

# 18th Annual Meeting of the Egon and Ann Diczfalusy Foundation

***8–10 October 2026***
***Szeged, Hungary***

## CONFERENCE PROGRAM



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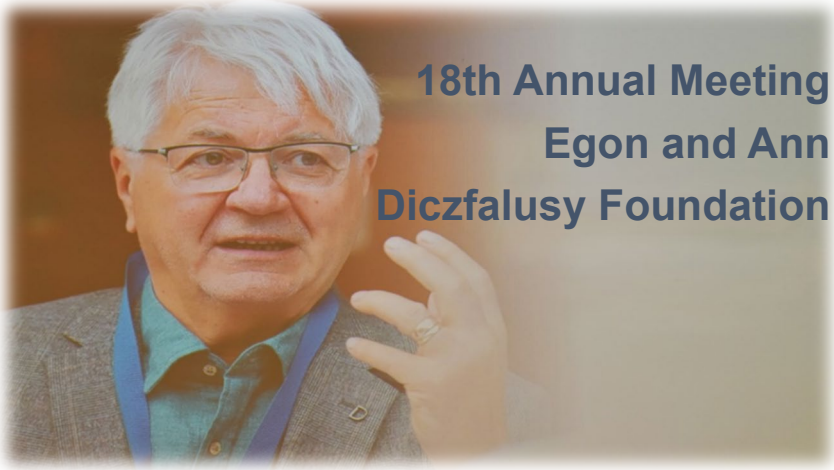
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## Dear Participants,

It is our great pleasure to welcome you to the 18th Diczfalusy Award Lecture (DAL) Symposium in Szeged. On behalf of the Organizing Committee, we warmly welcome our participants, guests, speakers, students and researchers.

The meeting continues the Diczfalusy Foundation's commitment to reproductive health, education and international scientific cooperation. The programme explores AI-driven women's health, obstetric practice and education, challenges in sexual and reproductive health, and reproductive longevity and fertility preservation.

The Board of Trustees will meet on Thursday, 8 October. The scientific programme on Friday and Saturday brings together lectures, panel discussions and the Best Poster and Abstracts Session. Audience questions are an integral part of both panel discussions, and we encourage you to take an active part.

We hope that the meeting will inspire useful discussions and lasting collaborations. We look forward to welcoming you to Szeged and sharing the Diczfalusy heritage with you

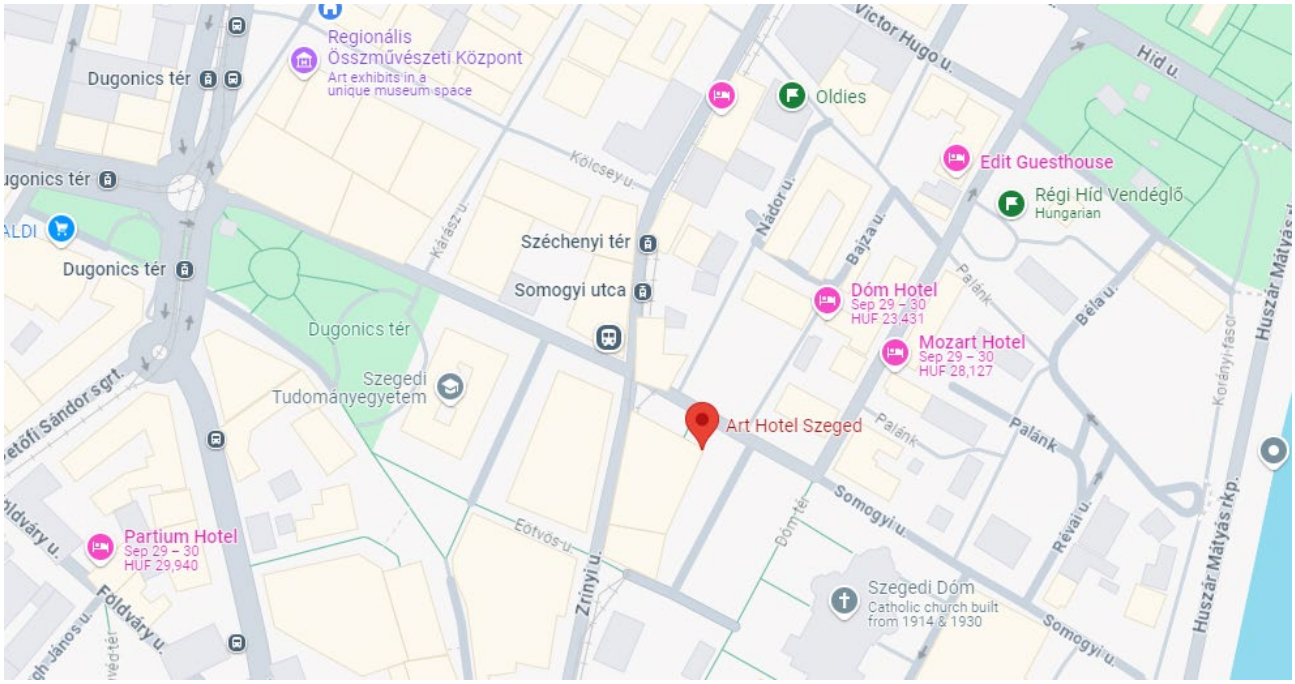
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**Prof. Dr. Ferenc Bari PhD DSc**
president of the Foundation

# Venue

## ART Hotel Szeged




## 6720 Szeged, Somogyi utca 16, Hungary

The Board meetings, scientific sessions, Thursday dinner and Friday reception will take place at ART Hotel Szeged.

# Scientific program

8-10 October 2026

## Thursday - 8 October Board Meeting

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| **14:00–15:30** | Board Meeting 1 — Strategy |
| **15:30–15:45** | Coffee break |
| **15:45–18:00** | Board Meeting 2 |
| **18:00–20:00** | Dinner |

## Friday - 9 October

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| **08:30–09:00** | Arrivals, registration and coffee |
| **09:00–09:15** | Opening ceremony — Tamás Szili-Török, Vice-Dean for Science and Innovation; Ferenc Bari, President of the Foundation |
| **09:15–09:30** | Legacy of Egon Diczfalusy — Cristian Furau, Arad, Romania |

### Theme 1 AI-Driven Women's Health

**Chair: Ferenc Bari**

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|---|---|
| **09:30–10:00** | Artificial Intelligence in Obstetric Ultrasound: Are We Ready for Clinical Practice? — Chiara Di Ilio, MD, Rome, Italy |
| **10:00–10:30** | AI for Better Tumour Recognition and Differentiation — Peter Horvath, Szeged, Hungary |
| **10:30–10:45** | Coffee break |
| **10:45–11:15** | Young Scientist Award: The Female Fertility Potential — Ontogenic, Iatrogenic and Environmental Influences — Ilary Ruscito, Italy |
| **11:15–11:45** | Individualising Endometriosis Treatment: The Role of GnRH Antagonists and Add-Back Therapy — Jaime Onofre |
| **11:45–12:00** | Beyond Morbidity: Integrating Maternal Well-Being and Health-Related Quality of Life into Contemporary Obstetric Care — Jessica Ybanez Morano, USA |
| **12:00–12:15** | Limits of Viability in Premature Neonates: Ethical Challenges and a Multidisciplinary Approach — Melinda Ildiko Mitranovici, Targu-Mures, Romania |
| **12:15–12:30** | Knowledge and False Beliefs Related to Contraception and Artificial Abortion:<br>Insights from a Representative National Survey — Qais Adnam Salloum, Szeged, Hungary |
| **12:45–14:00** | Lunch — ART Hotel Restaurant |

## Friday - 9 October afternoon

### Theme 2 Time to Go Back to Normal

**Chair: Aleksandra Vejnovic**

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| **14:00–15:30** | Vaginal Birth After Caesarean (VBAC)- István Sziller, Budapest, Hungary<br>Chronic Complications of Caesarean Section-Aleksandra Vejnović, Novi Sad,<br>Serbia<br>Panel Discussion: Education in Obstetrics — Moderator: Aleksandra Vejnovic<br>(Audience questions are an integral part of the panel discussion. Please prepare a question.)<br>University representatives from member countries will discuss current residency programmes, key challenges, practical training solutions and opportunities for exchange or DAL fellowship training. |
| **15:30–15:45** | Coffee break |
| **15:45–16:15** | Changing the Conversation: The Modernising Menopause Counselling Educational Programme — Laura Lóczi, PharmD |
| **16:15–16:35** | Different Positions in Labour, Including Water Birth: Sharing Experience —<br>Milada Baresova, Czech Republic |
| **16:35–16:55** | History of Midwifery — Lise-Lotte Franklin, Dalarna, Sweden |
| **16:55–17:15** | Golden Hour of Breastfeeding — Gyopárka Oprea, Romania |
| **17:15–17:45** | Home Delivery — Panel Discussion — Midwives and gynaecologists<br>(Audience questions are an integral part of the panel discussion. Please prepare a question.) |
| **17:50–19:15** | Best Poster & Abstracts Session — competition for best abstract and poster |
| **19:30–21:00** | Reception — ART Hotel Restaurant |

## Saturday 10 October

### Theme 3 Challenges in Reproductive Health

**Chair: Christian Furau**

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| **08:30–09:00** | Arrivals and coffee |
| **09:00–09:20** | ESCRH Position Paper on Sexual and Reproductive Health and Rights — Belgrade 2026 — Teresa Bombas, Portugal |
| **09:20–09:40** | ESCRH Recommendations on Postpartum Contraception — Jose Quilez, Spain |
| **09:40–10:00** | Counselling Those with Hormone Hesitancy — Cristian Furau, Romania |

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| **10:00–10:15** | The EBCOG/ESCRH Curricula, Exams and Fellowship in Sexual and Reproductive Health Care — Teresa Bombas, Portugal & Cristian Furau, Romania |
| **10:15–10:30** | Questions and discussion |
| **10:30–11:00** | Diczfalusy Lifetime Scientific Achievement Award: Male Contraception Landscape — New Technologies and Perspectives — Regine Sitruk-Ware, USA–France (online) |
| **11:00–11:15** | Coffee break |

## Theme 4 Reproductive Longevity & Fertility Preservation

**Chair: Péter Kovács**

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| **11:15–11:30** | Demographic Challenges — How Can ART Help? — Peter Kovács, Hungary |
| **11:30–11:45** | In Vitro Fertilisation — How It Started, Current Practices and Future Perspectives — Hana Visnova, Czech Republic |
| **11:45–12:00** | PCOS–PMOS — Have the Reproductive Challenges Changed? — Peter Koliba, Czech Republic |
| **12:00–12:15** | The Pros and Cons of Social Oocyte Vitrification — Attila Török, Hungary |
| **12:15–12:30** | Infertility: What About the Male Partner? Practical Implications of the New Guidelines — Zsolt Kopa, Hungary |
| **13:00** | Closing remarks |

Organon is an independent supporter of this session. Organon had no influence on the scientific content, agenda development, speaker selection, or educational materials presented during the program. All content has been developed independently by the scientific organizers and faculty.

# Abstracts

**Chiara Di Ilio**
*Fondazione Policlinico Universitario Agostino Gemelli*

**Artificial Intelligence in Obstetric Ultrasound: Are We Ready for Clinical Practice?**

Artificial intelligence (AI) is already widely used in our daily life. However, its use in prenatal medicine raises different questions, as it may directly affect diagnosis, clinical decisions, and patient care.
Obstetric ultrasound is the main imaging tool for prenatal diagnosis, but its diagnostic performance remains inherently operator-dependent. AI applications could help reduce this variability and make ultrasound assessment more standardized.
AI can support obstetric ultrasound at different steps, from image acquisition and standard-plane recognition to automated measurements and anomaly detection. While its first applications mainly focused on automation, AI is now moving beyond measurements and can extract information directly from ultrasound images.
However, promising results in retrospective studies are not enough to support clinical use. As recently highlighted by ISUOG, AI tools need to be tested for their performance, safety, and generalizability in the clinical setting in which they will be used before entering clinical practice. Prospective studies in real-world practice are therefore essential.
The role of AI might also differ depending on the experience of the operator. For less experienced operators, AI can provide real-time guidance to support image acquisition and interpretation, helping them obtain appropriate sonographic planes and recognize abnormalities. For experienced operators, it can automate repetitive tasks and save time that could be dedicated to image interpretation, patient care and clinical decision-making.
Using AI in obstetric ultrasound does not mean that human operators will be replaced. The real value of AI applications may lie in reducing variability, saving time, and supporting clinicians differently according to their level of experience.

