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Abstract Book

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Dear Colleagues,

Maternal Fetal Medicine and Perinatology Society of Turkey is the leading organization of mother and newborn health in Turkey for more than 20 years since our birth as a working group.

Perinatal-Neonatal Medicine and High-Risk Pregnancy Subgroup, which is one of our four original subgroups, are proud to organize and invite you to the "Perinatal Medicine 2019" which will be held between 9-11 May 2019 at Hilton Hotel İzmir, Turkey this year.

Hope to meeting you in Izmir in spring of 2019...

Sincerely,

Prof. M. Sinan BEKSAÇ  
Congress Co-Chair

Prof. İnanç MENDİLÇİoğlu  
Congress Co-Chair

Prof. Sermet SAĞOL  
Congress Co-Chair
Değerli Meslektaşlarımız,

Çalışma grubu olarak doğuşumuzdan bu yana geçen 20 yılı aşkın süredir anne ve yenidoğan sağlığının Türkiye’deki öncü kuruluşu “Türkiye Maternal Fetal Tıp ve Perinatoloji Derneği”dir.

4 özgün sub grubumuzdan biri olan “Perinatal-Neonatal Tıp ve Yüksek Riskli Gebelikler Subgrubu” bu yıl 9-11 Mayıs 2019 tarihlerinde Hilton Hotel İzmir’de “Perinatal Tıp 2019” toplantısını düzenlemenekten ve sizi davet etmekten onur duymaktadır.

Tüm dünyada yeni sayılabilecek olan maternal-fetal tıp ve perinatoloji kavramının ülkemiz koşullarında en doğru yolda şekillenmesi için yoğun çaba göstermektediz. Bu bilim dalının her ülkede olduğu gibi ülkemizde de yerleşik ve çağdaş tıbbi uygulamalarını gerçekleştirmek kolay olmamaktadır. Uygulayıcı eğitimi, toplum bilinçlenmesi ve hizmetin yaygınlaşması zaman ve yoğun emek gerektirmektedir. Bu nedenle perinatoloji yandali asistan ve uzmanlarının yanı sıra konuya ilgi duyan kadın hastalıkları ve doğum hekimlerinin de biliçlenmesini ve neonatoloji disiplini ile paylaşımlarını ayrıca önemsiyoruz.

Kurumsal yapımızın en büyük belirtisi olan başarılı eğitim organizasyonlarımızın ve güçlü sosyal ilişkilerimizin önemli bir örneği olarak bu yıl da SEESM Derneği ile işbirliği içinde çok verimli olacağını inanıyoruz bir çalışma planladık.

Üç gün süreli bu buluşmamızda perinatoloji biliminin preklinik ve klinik özel konularının cevap bekleyen sorularını neoatal ilişkileri ile birlikte yoğun ve yoğun olmayacak şekilde birlikte tartışmayı umuyoruz. Tüm portali ve yurt dışında konuşmacılar konularında işlerini olan deneyimli kişilerdir. Oturumlar dışında kalan zamanlarında da doğrudan kendileri ile iletişim kurup, tartışabileceğiniz bir platform hazır olacaktır.

2019 İlkbaharında İzmir’de buluşmak umudiyile...

Prof. Dr. M. Sinan BEKŞAŞ
Congress Co-Chair

Prof. Dr. İnanç MENDİLCİOĞLU
Congress Co-Chair

Prof. Dr. Sermet SAĞOL
Congress Co-Chair
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Esin Koç, Türk Neonatoloji Derneği
Olivera Kontic, South East European Society of Perinatal Medicine
İnanç Mendilcioğlu, Türkiye Maternal Fetal Tıp ve Perinataoloji Derneği
Sermet Sağol, Türkiye Maternal Fetal Tıp ve Perinataoloji Derneği

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Perinatal Medicine 2019

ORAL PRESENTATIONS

SÖZEL BİLDİRİLER

Anahtar kelimeler: Yenidoğan, Hemolitik hastalık, minor kan grubu, gebelik
OP-002 Preterm bebeklerdeki hafif düzeyde olan intraventriküler kanamanın uzun dönemde olan etkisinin araştırılması

Şenem Alkan Özdemir¹, Şebnem Çalkavur², Gonca Koç¹, Rüya Çok¹, Ferit Kulalı¹, Meral Yıldız³, Oğuzhan Kalkanlı¹, Tülin Gökmen Yıldırım¹

¹İzmir Sağlık Bilimleri Üniversitesi Dr. Behçet Uz Çocuk Hastalıkları ve Cerrahi Eşitik ve Araştırma Hastanesi, Neonatoloji Bilim Dalı, İzmir
²İzmir Sağlık Bilimleri Üniversitesi Dr. Behçet Uz Çocuk Hastalıkları ve Cerrahi Eşitik ve Araştırma Hastanesi, Radyoloji Bilim Dalı


Bulgular: Çalışmaya üç yıllık izlemede dahil edilmek kriterlerini karşılayan TfUS’de evre I ve II kanama olarak kabul edilen 48 olgu ile kanama izlenmeyen 80 olgu alındı. Çalışmaya alınan oğular ortalama 19±2.5 ayda BAYLEY II testiyle değerlendirildi, İVK’si olmayan grupta MDI skoru anlamında derecede daha yüksek bulundu(p=0.04). Hiçbir olguda serebral palsi, körlük ve sağırık saptanmadı.<= 29 hafta olan oğuların subgrup analizi yapıldığında hem MDI hem PDI skorları İVK’si olmayan grupta yüksek bulundu (p=0.003, p=0.001). Multiregresyon analizinde; 5.dk APGAR skoru, ilk 120 saat içinde hipernatremi, kilo kaybının yeterli oranda olmaması İVK için belirleyici bulundu (p<0.001). Kranial MRG değerlendirilmelerinde TfUS’de kanama olmayan hastalarda önemli derecede periventriküler lokomalazi olduğu saptandı.

Sonuç: Hafif düzeyde İVK’si olan preterm bebekler erken dönemde kanamaya olan hastalara benzer nöрогelişim gösterebilse de, TfUS’de İVK olmasına bile izlemede mutlaka kraniyal MRG ile değerlendirilmeli ve nörogelişimsel olarak uzun süre yakın takip edilmelidir.

Anahtar kelimeler: germinal matriks kanamaları, intraventriküler kanama, nörogelişim, nöroradyoloji, prematürite
OP-003 Yenidoğan yoğun bakım ünitesinden palivizumab profilaksisi ile taburcu edilen bebeklerde alt solunum yolu enfeksiyonlarının sıklığı ve risk faktörlerinin belirlenmesi

Senem Alkan Özdemir, Büşra Acar, Rüya Çolak, Ferit Kulali, Oğuzhan Kalkanlı, Meral Yıldız, Dilem Eriş, Şebnem Çalkavur, Tülin Gökmen Yıldırım

İzmir Sağlık Bilimleri Üniversitesi Dr. Behçet Uz Çocuk Hastalıkları ve Cerrahisi Eğitim ve Araştırma Hastanesi Neonatoloji Bilim Dalı, İzmir

Giriş: Bebeklerin çoğu hayatın ilk yılında RSV enfeksiyonu geçirmektedir. RSV alt solunum yolu enfeksiyonu (ASYE) ile hastene yatış en sık 6 aydan küçük bebeklerde olur. Prematurite, kronik akciğer hastalığı olanlar, konjenital kalp hastalığı olan ve ciddi immün yetmezliği olan bebekler RSV enfeksiyonu açısından büyük risk taşır ve Palivizumab profilaksisi risk gruplarında hastane yatış sıklığını düşürebilir. Çalışmamızda; yenidoğan yoğun bakım ünitesinden palivizumab profilaksisi ile taburcu edilen bebeklerdeki hayatın ilk iki yılı boyunca ASYE nedeni ile olan yatış sıklığını ve risk faktörlerini belirlemeyi amaçladık.


Bulgular: Palivizumab programına alınan toplam 558 hastanın 252 (%45) tanesinde profilaksiye uyum göstermemesi, 80 olgunun sezon dışında bulgusu olan olgular çalışma dışı bırakıldı. Çalışma grubunda yer alan olguların 80’ının ASYE nedeni ile yatışının olduğu, 106 olgunun ise yatış gerektirdiği görüldü. Olguların %69’unun prematurite, %19’unun kalp hastalığı ve %10 kronik akciğer hastalığı nedeni ile profilaksi aldığı görüldü. Hastaneye yatış yapılan olguların solunum PCR değerlendirilmesinde ise %84 oranında RSV dışı etkenlerin ürediği (en sık influenza) görülüştü. Risk faktörleri ele alındığında ise ASYE nedeni ile yatış yapılan olguların oksijen alma süresinin daha uzun, taburculukta bronkodilatör ve steroid kullanımın daha fazla olduğu görüldü.

Sonuç: Premature bebeklerde taburculuk sonrası ASYE nedeni yatışın yüksek ancak palivizumab profilaksisi altında bu oran oldukça düşktür bu nedenle profilaksiye uyuma çok dikkat edilmelidir. İlk altı ay içinde taburculuğun influenza mevsiminde gerçekleşmiş bebeklerde ise aile korumasının önemini vurgulanmalıdır.
Objective: To emphasize the importance of doppler ultrasonography on the examination of fetal intra-abdominal masses.

Methods: In this case, for the prenatal diagnosis doppler ultrasonography was used and for the postnatal diagnosis both intra-venous contrasted CT (computed tomography) and histopathological examination methods were used.

Results: A 29-year-old primigravid patient was referred to our perinatology outpatient clinic because of a cystic mass in the fetal abdomen at her 34th gestational week. In her obstetric follow ups, the combined risk was found to be 1/1280 in her first trimester screening. She had no targeted ultrasonographic examination in second trimester. In our practice fetal ultrasonography showed a 51x 34 mm mass at the right side of the gallbladder in the right lobe of the liver, and this mass was significantly vascularized with mixed echogenicity. The blood supply of the mass was provided directly from the right portal vein and then blood flow was turning to the right atrium with right hepatic vein. With these findings, firstly AVM (arteriovenous malformation) was considered as a diagnosis. No sign of fetal heart failure was detected. At the 38th gestational week the patient gave birth to 2750 g male infant by C-section because of fetal distress in our clinic. Postpartum doppler ultrasonography revealed a cystic, multiseptic, calcified lesion with a low resistant pulsatile venous flow pattern. The diagnosis was intrahepatic fetal umbilical vein AVM. Because of the postpartum interruption of blood flow in umbilical vein it was transformed into a vascular malformation in which the blood flow was provided by the right hepatic artery and then pouring to the hepatic vein. Intravenous contrasted CT scan was performed after two months and a mass that could not differentiate between AVM and hemangioendothelioma was detected in the liver of newborn. Comprehensive right hepatectomy was performed and the baby was followed postoperatively for 7 days in our clinic. In the 16th month, we are still following up the baby. The pathological examination of the mass was identified as an AVM with dystrophic calcification foci inside.

Conclusion: Hepatic AVMs are rare vascular malformations. They may cause heart failure in fetus and neonate. Fetal doppler ultrasonography may be a guide in the prenatal diagnosis of arteriovenous malformations. However, definitive diagnosis is possible with pathological examination.

Key words: Arteriovenous malformation, fetus, prenatal diagnosis, ultrasonography
Ultrasonographic imaging at 34th week of the gestation:

Figure 1:
Figure 2:
Figure 3:
Figure 4:
Amaç: Intraabdominal yer kaplayan oluşumların incelenmesinde doppler ultrasonografi tekniğinin önemini vurgulamaktır.

Yöntem: Olgunun prenatal tanısı için doppler ultrasonografi kullanılırken postnatal tanısı için intravenöz kontrast BT (Bilgisayarlı Tomografi) ve histopatolojik inceleme yöntemleri kullanılmıştır.

Bulgular: 29 yaşında G1 olan olgu 34. gebeğinde fetal batında kistik kitle nedeniyle perinatoloji poliklinikimize yönlendirilmişti. Medikal hikayesinde özellik olmayan gebeğin ilk trimester tarama testinde kombine risk 1/1280 saptanmış olup 2. düzey ultrasonografik muayenesi bulunmamaktadır. Yapılan fetal ultrasonografide, karaciğer içerisinde sağ lopta safra kesesinin sağında 51x34 mm boyutlarında sağ portal venden beslendiği ve sağ hepatik ven ile sağ atriyuma dönüşümlü belirgin düzeye vaskülerize mikst ekojenitede kitle izlenmiştir. Bu bulgularla tanı olarak ön planda AVM (arteriovenöz malformasyon) düşünülmüştür. Fetal kalp yetmezliği bulunmamakla kalmayıp, kliniğimizde takibe alınan gebe 38. haftada fetal distres endikasyonuyla acil sectio ile 2750 gr erkek bebek doğurmuştur. Postpartum doppler ultrasonografide multiseptal, kalsifiye, düşük dirençli pulsatil venöz akım akım paternine sahip kistik lezyon saptanmıştır. Klinikteki bu durumda, patolojik inceleme sonucunda distrofik kalsifikasyon odakları içeren AVM saptanmıştır.


Anahtar kelimeler: arteriovenöz malformasyon, fetüs, prenatal tanı, ultrasonografi
34. Gebelik haftasındaki görüntüler:

Resim 1:
Resim 2:
Resim 3:
Resim 4:
Objective: Pregnancy between the ages of 10-19 years is defined as adolescent pregnancy. Approximately 11% of all births in the world are delivered by adolescent pregnant women; and nearly 70,000 adolescent pregnant women die due to obstetric complications every year. Especially the influx of refugees in the last five-year period, resulted in the emergence of immigrant communities at low socio-economic levels in Turkey, leading to increased rates of adolescent pregnancies. The aim of this study was to compare the pregnancy outcomes of adolescent and adult women, who give birth in a tertiary hospital.

Method: In this retrospective study, hospital records of 1046 pregnant women were screened, who were followed up for pregnancy in the antenatal period and who consequently gave birth in a tertiary care hospital in the period between January 2017 and February 2018. There were two groups in our study, consisting of pregnant women in adolescent ages (10-19 years) in one group and of adult women in the other. Between the groups, demographic and clinical data were compared. A p-value of <0.05 was considered significant.

Results: Of 1046 pregnancies screened in the hospital records, the study included a total of 948 pregnant women, comprising 897 adult (94.6%) and 51 adolescent (5.4%) individuals. The mean age of the adolescent group was 17.0 ± 1.7 years. Significantly higher numbers of gravidity (2.97±1.48 vs. 1.43±0.6), parity (1.66±1.19 vs 0.31±0.58) and smokers (24.7% vs. 1.5%) were found in the adult group compared to the adolescent group (p<0.05). The presence of gestational diabetes (1.5%) and folic acid use (15.4%) were significantly lower in the adolescent group (p<0.05). There were no significant differences in the obstetric complications and pre-postpartum hematocrit values between the two groups (p>0.05). However, the need for neonatal intensive care was significantly higher in the adolescent group compared to the adult-age group (18.5% vs. 6.9%, respectively; p=0.001).

Conclusion: In our study, there were no significant differences in obstetric complications between the adolescent and adult groups as most of the adolescent pregnant women were in the late adolescent period between 17-19 years, which was an age range close to that of the adult-age group.

Key words: Adolescent, pregnancy, pregnancy outcome
Amaç: 10-19 yaş aralığındaki gebelikler adölesan gebelikler olarak tanımlanır. Dünyadaki tüm doğumların yaklaşık %11'i adölesan gebelikler tarafından gerçekleşmekte olup, her yıl 70.000'e yakın adölesan gebelikte obstetrik komplikasyonlar nedeniyle ölmektedir. Özellikle son beş yılda gerçekleşen mülteci akınları, Türkiye'de sosyo-ekonomik seviyesi düşük bir göçmen toplum oluşmasına ve adölesan gebeliklerde artışa neden olmuştur. Bu araştırmanın amacı, üçüncü basamak bir hastanede doğum yapan adölesan yaş grubu gebeller ile yetişkin yaş grubundakı gebelerin gebelik sonuçlarını karşılaştırmaktır.

Yöntem: Bu retrospektif çalışmada, Ocak 2017 ile Şubat 2018 arası üçüncü basamak bir hastanede antenatal takibi ve doğumu gerçekleşen 1046 gebelik hastane kayıtları tarandı. Adölesan yaş grubu (10-19 yaş) gebelere ve erişkin yaş grubu gebelere olmak üzere iki grup oluşturuldu. Grupların gravida ve parite sayısı, sigara kullanımı, akraba evliliği, antenatal takip sayısı, folik asit ve demir preparatı kullanımı, pre- postpartum hematokrit değerleri, gestasyonel diyabet-hipertansiyon varlığı ve hepatit-B taşıyıcılığı, doğum haftası ve şekli ile obstetrik komplikasyonlar, yenidoğan ağırlığı ve yoğun bakım ihtiyacı verileri karşılaştırıldı. p<0,05 anlamlı olarak değerlendirildi.

Bulgular: Kayıtları taranan 1046 gebelik hastane kayıtları ile uyumlu olan 897 erişkin (%94,6) ve 51 adölesan (%5,4) toplam 948 gebe çalışmaya alındı. Adölesan gebe grubunda yaş ortalaması 17,0±1,7 idi. Erişkin yaş grubunda adölesan yaş grubuna göre; gravida (2,97±1,48 vs. 1,43±0,6) ve parite (1,66±1,19 vs. 0,31±0,58) sayıları ile sigara kullanımı (%24,7 vs. %1,5) anlamlı derecede yüksek (p<0,05). Adölesan grupta gestasyonel diyabet varlığı (%1,5) ve folik asit kullanımı (%15,4) anlamlı derecede düşüktü (p<0,05). Obstetrik komplikasyonlar ve pre-postpartum hematokrit değerleri için her iki grup arasında anlamlı bir fark yoktu (p>0,05). Ancak yenidoğan yoğun bakım ihtiyacı adölesan grupta erişkin yaş grubuna göre anlamlı derecede yüksekti (sirasıyla, %18,5 vs. %6;9; p=0,001).

Sonuç: Çalışmamızda adölesan gebeliklerin çoğunun, erişkin yaş grubuna yakın 17-19 yaş aralığındaki geç adölesan dönem gebeler olması nedeniyle, obstetrik komplikasyonlar bakımından adölesan ve erişkin yaş grubu gebelere arasında anlamlı fark bulunamamıştır.

Anahtar kelimeler: Adölesan, gebelik, gebelik sonuçları
The efficacy of amnioreduction in the management of twin to twin transfusion syndrome

Emre Ekmekci, Fedi Ercan
Sanlıurfa Education and Research Hospital, Perinatology Department, Sanlıurfa

Objective: The aim of this study was to evaluate the efficacy of amnioreduction at patients with the diagnosis of twin to twin transfusion syndrome (TTTS) in consideration with stages.

Methods: Patients who underwent amnioreduction for TTTS at Perinatology Clinic of Sanlıurfa Training and Research Hospital between July 2017 and January 2019 were evaluated. All patients with stage 2 and above were given the option of fetoscopic laser photocoagulation (FLP), selective fetocide and amnioreduction. Cases with stage 1 and over stage 2 who were managed with amnioreduction were evaluated weekly after amnioreduction. Amnioreductions were aimed to reduce the amniotic fluid in the recipient fetus to below 10cm deepest vertical pocket length and were repeated if necessary. Gestational ages (GA) at the diagnosis, Quintero stages, total number of amnioreductions and pregnancy outcomes were recorded.

Results: A total of 21 TTTS cases were diagnosed in this period. Three patients were referred to appropriate center for FLP. 6 cases were out of follow-up. No patient preferred selective fetocide. Amnioreduction was performed in 12 patients. The data is summarized in table.

Conclusion: Although, the primary approach for TTTS is FLP, amnioreduction seems to be effective in case of difficulties to reach the appropriate centers. Higher GAs can be reached with amnioreduction, fetal and neonatal morbidity-mortality can be reduced. The primary complication of the procedure is being as membrane rupture in early third trimester.

Key words: TTTS, amnioreduction, quintero

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<td>34</td>
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İkizden ikize transfüzyon sendromu olgularının yönetiminde amniyoredüksiyon yönteminin etkinliği

Emre Ekmekci, Fedi Ercan

Şanlıurfa Eğitim ve Araştırma Hastanesi, Perinatoloji bölümü, Şanlıurfa

Amaç: İkizden ikize transfüzyon sendromu (TTTS) tanısı ile amniyoredüksiyon uygulanan hastaların sonuçlarının ve amniyoredüksiyonun yönetimdeki etkinliğinin olguların evresi göz önünde bulundurularak değerlendirilmesi.


Sonuç: TTTS olgularında şu an için primer tedavi yaklaşımı FLP olsa da uygun merkezlerde ulaşmada zorluklar gibi nedenlerle amniyoredüksiyon işlemi de etkifini göstermektedir. Amniyoredüksiyona daha iyi gebelik haftalarına ulaşılabilmesi, fetal ve neonatal morbidity-mortalite azaltılabilmesi. İşlemlere bağlı primer komplikasyon erken üçüncü trimester membran rüptürü olarak görülmektedir.

Anahtar kelimeler: TTTS, amniyoredüksiyon, quintero

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OP-007 Neonatal outcomes of maternal early- and late-onset preeclampsia

Melek Büyükeren, Hasan Tolga Çelik, Mehmet Sinan Beksaç, Gökçen Örgül, Şule Yiğit, Murat Yurdakök

1Division of Neonatology, Department of Pediatrics, Hacettepe University Faculty of Medicine, Ankara, Turkey
2Division of Perinatology, Department of Obstetrics and Gynecology, Hacettepe University Faculty of Medicine, Ankara, Turkey

Rationale: To demonstrate neonatal outcomes of infants born to mothers with early-onset preeclampsia (EP) and late-onset preeclampsia (LP) and infants of early preeclamptic mothers that were delivered before and after 34 weeks of gestation.

Materials and Method: This retrospective study, we evaluated pregnant women treated for preeclampsia in Hacettepe University Hospital between 2010 and 2017 and their neonatal outcomes. The women were classified as having EP if diagnosed before 34 weeks of gestation (91 patients) and LP if diagnosed after 34 weeks of gestation (34 patients) (2). The women in the EP group were further divided into subgroups, including those who gave birth before 34 weeks of gestation (early birth; n=57) and after 34 weeks of gestation (late birth, n=34). Necessary clinical and demographic data were withdrawn from the electronic registry of Hacettepe University Hospital.

Results: Neonates in the EP/late birth subgroup had significantly lower gestational age and birth weight. Small for gestational age frequency were higher in the early-onset subgroup born after 34 weeks’ gestation compared to the late-onset preeclampsia group (p=0.016). After correcting for gestational week and birth weight, neutrophil count was still significantly lower in the EP/late birth subgroup (p=0.002).

