-0003
3. Associate Professor of Obstetric & Gynecology, Reproductive Health Research Center, Department of Obstetrics & Gynecology, Al-zahra Hospital, School of Medicine, Guilan University of Medical Sciences, Rasht, Iran / forozanmilani@yahoo.com/ 09111315936/ https://orcid.org/00006993-0430-0002-
4. Assistant Professor of Infertility & IVF, Reproductive Health Research Center , Department of Gynecology, School of Medicine, Alzahra Hospital, Guilan University of Medical Sciences, Rasht, Iran/ Dr.Zahrarafiei1397@gmail.com/ 09111430338/ orcid.org/0000-0003-6983-2286
5. PhD in Reproductive Biology/Reproductive Health Research Center, Department of Obstetrics & Gynecology, Al-Zahra Hospital, School of Medicine, Guilan University of Medical Sciences, Rasht, Iran/ nasringhanami@gmail.com/+989119400816-/ https://orcid.org/0000-

3955-0060-0003

6. MSc of Midwifery , Reproductive Health Research Center, , Al-zahra Hospital, Guilan University of Medical Sciences, Rasht, Iran/ dalilheirati@gmail.com/09116373269/http://orcid.org/0000-0003-0832-2177
7. MSc in Epidemiology, Vice-Chancellorship of Research and Technology, Guilan University of Medical Science, Rasht, Iran/ 09112424589/habib.eslami88@yahoo.com/ https://orcid.org/00001994-7420-0002-

Background and Aim: Previous studies have shown an association between chronic endometritis and endometrial polyps, and only one study in infertile women reported an association between tubal obstruction and polyps. This study aimed to compare the prevalence of endometrial polyps in two groups of women with tubal factor infertility and male factor infertility.

Methods: This case-control study was performed on infertile women. The case group included women with tubal factor infertility and the control group included all women with male factor infertility. In all patients, vaginal ultrasound was performed between days 812- of the menstrual cycle to diagnose endometrial polyp, its size, and number. Demographic and obstetrics variables were recorded. Patients underwent hysteroscopy and polypectomy and the diagnosis of the polyp was confirmed by pathology report.

Results: In the present study, 245 people participated in two groups. There was a statistically significant difference between the two groups in terms of demographic and obstetric characteristics like type of infertility, duration of infertility, and gravidity. The prevalence of polyps in the tubal factor group was higher than in the male factor group [63(60%) vs 12(9.8%)], and this difference was statistically significant (P=0.0001). In addition, the prevalence of chronic endometritis in the tubal factor group was higher than in the male factor group [19(18.8%) vs 4(3.3%)], and this difference was statistically significant (P=0.001).

Conclusion: In the present study, a strong association was observed between endometrial polyps and tubal obstruction, and considering that the most common cause of tubal obstruction is pelvic and genital infections, antibiotic treatment can be considered as treatment, especially in patients with recurrent polyps. However, further studies are needed to confirm the findings of this study.

Keywords: endometrial polyp, tubal factor infertility, male factor infertility, PID

Presentation Type: Oral

Evaluation of NK cell subsets percentage, function and their relationship with serum vitamin D levels in women with stage III and IV endometriosis

Submission Author: Maryam Hashemi

Maryam Hashemi[1], Mehri Ghafourian [2], Samira Najafi[3]

1. Department of Obstetrics & Gynecology, School of Medicine, Isfahan University of Medical Sciences, Isfahan, Iran
2. Fertility Infertility and Perinatology Research Center, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran.
3. Department of Immunology, School of Medicine, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran.

Background and Aim: Different immune cells, including natural killer (NK) cells play critical role in pathogenesis of endometriosis. Moreover the vitamin D level affects the function of immune system. The aim of this study was to evaluate the percentage of NK cells and their subsets and its relationship with serum levels of vitamin D and IFN-γ in women with endometriosis

Methods: In this case-control study, 29 women with stage III-IV endometriosis and 30 healthy controls were participated. The percentage of NK cells, and their subsets including CD56dim CD16+, CD56bright CD16- and CD56bright CD16bright were measured in the peripheral blood samples using flow cytometry. Serum levels of vitamin D and IFN-γ were also measured using the ELISA technique.

Results: The mean percentage of NK cells in women with endometriosis increased significantly compared to the control group (P=0.03). The percentage of CD56dim CD16+ (p=0.007) and CD56bright CD16bright (p=0.043) increased significantly in patients in comparison with control group but the percentage of CD56bright CD16- subset was not significant. Although the serum levels IFN-γ and vitamin D in women with endometriosis were increased compared to the control groups but the results were not significant. There was no relationship between NK cells and their subsets with vitamin D3 and IFN-γ in the studied group.

Conclusion: According to our findings, the study of percentage and function of NK cells can be useful in predicting endometriosis disease. However, more comprehensive studies in the future are required to draw definitive conclusions about these observations.

Keywords: Endometriosis, NK cells, IFN-gamma, Vitamin D

Presentation Type: Oral

A randomized trial assessing the efcacy of Silymarin on endometriomarelated manifestations

Submission Author: Safoura Rouholamin

Safoura Rouholamin[1]

1. Associated professor

Background and Aim: To study the efect of silymarin on the Interleukin6 (IL6) level, size of endometrioma lesion, pain, sexual function, and Quality of Life (QoL) in women diagnosed with endometriosis.

Methods: This randomized, doubleblind placebocontrolled clinical trial was performed on 70 women with endometriosis which was divided into two groups of intervention and control. The intervention was 140 mg silymarin (or matching placebo) administered twice daily for 12 weeks.