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**Jaime Onofre**

**Individualising Endometriosis Treatment: The Role of GnRH Antagonists and Add-Back Therapy**

Endometriosis is a chronic, oestrogen-sensitive inflammatory condition requiring care beyond isolated treatment episodes. Persistent pain may reflect active lesions, sensitisation, pelvic-floor dysfunction, adenomyosis or other coexisting conditions; symptom severity does not consistently correspond to anatomical disease extent. We propose a life-course, reassessment-driven approach guided by symptoms, impact on quality of life, reproductive priorities, treatment response, safety and patient preferences, alongside endometriosis phenotype (superficial peritoneal endometriosis, ovarian endometrioma or deep endometriosis).
For selected patients with unacceptable pain or ineffective or poorly tolerated first-line hormonal treatment, GnRH antagonist therapy with add-back may be considered. It may suit longer-term symptom management by combining effective ovarian suppression with immediate treatment initiation, avoiding the initial flare associated with GnRH agonists, while add-back mitigates hypo-oestrogenic effects. Trials demonstrate efficacy versus placebo; selected regimens have shown sustained symptom control and relatively small bone mineral density changes through 24 months. However, direct comparative evidence has not established superiority over other hormonal treatments or identified a preferred product.
Persistent symptoms should prompt reassessment before treatment is changed or escalated. Surgery, fertility-directed care and multidisciplinary pain management remain important when they better address the patient's needs. Systemic health must inform treatment selection: ovarian suppression can affect bone, particularly during adolescence and peak bone-mass accrual, while prolonged hypo-oestrogenism warrants attention to cardiometabolic health. Add-back may mitigate bone loss but does not eliminate product-specific risks or the need to consider baseline skeletal health, treatment duration and monitoring. Cardiovascular health should inform risk–benefit assessment, although evidence does not show that GnRH antagonists prevent cardiovascular

disease. Products differ in dose, add-back regimen, tolerability, authorisation and duration. GnRH antagonist therapy with add-back is therefore one component of individualised chronic care, balancing symptom relief with quality of life, reproductive goals and systemic safety.

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**Professor Jessica Ybanez-Morano, MD, MPH, FACOG, CPE**[a & b]
[a]*Society of Laparoscopic and Robotic Surgeons*[Past President, SLS]*Miami, FLORIDA, USA* [b]*Northeast Ohio Medical University*[Professor, NEOMED]*, Department of Obstetrics and Gynecology, Rootstown, OHIO, USA*

**Beyond Morbidity: Integrating Maternal Well-Being and Health-Related Quality of Life into Contemporary Obstetric Care**

**Introduction/Objectives:** Maternal health is commonly assessed through morbidity and mortality, measures that may not capture the full impact of pregnancy on patients' daily lives. This review considers the role of maternal well-being and health-related quality of life (HRQoL) in contemporary obstetric care and the potential contribution of patient-reported outcome measures (PROMs).
**Methods:** A narrative approach was used to examine the concepts presented in this review: the multidimensional nature of maternal HRQoL and the potential integration of PROMs into routine obstetric care.
**Results:** Maternal well-being encompasses physical, psychological, and social domains that may be affected even in uncomplicated pregnancies. These experiences may not be apparent from conventional clinical outcomes alone. PROMs offer a way to elicit patients' perspectives, support communication, and identify concerns that may inform individualized care. Their practical use depends on selecting relevant, accessible measures and establishing workflows for reviewing responses and addressing identified needs.
**Conclusions:** Maternal well-being and HRQoL are important complements to morbidity and mortality outcomes. Integrating appropriate PROMs into obstetric care may support a more comprehensive, patient-centered understanding of pregnancy and help align care with patients' experiences and priorities.

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**Melinda Ildiko Mitranovici**
*Department of Obstetrics and Gynecology, Emergency County Hospital Hunedoara, 14 Victoriei Street, 331057 Hunedoara, Romania "George Emil Palade" University of Medicine, Pharmacy, Sciences and Technology, 540142 Targu Mures, Romania*

**Limits of viability in premature neonates, ethical cahllenges and multidisciplinar approach**

**Background**: Currently, the World Health Organization sets the lower limit of viability at 22 weeks of gestation, or a birth weight of 500 g. However, there are variations among healthcare providers regarding the gestational age considered the threshold of viability. The management and treatment of these extremely preterm newborns remain controversial and raise important ethical concerns.
**Materials and methods**: The lack of coherent national guidelines and legislation represents an important burden for our healthcare system. We reviewed 12 000 manuscripts and 75 refferences were included. Statistically, in our country in 2024, the mortality of newborns at the limit of viability increased significantly. From a legal perspective, there is a grey zone between 22 weeks of gestation or 500 g of birth weight and 27 weeks and 6 days in Romania. If the newborn is born alive, the event is legally considered a birth; if the newborn is dead, it is considered a miscarriage. This situation highlights the complexity of managing such cases, starting with antenatal counseling.
**Results**: In our presentation we evaluated the factors involved in healthcare professionals' management decisions in cases of neonates born at the margins of viability, and also we identified feasable moddels of risk stratification in patients. Important issues that are not included in many current guidelines will be evaluated including ethical issues, cultural differences across countries, and legislation. The importance of healthcare professionals' training is also highlighted in the management of these neonates, together with the need for a multidisciplinary strategy. Various approaches currently used across the world raise concerns about their potential impact on the quality of care provided to these infants and add emotional stress to those involved.

**Conclusions**: The neonatal mortality rate in Romania has reached 6.6 per 1000 live births, the highest in Europe. This situation is partly due to the lack of medical equipment in hospitals, the shortage of qualified personnel, and insufficient training opportunities for healthcare professionals. The obstetric and neonatal teams should therefore offer a coherent and balanced plan of care, adjusted to local standards and the availability of neonatal support. Prenatal counseling for parents before the delivery of a premature infant provides the opportunity to establish a trusting relationship and an appropriate environment for decision-making regarding neonatal resuscitation. A risk stratification model based on deep learning machine and a national platform available will help us to improve the pregnancy outcomes.

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*[a]Qais Adnan Salloum, Department of Obstetrics and Gynecology, University of Szeged, Szeged, Hungary. Email: qais.salloum@med.u-szeged.hu*

**Knowledge and False Beliefs Related to Contraception and Artificial Abortion: Insights from a Representative National Survey**

**Introduction:** Thorough understanding of contraceptive methods is critical for making informed reproductive choices. In Hungary, however, contraceptive practices remain influenced by insufficient sexual education and a longstanding historical dependence on abortion. The country offers a particularly instructive case within Central and Eastern Europe, given its specific socio-cultural and policy context.

**Methods:** The study drew on data from a nationally representative sample of 1,506 Hungarian adults, obtained through a mixed-mode survey (online and in-person) conducted in 2024. Subjective and objective knowledge of contraception, sources of information, and socio-demographic predictors were analysed using descriptive statistics, Chi-squared tests, and logistic and Poisson regression models.

**Results:** The most commonly reported sources of contraceptive information were the internet, doctors, and parents. Although 75% of respondents considered their knowledge sufficient, only 2 out of 779 participants answered all five objective knowledge questions correctly. Women and older respondents were more likely to consult doctors, while men relied more frequently on the internet. Use of the internet and traditional media was associated with lower objective knowledge scores. Misconceptions were widespread: only 12% correctly identified hormonal IUDs as the most effective method, and over half believed they carry greater health risks than childbirth. A majority (58%) held the view that long-term IUD use causes infertility. Abortion-related myths were also prevalent, with 42% associating abortion with breast cancer and 60% with infertility, despite the lack of scientific evidence supporting these claims.

**Conclusions:** A substantial discrepancy exists between perceived and actual knowledge regarding contraception and abortion in Hungary. Interventions should target younger and less-informed groups, with an emphasis on providing medically accurate information. This study is the first nationally representative investigation in Hungary to examine subjective and objective contraceptive knowledge together. It contributes rare comparative evidence from Central and Eastern Europe and offers insights relevant to other countries facing similar socio-political conditions.

*Grant support: This study was supported by the Momentum Programme of the Hungarian Academy of Sciences under Grant LENDULET_2021-78.*

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**Istvan Sziller**
*Department of Obstetrics and Gynecology, Szent Imre University Teaching Hospital, Budapest, Hungary*

**Vaginal birth after Cesarean Section**

Due to the high frequency of Cesarean section (CS) in Hungary over the last decade, one in 6 pregnant women presenting for spontaneous onset or induction of labor at or close to term has a history of Cesarean section. Thus, decision about trial of labor (TOLAC) or a scheduled repeat Cesarean section (ERSC) is a frequent challenge for both the physician, and the pregnant couple. Advantages of vaginal birth after Cesarean section (VBAC) include lack of complications of major abdominal surgeries, absence of possible placental disorders in subsequent pregnancies, less postoperative pain and shorter hospital stay. The most significant possible complication of TOLAC is uterine rupture occurring in less than 1% of vaginal attempts after previous CS. While VBAC is safer than ERSC, an unsuccessful TOLAC leading to emergency CS carries the highest rate of severe complications for both the mother and her fetus. Generally, a pregnant woman's chance of a successful VBAC is between 60-80%. History of vaginal delivery, spontaneous onset of labor and low transverse incision in previous CS are the most important factors of a successful VBAC. On the other hand, induction of labor, post term pregnancy, advanced maternal age, high maternal BMI, short interpregnancy interval, and fetal macrosomia are the best-known risk factors of an unsuccessful TOLAC. Decision about vaginal or abdominal attempts after previous CS should be made on an individual basis after careful evaluations of medical history, physical examination and patient's preference.

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**Aleksandra Vejnovic[a,b,c], Mirjana Bogavac[a,b], Tihomir Vejnovic[a,b,c]**
*[a]University of Novi Sad, Faculty of Medicine, Department of Gynecology and Obstetrics; Novi Sad, Serbia b University Clinical Center of Vojvodina, Clinic for Gynecology and Obstetrics; Novi Sad, Serbia c Egon and Ann Diczfalusy Foundation; Szeged, Hungary*

**Chronic Complications of Cesarean Section**

**Introduction:** A cesarean scar niche is an indentation of the myometrium at the site of the hysterotomy with a depth of ≥2 mm. It is present in 24–84% of women after cesarean section and may cause gynecological and obstetric complications. Certain elements of the surgical technique have been recognized as significant contributing factors to niche formation. However, the effects of the Vejnović modification of cesarean section on the incidence and dimensions of the niche have not been sufficiently investigated.
**Objective:** To examine the ultrasound characteristics of the niche after a first cesarean section performed using the Vejnović modification.
**Material and Methods:** This prospective descriptive study included 36 patients at a university clinic in Novi Sad. Niche characteristics were measured once by native 2D transvaginal ultrasound, using the methodology of Jordans et al., at least three months after the first cesarean section. The parameters were analyzed in relation to the course of labor, perioperative data and symptoms.
**Results:** A niche was detected in 55.56% of patients. Mean residual myometrial thickness (RMT) was 7.47±2.48 mm and the healing ratio was 0.69±0.14. In all patients, RMT was >3 mm and the healing ratio was >0.4, which classifies all detected niches as small niches. RMT and the distance from the vesicovaginal fold were significantly greater after preterm delivery (p=0.011; p=0.003). In patients with a niche, RMT was greater after emergency than after elective cesarean section (8.44 vs. 5.94 mm; p=0.014), and adjacent myometrial thickness was lower in the active phase of dilatation (p=0.004). No patient reported postmenstrual spotting, while 18.18% reported dyspareunia.
**Conclusion:** After a first cesarean section performed using the Vejnović modification, a niche is detected by native ultrasound in approximately half of patients, exclusively as a small niche and with infrequent symptoms. Changes in the lower uterine segment during pregnancy and labor affect scar formation.

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**Joyce C Harper[a], Rossella E Nappi[b], Petra Stute[c], Laura Lóczi[d]**
*[a]Joyce C Harper - UCL Institute for Women's Health, London, UK [b]Rosella E Nappi - Department of Clinical, Surgical, Diagnostic and Pediatric Sciences, University of Pavia, Pavia, Italy; and Research Center for Reproductive Medicine, Gynecological Endocrinology and Menopause, IRCCS San Matteo Foundation, Pavia, Italy [c]Petra Stute - Department of Obstetrics and Gynecology, University Clinic Inselspital Bern, Freiburgstrasse 18, 3010, Bern, Switzerland [d]Gedeon Richter Plc, Budapest, Hungary*

**Changing the conversation: The Modernising Menopause Counselling educational programme**

**Background**: Rising awareness of menopause has led to higher expectations, more complex questions, and an overwhelming volume of information that many women struggle to navigate. Women often present with fragmented symptoms and uncertainty, while healthcare professionals face pressure to provide clear, consistent, holistic guidance. This highlights the need for a structured approach that supports effective assessment and meaningful patient engagement.
**Aims**: To introduce an enhanced menopause counselling project designed to strengthen HCP confidence, improve patient understanding, and support shared decision-making through structured educational materials and practical tools.
**Methods**: The project was based on a scoping review of abstracts, publications, and clinical guidelines, alongside expert interviews across Europe. Insights were synthesised into a three-step counselling model: *Symptoms*, *Stories*, and *Solutions*, supported by the plain-language patient tool (*My Menopause Consultation*).
**Results**: The material offers practical guidance for connecting symptoms, aligning on their impact, and exploring management options. The patient tool helps women map symptoms across mental, physical, and sexual/urinary domains and create a personalised "wish list," improving clarity and engagement. The approach encourages supportive dialogue that builds trust and helps women feel informed and understood.
**Conclusions**: This project provides an evidence-based, practical framework that enhances menopause counselling by reducing confusion, improving alignment, and supporting holistic, patient-centred care. Expected benefits include more effective consultations, greater HCP confidence, and improved support for women navigating menopause.