Conclusion: Our study compared neonatal and hematological outcomes between EP and LP infants and between EP infants born after 34 weeks of gestation and LP infants.

Key words: Newborn, early-onset preeclampsia, late-onset preeclampsia, neutropenia, small for gestational age
Introduction: The obesity is a common health problem and programmed starting from the fetal life. It is known that maternal obesity may cause a predisposition to obesity development and breast milk contains a number of complex molecules that regulate the baby's appetite and growth. We aimed to investigate the macronutrient content in breast milk of obese moms in the neonatal period to explain a mechanism for developing obesity.

Patients and Methods: Thirty-six maternal-neonatal pairs were included in this prospective and cross-sectional study at our University Hospital. Mothers were selected according to the pregnancy body mass index and classified as either normal or obese. Breast milk samples were collected at postpartum day 7 and kept at -20°C refrigerator before the analysis. Breast milk macronutrient contents were then analysed with Fourier Transform Infrared Spectroscopy (FTIRS) method. Demographic characteristics and anthropometric measurements were also obtained.

Results: In FTIRS analysis, although the lipid band of obese mothers' milk was found to be more elevated, the difference was not statistically significant between two groups (p <0.05). Nevertheless the carbohydrate and protein content were not statistically different in comparison with the control group. There was no statistical difference between obese and control groups in terms of demographic characteristics and anthropometric measurements.

Conclusion: This preliminary study shows that the macronutrient content of mother's milk is not different in comparison with the obese and non-obese mothers in the first month of life. Therefore we think that the macronutrient content of breast milk is not likely to play a role in the programming of obesity in the neonatal period. Further investigations may focus on the role of breast milk feeding in later periods in developing obesity.

Key words: Breast milk, FTIRS, macronutrient, maternal obesity
OP-008 Anne sütü makronutriyent içeriği ile maternal obezite arasında ilişki var mı: Preliminar çalışma

Esra Arun Özer¹, Sema Tanrıverdi¹, Aylin Seren Güller², Erdener Özer³, Akın Sevinç²

¹Celal Bayar Üniversitesi Tıp Fakültesi Çocuk Sağlığı ve Hastalıkları Anabilim Dalı, Yenidoğan Bilim Dalı, Manisa
²Alınbazı Üniversitesi Tıp Fakültesi Biyokimya Anabilim Dalı, İstanbul
³Dokuz Eylül Üniversitesi Tıp Fakültesi, Patoloji Anabilim Dalı, İzmir


Hastalar ve Yöntem: Prospektif, olgu-kontrol olarak planlanan araştırma, Yenidoğan Polikliniğine başvuran, term, sağlıklı ve tekil gebeliklerden doğmuş, anne sütüyle beslenen, herhangi bir hastalığı bulunmayan, postnatal 7 günden büyük bebekleri olan annelerin sabah alınan süt örnekleri -20 °C'de saklandı. Örnekler uygun ortamda transport edildikten sonra, Fourier Dönüşümlü Kızılötesi Spektroskopi (FTIRS) cihazı ile makronutriyent içerikleri analiz edildi. Vücut kitle indeksi 30 kg/m²'den yüksek olan anneler “obez” olarak kabul edilerek, obez olan ve olmayan anne sütleri iki grupta değerlendirildi ve makronutriyent içerikleri istatistiksel olarak karşılaştırıldı.

Sonuçlar: Çalışmaya alınan 36 annenin 17’si (% 47.2) obezite grubunda, kalanı ise kontrol grubunda kabul edildi. Her iki grup arasında demografik özellikler ve antropometrik ölçümler bakımından istatistiksel farklılık yokuğu. FTIRS analizinde lipid bandında obez anne sütlerinde yükseklik bulunmasına karşın, fark istatistiksel olarak anlamalı değildir (p<0.05). Ayrıca anne sütünün karbonhidrat ve protein içerikleri de kontrol grubuna göre farklı bulundu.

Yorum: Bu preliminar çalışmanın sonuçları, obez anne sütlünün makronutriyent içeriklerine bakıldığında, yaşamın ilk ayında obez olmayan anne sütlерinden farklı olmadığını göstermektedir. Obezitenin programlanmasındaki maternal obezitenin rolünün, yenidoğan dönemindeki anne süt makronutriyent içeriği ile ilişkili olmayacağını sonucuna varılmıştır.

Anahtar Kelimeler: Anne sütü, FTIRS, makronutriyent, maternal obezite

Resim 1. FTIRS analizi ortalamaları
Aim: Cystic fibrosis (CF), autosomal recessive, lungs, pancreas, mucus secreting glands in the intestines, liver and sweat glands, including all of the epithelial surface affecting the mortality and morbidity of the high, cystic fibrosis transmembrane regulator (CFTR) gene with the mutation of the genetic transition is a disease. More than 2,000 CFTR mutations have been identified, except for the most common F508 mutation in the CFTR gene. The aim of this study was to determine the frequency of CF mutations and new mutations in the CFTR gene in infants with respiratory distress.

Material and methods: Twenty-five newborn infants who were hospitalized in our clinic between May 2017 and January 2018 due to respiratory distress and 20 newborn babies without respiratory distress were included in this study. PCR and RFLP methods were used to investigate CFTR gene.

Results: The mean gestational age of 20 infants in the patient group was 34.25 ± 4.65 (26-40) weeks and the mean birth weight was 2273.00 ± 994.63 (610-3850) grams. The mean gestational age of the 20 babies in the control group was 38.20 ± 1.15 (37-41) weeks, and the mean birth weight was 3278.00 ± 585.622 (1970-4180) gram. In 14 of the babies in the control group, the CFTR gene analysis was normal, whereas in others, p.E1228G (c.3683 A> G) (n = 1), p.E217G (c.650A> G) (n = 1), p.E632TfsX9 (c.1894_1895del AG). (n = 1), p.1807M (c.2421A> G) (n = 2), p.S573F (c.1718C> T) (n = 1) heterozygotes were detected. KFTR gene analysis was normal in 16 of the patients in the patient group, whereas in others p.A46D (c.137C> A) (n = 1), p.D1312G (c.3935A> G) (n = 1), p.R117H (c. 4276T> C (n = 1), p.S1476P (c.4276T> C) (n = 1) heterozygotes were detected. There was no significant difference in the control and patient group KFTR gene analysis (p = 0.340).

Conclusion: This study demonstrates the importance of CFTR gene analysis in asymptomatic newborn infants for follow-up and early diagnosis of CFTR-related disorders that may develop months or years after birth. In this study, c.1894_1895del AG (p.E632TfsX9) heterozygous mutation detected in the KFTR gene in an asymptomatic baby was first encountered in the literature.

Key words: Cystic fibrosis, mutation, CFTR gene, newborn
OP-009 Solunum yolu problemi olan preterm ve term yeniden doğanlarda kistik fibrozis mutasyon sıklığının belirlenmesi

Sema Tanrıverdi1, Hüseyin Onay2, Esra Özer2, Muzaffer Polat3

1Manisa Celal Bayar Üniversitesi Tip Fakültesi Çocuk Sağlığı ve Hastalıkları AD, Neonatoloji BD, Manisa
2Ege Üniversitesi Tip Fakültesi Tıbbi Genetik AD, İzmir
3Manisa Celal Bayar Üniversitesi Tip Fakültesi Çocuk Sağlığı ve Hastalıkları AD, Manisa

Amaç: Kistik Fibrozis (KF), otozomal resesif, akciğerler, pankreas, barsaklarda mukus salgılayan bezler, karaciğer ve ter bezleri olmak üzere epiteylal yüzeyi bulunan tüm organ sistemlerini etkileyen mortalite ve morbiditesi yüksek, kistik fibrozis transmebran regülatör (KFTR) geninin mutasyonu ile ortaya çıkan genetik geçişli bir hastalıktır. KFTR geninde en sık rastlanılan ΔF508 mutasyonu dışında 2.000’nin üzerinde KFTR mutasyonu daha tanımlanmıştır. Bu çalışmada, solunum sıkıntısı olan bebeklerde KF mutasyon sıklığının ve KFTR genindeki yeni mutasyonların saptanması amaçlanmıştır.


Sonuç: Bu çalışmamız asemptomatik yeniden doğan bebeklerde KFTR gen analizinin, doğumdan aylar hatta yıllar sonra gelişebilecek KFTR ile ilişkili bozukluklar açısından takip ve erken tanda önemini göstermektedir. Bu çalışmamızda asemptomatik bir bebekte KFTR geninde saptanan c.1894_1895del AG (p.E632TfsX9) heterozigot mutasyonuna literatürde ilk kez rastlandı.

Anahtar kelimeler: Kistik fibrozis, mutasyon, KFTR geni, yeniden doğan
The effect of cigarette exposure on cord blood gas and carboxyhemoglobin level in pregnancy

Sema Tanrıverdi, Esra Arun Özer
Manisa Celal Bayar University Medical School, Department of Pediatrics, Division of Neonatology, Manisa, Turkey

Aim: Smoking is an important health problem. Active or passive exposure to smoking during pregnancy adversely affects fetus. Nicotine and carbon monoxide in the cigarette impair the fetal oxygenation and fetal acid base balance. In this study, the effect of active or passive smoking exposure on cord blood gas and the relationship between carboxyhemoglobin (COHb) levels in pregnancy were investigated.

Material and methods: A total of 368 term newborn infants born alive between January 2018 and January 2019 were included in the study. Blood gas parameters and COHb levels were measured in the blood sample taken from the umbilical artery after delivery. Smoking exposure during pregnancy was questioned in detail.

Results: Of the 368 term infants included in the study, 161 had active or passive smoking exposure, while 207 had no active or passive smoking exposure. The mean birth weight of the babies exposed to smoking was 3155 ± 496 grams, the mean birth weight of the babies not exposed to smoking was 3246 ± 454 grams. The mean pH of the babies exposed to smoking was 7.32 ± 0.07 mmHg, pCO2 40.6 ± 9.4 mmHg, pO2 50.1 ± 23.3 mmHg, COHb 3.43 ± 1.28%, mean pH 7.31 ± 0.08 mmHg in infants not exposed to smoking, pCO2 41.9 ± 9.3 mmHg, pO2 was 42.5 ± 25.1 mmHg and COHb was 2.55 ± 1.32%. pO2 and COHb levels were significantly higher in babies exposed to smoking (p <0.001; p = 0.03). Of the 161 infants exposed to smoking, 96 (59%) developed tachypnea, 32 (19%) needed oxygen. Tumors developed in 89 (42%) of 207 infants who were not exposed to smoking and 20 (9%) needed oxygen. There was a significant correlation between cigarette exposure and tachypnea and oxygen demand (p = 0.002; p = 0.005).

Conclusion: In this study, no significant relationship was found between pregnancy and fetal asidemia in pregnancy; however, fetal COHb levels were significantly higher. There was a significant relationship between active or passive smoking during pregnancy and postnatal period and postnatal tachypnea and oxygen demand.

Key words: Smoking, cord blood gas, carboxyhemoglobin, newborn
OP-010 Gebelikte sigara maruziyetinin kordon kan gazına ve karboksihemoglobin düzeyine etkisi

Sema Tanrıverdi, Esra Arun Özer

Manisa Celal Bayar Üniversitesi Tip Fakültesi Çocuk Sağlığı ve Hastalıkları AD, Neonatoloji BD, Manisa


Bulgular: Çalışmaya alınan 368 term bebeğin 161’inin aktif veya pasif sigara maruziyeti varken 207’sinin aktif veya pasif sigara maruziyeti yoktu. Sigaraya maruz kalma bebeklerin ortalaması doğum ağırlığı 3155±496 gram, sigaraya maruz kalmayan bebeklerin ortalaması doğum ağırlığı 3246±454 gramdı. Sigaraya maruz kalan bebeklerin kan gazında ortalama pH 7.32±0.07 mmHg, pCO₂ 40.6±9.4 mmHg, pO₂ 50.1±23.3 mmHg, COHB %3.43±1.28, sigaraya maruz kalmayan bebeklerin kan gazında ortalama pH 7.31±0.08 mmHg, pCO₂ 41.9±9.3 mmHg, pO₂ 42.5±25.1 mmHg, COHB %2.55±1.32 bulundu. Sigaraya maruz kalan bebeklerde pO₂ ve COHb düzeyleri anlamlı olarak yüksek saptanmıştır (p<0,001; p=0,03). Sigaraya maruz kalan 161 bebeğin 96(%59)’sında takipne gelişti, 32 (%19)’ünün oksijen ihtiyacı olduğu. Sigaraya maruz kalan 207 bebeğin 89(%42)’unda takipne gelişti, 20(%9)’ünün oksijen ihtiyacı olduğu. Sigara maruziyeti ile takipne ve oksijen ihtiyacı arasında anlamlı ilişki bulundu (p=0,002; p=0,005).

Sonuç: Bu çalışmada gebelikte sigara maruziyeti ile fetal asidemi arasında anlamlı bir ilişki saptanmamıştır; ancak fetal COHb düzeyleri anlamlı olarak yüksek bulunmuştur. Gebelikte aktif veya pasif sigara maruziyeti ile postnatal dönemde geçici takipne ve oksijen ihtiyacı arasında anlamlı ilişki bulundu.

Anahtar Kelimeler: Sigara, kordon kan gazi, karboksihemoglobin, yenidoğan.
Aim: To compare the birth weight percentiles of the babies of pregnant women who were not diagnosed with gestational diabetes as a result of 50 grams and 75 grams of glucose tolerance test.

Methods: This retrospective cohort study included pregnant women who were evaluated by the 50 g or 75 g glucose loading test in the Department of Gynecology and Obstetrics of the Faculty of Medicine of Hacettepe University between 01.01.2013 and 31.12.2017 and were not diagnosed with gestational diabetes. Patients were divided into two groups according to the glucose tolerance test: 1) 50 g group and 2) 75 g group.

Maternal age, parity and birth weight percentiles were compared between groups.

Results: A total of 1600 patients were included in the study (50 g group = 1188, 75 g group = 412). There was no statistically significant difference between the groups in terms of median maternal age (p = 0.27), but there was a statistically significant difference in terms of parity and birth weight percentiles (p values <0.001 and 0.03, respectively).

Conclusion: The birth weight percentages in the 50 g glucose tolerance test group were significantly higher than the birth weight percentages in the 75 g glucose tolerance test group.

Key words: gestational diabetes, 50 g glucose tolerance test, 75 g glucose tolerance test, birth weight

Table 1: Comparison of 50 g and 75 g groups in terms of maternal age, parity and birth weight percentiles

<table>
<thead>
<tr>
<th>Variables</th>
<th>50g group (n=1188)</th>
<th>75g group (n=412)</th>
<th>p values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal age (years)</td>
<td>age (median, IQR)</td>
<td>31 (7)</td>
<td>31 (8)</td>
</tr>
<tr>
<td>Parity (n, %)</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Nulliparous</td>
<td>485 (40.8%)</td>
<td>234 (56.8%)</td>
<td></td>
</tr>
<tr>
<td>Multiparous</td>
<td>703 (59.2%)</td>
<td>178 (43.2%)</td>
<td></td>
</tr>
<tr>
<td>Birth weight percentile (median, IQR)</td>
<td>62.5 (42)</td>
<td>54 (47)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

IQR: interquartile-range
OP-011 50 gram ve 75 gram glukoz yükleme testi sonucunda gestasyonel diyabet tanısı konulmuyan gebelerin bebeklerinin doğum kilosu persentillerinin karşılaştırılması

Atakan Tanaçan

Hacettepe Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı, Perinatoloji Bilim Dalı, Ankara, Türkiye

Amaç: 50 g ve 75 g glukoz yükleme testi sonucunda gestasyonel diyabet tanısı konulmuyan gebelerin bebeklerinin doğum kilosu persentillerinin karşılaştırılması.

Yöntem: Bu retrospektif kohort çalışmaya, 01.01.2013-31.12.2017 tarihleri arasında Hacettepe Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı’nda 50 g ya da 75 g glukoz yükleme testi ile değerlendirilip gestasyonel diyabet tanısı konulmamış olan gebeler dahil edildi. Hastalar uygulanan glukoz yükleme testine göre iki gruba ayrıldı: 1) 50 g grubu ve 2) 75 g grubu. Maternal yaş, parite ve doğum kilosu persentilleri gruplar arasında karşılaştırıldı.

Bulgular: Çalışmaya toplam 1600 hasta dahil edildi (50 g grubu=1188, 75 g grubu=412). Gruplar arasında ortanca maternal yaş açısından istatistiksel olarak anlamlı fark bulunmazken (p=0.27), parite ve doğum kilosu persentilleri açısından istatistiksel olarak anlamlı fark tespit edildi (p değerleri sırası ile, <0.001 ve 0.03).

Sonuç: 50 g glukoz yükleme testi grubundaki doğum kilosu persentilleri 75 g glukoz yükleme testi grubundaki doğum kilosu persentillerinden anlamlı olarak yüksek bulundu.

Anahtar kelimeler: Gestasyonel diyabet, 50 g glukoz tolerans testi, 75 g glukoz tolerans testi, doğum ağırlığı

Tablo 1: 50 g ve 75 g gruplarının, maternal yaş, parite ve doğum kilosu persentilleri açısından karşılaştırılması

<table>
<thead>
<tr>
<th>Değişkenler</th>
<th>50g grubu (n=1188)</th>
<th>75g grubu (n=412)</th>
<th>p değeri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal yaş (yıl) (ortanca, IQR)</td>
<td>31 (7)</td>
<td>31 (8)</td>
<td>0.27</td>
</tr>
<tr>
<td>Parite (n, %)</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
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<td></td>
</tr>
<tr>
<td>Doğum kilosu persentili (ortanca, IQR)</td>
<td>62.5 (42)</td>
<td>54 (47)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

IQR: interquartile-range
OP-012 Severe thrombocytopenia in pregnancy: Etiological factors and pregnancy outcomes

Erdem Fadiloglu

Division of Perinatology, Department of Obstetrics and Gynecology, Hacettepe University, Ankara

Objectives: To determine the outcome of the pregnancies with severe thrombocytopenia prior to delivery.

Methods: We retrospectively evaluated the patients delivered at Hacettepe University Hospital with a thrombocyte count less than 70.000/µl between 2013 and 2018. We included patients with definitive diagnosis of Idiopathic Thrombocytopenic Purpura (ITP), Gestational Thrombocytopenia (GT) and Hypertensive Disorders of Pregnancy.

Results: Fifteen out of 27 patients had an initial diagnosis of thrombocytopenia in 1st trimester and the most common diagnosis was found to be ITP (70.4 %). Median platelet counts prior to delivery was found as 54.000 (36.000 – 70.000/ µl). Fifteen out of 27 patients required any kind of blood product transfusion, in which majority of the patients were found to be ITP and the most common used blood product was thrombocyte suspensions. On the other hand, none of the patients had required additional surgical interventions for postpartum or intrapartum hemorrhage. Analysis regarding the newborns revealed 15 out of 27 newborns as thrombocytopenic, but none of them had related complications such as intracranial hemorrhage.

Conclusion: Severe thrombocytopenia in pregnancy should be managed carefully due to theoretical risk of increased complications. Patients with ITP are also found to be more prone to be diagnosed at earlier gestational weeks and require more blood product transfusions.

Key words: Thrombocytopenia, pregnancy, idiopathic thrombocytopenic pregnancy, gestational thrombocytopenia, hypertensive disorders of pregnancy
OP-012 Gebelikte ciddi trombositopeni: Etiyolojik faktörler ve gebelik sonuçları

Erdem Fadıloğlu

Perinatoloji Bilim Dalı, Kadın Hastalıkları ve Doğum Anabilim Dalı, Hacettepe Üniversitesi, Ankara

Amaç: Doğum öncesi ciddi trombositopenisi olan hastaların gebelik sonuçlarının incelenmesi

Yöntem: Bu çalışmada, retrospektif olarak Hacettepe Üniversitesi'nde 2013-2018 yılları arasında doğum yapan ve platelet sayısı doğum öncesi 70.000/µl'nin altında olan hastalar değerlendirilmiştir. Çalışmaya Gestasyonel Trombositopeni (GT), İdiopatik Trombositopenik Purpura (ITP) ve Gebelik Hipertansif Hastalıklarına bağlı trombositopeni vakaları dahil edilmiştir.

Sonuç: Çalışmaya dahil edilen 27 hastadan 15 tanesi ilk trimesterde tanı aldığını ve en sık koyulan tanıların ITP (70.4 %) olduğunu göster dik. Doğum öncesi ortanca platelet sayısı 54.000 (36.000 – 70.000/ µl) olarak bulundu. Tüm hastalardan 15 tanesine herhangi bir kan ürünü transfüzyonu yapılmış iken, transfüzyon ihtiyacı en fazla olan hasta grubu ITP’li hastalar olarak gösterildi. En sık kullanılan kan ürünü ise trombosit süspansiyonları olarak bulundu. Diğer taraftan, çalışmada hiçbir hastanın kanamaya yönelik yapılan ek bir cerrahi işleme ihtiyacı olmuştur. Yenidoğanlar değerlendirildiğinde ise 15 yenidoğanın trombositopenik olarak değerlendirildiği ancak hiçbirinin intrakranial kanama gibi trombositopenik ilişkili bir komplikasyon yaşamadığı görüldü.

Sonuç: Ciddi trombositopeni teorik olarak mevcut olan artmış komplikasyon riski nedeniyle gebelik sırasında dikkatli yönetilmelidir. ITP hastaları ise erken haftalarda daha sık tanı almaya ve gebelik sırasında daha fazla kan ürünü transfüzyonuna ihtiyaç duymaya eğilimlilerdir.

Anahtar kelimeler: Trombositopeni, gebelik, idiopatik trombositopenik purpura, gestasyonel trombositopeni, gebeligin hipertansif hastalıkları
OP-013 Perinatal mortality and morbidity in epileptic women

Emine Aydin

Medipol University School of Medicine, Çamlıca Hospital

The prevalence of epilepsy in pregnant women ranges between %0.2-0.4. Fetal and obstetric complications related with epilepsy are higher than pregnancies without epilepsy. Evaluation of these patients and management of them varies in different centers. In this study, we aimed to describe the outcome of pregnancy in women with epilepsy in Hacettepe University.

We scanned all of the birth recordings pregnancies between December 2002 and January 2014 at Hacettepe University, Department of Obstetrics. We examined patients’ files who had epilepsy and excluded the patients who are not fully followed at our institute during pregnancy. At the end 114 pregnant women with epilepsy (PWWE) were included the study. Patients’ demographics, duration epilepsy, gestational week, birth weight, pre-gestational history, type of delivery, APGAR scores (1st and 5th min.), perinatal and maternal complications, comorbid diseases and pregnancy outcome were recorded.