Results: he volume of endometrioma lesions, the level of IL6 concentration in serum, pain, sexual function, and QoL were analyzed before and after the intervention. The means of endometrioma volume ($P = 0.04$), IL6 ($P = 0.002$), and pain ($P < 0.001$) were reduced signifcantly in the silymarin group after intervention. However, the QoL and female sexual function did not improve substantially in the two groups ($P > 0.05$). Silymarin signifcantly reduced interleukin6 levels, sizes of endometrioma lesions, and painrelated symptoms

Conclusion: In conclusion, silymarin can be considered as a feasible option for treatment women with endometriomaassociated symptoms that has few side efects.

Keywords: endometrioma, pain, sexual function, quality of life, silymarin

Presentation Type: Oral

post pandemic gynecologic cancer managment recommendation

Submission Author: Leila mousavi seresht

Leila mousavi seresht[1]

1. fellowship of gynecology oncology, assistant professor of isfahan university of medical science

Background and Aim: The unexpected death of more than 6.2 million people from corona disease in the previous two years was a reminder that adequate treatment resources are just as vital for managing illness as awareness of recommended treatments and alternative therapies

Methods: According to the American, British, SGO guideline

Results: The delay in cancer treatment caused by the fear of COVID was the cause of the next health crisis. According to the principle of several guidelines, including the British Gynecological Cancer Society guideline, depending on the type and aggressiveness of the tumors, a delay of 4–12 weeks in performing surgery can be authorized , and a delay of 24- weeks in patients with COVID was also allowed and it was estimated that these delays would be related to delays in diagnosis and even surgical treatment in 38% of cancer patients, in other words, equal to 2.3 million surgeries

Conclusion: Despite all of these protocols, even when implemented concurrently, based on mathematical models and estimated 10-year survival for each malignancy, these treatment delays were predicted to have a considerable impact on cancer patients' survival, and a return to the prior follow-up routine as soon as possible was recommended

Keywords: covid-19, gynecologic malignanacy, survival

Presentation Type: Oral

Updates on indications and methods of colposcopy ; based on the 2019 guidelines

Submission Author: Soheila Aminimoghaddam

Soheila Aminimoghaddam[1]

1. Iran university of medical sciences , school of medicine

Background and Aim: According to this guideline , management of patients is based on the risk assessment system, rather than making decisions based only on the current pathology report.

Methods: The history of HPV infection as well as the genotype of the virus plays an important role in management. If the immediate risk of CIN 3 is less than 4%, the 5-year risk of CIN 3 is carefully considered. But if the risk of CIN3_ which is a true premalignant lesion_ is between 4 and 24%, the patient will undergo colposcopy. In case of an immediate risk of 25 to 59%, colposcopy or treatment can be considered.

Results: Minor abnormalities in Pap smear such as ASCUS and LSIL in case of positive HPV , have a risk of CIN 3 greater than 4% and require colposcopy, but negative HPV cases do not need colposcopy. If Pap smear is normal but HPV is positive for two consecutive years, it is also indicated for colposcopy. ASCH, HSIL and AGC are subjected to colposcopy due to the risk of cancer, even if HPV is negative, and are part of the special situation. In HSIL, ASCH, or AGC that is HPV positive, the risk of immediate CIN 3 is 2559%- and colposcopy is performed. Colposcopy is also used in the follow-up of patients who have been treated for CIN 2 and 3. In patients who meet all the following criteria, random biopsy is not recommended: *Cytology less than HSIL *HPV 16 _18 is not positive *Colposcopy impression is completely normal *SCJ is completely visualized. Otherwise, 2 to 4 biopsies are performed.

Conclusion: Sweden score and modified Reid score can be used to check the need for biopsy.

Keywords: Colposcopy , pap smear , CIN ,HPV

Presentation Type: Oral

The interaction of high and low-risk human papillomavirus genotypes increases the risk of developing genital warts: A population-based cohort study

Submission Author: Leila mousavi seresht

Leila mousavi seresht[1]

1. fellowship of gynecology oncology, assistant professor of isfahan university of medical science

Background and Aim: Cervical cancer is among the most common type of cancers in women and is associated with human papillomavirus (HPV) infection. Genital warts are also reported to be linked with HPV infection types 11 and 6. In turn, clinical characteristics and morphological features of warts may be useful in the prediction of prognosis and in making treatment decisions.

Methods: we have investigated the association of high and low-risk HPVs genotype with genital wart risk, as well as pathological and cytological information in cases recruited from a population-based cohort study of 1380 patients

Results: Patients infected with HPV genotype 6 or 11 had an increased risk of having warts, with OR of 2.34 (95% CI: 0.9555.737-, P = 0.06). Also, this association was enhanced in the presence of high plus low-risk HPV for having genital wart (OR: 2.814; 95%: 1.2086.55-, P = 0.017) and cases having high-risk HPV (OR: 2.329; 95% CI: 1.0295.269-, P = 0.042). Moreover, we observed patients with genital warts having CIN23/, indicating the importance of informing the physician to the patient to prevent more severe lesions.

Conclusion: Our data demonstrated that patients with both low/high-risk HPV types had an increased risk of developing genital warts and persistent infection with HPV was a necessary precursor for the increase in cervical lesions.