*References:*
*1. Gedeon Richter Plc. Modernising menopause counselling: an educational guide for healthcare professionals. February 2026.*
*2. Gedeon Richter Plc. Modernising Menopause Counselling Programme [Internet]. 2026. Available from: https://menopause.rg.amarone.hu/*

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**Milada Baresova**
*Department of Obstetrics and Gynaecology, First Faculty of Medicine, Charles University and Bulovka University Hospital, Prague, Czech Republic*

This presentation draws on clinical experience from the Bulovka Midwifery Centre, a midwifery-led care programme integrated into a university maternity unit. It focuses on the assessment of labour progress and the individual selection of maternal positions for common clinical situations, including a high or unengaged fetal head, deflexion, asynclitism, ineffective contractions and delayed fetal rotation or descent. Practical approaches include Side-Lying Release, Abdominal Lift and Tuck, the Flying Cowgirl position and Rebozo techniques. Position changes during fetal descent and crowning are also discussed in relation to perineal protection and the prevention of birth injury.
The second part addresses water birth, which has been available at the Bulovka Midwifery Centre since June 2024.

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**Lindgren H, Erlandsson K, Franklin L**
*Dalarna University, School of health and welfare, Department sexual, reproductive, perinatal and global health*

Most pregnancies and births are normal physiological processes, and most newborns are born healthy. However, without skilled support during pregnancy, childbirth, and the postpartum period, preventable complications can arise for both mothers and babies. This presentation argues that midwives are specialists in prevention, providing care that promotes maternal and newborn health, supports early bonding, and reduces unnecessary medical interventions. Drawing on experiences from the 1930$^{th}$ and onwards, Sweden and other Nordic countries where midwives are Master degree holders in Reproductive Health, autonomous, regulated professionals, highlights the value of integrating midwives into health systems as primary providers of normal maternity care. Midwives do not replace doctors or nurses; rather, they complement their roles by creating a bridge between normal and complicated care. Through high-quality education, clear regulation, and strategic deployment, particularly in underserved communities, midwives can strengthen primary healthcare, improve access to services, promote trust within communities, and contribute to healthier mothers, healthier babies, and more sustainable health systems.

**Gyopárka Oprea**
*[a]Romanian Midwives Association*

**Introduction/Objectives:** The “Golden Hour” of breastfeeding—immediate, uninterrupted skin-to-skin contact and support for breastfeeding within the first hour after birth—is an evidence-based clinical intervention. It is associated with improved breastfeeding initiation and continuation, neonatal thermal and metabolic stability, maternal–infant bonding, and potentially better maternal mental health. Despite its effectiveness and low cost, implementation remains inconsistent in some European maternity settings. It may be dismissed as a lifestyle preference or an expression of parental entitlement rather than recognised as part of essential clinical care. This presentation reviews the evidence, examines this perception, and identifies strategies for implementation.
**Methods:** A narrative review was undertaken of recommendations, systematic reviews, and studies addressing skin-to-skin contact and breastfeeding initiation. Evidence concerning neonatal and maternal outcomes, feasibility, costs, and implementation barriers was synthesised, with attention to caesarean birth, professional practices, organisational culture, and family-centred care.
**Results:** Evidence supports immediate and uninterrupted skin-to-skin contact for stable mothers and newborns. The intervention requires no specialised equipment and can be incorporated into routine care. Potential benefits extend beyond breastfeeding outcomes to maternal wellbeing, early bonding, parenting confidence, and the dynamics of the family and caregiving network. Nevertheless, these outcomes may be regarded as secondary to “medical” priorities, creating a false separation between safety, mental health, and relational wellbeing. Additional barriers include non-urgent separation, routines, staffing pressures, safety concerns, insufficient training, limited support after caesarean birth, and resistance to changing workflows. Successful implementation combines clear protocols, appropriate observation, multidisciplinary education, leadership commitment, and audit.
**Conclusions:** The Golden Hour should not be treated as an optional parental request but as a low-cost clinical intervention with interconnected neonatal, maternal, and family benefits. Closing the evidence-to-practice gap requires maternity systems to recognise breastfeeding support, maternal mental health, bonding, and caregiver confidence as integral clinical outcomes, while preserving clinical judgement and safety.

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**Teresa Bombas, Manuela Farris, Sharon Cameron, Cristian Farau, Maja Banovic, José Quilez, Ana Mitrovic Jovanovic, Kristina Gemzell-Danielson, Berna Dilbaz, Giovanni Grandi, Amália Pacheco, Ali Kubba, Johannes Bitzer**
*[1]Specialist in Obstetrics & Gynaecology, Hospital and University Centre of Coimbra, Portugal Member of the Scientific Committe from ESCRH Secretary of the Portuguese Society of Contraception[SPDC] Past-President of the European Society of Contraception and Reproductive Health[ESCRH] Past- Chair of the FIGO Committee for Safe Abortion*

**The ESCRH Position Paper on Sexual and Reproductive Health and Rights (Belgrade 2026): evidence, rights and a call to action for Europe**

Sexual and reproductive health and rights (SRHR) are fundamental human rights. Across the 53 Member States of the WHO European Region, access to them remains deeply unequal. Political regression, misinformation, funding cuts and humanitarian crises are threatening gains that were hard to win. The European Society of Contraception and Reproductive Health (ESCRH) developed a position paper to set out an evidence-based, rights-centred stance on SRHR.

*The State of SRHR in Europe: Key Indicators*

- **Contraception:** Unmet need for family planning ranges from 5% to 23% across the Region. Only 21 of 47 countries cover contraception, including at least one LARC, in their national health system. Eight still require parental consent for minors, 8 provide free emergency contraception, and 14 offer postpartum contraception at hospital discharge.
- **Abortion:** Abortion policy scores range from 94.6% (Sweden) to 0% (Andorra). Mifepristone is unavailable in 10 countries. Mandatory waiting periods, third-party authorisation and poorly regulated conscientious objection persist.
- **HPV and violence:** HPV vaccination is not routine in 20 of 53 countries. An estimated 180,000 girls and women are at risk of FGM each year, and one in four women in Europe experiences intimate partner violence during her lifetime.

*ESCRH 10 Core Positions*

1. SRHR are fundamental human rights. All individuals are entitled to the highest attainable standards of sexual and reproductive health, free from discrimination, coercion, and violence.
2. Evidence-based medicine and human rights principles must guide SRHR policy and clinical practice at every level.
3. Contraception is an essential, life-saving intervention. Universal, equitable, and free access to a full range of modern contraceptive methods must be guaranteed globally.
4. Safe abortion must be accessible, legal, and provided with dignity to those who seek it. Conscientious objection must never impede timely access to care.
5. Comprehensive, age-appropriate sexuality education is a right, not a privilege. It must be delivered to all young people, free from ideological interference.
6. Sexually transmitted infections (STIs), including HIV, demand robust prevention, screening, and treatment strategies — especially for vulnerable populations.
7. Reproductive tract cancers are largely preventable. Vaccination, screening, and treatment must be universally available.
8. Gender-based violence (GBV), including female genital mutilation (FGM), is a public health crisis and a human rights violation requiring immediate action.
9. Marginalized populations, including adolescents, LGBTQIA+ individuals, migrants, refugees, people with disabilities, older adults, and sex workers, require dedicated, inclusive SRHR services.
10. Misinformation, censorship, and politically or ideologically motivated restrictions on SRHR must be actively countered through research, advocacy, and solidarity.

The evidence is clear and the rights are established. What is missing is political will. ESCRH calls on governments, health systems, professional bodies, researchers and civil society to treat SRHR

as essential healthcare, to protect it in law, and to monitor it with disaggregated data. Regression in SRHR anywhere is a threat to human rights everywhere.

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**Jose Cruz Quílez Conde**
*Department of Obstetrics and Gynecology, University Hospital of Basurto, Bilbao[Spain]. Secretary of European Society of Contraception and Reproductive Health*

We´ll introduce ESCRH Consensus Recommendations for Europe, that European society of contraception (ESCRH) published in october of 2025. This Recommendations aims to promote a change in the traditional models of contraceptive counselling related to pregnancy, trying to make this counselling being part of the pregnancy care, considering the antenatal period as a gold opportunity to discuss postpartum contraceptive options.
In addition, in this lecture, you can find a review of current clinical guidelines to provide consensus recommendations for Europe.

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**Regine Sitruk-Ware**
*Population Council, New York, NY, USA*

**Male Contraception Landscape: New Technologies and Perspectives**

While there are several easy-to-use reversible female contraceptives, little is available for men. Introduction of novel, cost-effective male contraceptives could have important downstream global health and economic benefits. Current options for male contraception include male condom or withdrawal, both with high failure rate, and vasectomy not easily reversible.
**The most advanced method of male hormonal contraception** in development is a transdermal gel delivering a progestin (Nestorone®) and testosterone. These steroids result in suppression of gonadotropins leading to the suppression of sperm production. The androgen contributes to the suppression and replaces the suppressed endogenous testosterone and maintains sexual function. This method has been tested in a large efficacy and safety study in 462 couples willing to use the method to prevent a pregnancy, as a joint development project between the Population Council and the NICHD. This user-controlled male contraceptive gel was effective, reversible, well-tolerated, and acceptable to couples.
Modified androgens are also studied as they may ensure both sperm suppression and androgenic actions. Hormonal methods given via various delivery systems show full reversibility within a few months.
**Novel non-hormonal contraception products** target the decrease in sperm motility, or acrosome reaction acceleration, to prevent fertilization. Biomarkers for each step of sperm function should be developed to establish efficacy before pregnancy trials. At this stage only one new molecule is in clinical stage, and other approaches are still in early research. The retinoic acid receptor alpha (RARα) has emerged as a compelling genetically and pharmacologically validated target for nonhormonal male contraception due to its essential role in spermatogenesis and identifying RARα antagonists led to the clinical advancement of YCT-529 as a nonhormonal male contraceptive currently in Phase 1 clinical trials. At an earlier stage, the Soluble Adenylyl Cyclase (sAC) short acting to block sperm motility show promising pre-clinical results and may become the first-of-their-kind nonhormonal, on-demand contraceptives for men.
**Reversible methods of vasectomy** are also in proof-of-concept trials. Preclinical, and early clinical findings support the safety, tolerability, and contraceptive potential of two different platforms using hydrogels injected in vas deferens to block the sperm transport. Adam™ is designed to be biodegradable and the second one Plan A™ is designed to be reversible by flushing out the hydrogel on demand.
As novel drugs and devices advance towards the clinic, the **regulatory path** for male contraceptives is unknown in contrast with well-established guidelines for female contraception. To address this, the Male Contraceptive Initiative convened a committee of 35 experts and published draft recommendations in a white paper. In parallel the WHO convened a panel of experts to design the Target Product Profile for male contraceptives. Those efforts will guide developers along the various steps of drug discovery and products or devices development.

**The search for novel methods must continue**. An array of choices is needed to allow couples to find the preferred method at each time of their reproductive life. Access to contraception and safe reproductive health care are a fundamental human right for all people and a necessary component of public health.

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**dr. Peter Kovacs**
*Dunamenti REK, Istenhegyi IVF Center Budapest, Hungary*

**Demographic challenges – how can ART help?**

Over the recent decades the number of children born has decreased worldwide. As a result, it is no longer just the developed Western world that is facing demographic challenges. With increasing life expectancy and decreasing birth rates the size of the population that needs to be taken care of increases while the number of those who could provide the required economic needs decreases.
Assisted reproductive technology (ART) has been available for decades and by now plays an increasingly important role in maintaining the size of the population. In Europe, around 3% of the births are the result of ART treatments; in some countries the proportion reaches as high as 8-10%.
There are many causes of the declining birth rates; one of them, and probably the most important one, is the intentional delaying of childbearing. The longer a woman, a couple waits the less likely that the desired family size can be reached and the need for ART services increases.
In vitro fertilization (IVF), the most advanced form of ART, is the most effective means of treating infertility, that has been defined as disease by WHO. However, it is asked increasingly often whether it could offer more than “just” to treat infertility. Could it help couples have more than one child? How should we approach the patient who expresses the desire to have more children? What tools do we have if this patient is already at a more advanced reproductive age?
Technologic developments often shape the care we provide, but just as often the needs of patients shape the care we can or should offer them. We need to prepare for a paradigm shift from treating “disease” to helping couples building families and the legal and technological requirements need to be put in place for this.