Mean maternal age was 29 (±5) years. We found that the mean gestational age at delivery were 37.5 weeks (263 days±15days). And mean birth weight was 2922gr (±641gr). Percentage of 1st min. APGAR scores less than 7 was %0.02, and 5th min APGAR score less than 7 was %0.01. %70.2 of patients delivered with c-section.

According to our findings mean gestational age was not in preterm range. Birthweight was well-matched with the gestational week. The high proportion of c-section delivery was attributed to the management of high risk population. As a result this study is an example of well established perinatal care.

Keywords: antiepileptic drug, epilepsy, fetal malformation, pregnancy outcome, seizure
OP-013 Epileptik kadınlarda perinatal mortalite ve morbidite

Emine Aydin

Medipol Üniversitesi Tıp Fakültesi Çamlıca Hastanesi

Gebe kadınlarda epilepsi sıklığı %0.2-0.4 civarındadır ve bu kadınlarda fetal ve obstetrik komplikasyon sıklığı daha fazladır. Bu hastaların değerlendirilmesi ve yönetimi ise pek çok merkezde değişkenlik göstermektedir. Biz ise bu bildiri ile Hacettepe Üniversitesi deneyimini sunmayı amaçladık. Aralık 2002-Ocak 2014 arası olan dönemde Hacettepe Üniversitesi Tıp Fakültesi Hastanesi’nde gerçekleşen tüm doğumlar taramak, epilepsi tanısı almış ve burada doğum yapmış tüm gebelere ulaşıldı. Tüm gebelik takibi ve doğum merkezimizde gerçekleşen gebeler veri grubuna dahil edildi. Bu eliminasyon sonrası dahil edilme kriterlerini sağlayan 114 gebe analize dahil edildi. Hastaların demografik özellikleri, epilepsi süresi, doğumda gebelik haftası, bebeklerin doğum ağırlığı, gebelik öncesi öykü, doğum şekli, APGAR skorları (1. ve 5. dk.), perinatal ve maternal komplikasyonlar, eşlik eden hastalıklar ve gebelik sonuçları kaydedildi. Ortalama anne yaşı 29 (± 5) idi. Doğum sırasındaki ortalama gebelik haftası 37,5 hafta (263 gün ± 15 gün), ortalama doğum ağırlığı 2922 gr (± 641 gr), 7’nin altında 1 dak. APGAR skoru sıklığı % 0.02 ve 5. dk. APGAR skoru sıklığı ise % 0.01 idi. Sezaryen doğum sıklığı ise % 70.2 idi. Bulgularımıza göre ortalama gebelik yaş preterm aralıkta değildi. Doğum ağırlığı, gebelik haftası ile uyumluydu. Yüksek sezaryen sıklığı orani, yüksek riskli gebelik populasyonunun yönetimine bağlıdı. Sonuç olarak, bu analizin iyi yönetilmiş perinatal dönem bakımının sonuçları iyilestirebileceğini düşünmektediz.

Anahtar kelimeler: antiepileptik ilaç, epilepsi, fetal malformasyon, gebelik sonuçları, nöbet
Objectives: The aim of this study was to evaluate the effects of the delivery route, and the anaesthesia methods used in obstetrics on the myocardium, through examination of the high sensitivity troponin T (hsTnT), as a sensitive marker of myocardial damage.

Methods: The study included postpartum 148 patients retrospectively classified in three groups in respect to mode of delivery. First group comprised 53 patients with spontaneous vaginal birth and no analgesia, second group comprised 49 patients with cesarian (C/S) with spinal anaesthesia and third group comprised 46 patients with C/S under general anaesthesia. The hsTnT were measured 6-12 hours after delivery. None of the subjects experienced myocardial infarction.

Results: The hsTnT values of the vaginal birth group were significantly higher than C/S [0.006ng/ml (0.003-0.055) vs (0.004ng/ml (0.003-0.024)] respectively, p:0.01]. When applied anaesthesia methods were considered only, spinal anesthesia group had lower hsTnT levels than vaginal delivery group (0.004ng/ml (0.003-0.021) vs 0.006ng/ml (0.003-0.055), p:0.01).

Conclusion: This study revealed that anaesthesia method during C/S does not differ in respect to myocardial injury. Vaginal birth without epidural analgesia was associated with higher hsTnT levels in normal range. There is a need for further studies on effect of anaesthesia in relation with haemodynamic stress on the myocardium during delivery.

Key words: delivery mode, anaesthesia methods, myocardial injury, high sensitivity troponin-t
Figure: patients selection

Table 1: Patients characteristics

<table>
<thead>
<tr>
<th></th>
<th>Group 1* (N= 53, 35.8 %)</th>
<th>Group 2# (N=49, 33.1%)</th>
<th>Group 3$ (N:= 46, 31.0%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years) (range)</td>
<td>26 (18-45)</td>
<td>29 (17-40)</td>
<td>28 (18-38)</td>
<td>0.190</td>
</tr>
<tr>
<td>BMI(kg/m2)</td>
<td>26.6 (17.5-44.9)</td>
<td>29.2(19.7-55.5)</td>
<td>29.2(20.8-43.5)</td>
<td>0.098</td>
</tr>
<tr>
<td>Level of education</td>
<td>N=53</td>
<td>N=49</td>
<td>N=50</td>
<td>0.164</td>
</tr>
<tr>
<td>≤8 years</td>
<td>32(60.4%)</td>
<td>26(53.1%)</td>
<td>19(41.3%)</td>
<td></td>
</tr>
<tr>
<td>&gt;8 years</td>
<td>21(39.4%)</td>
<td>23(46.9%)</td>
<td>27(58.7%)</td>
<td></td>
</tr>
<tr>
<td>Occupational status</td>
<td>N=6(11.3%)</td>
<td>N=8(16.3%)</td>
<td>N=12(26.1%)</td>
<td>0.151</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigarette smoker</td>
<td>N=4(7.5 %)</td>
<td>N=9(6.1 %)</td>
<td>N=11(23.9 %)</td>
<td>0.013</td>
</tr>
<tr>
<td>Parity</td>
<td>N=7(13.2%))</td>
<td>N=13(26.5%))</td>
<td>N=11(23.9%))</td>
<td>0.214</td>
</tr>
<tr>
<td>Nulliparity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indications</td>
<td>N/A</td>
<td>N=43(87.7%)</td>
<td>N=26(56.2%)</td>
<td>0.001</td>
</tr>
<tr>
<td>Emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*vaginal birth, # C/S under spinal anaesthesia, $ C/S under general anaesthesia
Data not distributed normally are stated as median, minimum and maximum
Table 2: Vital signs of groups pre/intra/postoperatively

<table>
<thead>
<tr>
<th></th>
<th>Group 1* (N=53, 35.8%)</th>
<th>Group 2# (N=49, 33.1%)</th>
<th>Group 3$ (N=46, 31.0%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative mean SBP (mmHg)</td>
<td>120(100-152)</td>
<td>120(90-156)</td>
<td>120(100-140)</td>
<td>0.621</td>
</tr>
<tr>
<td>Preoperative mean DBP (mmHg)</td>
<td>75(60-85)</td>
<td>70(42-99)</td>
<td>70(60-106)</td>
<td>0.535</td>
</tr>
<tr>
<td>Intraoperative mean SBP (mmHg)</td>
<td>120(100-140)</td>
<td>104(63-148)</td>
<td>121(79-156)</td>
<td>0.000</td>
</tr>
<tr>
<td>Intraoperative mean DBP (mmHg)</td>
<td>75(60-90)</td>
<td>53(27-90)</td>
<td>70(40-96)</td>
<td>0.000</td>
</tr>
<tr>
<td>Postoperative mean SBP (mmHg)</td>
<td>120(100-130)</td>
<td>110(90-130)</td>
<td>110(90-130)</td>
<td>0.012</td>
</tr>
<tr>
<td>Postoperative mean DBP (mmHg)</td>
<td>70(60-85)</td>
<td>70(50-85)</td>
<td>70(40-85)</td>
<td>0.012</td>
</tr>
<tr>
<td>SBP difference (preoperative-intraoperative)</td>
<td>0(-30-90)</td>
<td>11(-23-68)</td>
<td>-4(-36-57)</td>
<td>0.000</td>
</tr>
<tr>
<td>DBP difference (preoperative-intraoperative)</td>
<td>-5(-25-15)</td>
<td>12(-17-60)</td>
<td>0(-26-39)</td>
<td>0.000</td>
</tr>
<tr>
<td>Preoperative pulse rate</td>
<td>83±7</td>
<td>90(70-143)</td>
<td>80(72-108)</td>
<td>0.000</td>
</tr>
<tr>
<td>Intraoperative pulse rate</td>
<td>85(75-110)</td>
<td>96±19</td>
<td>85(46-136)</td>
<td>0.004</td>
</tr>
<tr>
<td>Postoperative pulse rate</td>
<td>85(70-112)</td>
<td>80(70-98)</td>
<td>80(70-98)</td>
<td>0.010</td>
</tr>
<tr>
<td>Preop Hb (gr/dl)</td>
<td>11.8(+1.2)</td>
<td>11.8(+1.74)</td>
<td>12.0(+1.56)</td>
<td>0.783</td>
</tr>
<tr>
<td>Postop Hb (gr/dl)</td>
<td>10.3(7.0-14.4)</td>
<td>10.40(7.814.4)</td>
<td>10.30(8.1-14.0)</td>
<td>0.994</td>
</tr>
<tr>
<td>Norepinephrine received</td>
<td>N/A</td>
<td>N=22(44.8%)</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

*Vaginal birth, # C/S under spinal anaesthesia, $ C/S under general anaesthesia

Data not distributed normally are stated as median, minimum and maximum

Normally distributed data are stated as mean ± SD.

Table 3: hsTnT values

<table>
<thead>
<tr>
<th></th>
<th>Group 1* (N=53, 35.8%)</th>
<th>Group 2# (N=49, 33.1%)</th>
<th>Group 3$ (N=46, 31.0%)</th>
<th>P</th>
<th>P1 (1-2)</th>
<th>P2 (1-3)</th>
<th>P3 (2-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>hsTnT (ng/ml)</td>
<td>0.0060 (0.003-0.055)</td>
<td>0.0040 (0.003-0.021)</td>
<td>0.0055 (0.003-0.024)</td>
<td>0.041</td>
<td>0.012</td>
<td>0.06</td>
<td>0.64</td>
</tr>
</tbody>
</table>

Kruskal Wallis test was used. Adjusted p values were given after Bonferroni correction.
Objective: To demonstrate the neonatal and obstetric outcomes of the patients with prenatal diagnosis of severe intrauterine growth retardation (IUGR).

Methods: We have included pregnancies complicated with severe IUGR and delivered at Hacettepe University Hospital between 2013-2018. We have retrospectively evaluated prenatal period and newborn outcomes. Severe IUGR was defined as a birthweight less than or equal to 3rd percentile according to gestational week. Etiological factors that may result in IUGR are classified as metabolic disorders, inflammatory diseases and congenital anomalies.

Results: Median maternal age was 32 (17-42), gravida and parity were 2 (1-5) and 1 (0-2), respectively for the 35 patients fulfilling the study criteria. Median gestational week at delivery was 37 (27-40) and birthweight was 2100g (550-2560). Umbilical cord blood gasp H was found as 7.33 (7.03 – 7.44). Nineteen out of 35 newborns had an APGAR score less than 7 at first ten minutes. Seven newborns had a congenital anomaly. Eleven pregnancies were found to be complicated with metabolic disorders such as gestational hypertension, preeclampsia, gestational diabetes. Three pregnancies were also found to be having systemic inflammatory diseases.

Conclusion: Physicians must be suspicious about increased risk of congenital anomalies in pregnancies complicated with severe IUGR. Furthermore, patients with metabolic disorders or inflammatory diseases are at increased risk for severe IUGR.

**Key words**: Intrauterine growth retardation, congenital anomaly, prenatal follow-up
Amaç: Prenatal takiplerde, bebekte ciddi intrauterin gelişme geriliği saptanan gebeliklerin, prenatal özelliklerinin ve yenidoğan sonuçlarının değerlendirilmesi.


Sonuç: Sonuç olarak, ciddi intrauterin gelişme geriliği saptanan bebeklerde konjenital anomalı riski açısından dikkatli olunmalı ve metabolik ve inflamatuar hastalık olan gebelerin prenatal takiplerinde intrauterin gelişme geriliği riski göz önünde bulundurulmalıdır.

Anahtar kelimeler: İntrauterin gelişme geriliği, konjenital anomali, prenatal takip
Hatice Kansu Celik, A. Seval Ozgu Erdinc, Burcu Kisa, Sinem Eldem, Necati Hancerliogullari, Yaprak Engin Ustun

University of Health Sciences Dr. Zekai Tahir Burak Women’s Health Care, Education and Research Hospital, Ankara, Turkey

Objective: To examine the accuracy of maternal serum glycosylated hemoglobin (HbA1c) and fasting plasma glucose (FPG) levels in predicting gestational diabetes at the first trimester in Turkish women with a low risk pregnancy and its relationship with fetal birth weight.

Methods: This cohort study was conducted retrospectively in a tertiary referral hospital from January 2010 to January 2017. HbA1c and FPG serum concentrations were measured in 670 pregnant women at the first trimester screening. HbA1c and FPG concentrations of women who subsequently developed gestational diabetes mellitus (GDM) were compared to those who did not, and investigated its relationship with fetal weight.

Results: First trimester screening was performed on 608 pregnant women, of whom 69 (11.3%) women had developed GDM. Median HbA1c and FPG concentrations were significantly higher in women developing GDM (n=69) in comparison to those with uncomplicated pregnancies. Hba1c levels above 5.6% with a sensitivity of 34.78%, specificity of 89.8%, with a diagnostic accuracy of 83.55%, and FPG levels above 86.85 mg/dl with a sensitivity of 69.57%, specificity of 61.78%, with a diagnostic accuracy of 62.66%. Hba1c and FPG combined had improved the predictive capability for GDM (OR: 7.26, 95% CI: 3.71-14.19). A noteworthy positive correlation was found between HbA1c and, FPG, 50 g GCT, age, BMI, parity, and birth weight.

Conclusion: Diagnostic accuracy of HbA1c for GDM prediction in Turkish women with a low risk pregnancy is 83.55% with a very good negative predictive value 91.49%. HbA1c and FPG combined enhanced the predictive capability for GDM.

Key words: Gestational diabetes mellitus, HbA1c, glycosylated hemoglobin, first trimester, prediction, screening
OP-017 Are maternal serum glycosylated hemoglobin and fasting plasma glucose levels at first trimester for predicting abortion useful in low risk Turkish pregnant women?

Umit Yasemin Sert, Hatice Kansu Celik, Ayse Seval Ozgu Erdinc

University of Health Science, Zekai Tahir Burak Woman’s Health, Education and Research Hospital, Ankara, Turkey

Objective: The aim of this study to evaluate whether maternal serum glycosylated hemoglobin (Hba1c) and fasting plasma glucose levels (FPG) at first trimester for predicting abortion useful in low risk Turkish pregnant women

Methods: This is an observational retrospective cohort study conducted in our tertiary maternal hospital between January 2010 and January 2017. Hba1c serum concentration was measured in 615 pregnant women at the first-trimester screening. We excluded pregnant women with Hba1c ≥ 6.5% at enrollment (n=4). We compared HbA1c and FPG concentrations of women who subsequently developed abortion with those who giving birth at term. A ROC curve was drawn to determine the sensitivity and specificity of FPG in determining abortion.

Results: First-trimester screening was performed in 528 pregnant women, of whom 34 (%6.4) women developed abortion. Median FPG concentration was significantly higher in women developing abortion (n=34) when compared to women with uncomplicated pregnancies (n=494) (87.72 ± 9.38 vs 84.23 ± 9.35, p=0.027). ROC analyses showed that the area under the curve indicative of FPG value for predicting abortion was 0.615 (95% confidence interval (CI): 0.512-0.712, p=0.020). The cut-off value according to the highest Youden index was calculated to be 87.40 mg/dl with a sensitivity of 61% and specificity of 65%.

Conclusion: Increased maternal FPG concentration were higher in pregnant women with abortion than in controls. However, FPG had low sensitivity for abortion prediction at the first trimester in Turkish women with a low risk pregnancy.

Key words: Abortion, glycosylated hemoglobin, HbA1c, fasting plasma glucose, first trimester

Table 1. Demographics, obstetric and neonatal outcomes

<table>
<thead>
<tr>
<th>Variable</th>
<th>Abortion Group (n=34)</th>
<th>Control groups (n=494)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years) (Mean±SD)</td>
<td>30.39 ± 6.93</td>
<td>28.45 ± 6.14</td>
<td>0.083</td>
</tr>
<tr>
<td>Gravidity Median (Min-Max)</td>
<td>2 (1-4)</td>
<td>2 (1-8)</td>
<td>0.668</td>
</tr>
<tr>
<td>Parity (Mean±SD) (Min-Max)</td>
<td>1 (0-3)</td>
<td>1 (0-5)</td>
<td>0.648</td>
</tr>
<tr>
<td>Abortion (Mean±SD) (Min-Max)</td>
<td>0 (0-1)</td>
<td>0 (0-6)</td>
<td>0.839</td>
</tr>
<tr>
<td>Prepregnancy BMI (Mean±SD)</td>
<td>25.85 ± 2.54</td>
<td>25.84 ± 3.95</td>
<td>0.976</td>
</tr>
</tbody>
</table>

* P<0.05, significant. BMI: Body Mass Index

Table 2. Maternal Hba1c and FPG levels between two groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Abortion Group (n=34)</th>
<th>Control groups (n=494)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hba1c</td>
<td>5.05 ± 0.48</td>
<td>4.98 ± 0.29</td>
<td>0.532</td>
</tr>
<tr>
<td>FPG (mg/dl)</td>
<td>87.72 ± 9.38</td>
<td>84.23 ± 9.35</td>
<td>0.027*</td>
</tr>
</tbody>
</table>

*P<0.05, significant. FPG: Fasting glucose level
Amaç: Doğum sonrası annenin zihin sağlığı sorunları bebeğin gelişimini etkilemekte, ileriki yaşlarda nörogelişimsel bozukluk riskini arttırmaktadır. Postnatal depresyon (PD) ve kaygı annelerde en sık görülen zihin sağlığı sorunlarıdır ve ikisinin birlikte ele alındığı çalışmalar nadirdir. Riskli bebek tanımı, perinatal dönemde nörogelişimsel olarak herhangi bir sorun gelişirebilecek potansiyele sahip bebekler için kullanılmaktadır. Çalışmamızda riskli bebeği olan annelerin tanı gruplarına göre PD ve kaygı düzeylerinin ve ilişkili faktörlerinin belirlenmesi amaçlandığı.


Bulgular: Hastaların % 86,2’si PT, % 5,2’si HIE, % 8,6’si diğer tanıları olan bebek ve annesi oldu. Depresyon oranı HIE (% 66,7) tanılı bebeklerin annelerinde daha fazla oldu ([PT, diğer için sırasıyla, % 18, % 20] (p=0,023)). Kaygı oranı HIE (% 50) grubunda sayısal fazla olmakla birlikte anlam kazanamadı ([PT, diğer için sırasıyla, % 19,2 ve % 10] (p=0,151)). Perinatal risk faktörleri ile kaygı ve depresyon ilişkisi bakıldığında kaygı ciddi sarılık (p=0,042), depresyon baba eğitim seviyesi düşüklogue bless gibi ilişkiliydi (p=0,015). Doğum ağırlığı-haftası, anne-baba yaş ve Bayley skorlarıyla ilişkili bulunmamıştır (p>0,05). Toplam örneklemde regresyon analizinde kayги ile model kurulamazken, depresyon 5. dakika APGAR skorunun düşüşü ile arttıktaydı (p=0,036, OR:0,19, B:-1,65). Sonuç: Çalışmamızda erken dönem PD ve kaygılarına riskli bebeklerin annelerinde sık görüldüğü; özellikle HIE tanılı bebek annelerin diğer gruplara göre daha duyarlı olduğu bulundu. Sonuçlarımız gelişimsel izlemde riskli bebeklerin bıtuncül ve aile merkezli olarak değerlendirilirken ve annelerin iyilik halinin desteklenmesinin gerektiğini vurgulamaktadır.

Anahtar kelimeler: riskli bebek, gelişim, depresyon, kaygı


Bulgular: 84 hastanın yaşları 27,87±5,43 yıl, gestasyonel hafta 38,6(35-41), BMI 26,97±2,86, gravidada 2(1-5)' idi.

Hastaların laboratuvar değerlerinde hemoglobin 11,88±1,30g/dl, beyaz küre 10.7x10⁹/L, trombosit 214x10⁹/L, INR 0,94±0,14, böbrek ve karaciğer fonksiyon testleri normaldi.

Hastaların 31(%36,9)'i miad gebelik, 12'si(%13) eski C/S, 3'ü(%3,6) Mükkerrer C/S+Maternal Kalp Hastalığı, 8'i(%9,5) Aritmi, 6'sı(%7,1) Akut Romatizmal Ateş, 7'si(%8,3) Mitral valv Prolapsusu, 5'i(%5) Mitral Stenoz, 1'i(%1,2) Pulmoner Hipertansiyon tanıları ile hastaneye yatırılmıştı. 10 hastada ek sistemik hastalık mevcuttu. Hastalardan 72'si(%85,7) antenatal kontrollerini düzenli yaptırmıştı. Tüm hastalara doğum öncesi kardiyoloji konsültasyonu yaptırılmıştı. 70 hastanın mevcut EKO sonuçlarına göre 11(%13,1) hastada Mitral Yetmezlik(MY), 12(%14,3) hastada MY+TY (Trikuspid yetmezlik), 20'sinde(%23,8) 3 kapaklı ilgili patolojiler mevcuttu. 27 hastanın(%32,1) EKO’su normaldi.

29(%35) hasta vajinal doğum yaparken, 55(%65) hastanın sezaryen ile doğumu gerçekleşmiştir. Primer sezaryan oranı %57,97 idi. 34(%40,5) hasta endokardit profilaksi yapmıştır. 40(%47,6) hasta kardiyak ilac (beloc, digoxin, ritmonorm vs) kullanırken 44 hasta herhangi bir kardiyak ajan kullanmıyordu. 18’i kalp ameliyatı geçirmişti(10’u ASD, 3’ü VSD, 2’si PDA nedeniyle operre , 2 hasta balon valvuloplasti, 1 hasta EPS).