Keywords: genital wart, HPV,cervical lesions

Presentation Type: Oral

Laparoscopic hysterectomy

Submission Author: Elham Akbari

Elham Akbari[1]

1. farmanieh Hospital

Background and Aim: Laparoscopic hysterectomy is a minimally invasive approach that has decreased morbidity, shorter hospital stay, and quicker return to normal activities compared with an abdominal approach

Methods: Oophorectomy and/or salpingectomy is indicated in some patients at the time of hysterectomy. Women without a definitive indication for adnexectomy should be counseled preoperatively about the risks and benefits of removing the ovaries and/or fallopian tubes. Antibiotic prophylaxis is given for all surgical approaches to hysterectomy. Patients undergoing laparoscopic hysterectomy (major surgery, defined as >30 minutes duration) are at least at moderate risk for venous thromboembolism and require appropriate thromboprophylaxis, whether mechanical or pharmacologic. The choice of instrumentation varies by surgeon and institution. Many surgeons use a uterine manipulator, which is a device that is placed in the vagina and cervix and allows visualization of the boundaries of the vaginal cuff with a cup that fits around the cervix, injection of dye (chromopertubation), and maintenance of pneumoperitoneum after the vaginal incision. Conversion to laparotomy occurs in up to 4 percent of laparoscopic hysterectomies. Potential complications include hemorrhage, urinary tract injury, vaginal cuff dehiscence, and bowel injury. In particular, the risks of urinary tract injury and cuff dehiscence are higher than for abdominal or vaginal hysterectomy. Same-day discharge from the hospital after laparoscopic hysterectomy is a safe option for women without perioperative complications or comorbidities that require inpatient observation and care. A longer hospital stay is a reasonable option for women who do not have sufficient support at home to manage care during the first postoperative day

Results: There are several types of laparoscopic hysterectomy, including: total laparoscopic hysterectomy, subtotal (supracervical) laparoscopic hysterectomy, and laparoscopic-assisted vaginal hysterectomy.

Conclusion: Laparoscopic hysterectomy is a minimally invasive approach that

has decreased morbidity, shorter hospital stay, and quicker return to normal activities compared with an abdominal approach.

Keywords: laparoscopy-hysterectomy-laparoscopic

Presentation Type: Oral

Pyelonephritis Following Total Laparoscopic Hysterectomy (TLH) Mimics Ureteral Injury Symptoms: A Case Report

Submission Author: Maryam Hashemi

Maryam Hashemi[1], Ataallah Ghahiri[2]

1. Department of Obstetrics & Gynecology, School of Medicine, Isfahan University of Medical Sciences, Isfahan, Iran
2. Department of Obstetrics & Gynecology, School of Medicine, Isfahan University of Medical Sciences, Isfahan, Iran

Background and Aim: The infection rates after laparoscopic hysterectomy were reported to be as high as 9% in one series of more than 10,000 cases, despite the advances in aseptic technique, antibiotic prophylaxis, and technology hence, the need to discuss preventive methods.

Methods: A 40-year-old woman undergone TLH due to abnormal uterine bleeding (AUB) unresponsive to medical therapy. She was discharged on postoperative day 2 in a good condition. On postoperative day 7, she presented with severe right flank pain which developed suddenly a day ago. There was tenderness on right costovertebral angle (CVA). She felt unwell in herself with no appetite. Her temperature was 38˚ c, pulse 120/min and blood pressure 11075/mmHg. The abdomen was normal in examination. Sonography of abdomen and pelvis was normal. There was no hydronephrosis. Laboratory data showed WBC: many, bacteria: moderate, and leukocyte esterase: positive in urinalysis (U/A). Urine culture (U/C) revealed 65000 CFU MRSE. Serum creatinine was 0.9 ng/dl. The diagnosis was pyelonephritis and ureteral injury was rule out. The patient was given antibiotics. She became better after 48 hours. Three days later she was discharged with oral antibiotics for 10 days.

Results: The overall rate of urinary tract infection (UTI) after a hysterectomy was 11.8%. Preventing infections in the postoperative period includes the removal of the urinary catheter when it is no longer needed. Early removal of the catheter after completion of the procedure or after 6 hours appears to be advantageous over removal 24 hours after the hysterectomy. Interestingly, a surgeon's awareness about the possibility of pyelonephritis (in the differential

diagnosis of ureteral injury) after the hysterectomy can reduce his/her anxiety.

Conclusion: The overall rate of urinary tract infection (UTI) after a hysterectomy was 11.8%. Preventing infections in the postoperative period includes removal of the urinary catheter when it is no longer needed. Early the removal of the catheter after completion of the procedure or after 6 hours appears to be advantageous over removal 24 hours after the hysterectomy. Interestingly, a surgeon's awareness about the possibility of pyelonephritis (in differential diagnosis of ureteral injury) after the hysterectomy can reduce his/her anxiety.

Keywords: Hysterectomy, Urinary tract infection, Laparoscopy

Presentation Type: Oral

Complications of laparoscopic surgery

Submission Author: Fereshteh Sarbazi

Fereshteh Sarbazi[1]

1. Erfan Niayesh Hospital

Background and Aim: Laparoscopic techniques have revolutionized the field of surgery. Most complications related to laparoscopic surgery occur during abdominal access, but other complications can occur related to abdominal insufflation and tissue dissection. The overall rate of these complications is low.

Methods: The most common vascular injury overall is laceration of the inferior epigastric artery, but injuries to major vascular structures can occur and are life-threatening injuries. When major vascular injury is identified, consultation with a surgeon experienced with vascular procedures should be obtained without delay. Moderate bleeding during laparoscopic surgery can be controlled with clips, suture ligation, or electrosurgical methods. Injury to the bowel can relate to initial abdominal access or during the course of the operation due to electrocautery, or tissue trauma during dissection. Injury to the stomach can be minimized by maintaining stomach decompression with a nasogastric or orogastric tube during the procedure. Injury to the bladder most commonly occurs during abdominal access. A history of prior pelvic surgery increases the risk of bladder injury. The risk of bladder injury can be minimized by catheterizing the patient prior to the procedure. The risk of port-site hernia is increased with larger-diameter ports (≥12 mm).