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**MUDr. Hana Višňová, Ph.D.**
*IVF CUBE, Prague*

**In Vitro Fertilisation — How It Started, Current Practices and Future Perspectives**

In vitro fertilization (IVF) has evolved in less than five decades from an experimental procedure into a complex field of personalized reproductive medicine. The birth of Louise Brown on 25 July 1978, following in vitro fertilization and transfer of an eight-cell embryo, marked the beginning of a new era. Subsequent milestones included donor-oocyte IVF, embryo cryopreservation, preimplantation genetic testing, intracytoplasmic sperm injection (ICSI), testicular or epididymal sperm extraction combined with ICSI, ovarian tissue replantation, and uterine transplantation. These developments transformed IVF from a single treatment attempt into an integrated system in which individual stages can be optimized.
Controlled ovarian stimulation using daily injections of gonadotropins (recombinant or urinary), combined with GnRH analogues, particularly GnRH antagonists to prevent a premature LH surge, is a standard first-line approach. Strategies for triggering final oocyte maturation include a GnRH agonist trigger to reduce the risk of OHSS, as well as dual or double triggers in selected patients with insufficient oocyte maturation. Mild ovarian stimulation or natural-cycle IVF may be considered for women with low ovarian reserve. Assessment of the uterine environment may include 2D/3D ultrasonography and hysteroscopy, while endometrial assessment may involve ultrasound and hormonal evaluation. The roles of the microbiome and uterine natural killer (uNK) cells remain under investigation. Contemporary embryology techniques include conventional IVF, ICSI, blastocyst culture, gamete vitrification, single-embryo transfer, and preimplantation genetic testing: PGT-A for aneuploidy, PGT-SR for structural chromosomal rearrangements, and PGT-M for monogenic disorders. However, reproductive medicine has also introduced numerous treatment “add-ons.” Sperm-selection methods, assisted hatching, embryo glue, time-lapse imaging, endometrial

receptivity testing, and immunomodulation are increasingly discussed or used, although evidence supporting their routine use remains insufficient.
A central challenge is therefore to distinguish established treatments from promising or experimental interventions.
The current direction of IVF is a shift from a “one-size-fits-all” model toward personalization based on validated predictors. This requires considering ovarian response, embryos, gametes, the endometrium, immunological factors, the microbiome, and genetics without assuming that every measurable difference warrants treatment. Future reproductive medicine is likely to integrate genetics, fertility preservation, regenerative approaches, data science, and artificial intelligence. Potential applications include prediction of embryo development and implantation, individualized ovarian stimulation, and automated embryo assessment. Emerging areas such as in vitro gametogenesis remain experimental, while polygenic risk assessment raises ethical questions.
IVF is also expanding beyond the treatment of infertility within couples. Donor oocytes, sperm, and embryos, gestational carriers, planned fertility preservation, third-party reproduction, and new models of parenthood increase the medical, psychological, ethical, and legal complexity of care.
Postponed parenthood represents a major challenge because gamete quality is strongly age-dependent; advanced maternal age, in particular, reduces oocyte genetic competence and increases the risk of pregnancy complications. The future of IVF will therefore depend on identifying which intervention, if any, is appropriate for each patient while maintaining realistic expectations, informed choice, safety, and evidence-based practice, thereby providing effective, individualized care across the reproductive pathway and diverse patient circumstances.

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**Peter Koliba**
*Department of Gynecology and Obstetrics, Bulovka University Hospital and 1st Faculty of Medicine, Charles University, Prague, Czech Republic*

**PCOS–PMOS: Have the Reproductive Challenges Changed?**

In May 2026, an international consensus renamed polycystic ovary syndrome (PCOS) as polyendocrine metabolic ovarian syndrome (PMOS). The new terminology better reflects the multisystem endocrine and metabolic nature of the condition and avoids the misleading emphasis on ovarian morphology. However, it does not change the current diagnostic criteria or immediately alter established fertility treatment pathways.
This review examines whether the transition from PCOS to PMOS changes the management of reproductive challenges. Oligo-anovulation remains the principal and most treatable cause of infertility, although evaluation must also consider female age, semen parameters, tubal patency and other infertility factors. Letrozole remains the first-line pharmacological treatment for anovulatory infertility without additional infertility factors. Treatment should follow a stepwise, time-limited approach, progressing to low-dose gonadotrophins, selected ovarian surgery or assisted reproductive technology when indicated. Conception does not eliminate the clinical consequences of PMOS. Evidence from 104 studies involving more than 106,000 pregnancies demonstrates increased risks of miscarriage, gestational diabetes and hypertensive complications, including in analyses matched for age and BMI. Preconception assessment should therefore include glucose tolerance testing, blood pressure measurement, lifestyle counselling and medication review.
The biological reproductive challenges have not changed with the new name. The clinical perspective has widened. PMOS encourages reproductive specialists to look beyond ovarian morphology and ovulation, integrate metabolic and pregnancy risks into fertility care, and move towards precision phenotyping that may eventually allow more individualised treatment.

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**Attila Török**
*Dunamenti REK Tapolca Institute, Tapolca, Hungary*

**The pros and cons of social oocyte vitrification**

**Introduction:** Using the assisted reproductive techniques, freezing the surplus embryos and their transfer in a later cycle quickly became a routine procedure. However, freezing oocytes might be also important to preserve fertility, for example in oncological cases. It soon became apparent that freezing eggs is much more challenging and has a much lower success rate than embryo freezing. However, with the development of freezing techniques, increasingly better results could be achieved. This allowed oocyte freezing to be carried out not only based on medical indications, but also for social reasons to preserve fertility. In Hungary, a legal possibility for egg freezing for social purposes since July 2025 is available.
**Methods:** Since domestic experiences are obviously not available, we consider it important to provide obstetricians and gynecologists with information about the method, its difficulties, and the expected success rate based on literature data.
**Results:** The embryological reasons that make egg freezing difficult and the recommended egg freezing technique will be discussed. The effectiveness of the method largely depends on the age at which eggs are frozen and how many eggs are successfully frozen. Based on a meta-analysis of literature data, at least 15 eggs must be frozen before the age of 35 to have an 80% chance of having 1 child. If freezing is performed after the age of 40, at least 40 eggs would be needed to achieve the same goal. Internationally, the return rate of patients is approx. 10%.
**Conclusions:** Egg freezing for social purposes only provides a chance for a later pregnancy, but its occurrence cannot be guaranteed under any circumstances. For this reason, very detailed information is required for those applying for it. The method is not covered by the health insurance in Hungary, therefore it involves significant costs.

**Pros for the method:**
1. It is good that there is now a legal option for this in our country.
2. Suitable method for fertility preservation.
3. It may be recommended for single individuals under the age of 35.

**Cons:**
1. There aren't enough domestic experiences yet.
2. A single stimulation is usually not sufficient to have an adequate number of eggs.
3. No reimbursement, the younger age group will make less use of it.
4.The chances decrease after the age of 35, and after the age of 40, it is almost pointless to undergo the procedure.
5. Low return rate.

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**Kopa Z.**
*Andrology Centre, Urol. Dept., Semmelweis University, Budapest, Hungary*

**Infertility: What About the Male Partner? Practical Implications of the New Guidelines.**

**Introduction/Objectives:** Male factor infertility contributes substantially to couple infertility, yet the male partner is still frequently evaluated late in the diagnostic pathway, sometimes only after unsuccessful assisted reproductive technology (ART). Recent guidelines increasingly emphasise a shift from semen-analysis-based classification towards comprehensive andrological phenotyping, etiological diagnosis, and couple-centred decision-making. This presentation aims to summarise the practical implications of current recommendations for the evaluation and management of the male partner in infertile couples.
**Methods:** Current recommendations on male infertility were reviewed with particular emphasis on the 2026 European Association of Urology Sexual and Reproductive Health guideline and the European Academy of Andrology guidelines, and their updated approach to male infertility. Key recommendations relevant to everyday clinical practice were evaluated, including semen analysis, hormonal and genetic testing, imaging, sperm DNA fragmentation (SDF), medical treatment, varicocele, and the diagnostic and therapeutic management of azoospermia.

**Results:** The contemporary approach recommends simultaneous evaluation of both partners, integrating female age and ovarian reserve into decisions concerning male treatment and the timing of ART. Semen analysis according to WHO standards remains fundamental but should not be interpreted as an independent diagnostic test of fertility. Abnormal findings require confirmation and comprehensive andrological assessment. Genetic testing has an increasingly important diagnostic and prognostic role, particularly in azoospermia and severe oligozoospermia, and may directly influence surgical sperm retrieval and reproductive counselling. SDF testing should be indication-driven rather than used as universal screening, with particular relevance in recurrent pregnancy loss, ART failure, and unexplained infertility. Medical treatment should increasingly be etiological: gonadotropin therapy (GN) is established for hypogonadotropic hypogonadism; clinical trials have recently focused on a phenotype-based GN approach, whereas routine empirical hormonal treatment and antioxidant supplementation in idiopathic infertility are not supported. Varicocele repair requires careful clinical selection and should not be based on subclinical ultrasound findings alone. In azoospermia, accurate differentiation between obstructive and non-obstructive forms is essential before intervention; genetic evaluation may predict the feasibility of sperm retrieval, while unnecessary diagnostic invasive procedures should be avoided. Male infertility should also be recognised as a potential marker of broader male health.
**Conclusions:** The practical message of the new guidelines is a transition from treating abnormal semen parameters towards treating the infertile man within the infertile couple. Early andrological evaluation, etiological diagnosis, selective use of advanced investigations, avoidance of ineffective empirical interventions, and individualised integration of male treatment with ART may reduce both underdiagnosis and overtreatment. The ultimate goal extends beyond improving semen parameters: achieving a healthy offspring while protecting the male partner's reproductive and long-term health.

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**Cristian Furău**
*"Vasile Goldiș" Western University of Arad, Faculty of Medicine, Arad, Romania*

**Counselling Those with Hormone Hesitancy: From "Pill Scare" to Informed, Autonomous Choice**

Background: Hormone hesitancy is an emerging challenge in reproductive healthcare, increasingly influenced by social media narratives, individual experiences, perceived health risks, and changing attitudes towards hormonal interventions. Although frequently associated with misinformation and the so-called "pill scare," reluctance to use hormonal contraception or other hormone-based therapies reflects a more complex interaction of personal values, bodily experiences, reproductive expectations, sociocultural influences, and trust in healthcare professionals.
Objective: To explore the multidimensional determinants of hormone hesitancy across the reproductive life course and propose a practical, person-centred counselling framework that supports informed, autonomous, and revisable healthcare decisions.
Approach: Drawing on contemporary qualitative research, studies of social media communication, and international recommendations from the World Health Organization (WHO) and the European Society of Contraception and Reproductive Health (ESCRH), this presentation examines the limitations of traditional information-correction strategies. Particular attention is given to concerns regarding fertility, mood changes, sexual wellbeing, perceived naturalness, and long-term hormonal safety. Evidence from a recent scoping review of 50 qualitative studies highlights five interconnected domains influencing hormonal contraceptive decisions: embodied experiences, interpersonal relationships, cultural beliefs, reproductive futures, and structural factors.
Key findings and clinical implications: Hormone hesitancy should be understood as a dynamic decision-making process rather than a knowledge deficit or a fixed refusal of treatment. Correcting misinformation alone may be insufficient, particularly when concerns originate from negative personal experiences, mistrust, or deeply held values. Effective counselling requires active listening, validation of patient experiences, individualized assessment of medical eligibility and absolute risks, transparent discussion of hormonal and non-hormonal alternatives, and respect for informed refusal. To translate these principles into clinical practice, the HORMONE framework is proposed: Hear the concern, Open the source, Recognize the experience, Measure individual risk, Offer options,

Navigate values, and Empower and revisit. This approach can be applied across the reproductive life course, from adolescent contraceptive counselling to menopausal hormone therapy.
Conclusions: Addressing hormone hesitancy requires a shift from persuasion and method uptake towards trust-building, shared decision-making, and reproductive autonomy. The success of counselling should not be measured by acceptance of hormonal treatment, but by the patient's ability to make an informed, medically appropriate, voluntary decision aligned with personal priorities. In this context, the clinician's role evolves from information provider to trusted interpreter of evidence and facilitator of autonomous choice.
Keywords: hormone hesitancy; hormonal contraception; contraceptive counselling; shared decision-making; reproductive autonomy; social media; patient-centred care.

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# Poster Abstracts

**Bojana Jovančević[a], Aleksandra Vejnović[a,b,c], Gabriel-Stefan Nađ[a,b], Aleksandra Ilić[b,d]**
*[a]Clinic of Obstetrics and Gynecology, University Clinical Center of Vojvodina, Novi Sad, Serbia [b]Faculty of Medicine, University of Novi Sad, Novi Sad, Serbia [c]Egon & Ann Diczfalusy Foundation, Szeged, Hungary [d]Center for Pathology, University Clinical Center of Vojvodina, Novi Sad, Serbia*

**Multifocal Abdominal Wall Endometriosis After Cesarean Section: A Surgical Challenge in the Presence of Cutaneous Involvement**

**Introduction**. Cesarean scar endometriosis is an uncommon manifestation of extrapelvic endometriosis and may present with diverse clinical and anatomical features. Although typically associated with cyclic pain and a palpable mass, multifocal disease with cutaneous and fascial involvement may pose a surgical challenge. We present a case requiring wide local excision and fascial reconstruction.
**Case Report**. A 31-year-old woman presented with multiple painful nodules along a previous Cohen cesarean section scar. Symptoms developed approximately 15 months after cesarean delivery and were associated with menstruation. She also reported recurrent brownish discharge from skin openings at both lateral ends of the scar. Ultrasonography demonstrated multiple heterogeneous lesions, including a dominant 45 × 20 mm lesion. Surgical exploration revealed two endometriotic conglomerates, approximately 40 mm on the right and 10 cm on the left. Both involved the skin and subcutaneous tissue and were firmly adherent to the fascia. The left lesion extended subfascially toward the rectus abdominis muscle without muscle fiber infiltration. Wide excision resulted in a 1 × 5 cm fascial defect, which was primarily reconstructed with polydioxanone sutures. Histopathology confirmed endometriosis with endometrial glands and stroma, hemorrhage, hemosiderin-laden macrophages, and fibrosis. Recovery was uneventful, with satisfactory wound healing at two weeks and a painless first postoperative menstruation.
**Conclusion**. Cesarean scar endometriosis may present as multifocal disease involving several abdominal wall layers. Cutaneous discoloration and cyclical discharge may indicate chronic local disease and should be carefully assessed to determine the extent of the lesion. Complete excision with appropriate fascial reconstruction is essential for effective treatment and restoration of abdominal wall integrity.