Bebeklerin ağırlığı 3.194±507 gr, APGAR 1. ve 5.dakika sırasıyla 7(2-8), 9(7-10) idi. 8 bebek (%9,5) çeşitli nedenlerle Yenidoğan Yoğun Bakıma gönderilmiştir.


Anahtar kelimeler: Gebelik, Kalp Hastalığı
Op-022 Perinatal and early postnatal outcomes of patients with fetal cardiac anomaly

Ezgi Turgut, Halis Özdemir, Deniz Karçaaltincaba, Merih Bayram, Semiha Tokgöz, Fatma Sedef Tunaoğlu

Department of Obstetrics and Gynecology, Gazi University Medical Faculty, Ankara, Turkey
Department of Pediatric Cardiology, Gazi University Medical Faculty, Ankara, Turkey

Objective: Pregnant women with fetal cardiac anomaly in our clinic evaluated for birth week, weight, fetal chromosomal anomaly and other fetal anomalies.

Methods: Twenty-nine patients with fetal cardiac anomalies between January 2018 and February 2019 were included.

Results: The most common cardiac anomaly was ventricular septal defect (24.1%). The mean age of the pregnant women was 29.8 (19-42). Associated fetal anomaly was omphalocole, limb anomalies, vermian agenesis and was observed in 5 fetuses (17.2%). Chromosomal examination was performed in 6 pregnant women (20.7%) and trisomy was found in 3 fetus (10.3%). 2 fetus with trisomy and 2 fetus with major cardiac anomalies were terminated (13.8%). Mean gestational age was 37 (29-41) and preterm delivery was present in 7 patients (24.1%). The number of deliveries with cesarean section was 17 (58.6%). The average birth weight is 2600 gr. Three fetuses with tricuspid atresia, 2 with pulmonary stenosis and 2 with aortic coarctation were treated with intravenous prostaglandin E1 after birth (24.1%). Atrial septostomy was performed in 2 patients and aorticopulmonary shunt in 1 patient with tricuspid atresia and right ventricular hypoplasia. One newborn with ebstein’s anomaly and two newborn with tricuspid atresia died in 1, 20, and 40, respectively (10.3%).

Conclusion: Early detection of congenital heart disease is of great importance in terms of predicting appropriate medical or surgical treatment methods. In prenatal period, congenital heart disease can be diagnosed, appropriate treatment, illumination and counseling can be provided.

Key words: Fetal cardiac evaluation, congenital heart disease, postnatal outcomes
OP-022 Fetal kardiyak anomali tespit edilen hastalarımızın özellikleri ve doğum sonrası sonuçları

Ezgi Turgut¹, Halis Özdemir¹, Deniz Karçaaltincaba¹, Merih Bayram¹, Semiha Tokgöz², Fatma Sedef Tunaoğlu²

¹Gazi Üniversitesi, Perinatoloji Bölümü, Kadın Hastalıkları ve Doğum Anabilimdalı, Ankara, Türkiye
²Gazi Üniversitesi, Çocuk Kardiyoloji Bölümü, Çocuk Sağlığı ve Hastalıkları Anabilimdalı, Ankara, Türkiye

Amaç: Kliniğimizde fetal kardiyak anomali tespit edilen gebelerin doğum haftası, doğum kiloları, kromozomal anomalileri ve diğer anomali coğrafyası, yapılan girişimler ve sonuçları değerlendirilmiştir.


Sonuç: Doğumsal kalp hastalıklarının erken tesbiti, uygun tıbbi veya cerrahi tedavi yöntemlerinin önceden belirlenmesi açısından büyük önem taşımaktadır. Prenatal dönemde doğumsal kalp hastalığı tesbiti uygun tedavi, aileyi aydınlatma ve danışmanlık verilebilir ve doğum sonrası da kardiyak açından yapılabilircekler için tedbirler alınabilmektedir.

Anahtar kelimeler: Fetal kardiyak değerlendirme, doğumsal kalp hastalığı, doğum sonuçları
OP-023 Plasenta akreata spektrumunun yönetimi; tek merkez deneyimi

Fırat Ökmen

Ege Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı, İzmir, Türkiye

Amaç: Plasenta akreata spektrumu (PAS); plasentanın tamamının veya bir kısmının uterin duvara anormal bir şekilde invaze olması şeklinde tanımlanır. PAS, ciddi postpartum kanamalara sebebiyet vererek maternal mortalite ve morbiditenin önemli bir nedenidir.

Bu çalışmanın amacı PAS olgularının yönetimini ilgili tek merkez deneyimini sunmaktadır.

Yöntem: Bu çalışma Ocak 2017 ile Aralık 2018 tarihleri arasında Ege Üniversitesi tıp fakültesi kadın hastalıkları ve doğum bölümüne, plasenta akreata spektrumu düşünülen olguların yönetimini retrospektif olarak değerlendirilmiştir.

33 olguda PAS ön tanısı düşünülmüş olup; 17 olguya postpartum histerektomi, 16 olguya uterin segmental rezeksiyon (USR) uygulanmıştır.

USR, plasental dokunun anormal şekilde yapıştığı uterin segmental duvarın çıkarılması ve kalan uterin dokuların rekonstruksiyonu olarak tanımlanabilir.

PAS ön tanısı antenatal dönemde ultrasonografi ve gereğinde manyetik rezonans görüntüleme ile konulmuş olup, kesin tanı tüm olgularda postpartum dönemde patolojik değerlendirime ile doğrulanmıştır.

Bulgular: 33 olgu PAS ön tanısı ile değerlendirilmiş olup 18 olgu USR ile tedaviyi tercih etmiştir, diğer olgular postpartum histerektomi tedavisini istemişlerdir. 18 hastaya USR planlanmış olup, 16 tanesine başarı bir şekilde USR uygulanmış, 2 hastaya hemodinamik stabilizeyi bozan massif utero plasental kanama nedeniyle peripartum histerektomi uygulanmıştır. 15 olguya sezaryen doğum sonrası plasenta çıkarma girişimi olmadan postpartum histerektomi uygulanmıştır. Total olarak 33 olgunun 17 tanesi postpartum histerektomi ile tedavi edilmişken 16 tane olgu USR ile tedavi edilmiştir. Olguların tümünün en az 1 en fazla 4 geçirdiği sezaryen öyküleri vardı. Postpartum histerektomi olan olguların tümü plasenta previa ile komplike iken, USR uygulanan 16 olgunun 14’ü plasenta previa ile komplike idi. 2 olguda plasenta anterior yerleşimi idi.

Sonuç: PAS ön tanısı ile girişim planlanan olgularda; fertilitesini korumak isteyen olgular deneyimli merkezlerde fertilite koruyucu cerrahi ile tedavi edilebilir.

Anahtar kelimeler: Plasenta akreata spektrumu, fertilite koruyucu cerrahi, yönetim
Are mean platelet volume (MPV) and / or Neutrophil / lymphocyte ratio (NLR) values useful as a predictive marker for intrahepatic cholestasis of pregnancy?

Hasan Eroğlu, Gökçen Örgül, Dilek Şahin, Aykan Yücel

Health Sciences University Etlik Zübeyde Hanım Gynecology Training and Research Hospital

Objective: The incidence of intrahepatic cholestasis of pregnancy (ICP) is characterized by itching and elevation in serum bile acid concentrations. Typically, it occurs in the third trimester of pregnancy with itching that may affect any part of the body, but is most commonly on the palms and soles. Biochemically, elevated serum bile acids and liver dysfunction and clinically characterized by significantly increased fetal complications such as spontaneous preterm delivery, fetal distress, meconium staining of amniotic fluid and sudden fetal death. In this study, we evaluated whether Mean platelet volume (MPV) and / or Neutrophil / lymphocyte ratio (NLR) values were useful as a predictive marker for gestational cholestasis.

Methods: The data of 122 patients who were diagnosed with intrahepatic cholestasis of pregnancy in our perinatology clinic between 2018-2019 without any additional systemic disease were retrospectively evaluated. 230 patients were enrolled into the study as a control group.

Results: The groups were statistically similar in terms of age, gravida, parity, body mass index and newborn birth weights (Table 1). There was no statistically significant difference between intrahepatic cholestasis of pregnancy and the control patients with regard to Neutrophil / Lymphocyte ratio (NLR) (p> 0.05), (Table 2). Mann Whitney U test for the difference between the two groups; roc analysis was performed to find the best predictive cut-off value for MPV. MPV was found to be 65% sensitivity 59% specificity for a cutoff 8.85 fL (Table 3).

Conclusion: MPV values were significantly increased in pregnancy cholestasis compared to healthy pregnancies. However, the predictive power of MPV for cholestasis is not strong enough to suggest the use of a single parameter in clinical practice.

Key words: Mean platelet volume (MPV), Neutrophil / lymphocyte ratio (NLR), Pregnancy cholestasis

Table 1. Comparison of control group and intrahepatic cholestasis of pregnancy patients according to some clinical and pregnancy characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Cholestasis (n=122)</th>
<th>Control (n=230)</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>29,11±6,21</td>
<td>28,64±5,18</td>
<td>0,064</td>
</tr>
<tr>
<td>BMI</td>
<td>29,08±4,27</td>
<td>29,17±4,66</td>
<td>0,242</td>
</tr>
<tr>
<td>Gravida</td>
<td>2,13±1,36</td>
<td>2,69±1,32</td>
<td>0,383</td>
</tr>
<tr>
<td>Parity</td>
<td>0,88±1,14</td>
<td>1,32±1,09</td>
<td>0,761</td>
</tr>
<tr>
<td>Abortion</td>
<td>0,26±0,62</td>
<td>0,37±0,67</td>
<td>0,018</td>
</tr>
<tr>
<td>Birth week</td>
<td>36,97±1,61</td>
<td>39,25±1,056</td>
<td>&lt;0,01</td>
</tr>
<tr>
<td>Birth weight</td>
<td>3052±498,9</td>
<td>3339±425</td>
<td>0,597</td>
</tr>
</tbody>
</table>

* SD: Standard Deviation
Table 2. Comparison of control group and intrahepatic cholestasis of pregnancy patients in terms of Mean platelet volume and Neutrophil lymphocyte ratio results

<table>
<thead>
<tr>
<th>Variables</th>
<th>Median</th>
<th>Minimum-Maksimum</th>
<th>Median</th>
<th>Minimum-Maksimum</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean platelet volume</td>
<td>9,30</td>
<td>7-18</td>
<td>8,6</td>
<td>6,7-11,5</td>
<td>&lt;0,01</td>
</tr>
<tr>
<td>Nöтроfil Lenfosit ratio</td>
<td>3,93</td>
<td>0,46-13,75</td>
<td>4,25</td>
<td>0,87-17,1</td>
<td>0,14</td>
</tr>
</tbody>
</table>

Figure 1. Roc curve analysis of Mean platelet volum results of patients with gestational cholestasis of control group (p <0.01, AUC = 0.66)
Mean platelet volume (MPV) ve/veya Nötrofil / lenfosit oranı (NLR) değerleri gebelik kolestazı için prediktif bir belirteç olarak yararlı mıdır?

Hasan Eroğlu, Gökçen Örgül, Dilek Şahin, Aykan Yücel

S.B.Ü Etlik Zübeyde Hanım Kadın Hastalıkları Eğitim ve Araştırma Hastanesi


Bulgular: Gruplar yaş, gravide, parite, vücut kitle indeksi, yenidoğan doğum ağırlıkları açısından istatistiksel olarak benzer bulundu (Tablo 1). Araştırmamızda kontrol grubu ile gebelik kolestazı tanılı hastaların Nötrofil / Lenfosit oranı (NLR) sonuçları arasında istatistiksel olarak anlamli fark saptanmamış (p>0,05), MPV sonuçları açısından anlamli fark saptanmıştır (p<0,01). (Tablo 2). Mann Whitney U testinde 2 grup arasında fark bulunduğu için; MPV için en iyi prediktif cut off değerini bulmak için Roc analizi yapıldı. Eğri altındaki alan %66,6 olarak bulundu. MPV’nin 8,85 fL değeri gebelik kolestazı tanıısı için sensitivitesi %65 spesifitesi %59 bulundu (Tablo 3).

Sonuç: Sağlıklı gebeliklerle karşılaştırıldığında, gebelik kolestazında MPV değerleri anlamli şekilde artmaktadır. Ancak, MPV’nin kolestaz için prediktif gücü, klinik uygulamalarında tek bir parametre olarak kullanılmasını önererek kadar güçlü değildir.

Anahtar kelimeler: Mean platelet volume, Nötrofil / lenfosit oranı, gebelik kolestazı

Tablo 1. Kontrol grubu ile gebelik kolestazı tanılı hastaların bazı klinik ve gebelik özelliklerine göre karşılaştırılması

<table>
<thead>
<tr>
<th>Değişkenler</th>
<th>Kontrol (n=122)</th>
<th>Kontrol (n=230)</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yaş</strong></td>
<td>Ortalama ±SS</td>
<td>Ortanca</td>
<td></td>
</tr>
<tr>
<td></td>
<td>29,1±6,21</td>
<td>29,5</td>
<td>0,064</td>
</tr>
<tr>
<td><strong>BMI</strong></td>
<td>29,0±4,27</td>
<td>28,0</td>
<td>0,242</td>
</tr>
<tr>
<td><strong>Gravide</strong></td>
<td>2,1±1,36</td>
<td>2,0</td>
<td>0,383</td>
</tr>
<tr>
<td><strong>Parite</strong></td>
<td>0,8±1,14</td>
<td>1,0</td>
<td>0,761</td>
</tr>
<tr>
<td><strong>Abortus</strong></td>
<td>0,26±0,62</td>
<td>0,0</td>
<td>0,018</td>
</tr>
<tr>
<td><strong>Doğum haftası</strong></td>
<td>36,9±1,61</td>
<td>39,25±1,056</td>
<td>&lt;0,01</td>
</tr>
<tr>
<td><strong>Gün</strong></td>
<td>3052±498,9</td>
<td>3339±425</td>
<td>0,597</td>
</tr>
</tbody>
</table>

* SD: Standard Deviation
Tablo 2. Kontrol gubu ile gebelik kolestazı tanılı hastaların Mean platelet volum ve Nötrofil Lenfosit oranı sonuçları açısından karşılaştırılması

<table>
<thead>
<tr>
<th>Değişkenler</th>
<th>Kolestaz Ortanca</th>
<th>Minimum-Maksimum</th>
<th>Kontrol Ortanca</th>
<th>Minimum-Maksimum x</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean platelet volum</td>
<td>9,30</td>
<td>7-18</td>
<td>8,6</td>
<td>6,7-11,5</td>
<td>&lt;0,01</td>
</tr>
<tr>
<td>Nötrofil Lenfosit oranı</td>
<td>3,93</td>
<td>0,46-13,75</td>
<td>4,25</td>
<td>0,87-17,1</td>
<td>0,14</td>
</tr>
</tbody>
</table>

*Mann Whitney U testi

Şekil 1. Kontrol gubu ile gebelik kolestazı tanılı hastaların Mean platelet volum sonuçlarının Roc eğrisi analizi (p<0,01, AUC=0,66)

![ROC Curve](image)
Comparison of patient satisfaction with vaginal dinoprostone and foley catheter for cervical ripening during labor induction

Kemal Sarsmaz1, Yasemin Kızılkaya2, Dilek Şahin1, Aykan Yücel

1Etlik Zübeyde Hanım Woman’s Health Care, Training and Research Hospital, Perinatology Department, Ankara, Turkey
2Etlik Zübeyde Hanım Obstetrics and Gynecology Teaching Hospital, Ankara, Türkiye

Objectives: Cervical ripening method is used to make the cervix more suitable for the birth in cases before commencement of labor. In the current literature, there are many studies in which cervical ripening methods are used during labor induction with the analysis of perinatal and maternal outcomes. However, there are only few studies evaluating the relationship between these methods and patient satisfaction.

Methods: This study was conducted with 80 patients who gave birth in 2019. Nulliparous and single pregnancies with vertex presentation whose gave birth on the third trimester were included. Foley catheter was used in 45 patients and vaginal dinoprostone ovule in 35 patients. We asked pain level during the application of cervical ripening method, pain level after the application until the birth and the level of general satisfaction level. These questions were evaluated by using visual analogue scale as “1 = lowest, 10 = highest”.

Results: There was no statistically significant difference in satisfaction level with regards to ripening method (p = 0.44). There was no statistically significant relationship between the ripening method and the time until delivery (p = 0.96). There was no significant relation between the type of delivery and ripening method (p = 0.10). There was no significant relationship between educational status, working status, planned status of pregnancy and general satisfaction score (p = 0.51, p = 0.21, p = 0.95, respectively).

Conclusions: At the end of the study, no statistically significant difference was found between the foley catheter and dinoprostone groups in terms of satisfaction scales. Both methods have similar acceptability in nulliparous patient group.

Key words: Dinoproston, foley catheter, cervical ripening, patient satisfaction
OP-025 Doğum indüksiyonu sırasında servikal olgunlaştırma amacı ile kullanılan vajinal dinoproston ve foley katater kullanımının hasta memnuniyeti ile karşılaştırılması

Kemal Sarsmaz¹, Yasemin Kızılkaya², Dilek Şahin³, Aykan Yücel

¹Etlik Zübeyde Hanım Kadın Hastalıkları ve Doğum Eğitim Araştırma Hastanesi, Perinatoloji Bilim Dalı, Ankara, Türkiye
²Etlik Zübeyde Hanım Kadın Hastalıkları ve Doğum Eğitim Araştırma Hastanesi, Ankara, Türkiye


Bulgular: İndüksiyon yöntemi ile genel memnuniyet durumu arasında istatistiksel olarak anlamli ilişki yoktur (p=0,44). Kullanılan indüksiyon yöntemi ile doğuma kadar geçen süre arasında istatistiksel olarak anlamli ilişki bulunmamıştır (p=0,96). Doğum şekilleri açısından kullanılan indüksiyon yöntemine göre anlamli ilişki yoktur (p=0,10). Öğrenim durumu, çalışma durumu ve gebelikin planlı olma durumu ile genel memnuniyet puanı arasında anlamli ilişki bulunmamıştır (sırasi ile p=0,51, p=0,21, p=0,95).

Sonuç: Çalışma sonucunda foley katater ve dinoproston grupları arasında bakılan memnuniyet ölçekleri açısından istatistiksel anlam fark saptanmamıştır. Her iki yöntem de nullipar hasta grupları içinde benzer kabul edilebilirlik göstermektedir.

Anahtar kelimeler: Dinoproston, foley katater, servikal olgunlaştırma, hasta memnuniyeti
Ertaş Karahanoğlu, Mehmet Keçecioğlu
Balıkesir Atatürk Şehir Kadın Hastalıkları Doğum Hastanesi

Giriş: Antenatal gebe eğitim programlarının temel amacı gebeyi gebelik süreci hakkında doğru bilgilendirmek, onu doğuma hazırlamak doğumda karşılaşıcağı sorunları baş etmesi için yöntemler hakkında bilgi vermektir. Biz çalışmamızda antenatal eğitim almış olguların gebelik sonuçlarını araştırdık.


Sonuçlar: Çalışmaya 145 gebe sınıfı eğitimi almış ve 150 eğitim almamış hasta dahil edildi. Çalışma gruplarının demografik özellikleri tablo 1 de verilmiştir. Antenatal eğitim alan ve alaman gebe grupları arasında bebeklerin doğum ağrılıkları, doğum haftası, doğum indüksyonu, doğum augmentasyonu, aktif faz süresi, arasında farklılık tespit edilmedi. Antenatal eğitim almış grubun doğum eyleminin evre 2 süresi nullipar hastalarda kısalmış olduğunu tespit ettik (71.4±14.3 dk vs 62±12.4 dk p=0.00). Multipar hastalarda evre 2 de bir kısılma tespit etmedik (22.5±4.5 dk, 23.1 ±43.3 dk p=0.07 ). Antenatal eğitim almış olmak sezaryen oranlarında azalmaya neden olmaktadır (%33 vs %38 p=0.01).

Tartışma: Hastaların doğum sürecine alışmasına karşılaşılmayacakları zorlulukları ve hekimle bu sorunları nasıl çözeceğini bilmek doğum sürecini kolaylaştırmaktadır. Özellikle hekim ve hasta koordinasyonunun büyük önem taşıdığı doğum eyleminin ikinci fazında ve ikinci safhasında bu hazırlık hastanın ve hekimin işini kolaylaştırmaktadır.

Tablo 1 Çalışma ve kontrol grubunun demografik özellikleri

<table>
<thead>
<tr>
<th></th>
<th>Antenatal sınıf eğitimi almış (n=145)</th>
<th>Antenatal sınıf eğitimi almamış (n= 150)</th>
<th>P değeri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yaş (yıl)</td>
<td>29.4±5.2</td>
<td>28.1±6.2</td>
<td>0.22</td>
</tr>
<tr>
<td>VKI(kg/m²)</td>
<td>26.5±3.8</td>
<td>26.2±3.6</td>
<td>0.29</td>
</tr>
<tr>
<td>Nulliparite (%)</td>
<td>%68.2 (99)</td>
<td>%66(99)</td>
<td>0.71</td>
</tr>
<tr>
<td>Doğum haftası</td>
<td>40.4±1.15</td>
<td>40.±1.13</td>
<td>0.44</td>
</tr>
</tbody>
</table>

Tablo 2 Antenatal sınıf eğitimi almış gebelerin intrapartum sonuçları

<table>
<thead>
<tr>
<th></th>
<th>Antenatal sınıf eğitimi almış (n=145)</th>
<th>Antenatal sınıf eğitimi almamış (n= 150)</th>
<th>P değeri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doğum indüksyonu (%)</td>
<td>%17(25)</td>
<td>%18(27)</td>
<td>0.88</td>
</tr>
<tr>
<td>Doğum augmentasyonu (%)</td>
<td>%33.4(44)</td>
<td>%34.6(52)</td>
<td>0.48</td>
</tr>
<tr>
<td>Aktif faz nullipar (saat)</td>
<td>5.1±3.1</td>
<td>5.3±3.4</td>
<td>0.67</td>
</tr>
<tr>
<td>Aktif faz multipar (saat)</td>
<td>3.9±2.1</td>
<td>4.1±2.2</td>
<td>0.65</td>
</tr>
<tr>
<td>Evre 2 nullipar (dakika)</td>
<td>62.4±12.4</td>
<td>71.2±14.1</td>
<td>0.00</td>
</tr>
<tr>
<td>Evre 2 multipar (dakika)</td>
<td>22.7±4.5</td>
<td>23.2±4.1</td>
<td>0.56</td>
</tr>
<tr>
<td>Sezaryen oranı(%)</td>
<td>%33(29)</td>
<td>%38(57)</td>
<td>0.01</td>
</tr>
</tbody>
</table>
Objectives: To find out expression pattern of beclin-1, an autophagy related protein, in normal first-trimester placentas, partial and complete hydatidiform moles (HM). Comparison of beclin-1 expression between normal pregnancies and HMs may provide an insight into HM pathogenesis and decidual changes in response.

