OC01: PLENARY: AWARD LECTURES, TOP ABSTRACTS

OC01.01  
Risk of complications in conservatively managed adnexal masses initially thought to be benign at subjective impression by the ultrasound examiner  
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Objectives: Traditional management of adnexal masses has been surgical removal because of the presumed risk of mass complications. However, large multicentre studies on long-term follow-up of adnexal masses assigned to conservative follow-up. After enrolment, patients were invited for follow-up scans after 3 months, 6 months and then yearly. Outcome parameters were the finding of spontaneous resolution or the performance of surgery during follow-up. In case surgery was performed, the intraoperative observation of mass torsion or rupture was registered and histopathology diagnosis of the mass was assessed for the presence of malignancy. A competing risk analysis was performed to calculate the event-probabilities.

Results: 2623 patients with an adnexal lesion presumed to be benign were seen at least once for follow-up. Median follow-up in this group was 22 months (interquartile range = 10–34). At two years of follow-up, spontaneous resolution was observed in 12% (N=310) of lesions and surgery was performed in 15% (N=393) of cases. The probability of observing a malignant tumour, torsion and cyst rupture at two years was 0.7%, 0.4% and 0.2%, respectively.

Conclusions: Conservative management of adnexal masses presumed to be benign at subjective assessment of the ultrasound investigator seems to be safe as the observed risk of complications is low.

OC01.02  
How to estimate the degree of bowel stenosis in patients with colorectal endometriosis?  
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Objectives: To compare the precision of different imaging techniques in estimating the degree of stenosis of the bowel lumen in patients with colorectal endometriosis.

Methods: This prospective study included 43 patients with rectosigmoid endometriosis who underwent segmental bowel resection. Before surgery, the percentage of bowel stenosis was estimated by the following exams: transvaginal ultrasonography (TVS), rectal water contrast transvaginal ultrasonography (RWC-TVS), magnetic resonance enema (MR-e) and computed tomographic colonography (CTC). The physicians who performed the exams were blinded to the results of the other imaging techniques. After surgery, the specimens were sent to the pathologist. Areas of interest were marked with suture threads. Large bowel specimens were stuffed with 10% buffered formalin-soaked paper rolls to maintain the anatomic integrity and to reduce shrinkage artefacts; they were then routinely fixed for 12–18 hours. Selected areas were sectioned transversally, embedded in paraffin maintaining the anatomic shape and cut with the microtome to obtain 3 μM thick whole-mount sections of the large bowel. Measures were obtained using a microscope eyepiece reticle. Imaging findings and results of pathologic examination were compared.

Results: At pathology, the mean (±SD) length of the resected bowel stenosis was 10.9 (±1.9) cm; the mean (±SD) largest diameter of the largest nodule was 34.2 (±5.9) mm; the mean (±SD) volume of the largest nodule was 10.6 (±5.8) cm3. The mean (±SD) degree of the stenosis of the bowel lumen was 64.1% (±15.6%).