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**Carla Teodora Pop[a,b], Marius Lucian Craina[b,c,d], Brenda Cristiana Bernad[a,e,f], Lavinia Hogea[e], Virgil Enătescu[e,g], Alexandru Caraba[h], Sorin Chiriac[i], Crisanta Alina Mazilescu[j], Cristian Vasile Pop[k], Elena Silvia Bernad[b,c,d]**

**Maternal Emotional Experience of the Fetus: Positive Responses and Concerns About Fetal Normality - A Cross-Sectional Study**

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**Introduction:** Pregnancy is associated with significant physical and psychological changes, with maternal concerns frequently focusing on fetal well-being. Perceptions of fetal movement, appearance, and normality may shape maternal emotional responses and the overall pregnancy experience. This study assessed maternal emotional responses to fetal-related experiences and concerns regarding fetal movement, fetal appearance, and perceived fetal normality. A secondary objective was to explore whether previous pregnancy experiences or exposure to the pregnancy and birth experiences of others were associated with these responses.
**Materials and Methods:** This cross-sectional study included 109 women, of whom 9 were currently pregnant and 100 reported retrospectively on their pregnancy experiences. Participants completed a 41-item summative Likert-type questionnaire based on the Pregnancy Experience Scale (PES). Each experience was rated for positive emotions (happiness, positivity, and excitement) and negative emotions (sadness, distress, and worry) on a four-point scale (0 = "not at all" to 3 = "very much"). The present analysis focused on three fetal-related domains: fetal movement, fetal appearance, and perceived fetal normality. Composite positive and negative emotion scores (range, 0–9 each) were calculated. Statistical analyses included the Wilcoxon signed-rank test, Friedman test with Bonferroni-corrected post-hoc comparisons, Mann–Whitney U test, and Spearman rank correlations.
**Results:** Positive emotional responses predominated, with a median positive score of 7 (IQR, 6–9), compared with 0 (IQR, 0–1) for negative responses ($p < 0.001$). High positive emotion ("a lot" or "very much") was reported by 92.6% of women for fetal movement, 86.2% for fetal appearance, and 78.0% for perceived fetal normality. Negative responses were uncommon but differed significantly across domains (Friedman $\chi^2 = 26.4$, $p < 0.001$), with significantly stronger negative responses to thoughts about fetal normality than to fetal movement or appearance (both $p < 0.001$). Positive responses also differed across domains (Friedman $\chi^2 = 6.9$, $p = 0.032$); however, no pairwise comparison remained significant after Bonferroni correction. Positive and negative scores did not differ significantly between primiparous and multiparous women ($p = 0.45$ and $p = 0.81$, respectively). Previous pregnancy experience ($\rho = 0.375$) and exposure to others' birth experiences ($\rho = 0.447$) were associated with stronger positive responses (both $p < 0.001$).
**Conclusions:** Fetal-related experiences were predominantly associated with positive emotions, whereas negative emotions, although uncommon, were concentrated particularly around perceived fetal normality. These findings suggest that the fetus represents an important source of positive emotional experience during pregnancy, while concerns regarding fetal normality may represent an important focus for individualized antenatal counselling. Because most participants reported retrospectively, the findings primarily reflect recalled pregnancy experiences and may be subject to recall bias.

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**István Balázs[a], Mátyás Hősei[a], Soma Végh[a], Dr. Andrea Surányi[a]**
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**Functional Assessment of the Placenta in Intrauterine Growth Restriction**

**Introduction/Objectives**: Proper placental function is essential for normal fetal growth and development. Structural and functional placental abnormalities may contribute to adverse perinatal outcomes, including intrauterine growth restriction (IUGR), which affects approximately 10% of newborns worldwide and is associated with increased perinatal morbidity and mortality. Strain elastography is a non-invasive ultrasound-based technique that assesses tissue deformability and provides information about tissue biomechanical properties. The aim of this study was to compare the biomechanical characteristics of the placenta in physiological pregnancies and pregnancies complicated by IUGR using strain elastography.
**Methods:** Transabdominal ultrasound examinations were performed at the Department of Obstetrics and Gynecology, University of Szeged. A total of 67 pregnant women participated in data collection, of whom 11 women with IUGR and 26 with physiological pregnancies met the criteria for the present analysis. Inclusion criteria were gestational age ≥30 weeks, anterior placental location, and singleton pregnancy. Multiple regions of interest (ROIs) were selected within the placenta, and areas exhibiting different degrees of stiffness were evaluated separately. Relative tissue deformability (strain %) and strain ratios between selected regions were calculated. Statistical comparisons between the groups were performed using a two-sample t-test.

**Results:** No statistically significant differences in strain % were observed between physiological and IUGR pregnancies in any of the examined placental regions. However, strain ratios were significantly lower in the IUGR group in both higher- and lower-stiffness placental regions. In higher-stiffness regions, the mean strain ratio was 1.262 in the IUGR group compared with 3.359 in physiological pregnancies ($p = 0.0237$). In lower-stiffness regions, the corresponding values were 0.2719 and 0.4898, respectively ($p = 0.0254$). These results suggest that strain ratios may reveal differences in placental biomechanical characteristics that are not reflected by strain % values alone.
**Conclusions:** Our findings indicate measurable differences in the biomechanical properties of placental tissue in pregnancies complicated by IUGR. Although strain % did not differ significantly between the groups, strain ratios showed significant differences between IUGR and physiological pregnancies, suggesting that this parameter may provide additional information on alterations in placental biomechanical properties. Placental strain elastography may therefore represent a promising complementary, non-invasive method for assessing placental abnormalities associated with impaired fetal growth and may potentially contribute to earlier detection and more personalized management of high-risk pregnancies.

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## Menopausal Symptom Burden Rather Than Reproductive Stage Is Associated with Psychological Distress in Romanian Women

**Introduction/Objectives**. Menopausal symptoms may substantially affect women's well-being, yet their relationship with psychological distress across different stages of the menopausal transition remains incompletely understood. Data from Romanian women are particularly limited. This study aimed to compare menopausal symptom burden and psychological distress across reproductive stages and to investigate whether psychological distress is associated with symptom burden beyond menopausal stage and hormone therapy use.
**Methods.** We conducted an observational, cross-sectional online survey among Romanian women aged 40–65 years. Reproductive stage was classified according to STRAW+10 criteria. Menopause-related symptoms were assessed using the Menopause Rating Scale (MRS), comprising somatic, psychological, and urogenital domains, and psychological distress using the Kessler Psychological Distress Scale (K10). Differences across reproductive stages were assessed using Welch's one-way ANOVA. Associations between symptom burden and psychological distress were examined using Pearson correlations and multivariable regression adjusted for reproductive stage and hormone therapy use. To reduce conceptual overlap between the psychological MRS domain and K10, an exploratory non-psychological symptom score combining the somatic and urogenital MRS domains was additionally examined.
**Results.** The study included 394 women: 107 premenopausal, 112 perimenopausal, 81 in early menopause, and 94 in late menopause. Total MRS scores differed significantly across reproductive stages ($p=0.019$), with higher mean scores during perimenopause and early menopause. Significant stage-related differences were also observed for somatic ($p<0.001$) and psychological symptoms ($p=0.020$), whereas urogenital symptoms did not differ significantly ($p=0.064$). In contrast, psychological distress assessed by K10 did not differ across reproductive stages ($p=0.292$). K10 was strongly correlated with total MRS score in the overall cohort ($r=0.673$, $p<0.001$), and this association remained significant within each reproductive stage ($r=0.596–0.728$, all $p<0.001$). Importantly, psychological distress remained associated with the exploratory non-psychological symptom score after excluding the psychological MRS domain ($r=0.556$, $p<0.001$). In multivariable analysis, this association persisted after adjustment for reproductive stage and hormone therapy use ($B=0.690$, $p<0.001$), while reproductive stage and hormone therapy use were not independently associated with K10.
**Conclusions.** Menopausal symptom burden varied across the menopausal transition, whereas psychological distress did not show a corresponding stage-dependent pattern. Psychological distress was instead consistently associated with individual symptom burden, including somatic and urogenital symptoms after excluding the psychological MRS domain, and this relationship persisted after accounting for reproductive stage and hormone therapy use. These findings suggest that assessment of psychological well-being during the menopausal transition should consider the individual burden of menopausal symptoms rather than reproductive stage alone.

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## EARLY MATERNAL RISK STRATIFICATION IN PRENATAL CARE: BRIDGING FAMILY MEDICINE AND OBSTETRICS TO PREDICT ADVERSE MATERNAL AND PERINATAL OUTCOMES

**Introduction/Objectives:** Adverse maternal and perinatal outcomes are frequently associated with risk factors identifiable before conception or during the earliest stages of pregnancy. Maternal risk stratification must therefore begin as early as possible, ideally during the preconception period, before pregnancy-related complications become clinically apparent. Through continuity of care and comprehensive knowledge of the patient's medical, reproductive and family history, the family physician is uniquely positioned to initiate this process. This review aimed to evaluate recent evidence on early maternal risk stratification and to explore its integration into a structured pathway bridging family medicine and specialized obstetric care.
**Methods:** A focused review of literature published between 2022 and 2025 was conducted, prioritizing systematic reviews, meta-analyses, prospective cohort studies and validated prediction models addressing major adverse maternal and perinatal outcomes. Risk determinants were analyzed according to their predictive relevance and timing of identification, including maternal demographic and anthropometric characteristics, personal and family medical history, reproductive and previous obstetric history, chronic conditions, medication exposure, lifestyle-related factors, clinical parameters, biochemical markers and first-trimester ultrasound variables. Outcomes of interest included preeclampsia, fetal growth restriction, spontaneous preterm birth, gestational diabetes mellitus and other clinically relevant adverse perinatal outcomes.
**Results:** Current evidence demonstrates that clinically relevant maternal risk can be identified before conception and further refined during early pregnancy. Maternal age, body mass index, chronic hypertension, pre-existing diabetes, parity and previous adverse obstetric outcomes represent readily accessible determinants for initial risk assessment. Family history, medication exposure and modifiable cardiometabolic and lifestyle factors provide additional opportunities for preconception risk identification and intervention. While prediction based on maternal characteristics alone generally shows moderate performance, multimarker approaches integrating clinical factors with mean arterial pressure, uterine artery Doppler indices and placental biomarkers improve predictive performance, particularly for preterm preeclampsia and placental dysfunction-related outcomes. Collectively, these findings support a sequential model in which baseline risk assessment begins in primary care, is reassessed at pregnancy confirmation, refined through targeted first-trimester obstetric screening and translated into individualized prevention and maternal–fetal surveillance.
**Conclusions:** Maternal risk stratification must begin before conception whenever possible and continue dynamically throughout pregnancy. Family medicine represents the first level of this continuum, enabling early recognition of pre-existing, reproductive and modifiable risk factors before specialized pregnancy screening becomes available. Subsequent integration with first-trimester obstetric assessment can refine the individual risk profile and guide timely prevention, referral and surveillance. Establishing a structured interface between family medicine and obstetrics may shift prenatal care toward an earlier, personalized and risk-oriented model, with prevention beginning before complications emerge.

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**Clitoral Artery Hemodynamics and Female Sexual Function: Preliminary Observations**

**Introduction:** Female sexual function is a complex process involving psychological, hormonal, neurological, and vascular mechanisms. Adequate genital blood flow plays an important role in the sexual response, while increased vascular resistance may potentially affect tissue perfusion. The clitoral artery can be evaluated non-invasively by Doppler ultrasonography, with the pulsatility index (PI) representing a Doppler-derived measure related to vascular resistance. Identifying a relationship between clitoral vascular hemodynamics and sexual function could provide additional insight into the vascular component of female sexual health and potentially contribute to the clinical assessment of sexual dysfunction.
**Objectives:** Assessment of the association between mean clitoral artery PI and sexual function measured by the Female Sexual Function Index (FSFI), with additional evaluation of the relationship between BMI and clitoral artery PI.
**Methods:** This observational study was conducted in a cohort of women evaluated at a private obstetrics and gynecology clinic in Timișoara, Romania, between January 2025 and July 2026. Thirty-three non-pregnant, non-postmenopausal women were included. Women who were postmenopausal or pregnant, as well as those with a history of clitoral trauma or laceration during childbirth or previous urogynecological procedures involving the clitoral region, were excluded. Mean clitoral artery PI was assessed by Doppler ultrasonography and sexual function was evaluated using the total FSFI score. Pearson and Spearman correlation analyses were performed to assess the relationship between PI and FSFI. Participants were stratified according to BMI into two groups: BMI <25 kg/m² and BMI >25 kg/m². PI values were compared using the Mann–Whitney U test.
**Results:** A moderate inverse association was identified between mean clitoral artery PI and total FSFI score. Pearson correlation demonstrated a statistically significant negative correlation ($r = -0.452$, $p = 0.008$), with an $R^2$ of 0.204. In contrast, Spearman rank correlation did not reach statistical significance ($\rho = -0.315$, $p = 0.075$), warranting cautious interpretation. Mean PI was 2.22 ± 0.77 in women with BMI <25 kg/m² and 1.93 ± 0.59 in those with BMI >25 kg/m². Although PI tended to be lower in the higher-BMI group, the difference was not statistically significant ($p = 0.294$). Several participants had very low FSFI scores and generally reported no sexual activity during the preceding four weeks, which may have influenced the observed association.
**Conclusions:** This preliminary observational study suggests a potential inverse association between mean clitoral artery PI and female sexual function. However, the small sample size and the lack of significance in the Spearman analysis warrant cautious interpretation. BMI was not significantly associated with differences in mean PI. Future studies should include larger, more comprehensively stratified populations and account for potential confounding factors such as menopausal status, hormonal therapy, smoking status, cardiovascular disease and other relevant comorbidities. Such studies may clarify whether the association between clitoral artery hemodynamics and sexual function is independent of these factors and determine the potential clinical role of clitoral artery Doppler assessment.