Methods: Curettage material of 24 women diagnosed as normal first-trimester pregnancy (obtained from dilatation & curettage of unwanted pregnancies, control group, n=8), complete HM (n=8) or partial HM (n=8) as a result of histopathological and immunohistochemical examination were enrolled in this study. Expression of beclin-1 among placental cell types was evaluated immunohistochemically and scored according to staining intensity.

Results: In normal first-trimester decidua, strong beclin-1 immunoreactivity was observed in endometrial glands, decidual cells, stromal cells and lymphocytes. On the contrary, beclin-1 expression was significantly weaker in endometrial glands, decidual cells, stromal cells and lymphocytes of partial and complete mole decidua (p<0.05). In normal placentas, both villous (VT) and extravillous trophoblasts (EVT) showed faint beclin-1 expression. A similar pattern of faint beclin-1 immunoreactivity was observed in EVTs of partial and complete HMs (p>0.05). Beclin-1 expression in VTs was stronger in partial molar placentas compared to normal and complete molar placentas (p<0.05) (Fig.1).

Conclusions: Beclin-1 expression is different in molar decidua. Decreased expression of beclin-1 among all decidual cell groups including glandular cells, lymphocytes, decidual and stromal cells might indicate decreased autophagy activation in molar decidua.

Key words: beclin-1, trophoblast, hydatidiform mole, autophagy

Fig.1: Beclin-1 immunohistochemistry in normal(A), partial(B) and complete mole(C) chorionic villi (asterisk: chorionic villus)
Objective: The placenta associated plasma protein A (PAPPA) and first trimester mean uterine artery pulsatility index (mean UtA PI) are accepted as biochemical and biophysical markers of the primary architecture and early-stage functions of the placenta. In this study we targeted to evaluate the diagnostic and predictive value of these markers in fetal growth restriction (FGR) cases.

Methods: The PAPPA raw MoM and mean UtA PI results of the cases that were diagnosed as FGR between August 2016 and January 2019 in Buca Maternity Hospital, retrospectively collected. Fetal anomalies, serologic or sonographic signs of infectious etiology, placenta previa, comorbidities that could be associated with FGR (preeclampsia and gestational diabetes) were excluded.

Results: Cross sectionally, a sample of 54 pregnancies were analysed. The median birth weight was lower in the cases with mean UtA PI≥2.5 (n:20) than the cases with mean UtA PI <2.5 (n:34), 2200 (1190-2700) vs 2670 (1750-2990) grams, respectively; p=0.008.

The first trimester PAPPA raw MoM values were moderately correlated with abdominal circumference (CC:-0.661, p<0.0001), estimated fetal weight (CC:0.618, p<0.0001) at FGR diagnosis and mean follow-up time (CC:0.669, p<0.0001).

Mean UtA PI values were moderately correlated with umbilical artery PI (CC:0.531, p=0.004) at FGR diagnosis, gestational age at delivery (CC:-0.599, p=0.001) and birth weight (CC:-0.681, p<0.0001).

Conclusion: Placental development and function is an uninterrupted process. As a marker of the trophoblastic function, first trimester PAPPA values was found to be significantly correlated with fetal biometric measurements at FGR diagnosis. Mean UtA PI, as a marker of uteroplacental perfusion, was found to be significantly correlated with fetal umbilical artery PI and delivery timing. If we look back, these first trimester screening components could add to the diagnosis and prediction of prognosis in the FGR suspected cases.

Key words: Fetal growth restriction, first trimester screening, PAPPA, uterine artery pulsatility indeks
Table 1. The correlations of the first trimester screening markers with the main prenatal and perinatal findings of the fetal growth restriction cases

<table>
<thead>
<tr>
<th></th>
<th>PAPPA raw MoM Correlation coefficients</th>
<th>p</th>
<th>Mean UtA PI Correlation coefficients</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal circumference percentiles</td>
<td>-0.661</td>
<td>&lt;0.0001</td>
<td>-0.376</td>
<td>0.053</td>
</tr>
<tr>
<td>Femur length percentiles</td>
<td>-0.531</td>
<td>0.004</td>
<td>-0.174</td>
<td>0.386</td>
</tr>
<tr>
<td>Estimated fetal weight absolute values</td>
<td>-0.420</td>
<td>0.021</td>
<td>-0.220</td>
<td>0.270</td>
</tr>
<tr>
<td>Estimated fetal weight percentiles</td>
<td>0.618</td>
<td>&lt;0.0001</td>
<td>-0.496</td>
<td>0.009</td>
</tr>
<tr>
<td>Gestational age at diagnosis</td>
<td>-0.564</td>
<td>0.001</td>
<td>-0.400</td>
<td>0.842</td>
</tr>
<tr>
<td>Umbilical artery PI (at diagnosis)</td>
<td>0.094</td>
<td>0.620</td>
<td>0.531</td>
<td>0.004</td>
</tr>
<tr>
<td>Middle cerebral artery PI (at diagnosis)</td>
<td>0.037</td>
<td>0.875</td>
<td>-0.138</td>
<td>0.573</td>
</tr>
<tr>
<td>Uterine artery PI (at diagnosis)</td>
<td>-0.334</td>
<td>0.316</td>
<td>0.288</td>
<td>0.420</td>
</tr>
<tr>
<td>Cerebroplacental ratio (at diagnosis)</td>
<td>-0.148</td>
<td>0.522</td>
<td>-0.342</td>
<td>0.152</td>
</tr>
<tr>
<td>Gestational age at delivery</td>
<td>0.272</td>
<td>0.146</td>
<td>-0.599</td>
<td>0.001</td>
</tr>
<tr>
<td>Birth weight</td>
<td>0.423</td>
<td>0.020</td>
<td>-0.681</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Follow-up time</td>
<td>0.669</td>
<td>&lt;0.0001</td>
<td>-0.262</td>
<td>0.186</td>
</tr>
</tbody>
</table>
OP-028 Fetal gelişim kısıtlılığı olgularında ilk üçay tarama dönemindeki bulgular tanı ve prognoz öngörüsünue katkı sağlayabilir mi?

Semir Köse¹, Sabahattin Altunyurt²

¹Buca Kadın Doğum ve Çocuk Hastalıkları Hastanesi, Perinatoloji Kliniği, İzmir
²Dokuz Eylül Üniversitesi, Kadın Hastalıları ve Doğum Anabilim Dalı, Perinatoloji Bilim Dalı, İzmir

Amaç: İlk üçay kombinle tarama testi (İÜKTT) bileşeni olan plasenta kökenli plazma protein-A (PAPPA) ve ilk üçay uterin arter pulsatile indeksi (UtA PI) plasentanın birincil mimarısını ve erken evrelerdeki işlevini yansıtan biyokimyasal ve biyofiziksel belirteçler olarak kabul edilir. Çalışmamızda fetal gelişim kısıtlılığı (FGK) tanısı alan olgulara ait ilk üçay tarama dönemdeki bulguların tanı ve prognoz öngörüsündeki değerini sınamak hedeflenmiştir.


Bulgular: Kesitsel olarak 54 gebeye ait sonuçlar analiz edildi. Ortanca doğum ağırlığı ortalama UtA PI ≥2.5 olan gebeliklerde (n:20) ortalama UtA PI <2.5 olan olgulardan (n:34) daha düşük idi; 2200 (1190-2700) gram'a karşılık 2670 (1750-2990) gram, p=0.008. İlk üçay PAPPA ham MoM değerleri FGK tanısı anında karın çevresi (KK: -0.616, p<0.0001), tahmini fetal ağırlık (KK: 0.618, p<0.0001) ve ortalamı izlem süresi (KK:0.669, p<0.0001) ile orta düzey korelasyonlar gösterdi (Tablo 1). Ortalama UtA PI FGK tanısı anında umbilikal arter PI ile (KK:0.531, p=0.004), doğumda gebelik haftası (KK:-0.599, p=0.001) ve doğum ağırlığı ile (KK:-0.681, p<0.0001) orta derecede korelasyon gösterdi (Tablo 1).

Sonuç: Plasental gelişim ve işlev kesintisiz bir süreçtir. PAPPA trofoblast işlevlerini yansıttan bir belirteç olduğundan FGK tanısı anındaki fetal biyometrik ölçümler ile analamlı korelasyonlar yansımiştir. Ortalama UtA PI ise uteroplazental perfüzyon indikatörü olarak fetal umbilikal arter Doppler indeksi ve doğum zamanı ile analamlı korelasyonlar göstermiştir. İlk üçay tarama döneminde plasental işlevin biyokimyasal (PAPPA) ve biyofiziksel (ortalama UtA PI) belirteçleri FGK tanısı almış olgulara prognostik bilgiler verebilir.

Anahtar kelimeler: Fetal gelişim kısıtlılığı, ilk üçay tarama, PAPPA, uterin arter pulsatile indeksi
Tablo 1. İlk üç ay tarama döneminde belirteçlerin fetal gelişim kısıtlılığı olgularına ait temel prenatal ve perinatal bulgular ile korelasyonları

<table>
<thead>
<tr>
<th>Belirteç</th>
<th>PAPPa Ham MoM</th>
<th>p</th>
<th>Ortalama UtA PI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Korelasyon katsayları</td>
<td></td>
<td>Korelasyon katsayları</td>
<td></td>
</tr>
<tr>
<td>Karın çevresi persentil değeri</td>
<td>-0.661</td>
<td>&lt;0.0001</td>
<td>-0.376</td>
<td>0.053</td>
</tr>
<tr>
<td>Femur uzunluğu persentil değeri</td>
<td>-0.531</td>
<td>0.004</td>
<td>-0.174</td>
<td>0.386</td>
</tr>
<tr>
<td>Tahmini fetal ağırlık</td>
<td>-0.420</td>
<td>0.021</td>
<td>-0.220</td>
<td>0.270</td>
</tr>
<tr>
<td>Tahmini fetal ağırlık persentil değeri</td>
<td>0.618</td>
<td>&lt;0.0001</td>
<td>-0.496</td>
<td>0.009</td>
</tr>
<tr>
<td>Tanıda gebelik haftası</td>
<td>-0.564</td>
<td>0.001</td>
<td>-0.400</td>
<td>0.842</td>
</tr>
<tr>
<td>Umbilikal arter PI (tanı anında)</td>
<td>0.094</td>
<td>0.620</td>
<td>0.531</td>
<td>0.004</td>
</tr>
<tr>
<td>Orta serebral arter PI (tanı anında)</td>
<td>0.037</td>
<td>0.875</td>
<td>-0.138</td>
<td>0.573</td>
</tr>
<tr>
<td>Uterin arter PI (tanı anında)</td>
<td>-0.334</td>
<td>0.316</td>
<td>0.288</td>
<td>0.420</td>
</tr>
<tr>
<td>Serebroplasental oran (tanı anında)</td>
<td>-0.148</td>
<td>0.522</td>
<td>-0.342</td>
<td>0.152</td>
</tr>
<tr>
<td>Doğumda gebelik haftası</td>
<td>0.272</td>
<td>0.146</td>
<td>-0.599</td>
<td>0.001</td>
</tr>
<tr>
<td>Doğum ağırlığı</td>
<td>0.423</td>
<td>0.020</td>
<td>-0.681</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Ortalama izlem süresi</td>
<td>0.669</td>
<td>&lt;0.0001</td>
<td>-0.262</td>
<td>0.186</td>
</tr>
</tbody>
</table>
Objective: The aim of this study is to investigate the relationship between first trimester screening test serum parameters with body mass index and hyperemesis gravidarum.

Methods: This study was planned as an observational case control study. The study included 311 women who underwent NT measurements. Pregnant women were divided into three groups according to body mass index: lean (bmi <25), normal (bmi 25-30), and overweight (bmi>30). In addition, the existence of hyperemesis gravidarum and antiemetic usage were recorded.

Results: The demographic characteristics of the patients in the groups were similar (age, gestational week, and CRL). The mean free β–hCG and free β–hCG MoM values of the lean pregnant women (bmi <25) were significantly higher (p = 0.003). Similarly, PAPP-A and PAPP-A MoM values were significantly higher in lean pregnant (bmi <25) (p = 0.000). There were no differences between the groups in terms of nt, nt MoM, free β–hCG, free β–hCG MoM, PAPP-A and PAPP-A MoM in women with and without hyperemesis gravidarum. Parametric and non-parametric tests were used for statistical analysis.

Conclusions: We found that free β–hCG and PAPP-A values were significantly lower in women whose body mass index was more than 30. The presence of hyperemesis gravidarum and antiemetic usage did not effect the serum parameters of the first trimester screening test. Readjustment for overweight pregnant women may be required when calculating the results of the first trimester screening test. Further studies are needed to clarify this issue.

Key words: nuchal translucency, body mass index, first trimester screening test parameters, free β–hCG, PAPP-A, nt
Objective: The amniotic sheet was described as an abnormal tissue stratum with free edge in the amniotic cavity, with no fetal deformity or with limitation of fetal movement. Its prevalence is reported to be between 0.14% and 0.75%. Although the etiology is not known, uterine synechiae, which occurs after uterine surgery, caesarean section or endometritis, are predisposing factors. Although amniotic sheets are associated with an increase in cesarean delivery rate, increased preterm delivery and increased malpresentation, they do not cause fetal deformity and poor fetal outcomes. However, intrauterine deaths associated with amniotic sheet have also been reported in the literature. In this study, the pregnancy results of 16 patients who were diagnosed as amniotic sheet were presented.

Methods: Sixteen patients who were diagnosed as amniotic sheet between 2017-2019 were included in the study. Information about patients and neonates was retrospectively obtained from the hospital registry system.

Results: The mean age of the patients was 29(21-45) and the mean gestational age was 20 weeks. 5 patients had previous cesarean section and 3 patients had a history of D&C and 3 patients have a history of abortus imminence during the current pregnancy. There were no patients with a history of PID and previous endometritis. There was no attachment between the amniotic sheet and the fetus and no restriction in fetal movements. The numerical data for risk factors and neonatal outcomes for amniotic sheet are given in Table 2 and Table 3. 3 newborns were hospitalized in the neonatal intensive care unit due to prematurity. None of the newborns had structural deformity due to amniotic sheet.

Conclusion: Amniotic sheets should be differentiated from amniotic band syndrome during routine obstetric ultrasound screening. Although amniotic sheet do not cause an increase in perinatal morbidity and mortality, there are studies linking placental detachment, preterm labor, premature rupture of membranes to poor obstetric and neonatal outcomes such as low birth weight and prematurity. In the light of this information, ultrasonographic diagnosis of amniotic sheet becomes important in pregnancy follow-up.

Key words: Amniotic fold, amniotic band syndrome
Table 1. Obstetric characteristics and neonatal outcomes of patients with amniotic sheet

<table>
<thead>
<tr>
<th></th>
<th>Minimum- Maximum</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Age</td>
<td>21-45</td>
<td>29</td>
</tr>
<tr>
<td>BMI</td>
<td>21-36</td>
<td>31</td>
</tr>
<tr>
<td>Gravida</td>
<td>1-7</td>
<td>2.5</td>
</tr>
<tr>
<td>Week at the diagnose</td>
<td>13-26</td>
<td>20</td>
</tr>
<tr>
<td>Gestational age at delivery</td>
<td>28-40</td>
<td>37.7</td>
</tr>
<tr>
<td>Birth weight</td>
<td>990-3780</td>
<td>2400</td>
</tr>
<tr>
<td>APGAR at 1 minutes</td>
<td>6-9</td>
<td>9</td>
</tr>
<tr>
<td>APGAR at 5 minutes</td>
<td>7-10</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 2. Distribution of predisposing risk factors

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of CS</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>History of D&amp;C</td>
<td>3</td>
<td>18.8</td>
</tr>
<tr>
<td>PID</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Abortus imminens in current pregnancy</td>
<td>3</td>
<td>18.8</td>
</tr>
</tbody>
</table>

Table 3. Birth and neonatal data in pregnancies with amniotic sheet

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malpresentation</td>
<td>4</td>
<td>%25</td>
</tr>
<tr>
<td>CS</td>
<td>11</td>
<td>%68</td>
</tr>
<tr>
<td>IUGR</td>
<td>3</td>
<td>%18.8</td>
</tr>
<tr>
<td>Preterm delivery</td>
<td>3</td>
<td>%18.8</td>
</tr>
<tr>
<td>PPROM</td>
<td>2</td>
<td>%12.5</td>
</tr>
</tbody>
</table>

Abbreviations: CS: Caesarean section, IUGR: Intrauterine growth retardation, D & C: Dilatation curettage, PID: Pelvic inflammatory disease, PPROM: Prematur early membrane rupture
OP-030 Amniyotik katlanı tanılı 16 olgunun gebeliklerinin ve gebelik sonuçlarının analizi

Nazan Vanlı Tonyalı, Dilek Şahin, Aykan Yücel
S.B.Ü Etilk Zübeyde Hanım Kadın Hastalıkları Eğitim ve Araştırma Hastanesi, Ankara

Amaç: Amniyotik katlanı, ilk olarak, fetal hareket kısıtlaması veya sonrasında fetal deformite olmaksızın, amniyotik boşluk içinde görülen serbest kenarı olan anormal doku tabakaları olarak tanımlanmıştır. Prevalansının %0,14 ile %0,75 arasında olduğu bildirilmiştir. Etyolojisi tam olarak bilinmemekle birlikte, uterin cerrahi, sezaryen, endometrit sonrası meydana gelen uterin enseşiler predispozan faktörlüdür. Amniyotik katlanılar her ne kadar sezaryen doğum oranında artış, artmış preterm doğum ve artmış malprezentasyonla ilişkilendirile de fetal deformite ve kötü fetal sonuçlara neden olmadığı kabul edilmektedir. Ancak, literatürde amniyotik katlanıyla ilişkili intrauterin Ölüler de bildirilmiştir. Bu çalışmada, kliniğimize refer edilen olgulardan amniyotik katlanı ile uyumu olarak değerlendirilen 16 hastanın gebelik sonuçları değerlendirilmiştir.


Sonuç: Rutin obstetrik ultrason taraması sırasında amniyotik katlanıların amniyotik sendromundan ayrılr bir önemi vardır. Amniyotik bantlar perinatal morbiditye ve mortalitede artış neden olmaz komplikasyonlar birlikte, plasenta dekolman, preterm doğum, erken membran rüptürü düşük doğum ağırlığı ve prematurite gibi kötü obstetrisk ve neonatal sonuçlar ile ilişkilendirilen çalışmalarla mevcuttur. Bu bilgiler işliğinde, amniyotik katlanının ultrasonografik olarak tanınması, gebelik takibinde önem kazanmaktadır.

Anahtar kelimeler: Amniyotik katlanı, amniyotik bant sendromu
Tablo 1. Amniyotik katlantısı olan hastaların obstetrik özellikleri ve yenidoğan sonuçları

<table>
<thead>
<tr>
<th>Özellik</th>
<th>Minimum</th>
<th>Maksimum</th>
<th>Ortalama</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yaş</td>
<td>21-45</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>BMI</td>
<td>21-36</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Gravida</td>
<td>1-7</td>
<td></td>
<td>2,5</td>
</tr>
<tr>
<td>Tanı haftası</td>
<td>13-26</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Doğum haftası</td>
<td>28-40</td>
<td></td>
<td>37,7</td>
</tr>
<tr>
<td>Doğum kilosu</td>
<td>990-3780</td>
<td></td>
<td>2400</td>
</tr>
<tr>
<td>1.dakika APGAR</td>
<td>6-9</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>5.dakifak APGAR</td>
<td>7-10</td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>

Tablo 2. Predispozan risk faktörlerinin dağılımı

<table>
<thead>
<tr>
<th>Faktör</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geçirilmiş CS</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Geçirilmiş D&amp;C</td>
<td>3</td>
<td>18,8</td>
</tr>
<tr>
<td>PID</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mevcut gebelikte abortus imminens</td>
<td>3</td>
<td>18,8</td>
</tr>
</tbody>
</table>

Tablo 3. Amniyotik katlantı izlenen gebeliklerdeki doğum ve yenidoğan verileri

<table>
<thead>
<tr>
<th>Özellik</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malprezentasyon</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Mevcut gebelikte CS ile doğum</td>
<td>11</td>
<td>68</td>
</tr>
<tr>
<td>IUGR</td>
<td>3</td>
<td>18,8</td>
</tr>
<tr>
<td>Preterm doğum</td>
<td>3</td>
<td>18,8</td>
</tr>
<tr>
<td>PPROM</td>
<td>2</td>
<td>12,5</td>
</tr>
</tbody>
</table>

Kısaltmalar: CS: Sezaryen, IUGR: İntra uterin gelişme geriliği, D&C: Dilatasyon küretaj, PID: Pelvik enfammatuar hastalı, PPROM: Prematur erken membran rüptürü
Maternal D vitamin düzeyinin trimester arası değişimi, D vitamini eksikliğinde görülen obstetrik ve neonatal sonuçlar

Bilge Pınar Keskinsoy, Merih Bayram

Gazi Üniversitesi Tıp Fakültesi Hastanesi, Kadın Hastalıkları ve Doğum Anabilim Dalı, Ankara, Türkiye

Vitamin D, diyetle alınabilen, temelde ultraviolet ışınları etkisi altında sentezlenebilen, kolesterolden derive prohormondur. Vitamin D eksikliği tüm dünyada yaygın bir problemdir. Vitamin D; plasental implantasyon, immun fonksiyonlar, inflamatur yanıt ve glukoz homeostazı üzerine etkilidir. Plazma 25(OH)D, vitamin D eksikliğini, endojen vitamin sentezini ve vitamin D takviyesini en iyi gösteren biyomarkerdir.

Kliniğimizde, Ocak-2016/Aralık-2017 arasında takip edilen, her trimesterde D vitamin düzeyi değerlendirilen 179 gebe çalışmaya (tez çalışması) dahil edildi. Hastaların tamamı 12. gebelik haftasından itibaren 1200 IU (9 damla)/gün D vitamini almaktaydı. Vitamin D düzeyleri; 20 ng/ml üzerinde olanlar yeterli, altında olanlar eksik olarak tanımlanırdı. İki grup arasında doğum şekli, GDM, preeklampsi, preterm doğum, SGA, bebek doğum kilosu ve boyu gibi obstetrik ve neonatal sonuçlar arasındaki farklılıkların değerlendirilmesi planlandı.