Results: For patients with risk factors for laparoscopic complications, an open surgical approach may be preferred. Vascular injury most commonly occurs during abdominal access and is second only to anesthesia as a cause of death from laparoscopy

Conclusion: Proper selection of patients, knowledge of surgical anatomy, and attention to proper abdominal access techniques may help to avoid complications. Risk factors for complications include prior surgery/abdominal adhesions, excessive bowel distention, very large abdominal or pelvic masses, and diaphragmatic hernia. Patients with poor cardiopulmonary reserve may not tolerate pneumoperitoneum.

Keywords: laparoscopy-complication-laparoscopic

Presentation Type: Oral

Ovarian suspension loop: an assembled device for ovarian lifting and immobilization during laparoscopic cystectomy

Submission Author: Kobra Tahermanesh

Kobra Tahermanesh[1]

1. Department of Obstetrics and Gynecology, College of Medicine, Iran University of Medical Sciences (IUMS), Tehran, Iran

Background and Aim: The mobility and smooth surface of the ovaries can pose a challenge during laparoscopic cystectomy, with difficulties in manipulation and visualization.

Methods: We describe assembling a device for ovarian lifting and immobilization that utilizes a nylon suture and a "scalp vein set" to create a loop. The loop can be passed into the pelvic cavity and then slid beneath the ovary, elevating and stabilizing it during surgery without the need to puncture the ovarian tissue or grabbing and damage the utero-ovarian infundibulopelvic ligaments.

Results: This device is inexpensive, and its components are easily accessible.

Conclusion: This assembled device prevents repetitive falling of the ovary into the pelvic cavity, facilitates laparoscopic ovarian cystectomy, and saves operative time.

Keywords: Ovary, adnexal cyst, ovarian cystectomy, adnexal mass, suspension loop, ovarian lifting

Presentation Type: Oral

Adherence to Mediterranean Diet and Outcomes of Assisted Reproduction Technologies

Submission Author: Ghazaleh Eslamian

Ghazaleh Eslamian[1]

1. Assistant professor, Department of Cellular and Molecular Nutrition, Faculty of Nutrition and Food Technology, National Nutrition and Food Technology Research Institute, Shahid Beheshti University of Medical Sciences, Tehran, Iran

Background and Aim: The recognition that nutrition can impact fertility, particularly with regards to assisted reproductive technologies (ART) in women, is growing. However, there is currently no specific dietary guidance available. This systematic review was conducted to assess the relationship between pre-treatment adherence to the Mediterranean Diet (MedDiet) and ART outcomes.

Methods: The systematic review involved a search of Persian and English language databases, using keywords related to Mediterranean dietary patterns, fertility, infertility, in vitro fertilization, and intra-cytoplasmic sperm injection in - Medline, PubMed, Embase, Science Direct, Magiran, ISD, ISC and Cochrane databases.
Results: In this systematic review five studies. Gaskin et al. found that women with higher MedDiet adherence had a greater chance of live birth compared to those with lower adherence. Vujkovic et al. reported a higher probability of pregnancy with high adherence to the Mediterranean diet by the couple. Sun et al. demonstrated that higher MedDiet adherence was associated with a larger number of embryos available. Karayiannis et al. showed that women with the highest MedDietScore had higher rates of clinical pregnancy and live birth compared to those with lower scores. However, Ricci et al. did not find a significant association between the Mediterranean diet score and in vitro fertilization outcomes.

Conclusion: This systematic review suggests that adherence to the Mediterranean diet before and during ART treatment may enhance the likelihood of achieving pregnancy. Therefore, it appears that the optimal "fertility diet" is similar to the Mediterranean dietary pattern.

Keywords: Mediterranean dietary patterns, fertility, infertility, IVF, ICSI

Presentation Type: Oral

A rare case of ectopic partial molar pregnancy following IVF

Submission Author: Nazanin Hajizadeh

Nazanin Hajizadeh[1], Sedigheh Hosseini[2], elena ghotbi[3]

1. Department of Obstetrics and Gynecology, Men's Health and Reproductive Health Research Center, Ayatollah Taleghani Hospital, Shahid Beheshti University of Medical Sciences, School of Medicine, Tehran, Iran.
2. Department of Obstetrics and Gynecology, Men's Health and Reproductive Health Research Center, Ayatollah Taleghani Hospital
3. Department of Obstetrics and Gynecology, Men's Health and Reproductive Health Research Center, Ayatollah Taleghani Hospital

Background and Aim: According to existing literature, apart from the rarity of ectopic molar pregnancy, its occurrence following assisted reproductive technology is exceedingly uncommon.

Methods: A 29 years old female who received assisted reproductive therapy (IVF) in our infertility clinic, at gestational age of 7w + 2d following embryo transfer presented with a favorable rise of β-hCG level with no detectable gestational sac in uterine cavity in the vaginal ultrasonogram. First dose of MTX (78) with simultaneous β-hCG titration of 110000 pg/mL was administered. The patient underwent a second TVS in which a mass in favor of molar ectopic pregnancy was reported.

Results: With the suspicion of molar EP the patient underwent explorative laparotomy. A 3*4 cm mass which was found adjacent to the right ovary was resected. Final pathology report was compatible with partial molar pregnancy. In follow up period after surgical resection the patient recovered completely without any recurrence.