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**AI-DRIVEN WOMEN'S HEALTH**

**Introduction and Objectives:** The digital transformation of healthcare systems creates opportunities for the use of artificial intelligence (AI) not only as a diagnostic tool, but also as a means of improving preventive healthcare. In women's health, particular importance lies in the potential to integrate data on individual risk, screening results, and healthcare utilization. The aim of this paper is to explore the potential of AI to support screening and early detection of women's diseases, as well as its possible role in increasing participation in preventive programmes and reducing inequalities in access to healthcare.
**Methods**: A narrative review of scientific and professional literature, international recommendations, and current public health documents addressing the use of AI in women's health was conducted. Particular attention was given to the applications of AI in cervical and breast cancer screening, risk assessment, triage following positive screening results, communication with women, and monitoring the utilization of preventive services. Potential risks associated with the implementation of AI in different populations were also considered.
**Results:** The greatest potential for AI application was identified in stages of the screening process where large volumes of data need to be transformed into clinically actionable information. In cervical cancer screening, AI is being developed for the analysis of cervical images, identification of precancerous and cancerous lesions, and support for the triage of HPV-positive women. In breast cancer screening, its role in mammographic image analysis and identification of findings requiring further assessment is being investigated. From a public health perspective, the added value of AI may also include identifying women who are not reached by screening programmes, personalized invitations, monitoring participation, and identifying groups facing barriers to accessing preventive services. At the same time, the benefits of AI are not independent of the quality of the healthcare system: an algorithm demonstrating high performance in one population may not perform equally well in another. Inadequate or incomplete data, algorithmic bias, protection of sensitive health information, and digital inequalities may contribute to widening existing health disparities.
**Conclusions:** AI in women's health should be viewed as part of a broader preventive medicine system rather than as a replacement for screening programmes or clinical assessment. Its greatest potential public health value may lie in connecting early detection and risk assessment with active outreach to women who remain outside preventive healthcare services. Such implementation requires clinical validation, transparency, data protection, and continuous monitoring of outcomes across different populations. The goal of AI implementation should be not only more accurate diagnosis, but also more equitable access to prevention and timely healthcare for women.

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**From Screening to Prehabilitation Triage: Do We Need a New Scoring Algorithm?**

**Introduction:** Prehabilitation represents an opportunity to targetedly influence modifiable risk factors (physical fitness, nutritional status, psychological well-being) before a planned surgical procedure. Current screening tools make it possible to evaluate frailty, functional capacity, or nutrition, but their direct use for indicating and selecting a specific prehabilitation intensity remains limited. Existing algorithms mostly do not take into account the surgical complexity of the procedure or specific clinical warning signs. Therefore, clinical practice lacks a simple and validated tool that would convert a complex evaluation of the patient into a specific level of prehabilitation care.
**Aim:** To analyze the possibilities of preoperative risk stratification in relation to prehabilitation and to present the concept of a new scoring system, the Prehabilitation Triage Score (PTS), designed to individualize the intensity of prehabilitation in gynecologic oncology patients.
**Methods:** Based on available screening approaches and clinically relevant determinants of perioperative risk, we created a multidomain PTS scoring system. This integrates patient factors

(functional performance, self-sufficiency, nutritional status, polypharmacy, falls, cognition, psychosocial status, age), the extent of the planned surgical procedure, and the presence of clinical warning signs ("red flags") that serve as risk modifiers.
**Results:** The PTS tool is currently being prospectively validated in patients indicated for elective oncogynecologic surgeries. The intended output of the scoring algorithm is the stratification of patients into three risk categories directly linked to the recommended intensity of prehabilitation:
Low risk – education and self-management,
Medium risk – home teleprehabilitation (mobility + nutrition)
High risk – outpatient or inpatient prehabilitation and multidisciplinary assessment.
**Conclusion:** Identification of frailty alone does not provide a sufficient basis for precise individualization of prehabilitation. The PTS scoring system represents a new conceptual approach connecting multidimensional risk stratification with a graded intensity of intervention, whose clinical applicability and predictive capability require prospective validation.

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**Alteration of Arterial Compliance During Menopause**

Background. Menopause involves hormonal changes that may affect vascular function. Pulse wave velocity (PWV), augmentation index (AIx), and pulse pressure are non-invasive indices of arterial stiffness.
Objective. To compare arterial compliance and hemodynamic parameters in premenopausal and postmenopausal women.
Methods. Prospective comparative study of 211 women without cardiovascular disease: 105 premenopausal and 106 postmenopausal. PWV, AIx, systolic and diastolic blood pressure, and pulse pressure were compared using t-tests.
Results. PWV was higher after menopause (9.4 ± 0.5 versus 7.2 ± 2.2 m/s; p = 0.012), as were AIx (−21 ± 5% versus −31 ± 10%; p = 0.008), systolic blood pressure (131 ± 6 versus 121 ± 10 mmHg; p = 0.038), and pulse pressure (61 ± 3 versus 51 ± 10 mmHg; p = 0.011). Diastolic blood pressure did not differ significantly (73 ± 3 versus 70 ± 0 mmHg; p = 0.231). Positive correlations with age were reported for PWV (r = 0.62) and AIx (r = 0.54), both p < 0.001.
Conclusions. Postmenopausal participants exhibited higher arterial stiffness and several adverse hemodynamic indices. Given the group design, age and menopausal status cannot be disentangled from these descriptive comparisons without further adjustment. Longitudinal studies are warranted.
Keywords. menopause; arterial stiffness; pulse wave velocity; augmentation index; cardiovascular risk

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**Explainable Machine Learning for Predicting Hematologic Toxicity in Women with Cervical Cancer: A Real-World Precision Oncology Study**

Background. Hematologic toxicity during cervical cancer treatment can disrupt chemotherapy and adversely affect patient care. Explainable machine learning may support risk stratification using routinely collected data.
Objective. To develop and interpret models predicting subsequent hemoglobin below 10 g/dL in women with cervical cancer.
Methods. Retrospective real-world study. Of 966 patients in the original cohort, 326 with baseline hemoglobin ≥10 g/dL and repeated measurements met the analysis criteria. Logistic regression,

random forest, extra trees and gradient boosting were assessed by five-fold cross-validation, ROC-AUC, precision–recall AUC, sensitivity and specificity. SHAP was used for interpretation.
Results. Subsequent hemoglobin <10 g/dL occurred in 99/326 patients (30.4%). ROC-AUC values were 0.704 (logistic regression), 0.754 (random forest), 0.756 (extra trees), and 0.698 (gradient boosting). The extra-trees model achieved PR-AUC 0.545, sensitivity 59.6%, and specificity 80.6%. Important SHAP predictors included carboplatin, paclitaxel, baseline hemoglobin, cisplatin, FIGO stage and blood counts. Baseline hemoglobin was lower among those with subsequent anemia (11.95 ± 1.8 versus 12.74 ± 1.9 g/dL; $p < 0.001$).
Conclusions. Machine-learning models showed moderate discrimination for subsequent anemia, with treatment and baseline laboratory variables contributing to predictions. External validation and prospective assessment are required before clinical use.
Keywords. cervical cancer; anemia; machine learning; SHAP; precision oncology

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**Vascular and Inflammatory Profiles in Hypertensive Disorders of Pregnancy: The Interplay Between Arterial Stiffness, IL-6 and CRP**

Background. Hypertensive disorders of pregnancy (HDoP) involve vascular dysfunction and systemic inflammation, potentially reflected by arterial stiffness, interleukin-6 (IL-6), and C-reactive protein (CRP).
Objective. To compare vascular and inflammatory profiles between women with HDoP and normotensive pregnant controls and explore associations among these markers.
Methods. Prospective comparative study including 200 pregnant women (100 HDoP, 100 controls). Aortic PWV and augmentation index were measured alongside circulating IL-6 and CRP. Correlation and multivariable regression analyses were reported.
Results. Compared with controls, HDoP participants had higher aortic PWV (8.2 ± 1.9 versus 6.3 ± 1.4 m/s), AIx (36.1 ± 11.3 versus 24.5 ± 8.7%), IL-6 (12.6 ± 7.4 versus 2.8 ± 1.9 pg/mL), and CRP (9.8 ± 6.1 versus 3.1 ± 2.6 mg/L); all $p < 0.001$. In the HDoP group, IL-6 correlated with PWV ($r = 0.62$) and CRP with AIx ($r = 0.54$), both $p < 0.001$. Among hypertensive participants, preeclampsia was associated with higher PWV (9.4 ± 1.8 versus 7.1 ± 1.5 m/s) and IL-6 (17.2 ± 8.6 versus 8.1 ± 4.2 pg/mL) than gestational hypertension.
Conclusions. Vascular stiffness and inflammatory markers were elevated in hypertensive pregnancy, particularly preeclampsia. Their joint assessment warrants further evaluation as a complementary risk-stratification approach; predictive clinical utility was not established by these comparisons.
Keywords. preeclampsia; gestational hypertension; arterial stiffness; interleukin-6; C-reactive protein

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**Age-Related Patterns of Luteinizing Hormone and Progesterone in Women During the Perimenopausal Transition (Burlica et al.)**

Background. Perimenopause is associated with heterogeneous hormonal changes. Variation in luteinizing hormone (LH) and progesterone across age groups may inform understanding of the transition.
Objective. To describe age-related patterns in LH and progesterone among perimenopausal women.
Methods. Retrospective observational study of 235 women aged 35–55 years, assessed in 2023–2024. Serum LH and progesterone were compared across age categories using one-way ANOVA; age correlations were explored.

Results. Mean age was 44.8 ± 5.6 years, mean LH 18.4 ± 11.2 mIU/mL and mean progesterone 0.9 ± 1.1 ng/mL. LH tended to increase and progesterone to decrease across age categories, but neither between-group difference was statistically significant (LH: $p = 0.21$; progesterone: $p = 0.18$). The correlations with age were weak and nonsignificant (LH $r = 0.22$, $p = 0.09$; progesterone $r = -0.19$, $p = 0.12$).
Conclusions. In this cohort, individual variability was considerable and age-group differences in LH and progesterone were not statistically significant. Serial hormone measurements and longitudinal clinical staging may better characterize perimenopausal trajectories.
Keywords. perimenopause; luteinizing hormone; progesterone; hormonal variability; aging

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### Ultrasound-Based Body Composition Assessment in Normal versus Pathological Pregnancy Using the BodyMetrix System

Background. Maternal adiposity may influence obstetric risk. Ultrasound-based body composition assessment could complement conventional anthropometric measurements.
Objective. To compare BodyMetrix-derived body composition measures between pregnancies categorized as normal and pathological.
Methods. Prospective comparative study of 200 pregnant women (100 in each group). Ultrasound-based BodyMetrix assessment used the Jackson–Pollock four-site approach to estimate body fat, fat mass, lean mass, body mass index and body water.
Results. The pathological-pregnancy group had higher body fat percentage (36.8 ± 7.5% versus 28.6 ± 6.4%; $p < 0.001$), fat mass (26.4 ± 6.8 versus 18.2 ± 5.1 kg; $p < 0.001$), and BMI (30.7 ± 5.6 versus 24.3 ± 3.8 kg/m²; $p < 0.001$), with lower lean mass (38.6 ± 7.1 versus 42.1 ± 6.3 kg; $p = 0.002$) and estimated body water (28.1 ± 5.7 versus 31.4 ± 4.2 kg; $p = 0.001$). The poster additionally displays device-generated relative risk estimates for heart disease, stroke and diabetes.
Conclusions. Body composition measures differed between the two groups. Whether BodyMetrix improves prediction of obstetric complications beyond standard clinical measures requires validation. Device-generated risk estimates should not be interpreted as observed incident clinical outcomes.
Keywords. pregnancy; body composition; adiposity; BodyMetrix; ultrasound

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### Pulse Wave Velocity Across the Spectrum of Pregnancy: From Physiological Vascular Adaptation to Hypertensive Disorders and Cardiovascular Risk

Background. Pregnancy involves changing vascular compliance. Hypertensive disorders, placental dysfunction and possibly thrombophilic conditions may be associated with higher arterial stiffness.
Objective. To synthesize reported PWV patterns across normal pregnancy, gestational hypertension and preeclampsia and discuss possible implications for maternal cardiovascular risk.
Methods. Narrative review of current evidence using PubMed, Scopus and Web of Science. The poster presents conceptual, illustrative PWV trajectories rather than pooled patient-level results or a quantitative meta-analysis.
Results. The conceptual synthesis depicts lower PWV during early-to-mid normal pregnancy followed by an increase toward term, with higher trajectories in gestational hypertension and especially preeclampsia. Mechanistic pathways involving placental dysfunction, endothelial injury, inflammation and maladaptation are outlined. The role of thrombophilia is discussed as a possible contributor, with limited direct evidence.