Çalışmamızda vitamin D yetersizliği, ilk trimesterde %59, ikinci trimesterde %72, üçüncü trimesterde %62 olarak saptanmıştır. Üçüncü trimesterdeki ortanca vitamin D düzeyi, birinci ve ikinci trimestere göre belirgin olarak yüksek saptanmıştır (p<0,001). Bebek kord kanı vitamin D düzeyleri; 20 ng/ml üzerinde olanlar yeterli, altında olanlar eksik olarak tanımlanırdı. İki grup arasında doğum şekli, GDM, preeklampsi, preterm doğum, SGA, bebek doğum kilosu ve boyu gibi obstetrik ve neonatal sonuçlar arasındaki farklılıkların değerlendirilmesi planlandı.

Çalışmamızda, 25(OH)D düzeyi, ilk trimesterde %59, ikinci trimesterde %72, üçüncü trimesterde %62 olarak saptanmıştır. Üçüncü trimesterdeki ortanca vitamin D düzeyi, birinci ve ikinci trimestere göre belirgin olarak yüksek saptanmıştır (p<0,001). Bebek kord kanı vitamin D düzeyi ile üçüncü trimester vitamin D düzeyi arasında pozitif yönde orta düzeyde korelasyon saptanmıştır (p<0,001/R:0,694). Ayrıca kord kanı D vitaminini yetersiz olan grupta doğum kilosu ve haftası anlamlı olarak düşük saptanmıştır. Maternal vitamin D yetersiz olan grup ile GDM, preeklampsi, doğum şekli, doğum haftası arasında ilişki saptanmamıştır.


Anahtar kelimeler: 25(OH)D, D vitamini eksikliği, maternal, neonatal sonuçlar
Tablo 1: Trimesterlere göre vitamin D düzeyinin karşılaştırılması

<table>
<thead>
<tr>
<th>Vitamin D, ortanca (IQR)</th>
<th>Trimester I</th>
<th>Trimester II</th>
<th>Trimester III</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 (10-21)</td>
<td>15 (10-20)</td>
<td>17 (12-23)</td>
<td>&lt;0,001</td>
<td></td>
</tr>
</tbody>
</table>

Şekil 1: Trimesterlere göre vitamin D düzeyinin karşılaştırılması

Tablo 2: Kord kanı vitamin D düzeyi ile annenin üçüncü trimester vitamin D düzeyi ile Korelasyon Analizi

<table>
<thead>
<tr>
<th>Vitamin D III. Trimester</th>
<th>R</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin D Bebek</td>
<td>0,694</td>
<td>&lt;0,001</td>
</tr>
</tbody>
</table>
Amaç: Antenatal izleminde posterior üretral valv tanışı alan olguların perinatal sonuçlarının ve neonatal izlemelerinin değerlendirilmesi.


Anahtar kelimeler: Posterior üretral valv, Vezikoüreteral reflü, Kronik renal hastalık
Gülenay Gencosmanoğlu Türkmen¹, Dilek Uygur²

¹University of Health Sciences, Dr. Sami Ulus Maternity and Children’s Research and Training Hospital, Ankara, Turkey
²Ankara Etlik Zübeyde Hanım Women’s Diseases Training and Research Hospital, Ankara, Turkey

Aim: To evaluate the 24-hour urine electrolyte levels in preeclamptic pregnant women.

Method: 24-h urine results were obtained retrospectively from medical records. 48 preeclamptic (26 severe, 22 mild) pregnant women were included in the study. Control group consisted of 39 healthy pregnant women. Samples were analyzed for electrolytes including sodium, chloride, potassium, phosphorus, calcium, magnesium and the results were compared between these groups. Statistical Analysis was done using Statistical Package for Social Sciences (SPSS®) software version 22.0 and presented as means (standard deviation). A p-value of ≤0.05 was considered statistically significant.

Results: The mean maternal age, gravida, parity and body mass index were similar in each group. There were no statistically significant differences in the urine levels of magnesium, potassium, chloride, sodium and phosphorus (p > 0.05). Urinary calcium excretion was significantly lower in preeclampsia group than in controls (p < 0.04). Urinary calcium levels between mild preeclampsia and severe pre-eclampsia were similar (p > 0.05).

Conclusion: Urinary levels of magnesium, chloride, sodium, potassium and phosphorus is not different in preeclamptic pregnant and these levels are not useful in the diagnosis of the disease. Urinary calcium excretion is reduced in preeclamptic women. However, the decrease in urinary calcium excretion cannot be used to identify the severity of preeclampsia.
Objective: Assisted reproductive technologies (ART) especially intracytoplasmic sperm injection (ICSI) is considered to be associated with birth defects according to the studies. There are few reports on hearing screening tests of these babies. We aim to determine the association between assisted reproductive technologies and hearing loss of newborns.

Material and methods: This retrospective study examined 246 intracytoplasmic sperm injection (ICSI) newborn between 2013 and 2015. All the patients conceived by ICSI. We examined the hearing screening results of babies.

Results: A total of 25 newborn could not pass the first screening test including 17 TEOAE and 8 ABR. Ten babies could not pass the advanced examination. Total hearing loss was found to be 4% within ART babies.

Conclusion: In conclusion, hearing screening tests expose distorted results in 4% of ICSI babies which is ten times more when compared with spontaneously conceived newborns. Babies should be assessed in terms of hearing loss carefully after ART.

Key words: Hearing screening, ICSI, Assisted reproductive technologies
Objectives: Transabdominal ultrasonography (TA-USG) is the centerplace of first and second trimester anomaly screening. We conduct this survey to know is there still a place for TA-USG for measuring cervical length in the era of routine cervical screening yet to be a debatable topic in selected cases like short cervix.

Methods: 226 patient enrolled for measuring cervical length both transvaginally and transabdominally during second trimester anomaly scan. Intraclass correlation coefficient (ICC) is used for validation of transabdominal measurements as we assume transvaginal way is a gold standard. ANOVA is used subgroup analysis.

Results: TA-USG is not a reliable way by comparison with transvaginal route (ICC: 0.653, as should correspond to 0.75-0.90 for good reliability).

Conclusions: Transvaginal ultrasonography is still an only way as both screening and diagnosing for cervical length for general and high-risk population

Key words: cervical length, short cervix
OP-036 Mogadişu Somali Türkiye Eğitim Araştırma Hastanesine hiperbilirubinemi ile başvuran yenidoğanlarda hiperbilirubinemi vitamin D düzeyi ilişkisini araştırılması

Elif Güdeloğlu

İzmir Dr. Behçet Uz Çocuk Hastalıkları ve Cerrahiye Eğitim ve Araştırma Hastanesi Süt Kliniği

Giriş: Hiperbilirubinemi yenidoğanlarda sık görülen ve postnatal izlemin düzenli yapılamadığı yerlerde önemli bir sağlık sorunudur. İndirekt hiperbilirubinemi hastaneye, sık yatış sebeplerinden olup, D vitamini tedavisi ile bu oranın azaltılabileceği düşünüldü. Bu çalışmada, yenidoğanlarda indirekt hiperbilirubinemi ile serum D vitamini düzeyi arasındaki ilişkisinin açıklanması amaçlanmıştı.

Hastalar ve Yöntem: Çalışmamız prospektif ve gözlemel bir araştırmadır. Çalışmamızda Mayıs 2017 - Ocak 2018 arasında Somali Mogadişu Türkiye Eğitim ve Araştırma Hastanesine başvuran ve indirekt hiperbilirubinemi saptanan, 125 yenidoğan olgusu incelendi. Hastaların cinsiyet, doğum haftası, ağırlığı ve şekli; başvurudaki vücut ağırlığı, boyu ve baş çevresi, beslenme durumu; annenin yaşı, eğitim durumu, beslenme özellikleri, vitamin gereksinimleri, gebelikte kullandığı ilaçlar, örtünme şekli, kronik hastalık durumları kaydedildi. Çalışmadaki olguların vitamin D düzeyine, kordon kanından bakıldı. 25(OH)D vitamin düzeyi <12 ng/ml altında olanlar Grup 1, 12-20 ng/ml arasında olanlar Grup 2, >20 ng/ml üzerinde olanlar Grup 3 olarak tanımlandı. Grup 1 deki hastalardan 5 ng/ml altındakiler Grup 1A, 5 ile 12 ng/ml arasındakiler Grup 1B olarak ayrıldı.

Bulgular: Yenidoğanların 64’ü erkek, 61’i kızdı. Maternal ve neonatal demografik özellikler açısından gruplar arasında istatistiksel fark gözlenmedi (p>0,05). Gebelike alanan vitamin D dozuya, bebekdeki düzey arasında bulunan fark, anlamlı bulundu. (p<0,05). Gruplar arasında, laboratuvar parametreleri (beyaz küre sayısı, hemoglobin değeri, hematokrit yüzdesi, aspartat aminotransferaz alaninaminotransferaz, alkalen fosfataz ve trombosit sayısı) bakımından anlamlı farklı bulunmadı. Ancak Grup 1'de total ve indirekt bilirubin düzeyleri anlamlı olarak yüksekken; Grup 2'de total ve indirekt bilirubin düzeylerinin düşükken fototerapi verilme süresi benzerdi. Çalışmada D vitamin düzeyi düşük olan yenidoğanlarda, sanlık düzeyi ile pozitif yönde anlamally korelasyon izlendi (r=0,45).

Sonuç: Bu çalışma, vitamin D düzeyi ile indirekt hiperbilirubinemi ilişkisini araştıran literatürdeki ilk çalışmadır. Somali’de annelerde ve çocuklanda görülen D vitamini eksikliği önemli bir sorundur. Çalışmanın sonuçlarına göre Dünya Sağlık Örgütünün yürütmesi gerektiğine destek programına annelerin düzenli D vitamini alma konusunda eklenmelidir.

Anahtar kelimeler: yenidoğan, d vitamini, hiperbilirubinemi
The efficacy of hematologic parameters in the prognosis of abortus imminens

Murat Akbaş, Faik Muştmaz Koyuncu

Manisa Celal Bayar University, Obstetrics and Gynecology Department, Perinatology Division, Manisa, Turkey

Objectives: To evaluate the hematologic parameters in abortion and abortus imminens and the role of these parameters in the prediction of abortion.

Methods: The records of 336 pregnant women who applied to Manisa Celal Bayar University obstetrics outpatient clinic between January 2018 and March 2019 were evaluated retrospectively. 53 women with spontaneous or missed abortion, 69 pregnant women with abortus imminens and 214 healthy pregnant women constituted the study groups. WBC (white cell count), PLT (platelet count), neutrophil and lymphocyte count, NLR (neutrophil/lymphocyte ratio), PLR (platelet/lymphocyte ratio), PCT (plateletcrit), PDW (mean platelet volume width), RDW (mean erythrocyte volume width and MPV (mean platelet volume) were evaluated between groups.

Results: PLT, PCT, RDW and MPV values were significantly different between the groups. PLT level was higher in the control group (p<0.001). PCT was lower in the abortion group compared to the other groups (p<0.001). In addition, RDW levels were higher (p<0.001) and MPV levels were lower (p=0.013) in the abortion group compared to the control group. There was no significant difference between the abortus imminens group and other two groups in terms of these two parameters. Other parameters were similar between groups.

Conclusions: Hematologic parameters including, NLR, PLR, RDW, MPV and PCT are known as inflammatory markers. In recent years, studies were conducted about the utilization of these markers in recurrent pregnancy loss and abortions. As a result of these studies, contradictory data were obtained. In our study, although the PCT and MPV values were higher and RDW was lower in the control group compared to the abortion group, the results in the abortus imminens group were similar to the other two groups. Prospective studies are needed to evaluate the use of these hematological parameters to determine the prognosis of pregnant women with threatened abortion.

Key words: Abortus imminens; MPV; PCT; RDW; PDW
OP-037 Abortus imminens vakalarının prognozunu belirliyede hematolojik parametrelerin etkinliği

Murat Akbaş, Faik Mümtaz Koyuncu

Manisa Celal Bayar Üniversitesi, Kadın Hastalıkları ve Doğum Anabilim Dalı, Perinatoloji Bilim Dalı, Manisa, Türkiye

Amaç: Hematolojik parametrelerin abortus gerçekleşen ve abortus imminens olan gebelerde değerlendirilmesi ve abortus öngörüsünde rolünü araştırmaktır.


Bulgular: Gruplar arasında PLT, PCT, RDW ve MPV değerleri anlamlı olarak farklı bulundu. PLT seviyesi kontrol grubunda daha yüksek saptandı (p<0.001). PCT abortus grubunda diğer gruplara kıyasla düşük saptandı (p<0.001). Ayrıca abortus grubunda RDW seviyesi kontrol grubuna göre daha yüksek (p<0.001) ve MPV seviyesi kontrol grubuna göre daha düşük bulundu (p=0.013). Abortus imminens grubunda ise bu iki parametre açısından diğer gruplara arasında anlamlı fark saptanmadı. Diğer parametreler gruplar arasında benzer bulundu.


Anahtar kelimeler: Abortus imminens; MPV; PCT; RDW; PDW
Objective: Gestational diabetes mellitus (GDM) is one of the most common metabolic disorders in pregnancy. Pregnancy causes to change the lipid metabolism. The first trimester is characterized by increased lipogenesis. Hyperlipidemia levels in pregnant women with GDM are higher than in normal pregnancies. In the literature, there are different studies assessing lipid values in pregnancy. However, there are limited studies which evaluate lipid values. We researched the relationship between insulin resistance and serum lipid concentrations of women with and without gestational diabetes mellitus.

Method: The study included 33 women with GDM and 30 without GDM. Total cholesterol, high density lipoprotein (HDL), low density lipoprotein (LDL), triglyceride, glucose and insulin concentrations of those women were measured. Insulin resistance was calculated according to the formula: homeostasis model assessment of insulin resistance- (HOMA-IR) = (serum fasting insulin (mU / mL) X serum fasting glucose (mg / dL)) / 405. T test was used to analyze differences between variables and linear regression was used to analyze the relationship between two groups.

Results: Women with GDM had higher LDL values (131.49± 73 mg/dL vs. 119.37 ±96 mg/dL, p=0.047) and HOMA-IR (3.27± 1.76 vs. 1.46±0.94 p=0.026) than those without GDM. HDL values (51.19±9.78 mg/dL vs. 64.39±16.34 p=0.003) were detected lower. In the regression analysis, only the relationship between LDL and HOMA-IR values (β = 0.159; p = 0.027) were found significant in the lipid parameters.

Discussion: In our study, according to our estimation of lipid profile, it was found that women with GDM had higher LDL levels and lower HDL levels than women without GDM and a significant relationship between insulin resistance and LDL was detected. In conclusion, the effect of increasing insulin resistance on LDL levels should be considered in women with GDM.

Key words: pregnancy, gestational diabetes, lipid profile, insulin resistance
OP-038 Gestasyonel diyabeti olan ve olmayan kadınların serum lipid konsantrasyonları ile insülin direnci arasındaki ilişkinin incelemesi

Özgür Yılmaz¹, Kenan Kırtekê², Burcu Artunç Ülkümen³

¹Manisa Şehr Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, Manisa, Türkiye
²Celal Bayar Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı, Perinatoloji Bilim Dalı, Manisa, Türkiye
³Celal Bayar Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı, Manisa, Türkiye


Materyal-Metot: Araştırmaya 33 GDM'li ve 30 sağlıklı gebe kadın alındı. Total kolesterol, yüksek dansiteli lipoprotein (HDL), düşük dansiteli lipoprotein (LDL), trigliserid, açlık glukoz ve insülin konsantrasyonları ölçüldü. Insülin direnci “homeostasis model assessment of insulin resistance- (HOMA-IR) = (serum açlık insulin (mU/mL) X serum açlık glikoz (mg/dL))/405 formülüne göre hesaplandı. Değişkenler arası farklılıklar t test; iki grup arasındaki ilişki ise lineer regresyon analizi ile incelendi.

Sonuçlar: GDM olan kadınların GDM olmayanlara göre LDL (131.49± 73 mg/dL vs 119.37 ±96 mg/dL, p=0.047) ve HOMA-IR (3.27± 1.76 vs 1.46±0.94 p=0.026) değerleri daha yüksek, HDL değerleri ise daha düşük (51.19±9.78 mg/dL vs 64.39±16.34 p=0.003) bulundu. Regresyon analizinde lipid parametreleri arasında sadece LDL değeri ile HOMA-IR değeri arasında anlamli ilişki saptandı (β=0.159; p=0.027).

Tartışma: Çalışmamızda GDM olan gebelerin GDM olmayan gebelere göre LDL düzeyleri daha yüksek, HDL düzeyleri ise daha düşük bulunurken insülin direnci ile LDL arasında anlamli bir ilişki saptandı. GDM olan kadınlarda insülin direnci düzeyindeki artış ile LDL arasındaki birliktelikler de dikkate alınmalıdır.

Anahtar kelimeler: gebelik, gestasyonel diyabet, lipid profili, insülin direnci
Objective: Twin pregnancies account for 3% of all live births and 97% of multiple pregnancies, of which 30% are monozygotic twin pregnancies. Two-thirds of monozygotic twin pregnancies are monochorionic (MC) diamniotic (DA), less than 1% monochorionic (MC) monoamniotic (MA) and rarely conjoined twins. The main cause of perinatal morbidity and mortality is preterm labor. In addition, specific complications caused by common fetoplacental circulation of MC twin pregnancy are also seen. The aim of the study is to analyze maternal and fetal outcomes of monochorionic (MC) twin pregnancies in our clinic.

Material/method: The hospital records of 89 MC twin pregnancies giving birth in our clinic between January 2017 – March 2019 were analysed and the data were evaluated. The results were expressed as mean ± standard deviation.

Findings: MC twin pregnancies account for 0.3% of all pregnancies and 16.82% of twin pregnancies in our hospital. 95.5% of these pregnancies were DA (85 cases) while 4.5% MA (4 cases). Descriptive analyzes are shown in Tables 1 and 2. The most common co-morbidities were anemia and hypertension (table 3-4). The mean gestational age during birth was 33.49±3.14 (21-38) in DA pregnancies and 31±2.94 (27-34) in MA pregnancies and 62.9% of all pregnant were delivered at 34 weeks and above (Figure 1). The mean birth weights and Apgar scores of newborns were show in table 2. 42.1% of newborns needed treatment at the neonatal intensive care unit. Antenatal steroid treatment was performed in 46.1% of these patients and 69.5% of the patients who were treated with steroids were hospitalized of neonatal intensive care (table 5). Twin to twin transfusion syndrome (TTTS) was observed in 14 cases (15.7%). Table 6 shows specific complications due to MC twin to twin pregnancies. Amniorreduction was performed in 4 patients and their mean gestational age during labor was 28.75±1.50.

Conclusions: Perinatal outcomes are especially related to the gestational age at birth and amnionicity twin pregnancy type. It is important to determine chorionicity in the first trimester and MC twin pregnancies should be followed more frequently and regularly because of possible risks.

Key words: monochorionic twin pregnancy, perinatal outcome, neonatal outcome

Reference:
Table 1: Clinical features of MC twin pregnancies

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mc-da</td>
<td>85</td>
<td>95,5</td>
</tr>
<tr>
<td>mc-ma</td>
<td>4</td>
<td>4,5</td>
</tr>
<tr>
<td>Invitro fertilization (mc-da)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>5,9</td>
</tr>
<tr>
<td>No</td>
<td>80</td>
<td>94,1</td>
</tr>
<tr>
<td>Invitro fertilization (mc-ma)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>75</td>
</tr>
<tr>
<td>Nationality</td>
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<td></td>
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<tr>
<td>TC</td>
<td>84</td>
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<tr>
<td>Refugee</td>
<td>5</td>
<td>5,6</td>
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Table 2: Clinical features of MC twin pregnancies

<table>
<thead>
<tr>
<th>Maternal characteristics (n:89)</th>
<th>Mean± standard deviation</th>
<th>Minimum-maximum values</th>
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<tr>
<td>Age</td>
<td>26,65±5,59</td>
<td>17-42</td>
</tr>
<tr>
<td>Gravidity</td>
<td>2,14±1,70</td>
<td>1-12</td>
</tr>
<tr>
<td>Parity</td>
<td>0,82±1,20</td>
<td>0-7</td>
</tr>
<tr>
<td>Body mass index</td>
<td>28,87±3,69</td>
<td>21-37</td>
</tr>
<tr>
<td>Gestational age during birth</td>
<td>33,38±3,15</td>
<td>21-37</td>
</tr>
<tr>
<td>Weight (n:175)</td>
<td>1995,51±563,95</td>
<td>670-3440</td>
</tr>
<tr>
<td>Apgar scores at 1. minute (n:175)</td>
<td>8,03±2,28</td>
<td>0-9</td>
</tr>
<tr>
<td>Apgar scores at 5. minute (n:175)</td>
<td>9,06±2,40</td>
<td>0-10</td>
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</table>

Table 3: Medical problems accompanying pregnancy

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>29</td>
<td>32,6</td>
</tr>
<tr>
<td>Hypertension</td>
<td>5</td>
<td>5,6</td>
</tr>
<tr>
<td>Fmf</td>
<td>1</td>
<td>1,1</td>
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</table>

Table 4: Complications of pregnancy

<table>
<thead>
<tr>
<th>Complication</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational Diabetes A1</td>
<td>4</td>
<td>4,5</td>
</tr>
<tr>
<td>Gestational Diabetes A2</td>
<td>2</td>
<td>2,2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Ablatio placenta</td>
<td>2</td>
<td>2,2</td>
</tr>
<tr>
<td>Placenta previa</td>
<td>1</td>
<td>1,1</td>
</tr>
<tr>
<td>Intrahepatic cholestasis of pregnancy</td>
<td>1</td>
<td>1,1</td>
</tr>
<tr>
<td>Postpartum hemorrhage</td>
<td>10</td>
<td>11,2</td>
</tr>
</tbody>
</table>
Figure 1: Distribution of pregnancies according to gestational age at birth

Table 5: The relationship between antenatal steroid administration and neonatal intensive care

<table>
<thead>
<tr>
<th>Intensive care admission</th>
<th>Yes</th>
<th>Number</th>
<th>%</th>
<th>Antenatal steroid</th>
<th>Yes completed</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes completed</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>57</td>
<td>19</td>
<td>76</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>75,0%</td>
<td>25,0%</td>
<td>100,0%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
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<td>25</td>
<td>70</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>26,3%</td>
<td>73,7%</td>
<td>100,0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>82</td>
<td>89</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>48,0%</td>
<td>52,0%</td>
<td>100,0%</td>
</tr>
</tbody>
</table>

Table 6: MC pregnancy-specific complications

<table>
<thead>
<tr>
<th>Complication</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No complication</td>
<td>56</td>
<td>62,9</td>
</tr>
<tr>
<td>Twin-twin transfusion syndrome stage 1</td>
<td>4</td>
<td>4,5</td>
</tr>
<tr>
<td>Twin-twin transfusion syndrome stage 3</td>
<td>1</td>
<td>1,1</td>
</tr>
<tr>
<td>Twin-twin transfusion syndrome stage 4</td>
<td>3</td>
<td>3,4</td>
</tr>
<tr>
<td>Twin-twin transfusion syndrome stage 5</td>
<td>6</td>
<td>6,7</td>
</tr>
<tr>
<td>Selective fetal growth restriction</td>
<td>18</td>
<td>20,2</td>
</tr>
<tr>
<td>Twin anemia-polycythemia sequence</td>
<td>1</td>
<td>1,1</td>
</tr>
</tbody>
</table>
OP-040 The role of the systemic inflammatory markers in the clinical follow-up of pregnant women with preterm premature rupture of membranes

Gülşah Dağdeviren, Aykan Yücel, Dilek Şahin

University Of Health Sciences, Etilik Zübeyde Hanım Women’s Health Care, Training And Research Hospital, Perinatology Department, Ankara, Turkey

Objectives: this study aims to investigate the role of neutrophil-lymphocyte ratio (nlr), lymphocyte-monocyte ratio (lmr), platelet-lymphocyte ratio (plr), mean platelet volume (mpv) and c-reactive protein (crp) in determining of the time until delivery after the the preterm premature rupture of membranes (pprom).