Conclusion: Ectopic molar pregnancy following Assisted Reproductive Therapy (ART) is an extremely rare entity,but it should be concider also in pregnancy following ART.

Keywords: Ectopic pregnancy, IVF, Mole

Presentation Type: Oral

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

Submission Author: Nazanin Hajizadeh

Nazanin Hajizadeh[1], Sedigheh Hosseini[2], Saghar Salehpour[3]

1. Department of Obstetrics and Gynecology, Men's Health and Reproductive Health Research Center, Ayatollah Taleghani Hospital, Shahid Beheshti University of Medical Sciences, School of Medicine, Tehran, Iran.
2. Department of Obstetrics and Gynecology, Men's Health and Reproductive Health Research Center, Ayatollah Taleghani Hospital
3. Department of Obstetrics and Gynecology, Men's Health and Reproductive Health Research Center, Ayatollah Taleghani Hospital

Background and Aim: 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.

Methods: 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)

Results: 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.

Conclusion: 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.

National Association of Iranian
Gynecologist & Obstetricians

Poster Presentations

Presentation Type: Poster

The effect of brand positioning on the loyalty of patients in medical centers.

Submission Author: Mohamad Dokhanchi

Mohamad Dokhanchi[1]

1. Scholar, Department of management, College of humanities, save branch, Islamic Azad university, Save, Iran

Background and Aim: Brand positioning is so much more than how well your logo stands from other companies. It's how your brand's vision, product, and identity are strategically positioned in a market saturated with other companies. And, more importantly, it's what you're known for in your customer's mind. Your audience ultimately decides where you sit compared to your competitors. Brand positioning is the space your brand and products hold in the market and in the minds of your customers. A unique and memorable brand position comes with a long list of advantages. At the top is the reward of being the company people think of first when they want to buy the product you sell. That often takes years, even decades, or the creation of a whole new market.

Methods: Fieldwork & Analysis

Results: A medical centers should pay particular attention to the price of their product, their customer service experience, the quality of their product or service, and the convenience they provide to buyers. brand positioning describes how a brand is different from its competitors and where, or how, it sits in customers' minds. A brand positioning strategy, therefore, involves creating brand associations in customers' minds to make them perceive the brand in a specific way.

Conclusion: At Brand positioning strategy, by shaping consumer preferences, brand positioning strategies are directly linked to consumer loyalty, consumer-based brand equity, and the willingness to purchase the brand. Effective brand positioning can be referred as the extent to which a brand is perceived as favorable, different and credible in consumers' minds.

Keywords: Brand positioning ، Branding ، Medical centers، patient ، Doctor.

Presentation Type: Poster

Primary Lymphoma of the Uterine Cervix

Submission Author: Nasrin Mansouri

Nasrin Mansouri[1]

1. Department of Obstetrics and Gynecology, Kermanshah University of Medical Sciences, Kermanshah, Iran

Background and Aim: Primary lymphoma of the uterine cervix is rare and confusing, due to non-specific symptoms. Clinical presentations are easily mistaken for squamous cell carcinoma of the cervix, other malignancies, andinflammatory process. Treatment and prognosis are considerably different in the long list of differential diagnoses.

Methods: we report a 34-year-old female was presented with a mass on the uterine cervix in an ultrasound exam. Multiple ultrasound exams of the uterus showed protrusion of a hypoechoic cystic mass with an irregular posterior margin from the posterior wall of the cervix to the posterior cul de sac. The lesion measured about 31x43x77mm, contained debris and thick internal septa. The lesion was extended to the lateral wall of the cervix and was hypovascular in doppler ultrasound.

Results: Rectal wall thickness was increased by 13mm and the radiologist suggested a rectoscopic exam. The radiologist suggested degenerated subserosal fibroma and recommended a transrectal biopsy of the mass. The mass was submitted to the pathology with the clinical diagnosis of uterine A second opinion was requested and a repeat with complementary IHC was done at a referral center. The pathologist reported: “IHC staining is consistent with Diffuse Large B-Cell Lymphoma (DLBCL), Non-Germinal Center Type.

Conclusion: Sometimes multiple biopsies and immunohistochemistry are needed for a definite diagnosis. Pathologists and clinicians must be aware of this entity in daily practice

Keywords: uterine cervix, extra-nodal lymphoma, primary

Presentation Type: Poster

Platelet to lymphocyte and neutrophil to lymphocyte ratio in first trimester of pregnancy, are they useful for predicting spontaneous miscarriage? A case-control study

Submission Author: Maryam Yazdizadeh

Maryam Yazdizadeh[1]

1. Affiliation: Shahid Akbarabadi Clinical Research Development Unit(ShACRDU),school of medicine،Iran University of Medical Sciences (IUMS), Tehran, Iran.

Background and Aim: Background: Miscarriage occurs in 15% of all clinical pregnancies. The pathogenesis is not completely known. However, defective placentation resulting in the maternal systemic inflammatory response is considered responsible for miscarriage. Platelet lymphocyte ratio (PLR) and neutrophil-lymphocyte ratio (NLR) are increasingly cited parameters of inflammation in the literature. However, no study evaluated the PLR and NLR rates in miscarriage so far. Objective: This study aimed to investigate whether complete blood count (CBC) inflammatory parameters such as NLR and PLR are increased in patients with miscarriage.