Conclusions. PWV may be a useful adjunctive marker of vascular adaptation and risk in hypertensive pregnancy. Standardized longitudinal studies are needed to establish gestational-age-specific reference ranges and validate clinical prediction.
Keywords. pulse wave velocity; arterial stiffness; pregnancy; preeclampsia; vascular adaptation

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**Age-Related Patterns of Luteinizing Hormone and Progesterone in Women During the Perimenopausal Transition (Loichita et al.)**

Background. Hormonal variability is a defining feature of the perimenopausal transition. Age-related trends in luteinizing hormone and progesterone remain heterogeneous.
Objective. To examine LH and progesterone variation across age groups in perimenopausal women.
Methods. Retrospective observational study of 235 women aged 35–55 years assessed in 2023–2024, using descriptive statistics, one-way ANOVA and age correlations.
Results. The cohort had a mean age of 44.8 ± 5.6 years. Mean LH was 18.4 ± 11.2 mIU/mL (median 16.2; range 2.1–68.5), and mean progesterone was 0.9 ± 1.1 ng/mL (median 0.6; range 0.1–5.8). Across four age groups (35–39, 40–44, 45–49 and ≥50 years), LH showed a nonsignificant increasing trend ($p = 0.21$) and progesterone a nonsignificant decreasing trend ($p = 0.18$). Correlations with age were weak (LH $r = 0.22$, $p = 0.09$; progesterone $r = −0.19$, $p = 0.12$).
Conclusions. No statistically significant differences in LH or progesterone were identified across age groups. The broad distributions underscore hormonal heterogeneity and the potential value of longitudinal assessment. These data appear identical to those in the Burlica et al. poster and require verification of cohort overlap before separate dissemination.
Keywords. perimenopause; luteinizing hormone; progesterone; age groups; observational study

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**Beyond Menopausal Timing: Obesity Rather Than Early Menopause Drives Metabolic Risk in Postmenopausal Women**

Background: Early menopause has been linked to increased cardiometabolic risk, although the contribution of menopausal timing independently of adiposity remains uncertain.
Objective: To examine whether early menopause independently predicts metabolic syndrome and to identify major metabolic risk determinants in postmenopausal women.
Methods: Retrospective observational study of 301 postmenopausal women in Arad (2022–2024), comprising 79 with early menopause at ages 40–45 and 222 with physiological menopause after age 45. Metabolic syndrome was evaluated using NCEP-ATP III and IDF criteria; multivariable logistic regression assessed potential predictors.
Results: Metabolic syndrome prevalence was 34.2% in the early-menopause group and 32.9% in the comparison group ($p = 0.68$). Mean body mass index was higher in women with early menopause (29.1 versus 26.7 kg/m²; $p = 0.022$). In adjusted analyses, menopausal timing was not independently associated with metabolic syndrome, whereas adiposity emerged as the more relevant risk signal.
Conclusions: Within this cohort, early menopause was not an independent determinant of metabolic syndrome. Cardiometabolic assessment after menopause should prioritize modifiable metabolic risk factors, including adiposity, rather than menopausal timing alone.
Keywords: postmenopause; early menopause; metabolic syndrome; obesity; cardiometabolic risk

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**Beyond Biology: Prenatal Care Deficiency as a Marker of Vulnerability in Adolescent Pregnancy**

Background: Adolescent pregnancy is shaped by clinical and social vulnerabilities that may be incompletely captured by structured obstetric records.
Objective: To characterize vulnerability indicators in clinical narratives and explore their relationship with prenatal-care deficiency and neonatal outcomes.
Methods: Retrospective cohort of 763 singleton adolescent pregnancies managed at a Romanian secondary obstetric centre between 2020 and 2024. Narrative documentation was available for 692 pregnancies. Clinical notes were reviewed for vulnerability indicators; associations were evaluated using contingency analyses, correlations and multivariable logistic regression.
Results: Among the 692 cases with narrative information, 88.4% had documented prenatal-care deficiency. Commonly documented indicators included anemia (29.9%), smoking during pregnancy (26.9%), infection (8.2%), Rh incompatibility (9.4%), hypertensive disorders (6.6%), obesity (6.1%) and rural residence (60.9%). Low birth weight occurred in 11.2% and preterm birth in 11.7% of neonates. Hypertensive disorders and maternal obesity were associated with lower odds of documented prenatal-care deficiency in the reported model; hypertensive disorders were associated with higher odds of low birth weight.
Conclusions: Prenatal-care deficiency was frequent in this adolescent cohort and occurred within a broader pattern of maternal vulnerability. Improved continuity, accessibility and documentation of antenatal care are priorities. Associations from retrospective records should not be interpreted causally.
Keywords: adolescent pregnancy; prenatal care; maternal vulnerability; anemia; neonatal outcomes

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**Vitamin D Deficiency in Menopause: Risk Marker or Independent Metabolic Driver?**

Background: Low serum 25-hydroxyvitamin D [25(OH)D] is common after menopause, but whether it independently predicts metabolic syndrome is uncertain.
Objective: To assess vitamin D status and its independent associations with metabolic syndrome and selected metabolic parameters in women with early and physiological menopause.
Methods: Retrospective observational study of 301 postmenopausal women (79 early menopause; 222 physiological menopause) evaluated in Arad during 2022–2024. Vitamin D deficiency was defined as 25(OH)D <20 ng/mL, insufficiency as 21–29 ng/mL and sufficiency as ≥30 ng/mL. Multivariable logistic and linear regression models examined associations.
Results: Vitamin D deficiency affected 62.0% of participants, insufficiency 13.7% and sufficiency 24.3%. Vitamin D deficiency was not independently associated with metabolic syndrome after adjustment (adjusted OR 1.12; 95% CI 0.62–2.02). Higher 25(OH)D levels were associated with lower fasting glucose ($\beta = -0.179$; $p = 0.002$). The observed metabolic syndrome association was more strongly linked to adiposity than vitamin D status.
Conclusions: Vitamin D deficiency was highly prevalent but was not an independent predictor of metabolic syndrome in this cohort. Its relationship with fasting glucose warrants further study;

observational findings do not establish causality or justify claims of metabolic benefit from supplementation.
Keywords: vitamin D; menopause; metabolic syndrome; fasting glucose; cardiometabolic risk

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**Ioana-Maria Vornic[1], Anamaria Ardelean[2], Oana Toduț[1], Roxana Furău[3], Cristina Onel[1], Gheorghe Furău[3], Cristian Furău[4]**
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**The Placental Apoptotic Switch in Spontaneous Abortion: An Immunohistochemical Study of p53 and Bcl-2**

Background: Altered regulation of placental trophoblast apoptosis has been implicated in spontaneous pregnancy loss. p53 participates in pro-apoptotic signaling, whereas Bcl-2 contributes to cellular survival.
Objective: To compare placental expression of p53 and Bcl-2 in spontaneous abortion and elective termination samples.
Methods: Comparative observational immunohistochemical study of placental tissue from 50 pregnancies: spontaneous abortion (n = 30) and elective termination controls (n = 20). Expression was evaluated semiquantitatively using H-scores and compared between groups.
Results: Placental p53 expression was higher in spontaneous abortion than in controls (230.33 ± 63.80 versus 171.22 ± 36.04; p = 0.003). Conversely, Bcl-2 expression was lower in spontaneous abortion (120.20 ± 100.00 versus 167.00 ± 92.73; p = 0.023). These opposing expression patterns are consistent with a shift toward a pro-apoptotic placental profile.
Conclusions: Spontaneous abortion samples showed increased p53 and reduced Bcl-2 immunohistochemical expression compared with controls. The findings support further investigation of apoptotic signaling in early pregnancy loss, without establishing that these changes are causal or diagnostically validated biomarkers.
Keywords: spontaneous abortion; placenta; apoptosis; p53; Bcl-2; immunohistochemistry

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**Ioana-Maria Vornic[1], Anamaria Ardelean[2], Oana Toduț[1], Roxana Furău[3], Cristina Onel[1], Gheorghe Furău[3], Cristian Furău[4]**
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**Loss of Placental Antioxidant Defense in Spontaneous Abortion: The Glutathione–MTH1 Axis**

Background: Oxidative stress may contribute to placental dysfunction and early pregnancy loss. Glutathione and the oxidized-nucleotide sanitizing enzyme MTH1 contribute to cellular redox protection.
Objective: To compare placental immunohistochemical expression of glutathione and MTH1 between spontaneous abortion and elective termination samples.
Methods: Comparative observational study of placental tissue from spontaneous abortion (n = 30) and elective termination (n = 20). Immunohistochemical expression of glutathione and MTH1 was evaluated using semiquantitative H-scores.
Results: Glutathione expression was markedly lower in spontaneous abortion than controls (61.11 ± 87.60 versus 288.88 ± 106.92; p < 0.001). MTH1 expression was also lower (92.66 ± 72.45 versus 189.22 ± 84.11; p = 0.010). Both findings are consistent with diminished placental antioxidant-defense signals in spontaneous pregnancy loss.
Conclusions: Reduced glutathione and MTH1 immunohistochemical expression characterized the spontaneous abortion group. These observational results support investigation of placental oxidative imbalance and its potential biomarkers, but do not establish a causal mechanism.

Keywords: spontaneous abortion; placenta; oxidative stress; glutathione; MTH1; immunohistochemistry

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**When Eating Behaviors Meet the Menstrual Cycle: Disordered Eating and Reproductive Health Signals in Adolescent Girls**

Background: Adolescence is a sensitive period in which eating behaviors, body-image concerns and menstrual health may intersect. Feasible school-based screening approaches are needed to inform larger population studies.
Objective: To pilot an anonymous school-based survey, estimate the frequency of menstrual and eating-behavior risk signals, and prepare a standardized protocol for Euroregional expansion.
Methods: Prospectively administered, cross-sectional pilot survey involving 74 high-school girls (grades IX–XII) in Arad, Romania. The self-administered questionnaire covered menstrual history, dietary restriction, body image, activity and psychosocial factors. Analyses were descriptive and based on aggregate response counts.
Results: Slightly or totally irregular menstrual cycles were reported by 62.2%, and 31.1% reported a history of ≥90 days without menstruation. Moderate or severe menstrual pain affected 78.4%, while 41.9% reported school or activity absence due to menstruation. Restrictive eating to control weight and loss-of-control eating were each reported by 63.5%; 29.7% reported fasting for ≥24 hours, and 50.0% reported compensatory exercise sometimes or frequently. Almost daily or daily stress was reported by 44.6%.
Conclusions: The pilot identified frequent self-reported menstrual and eating-behavior risk signals and offers a foundation for Euroregional multicentre research. The aggregate data cannot establish participant-level associations or causality; the questionnaire is a screening research tool, not a diagnostic instrument.
Keywords: adolescent health; menstrual health; eating behaviors; prospective pilot; Euroregional research

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**From Barriers to Equity-Oriented Prenatal Care: A MATCARE Framework for Roma Women and Disadvantaged Communities**

Background: Roma women and other disadvantaged groups in Europe may face intersecting socioeconomic, geographic, administrative and discriminatory barriers to timely, continuous prenatal care.
Objective: To synthesize evidence on barriers to prenatal care and transferable equity-oriented interventions, and propose a practical MATCARE framework for implementation and evaluation.
Methods: A scoping-review approach was structured around Joanna Briggs Institute guidance and PRISMA-ScR reporting principles. Two evidence streams were considered: Roma-specific prenatal-care evidence and interventions from other disadvantaged populations. The PROGRESS-Plus and Levesque frameworks informed the mapping of inequities and access barriers.
Results: The evidence synthesis identified delayed entry to prenatal care, discontinuity, communication barriers, distrust and administrative or social exclusion as recurring challenges. Promising approaches combined trusted community personnel, proactive outreach, culturally responsive communication, continuity of care and formal community–clinical linkage. The proposed

MATCARE framework integrates vulnerability assessment, access barriers, a coordinated care pathway, proximal service outcomes and maternal/perinatal outcomes.
Conclusions: MATCARE offers a structured model for prospective evaluation of equity-oriented prenatal care. Effectiveness, feasibility and sustainability require empirical testing, including meaningful community participation and long-term monitoring. The source poster did not provide final PRISMA study counts, which are therefore not reported here.
Keywords: Roma women; prenatal care; health equity; MATCARE; scoping review; access barriers

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**Cristina Onel[1], Anamaria Ardelean[2], Oana Toduț[1], Roxana Furău[3], Gheorghe Furău[4], Mario Varcaccio[5], Victoria Ciobanu[3], Ioana Vornic[2], Izabella Petre[3], Cristian George Furău[1,6]**
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**Beyond Blood Pressure: Linking Insulin Resistance, Placental Function and Uterine Artery Doppler in Early Preeclampsia Risk**

Background: Preeclampsia is a major contributor to maternal and fetal morbidity. Combining maternal metabolic indicators, placental biomarkers and uterine artery Doppler findings may improve early risk characterization.
Objective: To examine relationships between first-trimester insulin resistance, pregnancy-associated plasma protein A (PAPP-A), uterine artery Doppler findings and later hypertensive disorders.
Methods: Retrospective observational study of 83 pregnant women assessed at 11–14 weeks of gestation in 2014–2015. First-trimester PAPP-A, insulin and HOMA-IR were assessed alongside uterine artery pulsatility/resistance indices and bilateral notching; subsequent hypertensive disorders were recorded.
Results: Nine of 83 women (10.8%) developed pregnancy-induced hypertension. Mean HOMA-IR was higher among affected women (14.12 versus 8.54), while mean PAPP-A was lower (0.70 versus 1.96). Abnormal uterine artery Doppler findings were more frequently reported in the affected group. The poster did not provide sufficient inferential statistics to quantify the independent predictive performance of a combined model.
Conclusions: The observed metabolic, placental and vascular differences support further investigation of multimarker risk assessment in early pregnancy. Larger prospective studies with validated prediction models are needed before clinical predictive claims can be made.
Keywords: preeclampsia; HOMA-IR; PAPP-A; uterine artery Doppler; first-trimester screening

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**Beyond Maternal Age: What Drives Cesarean Delivery in Adolescent Pregnancy?**

Background: Cesarean delivery is frequent among adolescent mothers, but the relative contribution of maternal age versus obstetric factors is not fully established.
Objective: To identify factors associated with cesarean delivery among adolescent mothers in a five-year Romanian cohort.
Methods: Retrospective analysis of 763 singleton deliveries among mothers aged 12–17 years at a secondary Romanian maternity hospital (2020–2024). Obstetric characteristics were evaluated using multivariable logistic regression.