Method: the study data were collected from the hospital records between January 2017 and December 2018. The patients with pprom, below 34 weeks of gestation without active labor, were included in the study. The crp, nlr, lmr, plr and mpv values of the patients were obtained from the blood sample taken at the first admission before antibiotic prophylaxis and betamethasone dose for lung maturation. The patients were divided into two groups according to time from membrane rupture to delivery; the patients in group i were defined as those who started spontaneous delivery in the first 72 hours, and the ones in group ii as those who started spontaneous delivery after 72 hours. The two groups were compared in terms of their crp, nlr, lmr, plr and mpv values.

Results: The study included 172 patients who met the inclusion criteria. There was no significant difference between the two groups in terms of plr and mpv values (p > 0.05). Crp, nlr and lmr mean values of group I and group II were calculated as (2.21; 8.93; 3.58 and 1.03; 6.08; 4.30) respectively (p <0.05). The roc curve was used to evaluate the diagnostic accuracy of the results of the analyses. The roc scores were found to be 0.611 for crp, 0.654 for nlr, and 0.642 for lmr.

Conclusion: In the patients with pprom, high nlr, crp and low lmr values may be helpful to predict delivery within 72 hours and provide appropriate patient counseling.

Key words: inflammatory marker, latency, preterm premature rupture of membranes (pprom)
Objectives: Intrauterine growth restriction (IUGR) is diagnosed when estimated fetal weight is below 10th percentile of that gestational age. Endothelial dysfunction is a common pathogenetic pathway underlying IUGR etiology. Endocan (ESM-1) is a novel marker of endothelial dysfunction and inflammation. This study was designed to compare serum endocan levels between pregnancies complicated with IUGR and the control group.

Study design: Forty-four pregnancies complicated with IUGR and 41 healthy pregnancies were included. Maternal serum endocan levels were evaluated by ELISA. Parametric data was assessed by student’s t-test and non-parametric data by Mann–Whitney U-test. Categorical variables were compared with chi-square test. ROC analysis was performed to define cut-off value of endocan in detecting IUGR.

Results: There was significant difference between serum endocan levels of pregnancies complicated with IUGR and the control group overall (793.0 (IQR:544.4-1896.0) ng/L vs 441.8 (IQR: 408.3-512.4) ng/L, p<0.001). ROC analysis showed that AUC for endocan to detect IUGR was 0.794 (CI (95%):0.695-0.893) which was statistically significant (p<0.001). The best cut-off to detect IUGR was 514.7 ng/dl (sensitivity 81.8% and specificity 76.6%).

Conclusions: There was significant difference between endocan levels of IUGR and control group. According to this study a cut-off value of 514.7 ng/dl may be useful in differentiating patients with IUGR. Further studies should be done related with endocan for prediction of IUGR of high risk patients in the first trimester.

Key words: Intrauterine growth restriction, endocan, ESM-1
OP-042 Tanısal invaziv işlemlerin kabul edilme oranları

Pınar Çalış

Dr. Sami Ulus Kadın ve Çocuk Hastalıkları Hastanesi, Kadın Hastalaıkları ve Doğum AD, Perinatoloji Bilim Dalı, Ankara

Amaç: Kliniğimizde anatomik tarama sonucu ya da kombinasyon veya üçlü test sonucu prenatal tanı için invaziv işlem önerilen gebelerin işlem kabul oranları, işlem sonucunda kromozomal anomali oranı ve terminasyon oranlarını araştırmak.


An analysis soluble endoglin (sEng) and matrix metalloproteinase 14 (MMP-14) with Elisa method in the diagnosis and severity of early/late-onset preeclampsia

Tuncay Yüce, Ali Ovayolu

Cengiz Gokcek Public Hospital, Department of Obstetrics and Gynecology, Gaziantep, Turkey

Purpose: Defective placentation and inadequate trophoblastic invasion have an important place in the etiology of preeclampsia (PE). Trophoblasts invades the maternal decidua and remodels spiral arteries with matriks metalloproteinaz-14  (MMP-14). To the best of our knowledge, studies of MMP-14 protein levels of PE patients’ sera remain unpublished. This study aims to investigate the value of serum MMP-14 and sENG in PE patients and healthy controls.

Methods: The study was conducted with 30 Late-onset preeclampsia patients (LOPE) as group1 (gestational age>34 weeks), 33 patients with normal pregnancies as group2 (gestational age>34 weeks), 31 early-onset preeclampsia patients (EOPE) as group3 (gestational age<34 weeks), and 31 patients with normal pregnancies as group4 (gestational age<34 weeks). Serum MMP-14 and sENG levels measured by ELISA were compared.

Results: The demographic data and laboratory parameters of the all groups were compared (Table 1). In all pregnant women, pregnancy week by increases was observed to decrease levels of MMP-14. sENG levels were highest in the EOPE group. There was no difference between sENG and MMP-14 levels in patients with mild (21 patients) and severe (9 patients) PE in LOPE (p=0.829, p=0.210, respectively). There was no difference between sENG and MMP-14 levels in patients with mild (8 patients) and severe (23 patients) PE in EOPE (p=0.887, p=0.739, respectively). There were mild (29 patients) and severe (32 patients) PE (group1 + group3), there was no significant difference between sENG levels (p=0.133), but there was a significant difference between MMP-14 levels (3.11±0.61, 3.54±1.00, p=0.047, respectively). There was no difference in sENG and MMP-14 levels between patients with body mass index (BMI)<30 (56 pregnant women) and BMI≥30 (69 pregnant women) (p=0.373, p=0.873, respectively). There was no correlation between sENG and MMP-14 levels (p>0.05).

Conclusion: Serum sENG and MMP-14 levels can be used as predictive markers in the diagnosis of PE. Serum MMP-14 level can be used as a marker in determining the severity of PE. Maintaining a proper follow-up of the levels of angiogenic/anti-angiogenic factors may be a useful biomarker in the prediction and diagnosis of PE and in decreasing the morbidity/mortality in PE.

Key words: severe pre-eclampsia, hypertension, implantation, endothelial dysfunction, trophoblast, biomarker, placenta
**Tablo 1. Comparison of demographic and laboratory parameters of the study and control groups**

<table>
<thead>
<tr>
<th>Variables</th>
<th>LOPE Group 1 (n=30)</th>
<th>Control Group 2 (n=33)</th>
<th>EOPE Group 3 (n=31)</th>
<th>Control Group 4 (n=31)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years, mean±SD)</td>
<td>28.9±6.4</td>
<td>25.8±6.0</td>
<td>29.1±6.6</td>
<td>28.9±6.6</td>
<td>0.122</td>
</tr>
<tr>
<td>BMI (kg/m², mean±SD)</td>
<td>32.2±5.4³</td>
<td>28.6±4.9⁸</td>
<td>31.3±5.0³</td>
<td>29.5±4.7⁵</td>
<td>0.020</td>
</tr>
<tr>
<td>Gestational age (weeks, mean±SD)</td>
<td>37.2±1.5³</td>
<td>37.7±1.5³</td>
<td>31.1±2.2³</td>
<td>30.5±2.0⁶</td>
<td>0.001</td>
</tr>
<tr>
<td>Gravidity (mean±SD)</td>
<td>3.3±2.4</td>
<td>3.5±5.4</td>
<td>3.1±1.7</td>
<td>3.7±2.3</td>
<td>0.887</td>
</tr>
<tr>
<td>Parity (mean±SD)</td>
<td>1.9±1.9</td>
<td>1.5±1.3</td>
<td>1.5±1.4</td>
<td>1.9±1.7</td>
<td>0.620</td>
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<tr>
<td>Syst TA (mm/Hg, mean±SD)</td>
<td>160±18⁶</td>
<td>105±10⁴</td>
<td>173±18⁶</td>
<td>104±16⁵</td>
<td>0.001</td>
</tr>
<tr>
<td>Diast TA (mm/Hg, mean±SD)</td>
<td>103±10³</td>
<td>65±⁶</td>
<td>110±11³</td>
<td>66±10⁵</td>
<td>0.001</td>
</tr>
<tr>
<td>Proteinuria (mean±SD)</td>
<td>2.67±1.1³</td>
<td>0±⁰</td>
<td>3.0±1.2³</td>
<td>0.0±0.2⁰</td>
<td>0.001</td>
</tr>
<tr>
<td>Hemoglobin (g/dL, mean±SD)</td>
<td>12.0±1.4³</td>
<td>10.9±1.3³</td>
<td>11.9±1.3³</td>
<td>11.4±1.2³⁰</td>
<td>0.004</td>
</tr>
<tr>
<td>Hematocrit (%)</td>
<td>36±3³</td>
<td>33±3⁴</td>
<td>35±3³</td>
<td>33±2³⁰</td>
<td>0.001</td>
</tr>
<tr>
<td>Platelets (x10³/µL, mean±SD)</td>
<td>240±84</td>
<td>235±82</td>
<td>200±83</td>
<td>236±51</td>
<td>0.152</td>
</tr>
<tr>
<td>WBC (µL/mL, mean±SD)</td>
<td>10.9±2.4⁶</td>
<td>10.5±2.6</td>
<td>10.4±3.0</td>
<td>9.9±2.8</td>
<td>0.587</td>
</tr>
<tr>
<td>BUN (mg/dl, mean±SD)</td>
<td>8.9±3.0⁶</td>
<td>7.3±2.5⁵</td>
<td>10.4±3.9⁶</td>
<td>6.4±2.1⁵</td>
<td>0.001</td>
</tr>
<tr>
<td>Creatinine (mg/dl, mean±SD)</td>
<td>0.56±0.11³</td>
<td>0.47±0.09⁷</td>
<td>0.66±0.17³</td>
<td>0.46±0.08⁷</td>
<td>0.001</td>
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<tr>
<td>ALT (IU/l, mean±SD)</td>
<td>20±30</td>
<td>10±4</td>
<td>22±30</td>
<td>11±4</td>
<td>0.054</td>
</tr>
<tr>
<td>AST (U/l, mean±SD)</td>
<td>22±17</td>
<td>16±3</td>
<td>31±35</td>
<td>14±3</td>
<td>0.005</td>
</tr>
<tr>
<td>Birth weight (gram, mean±SD)</td>
<td>2960±691³</td>
<td>3249±483³</td>
<td>1650±467³</td>
<td>3172±346³</td>
<td>0.001</td>
</tr>
<tr>
<td>sENG (ng/ml, mean±SD)</td>
<td>17.24±1.73³</td>
<td>18.49±2.01³⑩</td>
<td>22.64±12.98³</td>
<td>18.21±14.48³⑩</td>
<td>0.015</td>
</tr>
<tr>
<td>MMP-14 (ng/ml, mean±SD)</td>
<td>2.83±0.31³</td>
<td>2.93±0.43³</td>
<td>3.82±0.94³</td>
<td>3.81±1.26³</td>
<td>0.001</td>
</tr>
</tbody>
</table>

LOPE Group 1: Late onset preeclampsia patient group, Control Group 2: Late onset preeclampsia control group, EOPE Group 3: Early onset preeclampsia patient group, Control Group 4: Early onset preeclampsia control group, Age: Maternal age, BMI: Body Mass Index, Gestational age: Gestational age at the time of diagnosis, Syst TA: Systolic blood pressure, Diast TA: Diastolic blood pressure, Proteinuria: Spot urine proteinuria by dipstick test, WBC: White blood cells, BUN: Blood urea nitrogen, ALT: Alanine aminotransferase, AST: Aspartate aminotransferase, sENG: Soluble Endoglin, MMP-14: Matrix metalloproteinase-14, n: Number, SD: Standard deviation, p<0.05 indicates statistical significance; a,b,c: different letters symbolize the difference between the groups.
OP-043 Erken/geç-başlangıçlı preeklampsi tanı ve şiddetinin değerlendirilmesinde, ELISA metodu ile ölçülen soluble endoglin and matriks metalloproteinaz-14 analizi

Tuncay Yüce, Ali Ovayolu

Cengiz Gökçek Kadın Doğum ve Çocuk Hastalıkları Hastanesi, Kadın Hastalıkları ve Doğum Bölümü, Gaziantep

Amaç: Preeeklampsi (PE) etiyolojisinde defektif plasentasyon ve yetersiz trofoblastik invazyon önemli yer tutmaktadır. Trofoblastlar, matriks metalloproteinaz-14 (MMP-14) yardımısı ile desiduayı invaze ederek, spiral arterlerin oluşumunu sağlar. Bu çalışmada amaç; PE ile ilişkisi doku düzeyinde gösterilmiş olan, ancak daha önce serumda ölçülmemiş MMP-14 ile soluble endoglin (sENG) düzeylerini preeklamptik gebelerde ve sağlıklı gebelerde karşılaştırmaktır.

Yöntem: Geç-başlangıçlı preeklamptik (LOPE) 30 kadından (gestasyonel yaş≥34 hafta) grup1, kontrol grubu olarak 33 sağlıklı gebeden (gestasyonel yaş≥34 hafta) grup2 oluşturuldu. Erken-başlangıçlı preeklamptik (EOPE) 31 kadından (gestasyonel yaş<34 hafta) grup3 ve kontrol grubu olarak 31 sağlıklı gebeden (gestasyonel yaş<34 hafta) grup4 oluşturuldu. ELISA yöntemi ile ölçülen serum MMP-14 ve sENG düzeyleri karşılaştırıldı.

Bulgular: Grupların demografik verileri ve laboratuvar parametreleri karşılaştırıldı (Table 1). Tüm gebelerde, gebelik haftası arttıkça MMP-14 seviyelerinin düştüğü görüldü. sENG seviyelerini EOPE grubunda en yüksek tespit edildi. LOPE’de hafif (21 hasta) ve şiddetli (9 hasta) PE olan hastaların sENG ve MMP-14 seviyeleri arasında fark bulunmadı (p=0.829, p=0.210, sırasıyla). EOPE’de hafif (8 hasta) ve şiddetli (23 hasta) PE olan hastaların sENG ve MMP-14 seviyeleri arasında fark bulunmadı (p=0.887, p=0.739, sırasıyla). PE gruplarındaki (grup1+grup3) hafif (29 hasta) ve şiddetli (32 hasta) PE olan hastaların sENG seviyeleri arasında fark bulunmadı (p=0.133), MMP-14 seviyeleri arasında ise anlamlı bir fark mevcuttu (3.11±0.61, 3.54±1.00, p=0.047, sırasıyla). Vücut kitle indeksi (BMI)<30 olanlar (56 kişi) ile BMI≥30 (69 kişi) olanlar karşılaştırıldığında ise, sENG ve MMP-14 seviyeleri arasında fark yoktu (p=0.373, p=0.873, sırasıyla). sENG ve MMP-14 seviyelerinin birbirleri ile olan ilişkisini incelendikinde ise anlamlı bulunmamıştır (p>0,05).


Anahtar kelimeler: şiddetli pre-eklampsii; hipertansiyon; implantasyon; endoteliyal disfonksiyon; trofoblast; biyobelirteç; plasenta
<table>
<thead>
<tr>
<th>Variables</th>
<th>LOPE Group 1 (n=30)</th>
<th>Control Group 2 (n=33)</th>
<th>EOPE Group 3 (n=31)</th>
<th>Control Group 4 (n=31)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
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<td>25.8±6.0</td>
<td>29.1±6.6</td>
<td>28.9±6.6</td>
<td>0.122</td>
</tr>
<tr>
<td>BMI (kg/m², mean±SD)</td>
<td>32.2±5.4</td>
<td>28.6±4.9</td>
<td>31.3±5.0</td>
<td>29.5±4.7</td>
<td>0.020</td>
</tr>
<tr>
<td>Gestational age (weeks, mean±SD)</td>
<td>37.2±1.5</td>
<td>37.7±1.5</td>
<td>31.7±2.2</td>
<td>30.5±2.0</td>
<td>0.001</td>
</tr>
<tr>
<td>Gravidity (mean±SD)</td>
<td>3.3±2.4</td>
<td>3.5±5.4</td>
<td>3.1±1.7</td>
<td>3.7±2.3</td>
<td>0.887</td>
</tr>
<tr>
<td>Parity (mean±SD)</td>
<td>1.9±1.7</td>
<td>1.5±1.3</td>
<td>1.5±1.4</td>
<td>1.9±1.7</td>
<td>0.620</td>
</tr>
<tr>
<td>Syst TA (mm/Hg, mean±SD)</td>
<td>160±18b</td>
<td>105±10c</td>
<td>173±18a</td>
<td>104±16c</td>
<td>0.001</td>
</tr>
<tr>
<td>Diast TA (mm/Hg, mean±SD)</td>
<td>103±10b</td>
<td>65±6c</td>
<td>110±11a</td>
<td>66±10c</td>
<td>0.001</td>
</tr>
<tr>
<td>Proteinuria (mean±SD)</td>
<td>2.67±1.1a</td>
<td>0±0b</td>
<td>3.0±1.2a</td>
<td>0.0±0.2b</td>
<td>0.001</td>
</tr>
<tr>
<td>Hemoglobin (g/dL, mean±SD)</td>
<td>12.0±1.4a</td>
<td>10.9±1.3b</td>
<td>11.9±1.3a</td>
<td>11.4±1.2ab</td>
<td>0.004</td>
</tr>
<tr>
<td>Hematocrit (%)</td>
<td>36±3a</td>
<td>33±3c</td>
<td>35±3ab</td>
<td>33±2bc</td>
<td>0.001</td>
</tr>
<tr>
<td>Platelets (x10³/µL, mean±SD)</td>
<td>240±84</td>
<td>235±82</td>
<td>200±83</td>
<td>236±51</td>
<td>0.152</td>
</tr>
<tr>
<td>WBC (µL/mL, mean±SD)</td>
<td>10.9±2.46</td>
<td>10.5±2.6</td>
<td>10.4±3.0</td>
<td>9.9±2.8</td>
<td>0.587</td>
</tr>
<tr>
<td>BUN (mg/dl, mean±SD)</td>
<td>8.9±3.0ab</td>
<td>7.3±2.5bc</td>
<td>10.4±3.9a</td>
<td>6.4±2.1c</td>
<td>0.001</td>
</tr>
<tr>
<td>Creatinine (mg/dl, mean±SD)</td>
<td>0.56±0.11b</td>
<td>0.47±0.09c</td>
<td>0.66±0.17b</td>
<td>0.46±0.08c</td>
<td>0.001</td>
</tr>
<tr>
<td>ALT (IU/l, mean±SD)</td>
<td>20±30</td>
<td>10±4</td>
<td>22±30</td>
<td>11±4</td>
<td>0.054</td>
</tr>
<tr>
<td>AST (U/l, mean±SD)</td>
<td>22±17</td>
<td>16±3</td>
<td>31±35</td>
<td>14±3</td>
<td>0.005</td>
</tr>
<tr>
<td>Birth weight (gram, mean±SD)</td>
<td>2960±691a</td>
<td>3249±483c</td>
<td>1650±467b</td>
<td>3172±346a</td>
<td>0.001</td>
</tr>
<tr>
<td>sENG (ng/ml, mean±SD)</td>
<td>17.24±1.73a</td>
<td>18.49±2.01ab</td>
<td>22.64±12.98b</td>
<td>18.21±4.48ab</td>
<td>0.015</td>
</tr>
<tr>
<td>MMP-14 (ng/ml, mean±SD)</td>
<td>2.83±0.31a</td>
<td>2.93±0.43a</td>
<td>3.82±0.94b</td>
<td>3.81±1.26b</td>
<td>0.001</td>
</tr>
</tbody>
</table>

LOPE Group 1: Late onset preeclampsia patient group, Control Group 2: Late onset preeclampsia control group, EOPE Group 3: Early onset preeclampsia patient group, Control Group 4: Early onset preeclampsia control group, Age: Maternal age, BMI: Body Mass Index, Gestational age: Gestational age at the time of diagnosis, Syst TA: Systolic blood pressure, Diast TA: Diastolic blood pressure, Proteinuria: Spot urine proteinuria by dipstick test, WBC: White blood cells, BUN: Blood urea nitrogen, ALT: Alanine aminotransferase, AST: Aspartate aminotransferase, sENG: Soluble Endoglin, MMP-14: Matrix metalloproteinase-14, n: Number, SD: Standard deviation, p<0.05 indicates statistical significance; a,b,c: different letters symbolize the difference between the groups.
Objective: The aim was to evaluate the possible etiologies for the second trimester fetal echogenic bowel (FEB) and outcome of pregnancies with FEB.

Materials and Methods: Results of 96 patients with hyperechogenic bowel pregnancy between April 2017 and December 2018 were evaluated retrospectively. History of bleeding in patients with intestinal echogenicity was investigated, targeted ultrasonographic examination was performed, Toxoplasmosis, Rubella, Cytomegalovirus serological evaluation was performed and amniocentesis was recommended for karyotype analysis and cystic fibrosis examination. Monochorionic twins were not included in the study.