Methods: Materials & methods: In this case-control study, the plasma markers including hemoglobin, hematocrit, platelet count (PLT), mean platelet volume (MPV), platelet distribution width (PDW), PLR, and NLR were evaluated and compared between the first-trimester miscarriage pregnancies and normal cases that their pregnancy lasted to term. All data were analyzed using SPSS version 22.0.

Results: Result: Totally, 240 participants (120 pregnancies in each group) were recruited for the study. PDW, NLR & PLR, and lymphocyte values were higher in the miscarriage group compared with the healthy pregnant women group ($p<0.001$). MPV values were found to be lower in the miscarriage group compared with the healthy pregnant women group ($p<0.001$).

Conclusion: Conclusion: Although, hemoglobin, hematocrit and platelets, and neutrophils in these two groups of pregnant women were without a statistically significant difference ($P> 0.05$). The higher inflammatory markers including

PDW, NLR, and PLR may help to speculate defective placentation in the pathogenesis of miscarriage. Measurement of these markers may be useful to predict pregnancy leading to miscarriage.

Keywords: Keywords: Spontaneous Abortion, Inflammation, Neutrophils, Lymphocytes, Blood Platelet, Pregnancy

Presentation Type: Poster

A Case oof COVIDD-19 Mortality in a Pregnaant Womman withh Diabetees Ketoaciddosis

Submission Author: Maryam Yazdizadeh

Maryam Yazdizadeh[1]

1. Department of Obbstetrics and Gyneccology, Faculty of MMedicine, Iran Univversity of Medical Sciences, Tehran, Iran

Background and Aim: SARS-CoV-2 is a newly identified virus that causes COVID 19, sppreading very fast in the woorld. Uncontrollled diabetes inn pregnancy can increase the rissk of pregnanccy outcomes. PPregnant womenn are at high rissk of developinng a viral infection, like SARSSCOV and on thhe other hand, diabetes ketoaacidosis (DKA)) which is couppled with COVVID-19, can inccrease maternall mortality. The patient was a 227-years-old female G3P1L1AAb1 with a histtory of a previoous cesarean seection. On 26 MMarch 2020, a fetal ultrasoundd revealed intra-uuterine fetal deaath (IUFD) andd also diagnosiss of DKA and CCOVID-19 in thhe patient that sshe was expiredd eventually due to the uncontroolled DKA. In this case reporrt, a pregnant wwoman with a ddiagnosis of IUUFD, DKA andd COVID-19 simultaneously isi described.

Methods: Case report

Results: Case report

Conclusion: To the best of thee authors of thiss paper's knowlledge, no previious work has bbeen reported ffor the comorbiidity of di and COVID-199 in pregnancy, but it seems thhat the coincidennce of the abovve-mentioned diiseases can delaay the recoveryy period and alsoo can increases mmaternal and feetal mortality. WWhen DKA andd COVID-19 apppear in the pattient simultaneoously, we cannnot control DKAA by the routine pprotocol treatmments of DKA wwhich were usedd formerly.

Keywords: Keywords: COOVID-19, IUFDD, Diabetes ketooacidosis, Pregnnancy.

Presentation Type: Poster

Spontaneous bladder rupture after normal vaginal delivery; a case report

Submission Author: Somayeh Ghasemzadeh

Somayeh Ghasemzadeh[1], Tahereh Behroozi Lak[2]

1. Maternal and Child Obesity Research Center, Urmia University of Medical Sciences, Urmia, Iran
2. Maternal and Child Obesity Research Center, Urmia University of Medical Sciences, Urmia, Iran

Background and Aim: The occurrence of a spontaneous rupture of the urinary bladder subsequent to a nontraumatic vaginal delivery is exceedingly rare and necessitates immediate surgical intervention. The present study documents a singular case of an idiopathic rupture of the urinary bladder following an uneventful vaginal delivery.

Methods: This report presents a case of spontaneous bladder rupture in a 19-year-old woman experiencing her first pregnancy, which occurred three days after a normal vaginal delivery.

Results: A 19-year-old primigravida woman presented to the emergency department three days subsequent to a nontraumatic vaginal delivery with complaints of abdominal pain and distension. Laboratory analysis revealed elevated serum creatinine levels. Diagnostic imaging, including sonography and computed tomography scans, indicated the presence of free fluid within the peritoneal cavity. An exploratory laparotomy was performed, during which a perforation was identified on the dome of the urinary bladder and subsequently repaired.

Conclusion: Rupture of the bladder in the postpartum period constitutes a life-threatening condition. Owing to its low incidence and the nonspecific nature of its symptoms, diagnosis is frequently delayed. The presence of abdominal pain and elevated serum creatinine levels in postpartum patients should prompt suspicion of bladder rupture.

Keywords: Bladder rupture, Vaginal delivery, post-partum

Presentation Type: Poster

Impact of traditional Iranian medicine in dealing with the challenges of endometriosis”

Submission Author: Mahshid Irani

Mahshid Irani[1], Mojgan tansaz[2]

1. Shahid Beheshti University of Medical Sciences
2. Shahid Beheshti University of Medical Sciences

Background and Aim: Endometriosis is a disorder in which tissue similar to the lining of uterus grows outside of the uterine cavity. This disease affects 10% of women during their reproductive age and there are various theories about its etiology. Physical, mental and social complications of endometriosis including acute pain, anemia, and infertility have affected the quality of patients’ life. Endometriosis does not have a definitive treatment and common treatments such as surgery and hormone therapy have unfortunate consequences such as adhesions, infertility, and carcinogenesis. Therefore, conducting medical research that can improve the quality of life and reproductive status seems logical.