Results: The overall cesarean delivery rate was 46.9% (358/763). Rates by age group were 50.0% (<15 years), 46.8% (15–16 years) and 45.6% (17 years), without a significant difference (p = 0.78). In adjusted analysis, non-cephalic presentation was strongly associated with cesarean delivery (adjusted OR 7.20; 95% CI 2.11–24.61; p < 0.001), as was premature rupture of membranes (adjusted OR 2.14; 95% CI 1.42–3.22; p < 0.001). Maternal age categories were not independently associated with cesarean delivery.
Conclusions: Among adolescent mothers, clinical obstetric circumstances were more informative for cesarean delivery than chronological age alone. Delivery planning should prioritize individualized obstetric assessment rather than age-based assumptions.
Keywords: adolescent pregnancy; cesarean delivery; maternal age; obstetric factors; intrapartum care

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**Suceveanu Bogdan Ionuț[1,2], Șandor Florin Mihai[1,3], Precup Cris Virgiliu[3], Delcea Cristian[1], Roxana Furău[2], Furău Cristian George[1,4]**
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**Violence Against Women: Impact on Sexual and Reproductive Health and Forensic Challenges**

Background: Violence against women, including intimate partner and sexual violence, is a public-health and human-rights concern associated with substantial sexual, reproductive and psychological consequences.
Objective: To synthesize epidemiological, clinical and medico-legal evidence on violence against women, focusing on reproductive coercion, sexual assault, forensic examination and coordination among health, justice and victim-support services.
Methods: A multidisciplinary narrative evidence synthesis drew on the academic material supplied by the authors, WHO, UNFPA/MSI, FRA/EIGE/Eurostat, Romanian institutional sources and peer-reviewed clinical and forensic literature. Themes included reproductive outcomes, reporting pathways, injury interpretation, biological evidence and intersectoral coordination.
Results: The cited WHO estimate indicates that approximately 31.6% of women globally have experienced physical and/or sexual intimate-partner or non-partner sexual violence during their lifetime. Reported associations include unintended pregnancy, abortion, sexually transmitted infections, miscarriage, stillbirth, preterm birth and low birth weight. Reproductive coercion may undermine reproductive autonomy. In the forensic literature cited by the authors, detectable anogenital injury was reported in 48% of women examined after sexual assault; absence of visible injury does not exclude assault, and the presence of injury alone does not establish consent or the circumstances of an event. Trauma-informed, consent-based assessment, accurate documentation, appropriate biological sampling and chain-of-custody procedures are central to medico-legal care. Underreporting and delayed presentation remain important challenges.
Conclusions: Violence against women requires integrated sexual and reproductive healthcare, forensic services, public-health prevention and survivor-centred legal and social support. Standardized, trauma-informed clinical and forensic pathways may improve continuity of care and documentation quality. As a narrative synthesis, this work does not provide new primary estimates or establish causal effects.
Keywords: violence against women; intimate partner violence; reproductive coercion; sexual and reproductive health; forensic examination; trauma-informed care

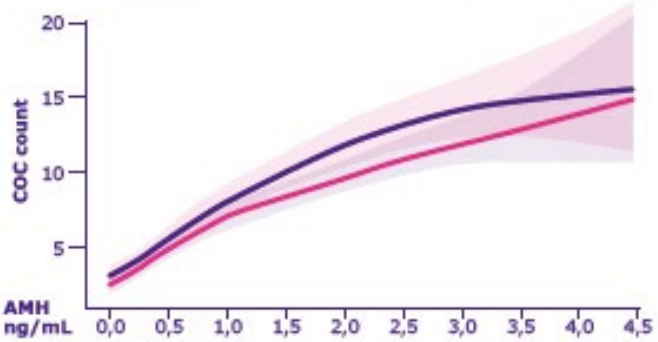
# Pergoveris®



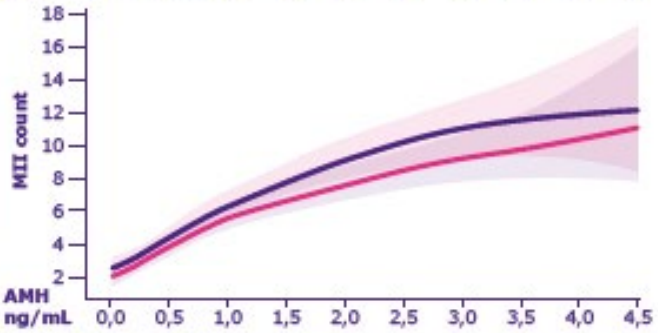
## STIMULATION WITH PERGOVERIS® RESULTED IN SIGNIFICANTLY IMPROVED FOLLICULAR RECRUITMENT AND EUPLOID BLASTOCYST COUNT VS U-HMG.[1]

**WOMEN WHO RECEIVED ≥300 IU**

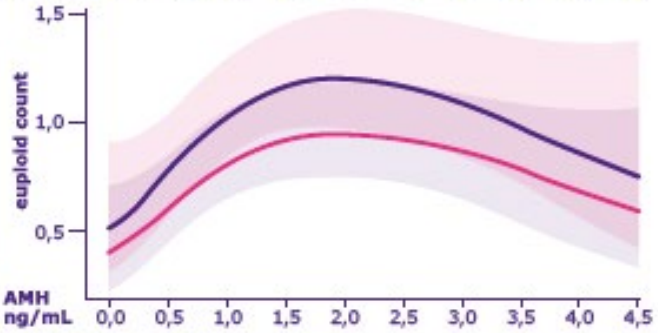
**14% HIGHER OOCYTE YIELD**
VS. HMG
(P < 0,001)




**12% HIGHER MII OOCYTE YIELD**
VS. HMG
(P = 0,003)




**IN HMG GROUP 22% LOWER EUPLOID BLASTOCYST**
(P = 0,006)




Adapted: Fatemi (2026), Front. Endocrinol. 17:1696657.

hMG  r-hFSH + r-hLH

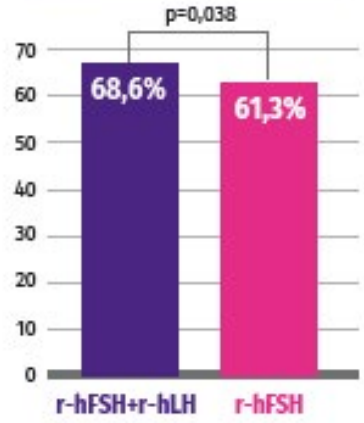
* Pergoveris® was associated with a higher #MII oocytes across AMH levels vs. hMG after multivariable adjustment. The effect was most significantly pronounced in women with normal ovarian reserve (AMH 1.0-3.5ng/mL, p = 0.001)

Number of mature oocytes retrieved (p<0.001) was the primary outcome and number of oocytes retrieved (p=0.003), and blastocyst count (p=0.006) were measured as a secondary outcome; GnRH antagonist

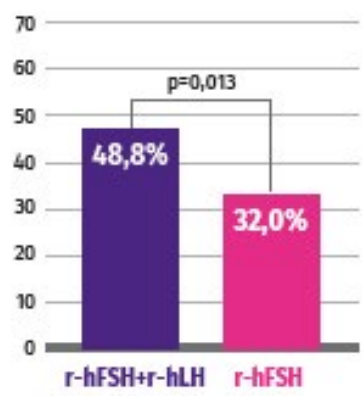
# TREATMENT WITH PERGOVERIS® RESULTED IN HIGHER OOCYTE YIELD, DAY 3 HIGH-QUALITY EMBRYOS, AND IMPLANTATION RATE VS R-HFSH.[2]

## RETROSPECTIVE STUDY'S SUBGROUP ANALYSIS OF WOMEN ≥ 35

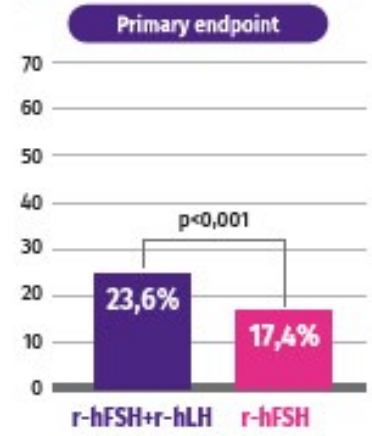
**12% HIGHER OOCYTE YIELD**
with r-hFSH+r-hLH vs r-hFSH




**52% HIGHER D3 HQ EMBRYO RATE**
with r-hFSH+r-hLH vs r-hFSH




**36% HIGHER IMPLANTATION RATE**
with r-hFSH+r-hLH vs r-hFSH




Adapted: Setti (2021) Rev Bras Ginecol Obstet. 2021;43(10):749-758.

Implantation rate was the primary outcome; oocyte yield and D3 HQ embryo rate were secondary outcomes; GnRH antagonist protocol


References:

**1.** Fatemi H, Steinmacher S, Melado L, ElKhatib I, Marqueta L, Ruiz F, Del Gallego R, Kalafat E and Lawrenz B (2026) Optimizing mature oocyte yield in IVF: clinical comparison of r-hFSH+r-hLH and HMG in women with a stimulation dosage of at least 300 IU of gonadotropins. Front. Endocrinol. 17:1696657. doi: 10.3389/fendo.2026.169665

**2.** Setti AS, Braga DPAF, Iaconelli A Júnior, Borges E Júnior. Improving Implantation Rate in 2nd ICSI Cycle through Ovarian Stimulation with FSH and LH in GNRH Antagonist Regimen. Melhorando a taxa de implantação no 2º ciclo de ICSI através do estímulo ovariano com FSH e LH no regime com antagonista do GnRH. Rev Bras Ginecol Obstet. 2021;43(10):749-758. doi:10.1055/s-0041-1736306


**For further information, please refer to the Summary of Product Characteristics (SmPC).**

The full current text of the Summary of Product Characteristics is available on the website of the National Center for Public Health and Pharmacy (NNGYK) (hereinafter: NNGYK; ogyei.gov.hu/gyogyszeradatbazis) or on the website of the European Medicines Agency (EMA) (www.ema.europa.eu).

Access via the OGYÉI website: www.ogyei.gov.hu ▶ Databases and Registers ▶ Medicinal Product Database ▶ enter the product name (Pergoveris) and select the appropriate strength from the drop-down list ▶ click "START SEARCH" ▶ click the corresponding database icon.

https://www.ema.europa.eu/hu/documents/product-information/pergoveris-epar-product-information_hu.pdf

For the latest pricing information, please refer to the information available on the website of the National Health Insurance Fund Administration (NEAK): www.neak.gov.hu

| | Gross Consumer Price (HUF) | Standard Reimbursement Amount (HUF) | Patient Co-payment with Standard Reimbursement (HUF) | Enhanced Reimbursement Amount (HUF) | Patient Co-payment with Enhanced Reimbursement (HUF) |
|---|---|---|---|---|---|
| PERGOVERIS (300 IU + 150 IU)/0.48 mL solution for injection in a pre-filled pen | 42 646 | 23 455 | 19 191 | 42 346 | 300 |
| PERGOVERIS (450 IU + 225 IU)/0.72 mL solution for injection in a pre-filled pen | 63 473 | 34 910 | 28 563 | 63 173 | 300 |
| PERGOVERIS (900 IU + 450 IU)/1.44 mL solution for injection in a pre-filled pen | 125 957 | 69 276 | 56 681 | 125 657 | 300 |

Access route: www.neak.gov.hu ▶ For Healthcare Professionals ▶ Pharmaceuticals / Medical Devices / Medical Spa Reimbursement ▶ Public Pharmaceutical Registry ▶ Final Registry


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