Methods: data were analyzed and classified by searching through traditional medicine books and articles in PubMed and Scopus databases with the keywords of infertility, “oojae & ooram rahem”, endometriosis and Persian medicine and herbal medicine.

Results: This disease is very complex and as it does not have a definite solution in medicine, the works done on complementary medicine and related articles are not much in this regard and most of the studies focus on pain and quality of life of patients. Plants such as rose, chamomile, ginger, marshmallow and Althaea have shown effects in controlling pain. In the sources of traditional Iranian medicine, in dealing with such a disease, emphasis is placed on lifestyle modification, temperament modification, compliance with the six principles of health, especially mental-psychological conditions, improvement of the digestive system, proper nutrition, prohibition of “sodaza”, and the use of single and compound drugs and manual practices is emphasized.

Conclusion: The capacity of complementary medicine, such as traditional

Iranian medicine, is very helpful in controlling and reducing complications, especially pain, improving quality of life, and improving fertility, but there is still a need for more research in this field.

Keywords: Persian medicine, endometriosis, dysmenorrhea, infertility, herbal medicine, lifestyle

Presentation Type: Poster

Using Bakri balloon as a visceral replacement for occupying pelvic cavity in pelvic exenteration, a case report

Submission Author: Maryam Yazdizadeh

Maryam Yazdizadeh[1]

1. Firoozgar Hospital, Iran University of Medical Sciences, Tehran, Iran

Background and Aim: Introduction and importance: Total pelvic exenteration is the choice treatment for locally advanced or recurrent cervical cancers. However, the procedure is usually associated with serious complications. One of the most common complications is “empty pelvic syndrome”. In this case report, we described a novel method to investigate its efficacy in prevention of empty pelvic syndrome

Methods: Case presentation: A 51-year-old woman presented with recurrent cervical cancer underwent TPE after chemoradiotherapy. After removing the organs of the pelvic cavity, A silicone-made Bakri balloon was placed in there through the laparotomy incision. The balloon was removed 5 days later through the vaginal canal. She was followed for 6 months after the surgery and did not experience neither complications nor the recurrence of the cervical cancer.

Results: Clinical Discussion: We intended to use a novel technique by placing a Bakri balloon in the pelvic cavity after the total pelvic exenteration. The silicone-made balloon creates an appropriate physical barrier to support colon and small intestine loops and other pelvic contents.

Conclusion: Conclusion: Bakri balloon, which has been used to control the post-partum hemorrhage, can be a useful tool to provide a physical barrier to prevent the descending of intestinal loops and a breeding ground for reconstruction of the pelvic floor.

Keywords: Keywords: Bakri Balloon; Pelvic Exenteration; Cervical Cancer

Presentation Type: Poster

Review on the most important regulators of PI۳K/AKT/mTOR pathway in ovarian cancer pathogenesis

Submission Author: Shokoofe Gerivani

Mahla Rafat[1], Shokoofe Gerivani[2], Hoda Rivandi[3], Seyedeh Kiana Lary Bagha[4], Fatemeh Karami[5]

1. 1. Department of Biology, College of Convergent Sciences and Technologies, Science and Research Branch, Islamic Azad University, Tehran, Iran
2. 1. Department of Biology, College of Convergent Sciences and Technologies, Science and Research Branch, Islamic Azad University, Tehran, Iran
3. 1. Department of Biology, College of Convergent Sciences and Technologies, Science and Research Branch, Islamic Azad University, Tehran, Iran
4. 1. Department of Biology, College of Convergent Sciences and Technologies, Science and Research Branch, Islamic Azad University, Tehran, Iran
5. Department of Medical Genetics, College of Medical Sciences and Technologies, Applied Biophotonics Research Center, Science and Research Branch, Islamic Azad University, Tehran, Iran

Background and Aim: Ovarian cancer is the sixth common female cancer and the leading cause of cancer related death among women. PI3K/AKT/mTOR signaling pathway was found to be critically altered during ovarian cancer evolution. Owing to the importance of this pathway in chemo- and radiotherapy resistance, present review was aimed to determine the most important genetic alterations within PI3K/AKT/mTOR and its down/upstream pathways.

Methods: An advanced literature search was conducted in PubMed, Google Scholar and Embase databases. Searching was included following keywords: PI3K OR phosphoinositide 3-kinases, AKT OR Protein kinase B (PKB), mTOR OR Mammalian target of rapamycin, gene expression and, ovarian cancer. All the articles since 2016 was included in the present study.

Results: It was demonstrated that suppression of PI3K/AKT/mTOR signaling pathway through inhibition of ubiquitin conjugating enzyme E2 S, TCP1, NUF2, miR-9, Y-box Binding Protein-1,CXCR4 and HERPUD1 genes expression positively regulate the PI3K/AKT/mTOR pathway. In contrast, the CADM1 gene expression inhibits ovarian cancer cells through negative modulation of PI3K/AKT/mTOR pathway.

Conclusion: Involvement of the found positive and negative regulators of PI3K/AKT/mTOR pathway in essential cell processes including apoptosis or cell replication maybe the potential reason behind more successful ovarian cancer therapy than PI3K/AKT/mTOR targeting, alone. Novel molecular therapy based on those PI3K/AKT/mTOR regulators can increase prognosis and overall survival of ovarian cancer patients.

Keywords: PI3K/AKT/mTOR signaling pathway, gene expression, ovarian cancer, treatment

Presentation Type: Poster

Comparing the effect of three trigger methods (human HCG, combination of recombinant HCG with GnRH agonist, and double recombinant HCG) on the fertility outcome of patients with poor ovarian response i

Submission Author: Hatav Ghasemi Tehrani

Hatav Ghasemi Tehrani[1]

1. 1. Associate Professor of Infertility & IVF, Department of Obstetrics & Gynecology, School of Medicine, Al-Zahra Hospital, Shahid Beheshti Hospital, Isfahan University of Medical Sciences, Isfahan, Iran.

Background and Aim: The aim of this study is comparing the effect of three trigger methods (human HCG, combination of recombinant HCG with GnRH agonist, and double recombinant HCG) on the fertility outcome of patients with in poor ovarian response in ovulation stimulation cycle (IVF/ICSI).

Methods: In this double-blind randomized clinical trial study, 158 patients with low ovarian reserve were divided to three groups: Group 1: Two doses of recombinant HCG (Ovitrelle) at a dose of 250 µg at 12 hour intervals, Group 2: HCG trigger (KARMA) alone at a dose of 10,000 units, and Group 3: 250 µg of recombinant HCG+ GNRH agonist.

Results: In groups 1 and 3, the number of oocytes, the number of M2 oocytes and the number of 2PN embryos was higher than group 2 after ovulation. The percentage of empty follicle syndrome was low in the two groups 1 and 3.

Conclusion: Dual trigger treatment with recombinant hCG and GNRH agonist and double recombinant hCG can improve fertility outcome patients with poor response in ovulation stimulation cycle. However, there were no significant differences among three groups regarding pregnancy results.

Keywords: recombinant HCG, GnRH agonist, Fertility, Pregnancy, Ovulation

Presentation Type: Poster

Prevalence of Vitamin D Deficiency and Risk Factors Among Pregnant Women Referring to Infertility Clinics of Urmia, Iran

Submission Author: Somayeh Ghasemzadeh

Tahereh Behroozi Lak[1], Somayeh Ghasemzadeh[2]

1. Maternal and Child Obesity Research Center, Urmia University of Medical Sciences, Urmia, Iran
2. Maternal and Child Obesity Research Center, Urmia University of Medical Sciences, Urmia, Iran

Background and Aim: A high prevalence of vitamin D deficiency in pregnant women has been reported from different regions around the world. There is evidence of an association between a low maternal vitamin D status and a high risk of adverse pregnancy outcomes. The current study aimed to determine the prevalence and evaluate the risk factors of vitamin D deficiency in pregnant women.

Methods: This cross-sectional study was performed on 187 pregnant women who referred to the infertility clinics. Socio-demographic and maternal characteristics were collected. Weight and height were measured using standardized methods. Blood samples were collected from all 187 pregnant women. Chemiluminescent immunoassay (CLIA) was used to evaluate serum vitamin D levels. The data was analyzed using IBM SPSS software (version 24). T-test or ANOVA was used as appropriate. Linear multivariate regression analysis was conducted to determine the risk factors of vitamin D deficiency.

Results: The mean serum vitamin D level was 14.06 ± 10.35 (SD) ng/ml. The prevalence of vitamin D deficiency (less than 20 ng/mL) was diagnosed in 69.5% of pregnant women. Parity, monthly income, BMI, and gestational age were significantly associated with the risks related to vitamin D deficiency in the linear multivariate regression model (p<005/).

Conclusion: The prevalence of vitamin D deficiency was high in pregnant women in Urmia, and preventing vitamin D deficiency during pregnancy is sensible. Vitamin D supplementation may be useful in preventing adverse pregnancy outcomes.

Keywords: Prevalence, Vitamin D, Deficiency, Pregnant

Presentation Type: Poster

Live birth after cleavage-stage versus blastocyst-stage embryo transfer in assisted reproductive technology. A randomized controlled study

Submission Author: Malihe Mahmoudinia

Malihe Mahmoudinia[1]

1. Assistant Professor of obstetrics & Gynecology, Fellowship of infertility, Supporting the family and the youth of population Research Core, Department of Obstetrics and Gynecology, Faculty of Medicine, Mashhad University of Medical Sciences, Mashhad, Iran

Background and Aim: Over the past years, transfer in the blastocyst stage has been developed which has been claimed to improve pregnancy outcomes. The aim of this study is to evaluate the pregnancy results between blastocyst stage embryo transfer and cleavage stage embryo transfer in the fresh cycle.

Methods: Patients undergoing the first ICSI which allocated to cleavage embryo transfer or blastocyst stage transfer. Patients were randomly put into either the cleavage embryo (N=112) or blastocyst transfer groups (n=107). Pregnancy outcomes were measured in both groups.

Results: There was no difference regarding age, BMI, serum FSH, duration of infertility, and etiology of infertility between the two groups ($p > .01$). The number of follicles, and total oocytes M2 oocytes were higher in the blastocyst stages. A considerably more mean number of embryos was transferred at the cleavage stage (1.860.564±) in comparison to the number of transferred blastocysts (1.630.523±). The blastocyst arm had more vitrified embryos than those in the cleavage arm (4.703.231± vs 2.132.152±). Although the rate of implantation (33.33% vs 37.38%) chemical pregnancy (28.57% vs 37.38%), clinical pregnancy (25.89% vs 28.03%) and live berth (23.21% vs 25.23%) were higher in blastocysts it is, no significant differences. the rate of abortion also was higher in blastocysts but it was no significant difference (7.14% vs 11.21%).

Conclusion: Blastocyst stage transfer could benefit more than transfer at cleavage embryo in the fresh cycle in the ICSI cycle.

Keywords: IVF/ICSI, Blastocyst stage, Cleavage stage, Pregnancy outcomes, embryo transfer