Results: The patients were referred to the perinatology clinic because of fetal echogenic bowel at 20.7 ± 2.3 weeks. Bleeding history was present in 12 (12.5%) patients. CMV IgM was observed in 1 (1%) patient and Toxoplasma IgM in 1 (1%) patient. Avidity values of both infections were high and no active infection was considered. In the ultrasonographic examination, the most common soft marker was pyelectasis (n:10, 10.4%), the other soft markers were choroid plexus cyst (n:5, 5.2%), echogenic cardiac focus (n:4, 4.2%), increased nuchal fold (n:2, %2.1), hypoplasia of nasal bone (n:1, 1%) (Table 2). Eight patients accepted amniocentesis and one patient had already underwent CVS before admission. Among the 8 cases, FEB was the only indication for amniocentesis in two patients and both test results were normal (Table 3). In the follow up, there were 8 FGR (8.3%), 9 GDM (9.4%), 7 polyhydramnios (7.3%), 3 oligohydramnios (3.1%), 2 non-immune hydrops (2.1%), and 1 GHT (1%) (Table 1). Gastrointestinal pathology was not observed in neonatal follow-up at the end of the first month.

Conclusion: Fetal echogenic bowel, its identification and follow-up has still not been standardized. Patients with FEB should not only be evaluated for chromosomal or genetic abnormalities but also should be followed for perinatal complications. Even if identified reason can not be found, these pregnancies should be considered as high risk.

Key words: Echogenic bowel, soft marker, pregnancy, ultrasonography
### Tablo 1: Demographic and clinical features of the study group

<table>
<thead>
<tr>
<th>Feature</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td>27.8 ± 5.8</td>
</tr>
<tr>
<td>Gravida</td>
<td>2 (1-6)</td>
</tr>
<tr>
<td>Parity</td>
<td>1 (0-3)</td>
</tr>
<tr>
<td>Median week at diagnosis of FEB</td>
<td>20.7±2.3</td>
</tr>
<tr>
<td>Gestational week at delivery</td>
<td>37.6 ±3.2</td>
</tr>
<tr>
<td>Birth weight</td>
<td>3061.8±726.8</td>
</tr>
<tr>
<td>Female</td>
<td>30/80(37.5)</td>
</tr>
<tr>
<td>Male</td>
<td>50 /80(62.5)</td>
</tr>
<tr>
<td>Singleton pregnancy</td>
<td>92(95.8)</td>
</tr>
<tr>
<td>Multiple pregnancy</td>
<td>4(4.2)</td>
</tr>
<tr>
<td>Bleeding history</td>
<td>12(12.5)</td>
</tr>
<tr>
<td>Toxoplasma IgM+</td>
<td>1/84(1%)</td>
</tr>
<tr>
<td>Rubella IgM+</td>
<td>0</td>
</tr>
<tr>
<td>CMV IgM+</td>
<td>1/84(1%)</td>
</tr>
<tr>
<td>FGR, Oligohydramnios</td>
<td>8(8.3)</td>
</tr>
<tr>
<td>Polyhydramnios</td>
<td>3(3.1)</td>
</tr>
<tr>
<td>Hypoplasia of nasal bone</td>
<td>7(7.3)</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>10(10.4)</td>
</tr>
<tr>
<td>Gestational diabetes mellitus</td>
<td>9(9.4)</td>
</tr>
<tr>
<td>Gestational hypertension</td>
<td>1(1)</td>
</tr>
<tr>
<td>Intrauterin exitus of one twin</td>
<td>1(1)</td>
</tr>
<tr>
<td>Non immune hydrops</td>
<td>2(2.1)</td>
</tr>
<tr>
<td>Vaginal delivery</td>
<td>35(10.4)</td>
</tr>
<tr>
<td>Ceserean delivery</td>
<td>45(46.9)</td>
</tr>
<tr>
<td>Termination of pregnancy</td>
<td>4(4.2)</td>
</tr>
<tr>
<td>Intrauterin exitus</td>
<td>2(2.1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>10 (10.4)</td>
</tr>
</tbody>
</table>

FEB, fetal echogenic bowel, FGR, fetal growth restriction

### Tablo 2: Ultrasonographic results of the study group

<table>
<thead>
<tr>
<th>Ultrasonographic Findings</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choroid plexus cyst</td>
<td>5(5.2)</td>
</tr>
<tr>
<td>Echogenic cardiac focus</td>
<td>4(4.2)</td>
</tr>
<tr>
<td>Pyelectasis</td>
<td>10(10.4)</td>
</tr>
<tr>
<td>Hypoplasia of nasal bone</td>
<td>1(1)</td>
</tr>
<tr>
<td>Increased nuchal fold</td>
<td>2(2.1)</td>
</tr>
<tr>
<td>Total</td>
<td>22(22.9)</td>
</tr>
<tr>
<td>Cardiac abnormalities</td>
<td>2(2.1)</td>
</tr>
<tr>
<td>Skeletal abnormalities</td>
<td>2(2.1)</td>
</tr>
<tr>
<td>Placental abnormalities</td>
<td>5(5.2)</td>
</tr>
<tr>
<td>Others</td>
<td>2(2.1)</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
</tr>
</tbody>
</table>
Tablo 3: Evaluation of the study group that amniocentesis and chorionic villus sampling were performed

<table>
<thead>
<tr>
<th>CVS(n:1) ve A/S(n:8)</th>
<th>Bleeding history</th>
<th>Test result</th>
<th>Ultrasonographic Findings</th>
<th>Pregnancy outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trisomy 21 (CVS)</td>
<td>None</td>
<td>FTS high risk</td>
<td>Atrioventricular septal defect</td>
<td>Termination</td>
</tr>
<tr>
<td>Trisomy 21</td>
<td>None</td>
<td>FTS high risk</td>
<td>Reverse a wave in ductus venosus</td>
<td>Termination</td>
</tr>
<tr>
<td>Trisomy 18</td>
<td>None</td>
<td>None</td>
<td>Dolichocephaly, hyperechogenic kidney</td>
<td>Termination</td>
</tr>
<tr>
<td>Normal karyotype</td>
<td>None</td>
<td>None</td>
<td>Echogenic cardiac focus</td>
<td>Unknown</td>
</tr>
<tr>
<td>Normal karyotype</td>
<td>None</td>
<td>FTS low risk</td>
<td>None</td>
<td>Unknown</td>
</tr>
<tr>
<td>Normal karyotype</td>
<td>None</td>
<td>TT low risk</td>
<td>Choroid plexus cyst</td>
<td>Delivery</td>
</tr>
<tr>
<td>Normal karyotype</td>
<td>None</td>
<td>TT high risk</td>
<td>None</td>
<td>Delivery</td>
</tr>
<tr>
<td>Normal karyotype</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Delivery</td>
</tr>
<tr>
<td>Normal karyotype</td>
<td>None</td>
<td>TT low risk</td>
<td>Pyelectasis</td>
<td>Delivery</td>
</tr>
</tbody>
</table>

FTS First trimester screening, TT triple test
OP-045 Erken ve geç preterm eylem olgularında MPV değerlendirilmesi

Murat Alan¹, Mustafa Kurt²

¹SBU Tepecik Eğitim Araştırma Hastanesi, İzmir
²Hitit Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı, Çorum

Bu çalışmamızın amacı, preterm eylemde hemogram parametrelerinden trombosit indeksindeki değişiklikleri değerlendirmek ve preterm eylemi tanı için prediktif değeri taşıyıp taşımadığını araştırmaktır. Perinatal morbidite ve mortalitenin önemli nedenlerinden biri olduğu için preterm doğuma neden olanabilecek durumların önlenmesi ve erken tedavisinin sağlanması gerekmektedir. Risk faktörlerinin ve patolojik mekanizmalarının anlaşıldığını rağmen, perterm doğuma neden olan faktörlere, son yirmi yılda IVF gebeliklerinin artması ve yeni doğan yoğun bakım şartlarının muntazam şekilde iyileşmesi gibi bir çok nedenle bir çok ülkede yükselmeye başlanmıştır. Trombositler inflamatuar süreçte, mikrobiyal konakçı savunmasına, yara iyileşmesine, anjiyogenezne katkılarıyla, inflamasıya eşlik eden oksitativ stres trombositleri de aktifleştirebilir. Trombositlerin diğer hücrelerle etkileme yeteneği ve kronik inflamatuar yanıba bağlı morfolojik değişiklikleri birçok hastalığın patofizyolojisinin rol oynayabileceği gösterilmiştir.


Anahtar kelimeler: MPV, hemogram, inflamasyon
Fetal echocardiography plays an important role in the diagnosis of congenital heart diseases (CHD) in utero. The aim of this study was to investigate the distribution of CHD diagnosed with fetal echocardiography, accompanying anomalies and mortality rates in these cases.

Method: The files of patients diagnosed with CHD by fetal echocardiography between 2016-2018 were analyzed retrospectively. Postnatal mortality rates in cases diagnosed with antenatal CHD were evaluated.

Results: Five thousand fetal echocardiography was performed in 2 years and 162 CHD were diagnosed. The mean age of the pregnant women was 27.9 ± 6.4. The distribution of cardiac anomalies in fetal echocardiography are seen in the figure 1. 37% of pregnant women did not continue their follow-up. 34.6% of all pregnancies were delivered in our hospital, 16% were terminated and 5.6% were intrauterine exitus. Mortality rate was 12.3%. In cases who died after delivery; hypoplastic left heart (HLHS) (45%), single ventricle (20%), double outlet right ventricle (DORV) (10.5%), ventricular septal defect (VSD)-pulmonary atresia (5.2%), atroventricular septal defect (AVSD)-tricuspid atresia (5.2%) and tetralogy of Fallot with pulmonary valve absence (5%) were observed.

Conclusion: There are discussions about the effect of prenatal diagnosis on mortality in CHD. In our study, most of the patients who died were hypoplastic left heart syndrome cases. In the cases of hypoplastic left heart syndrome, even though antenatal diagnosis affects preoperative clinical status, the effect on mortality has not been demonstrated. Further studies are needed to evaluate the benefits of prenatal diagnosis in CHD and its effect on survival.

Key words: fetal, congenital, heart
Figure 1: Distribution of cardiac anomalies in fetal echocardiography

CARDIAC ANOMALIES IN FETAL ECHO

- VSD: 22%
- HLHS: 16%
- AVSD: 15%
- Other CHD: 20%
- Tetralogy of Fallot: 6%
- Single ventricle: 10%
- DORV: 11%
Fetal ekokardiyografı konjenital kalp hastalıklarının in utero tanısında önemli bir rol oynar. Bu çalışmanın amacı fetal ekokardiyografı ile tanı konulan konjenital kalp hastalıklarının (KKH) dağılımı, eşlik eden anomalileri ve bu olgulardaki mortalite oranlarını araştırmaktır.


Bulgular: 2 yılda 5 bin fetal ekokardiyografı yapıldı ve 162 adet konjenital kalp hastalığı tanısı konuldu. Gebeğin ortalama yaşları 27,9±6,4 idi. Fetal ekokardiyografide saptanan kardiyak anomalilerin dağılımı şekil 1’de görülmektedir. Gebeğin %37’si takiplere devam etmedi. Tüm gebeğin %34,6’sı hastanemizde doğmuş, %16’sı sonlandırma ve %5,6’sı intrauterin eksişti olup, Mortalite oranı %12,3 idi. Doğum sonrası eksişti olan olgularda; hipoplastik sol kalp (%45), tek ventrikül (%20), çift çıkışı sağ ventrikül (%10,5), ventriküler septal defektli (VSD)-pulmoner atrezi (%5,2), atriyoval ventriküler septal defekt (AVSD) ve trikuspit atrezi (%5,2) ve pulmoner kapak yoklu önlü Fallot tetralojisi (%5) izlendi.


Anahtar kelimeler: fetal, konjenital, kalp
Fetal ekokardiyografide saptanan kardiyak anomalilerin dağılımı

- Diğer KKH: 20%
- VSD: 22%
- Fallot tetraligisi: 6%
- Tek ventrikül: 10%
- Çift çıkışlı sağ ventrikül: 11%
- Atrofoplastik sol kalp: 16%
- AVSD: 15%
OP-047 Renal çift toplayıcı sistem vakalarımızın prenatal bulguları ve postnatal sonuçları

Didar Kurt, Tuğba Saraç Sivrikoz, Aylin Onan Yılmaz, Lütfiye Uygur, Çiğdem Kunt İşgüder, İbrahim Kalelioğlu, Recep Has, Atıl Yüksel

İstanbul Üniversitesi İstanbul Tip Fakültesi, Kadın Hastalıkları ve Doğum Kliniği, Perinatoloji Bölümü, İstanbul, Türkiye

Amaç: Prenatal dönemde çift toplayıcı sistem tanısı alan olguları, ultrasonografik özellikleri ve postnatal sonuçları açısından değerlendiririk.

Metod: Bu çalışma hastanemizde son 4 yıllık sürede prenatal dönemde renal çift toplayıcı sistem anomalisi tanısı alan olgularının ultrasonografi verileri ve postnatal klinik bulguları kayıt altına alınarak yapılmıştır.

Bulgular: Toplam 28 vakânın prenatal bulguları incelemiştir. Bu olgulardan 1 tanesi intrauterin mort fetalis olduğu, 1 tanesi termine edildiği, 1 vakaya ulaşılamadığı ve 5 vakânın da gebeliği devam ettiği için, postnatal dönemde toplam 20 vakânın verileri incelemiştir. Ortalama tanı haftası±SD; 25.78±5.05 idi. Etkilenen vakaların 9 tanesi (%32.1) kız, 19 tanesi (%67.9) erkek cinsiyetindeydi. Etkilenen böbrek 10 vakada (%35.7) sağ taraf, 13 vakada (%46.4) sol taraf, 5 vakada (%17.9) her iki böbrekti. Prenatal dönemde vakaların 21 tanesinde (%75) renal pelvislerde dilatasyon mevcuttu. Dilate olan kısmın 10 vakada (%35.7) üst taraf, 3 vakada (%10.7) altında, 8 vakada (%28.6) ise her iki tarafta, bunların 16 tanesinde kaliektazi de vardı. Toplam 3 vakada böbrekte kortikal kist (%10.7), 12 vakada (%42.9) megauureter ve 15 vakada (%53.6) ise üreterosele saptanmıştır. Postnatal tüm hastalara proflaktik antibiyotik tedavisi verilmiştir, sadece 2 vakada idrar yolu enfeksiyonu gelişmiştir. Postnatal 11 vakada vezikoüreteral reflü (VUR) saptanmış, 2 vakada (%10) böbrek yetme zığı gelişmiştir. Postnatal 12 vakada üreterosele yönelik, 3 vakada VUR’a yönelik, 2 vakada darlığa yönelik operasyon gerektirmiştir.

Sonuç: Prenatal dönemde çift toplayıcı sistem anomalisi tanısı başarı ile koyulabilme tedir. Bu vakaların prenatal tanınması, postnatal dönemde uygun takip ve tedavilerin erken düzenlenmesi için önem taşımaktadır.

Anahtar kelimeler: Çift toplayıcı sistem, prenatal tanı, üreterosele, vezikoüreteral reflü
Ege Üniversitesi Tıp Fakültesi Hastanesi, Kadın Hastalıkları ve Doğum Anabilim Dalı, Perinatoloji Bilim Dalı, İzmir, Türkiye


Anahtar kelimeler: galen, anevrizma, perinatal, seri

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<th>2</th>
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<th>4</th>
<th>5</th>
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<td>37</td>
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<td>25</td>
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<tr>
<td>Ek Bulgular</td>
<td>sağ kalp yetmezliği, kardiyomegali</td>
<td>Kardiyomegali</td>
<td>Yok</td>
<td>Kardiyomegali</td>
<td>Kardiyomegali, triküspid yetmezliği, asit</td>
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<tr>
<td>GVA Çapı (Doğumda)</td>
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<td>13 mm</td>
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<td>36x30mm</td>
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<td>37</td>
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<td>32</td>
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<td>NSVD</td>
<td>C/S</td>
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<td>APGAR Skoru (1-5 dk)</td>
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<td>7/9</td>
<td>7/8</td>
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<td>Embolizasyon</td>
<td>Postpartum 4.gün</td>
<td>Postpartum 2.gün</td>
<td>Yapılmadi</td>
<td>Postpartum 3. gün</td>
<td>Yapılmadi</td>
</tr>
</tbody>
</table>
OP-049 Mean platelet volume of patients who have plasental invasive anomalies

Ülkü Ayşe Türker, Esra Kartal, Ahmet Demirci, Engin Korkmazer, Kaan Pakay

Republic of Turkey Ministry of Health, Saglik Bilimleri University, Bursa Yüksek İhtisas Education and Research Hospital, Bursa, Turkey

Aim: Plasental invasion anomaly (PIA) is defined as abnormal adhesion of myometrium placenta due to lack of decidua basalis. Risk factors for PIA include advanced maternal age, increase in parity, presence of submucous leomyoma, pelvic radiotherapy but the most important risk factor is previous uterine surgery. PIA is increasing in frequency due to increased cesarean rates. The diagnosis is made by the loss of the hypoechoic area in the ultrasonography, the presence of intraplacental sonolusen lacuna, irregular vascular occlusion in the placenta and the increased vascular signal in doppler ultrasonography. Magnetic resonance imaging is also used. Many parameters have been studied in the prediction of PIA but there is no clear indicator. We aimed to evaluate the relationship between mean platelet volume and PIA.

Methods: Forty pregnant patients diagnosed with PIA and 50 controls were recruited for this retrospective study, between 18-35 years and between June 2017 and December 2018 in the Department of Obstetrics and Gynecology, Bursa Yüksek İhtisas Education Research Hospital. Exclusion criteria were as follows: neonatal with congenital anomaly, ex fetus, multiple gestations, who have never been diagnosed before, patients who had been using alcohol and smoking. A total of 90 patients were analyzed in this study. In addition, age, body mass index, gravida, parite, previous uterine surgery of the patient group were recorded.

Results: Patients who underwent cesarian section due to the diagnosis of 40 PIAs and 50 without PIA diagnosis and who underwent cesarian section because of uterine surgery history were included in the study. The groups were similar with descriptive demographic characteristics (Table 1). A significant difference was observed between the two groups in terms of mean platelet volume (Table 2).

Conclusion: We think that MPV can be used in addition to radiological markers in terms of prediction of PIA. We believe that there is a need for more studies because of the low number of patient and a single center study.

Key words: Placental invasion anomaly, mean platelet volume
Table 1: Descriptive demographic characteristic

<table>
<thead>
<tr>
<th></th>
<th>PIĄ (n=40)</th>
<th>PIĄ olmayan (n=50)</th>
<th>p değeri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>34±4.65</td>
<td>33.76±5.18</td>
<td>0.872</td>
</tr>
<tr>
<td>BMI</td>
<td>25.61±2.12</td>
<td>25.06±2.03</td>
<td>0.384</td>
</tr>
<tr>
<td>Gravida</td>
<td>4 (2-9)</td>
<td>4 (2-11)</td>
<td>0.951</td>
</tr>
<tr>
<td>Parity</td>
<td>2 (1-7)</td>
<td>2 (1-10)</td>
<td>0.938</td>
</tr>
<tr>
<td>Previous uterin surgery</td>
<td>2 (1-7)</td>
<td>2 (1-4)</td>
<td>0.063</td>
</tr>
</tbody>
</table>

BMI: Body mass index  p<0.05 statistically significant

Table 2: between the two groups in hematological value

<table>
<thead>
<tr>
<th></th>
<th>PIĄ (n=40)</th>
<th>NOT A PIĄ (n=50)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperatif hemoglobin (g/dl)</td>
<td>9.51±1.52</td>
<td>9.55±1.13</td>
<td>0.869</td>
</tr>
<tr>
<td>Preoperatif platelet (/mm³)</td>
<td>244200±71037.2</td>
<td>239720±82609.6</td>
<td>0.838</td>
</tr>
<tr>
<td>Preoperatif MPV(femtolitre)</td>
<td>8.8±1.3</td>
<td>9.3±1.7</td>
<td>0.0431</td>
</tr>
<tr>
<td>Preoperatif AST (IU/L)</td>
<td>23.25±9.72</td>
<td>25.76±12.61</td>
<td>0.493</td>
</tr>
<tr>
<td>Preoperatif ALT (IU/L)</td>
<td>17.33±5.87</td>
<td>19.72±9.3</td>
<td>0.510</td>
</tr>
<tr>
<td>Preoperatif glucose (mg/dl)</td>
<td>83.19±11.41</td>
<td>82.24±11.16</td>
<td>0.792</td>
</tr>
<tr>
<td>Preoperatif urea (mg/dl)</td>
<td>10.93±7.07</td>
<td>9.71±3.59</td>
<td>0.385</td>
</tr>
<tr>
<td>Preoperatif creatinine (mg/dl)</td>
<td>0.74±0.36</td>
<td>0.57±0.12</td>
<td>0.483</td>
</tr>
</tbody>
</table>
OP-049 Plasental invazyon anomalisi olan hastalarda ortalama platelet volümünün yeri

Ülkü Ayşe Türker, Esra Kartal, Ahmet Demirci, Engin Korkmazer, Kaan Pakay

S.B.Ü Tıp Fakültesi, Bursa Yüksek İhtisas EAH, Kadın Hastalıkları ve Doğum Anabilim Dalı, Bursa


Sonuç: PIA’sini öngörme açısından radyolojik belirteçler yanında MPV’nin de kullanılabileneğini düşünmektediriz. Hasta sayımızın az olması ve tek merkezli bir çalışma olması sebebi ile daha fazla çalışma olması sebebi ile daha fazla çalışmaya ihtiyaç olduğu kanaatindeyiz.

Anahtar kelimeler: Plasental invazyon anomalisi, ortalama platalet hacmi
Tablo 1: Gruplar arasındaki tanımlatıcı demografik özellikleri

<table>
<thead>
<tr>
<th></th>
<th>PİA (n=40)</th>
<th>PİA olmayan (n=50)</th>
<th>p değeri</th>
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</thead>
<tbody>
<tr>
<td>Yaş</td>
<td>34±4.65</td>
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<td>0.872</td>
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<tr>
<td>VKİ</td>
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<td>25.06±2.03</td>
<td>0.384</td>
</tr>
<tr>
<td>Gravide</td>
<td>4 (2-9)</td>
<td>4 (2-11)</td>
<td>0.951</td>
</tr>
<tr>
<td>Parite</td>
<td>2 (1-7)</td>
<td>2 (1-10)</td>
<td>0.938</td>
</tr>
<tr>
<td>Geçirilmiş uterin cerrahi</td>
<td>2 (1-7)</td>
<td>2 (1-4)</td>
<td>0.063</td>
</tr>
</tbody>
</table>

VKİ: Vücut kitle indeksi p<0,05 istatistiksel olarak anlamlı kabul edilmiştir.

Tablo 2: PİA ve kontrol grubunun hematolojik verileri

<table>
<thead>
<tr>
<th></th>
<th>PİA (n=40)</th>
<th>PİA OLMAYAN (n=50)</th>
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</tr>
<tr>
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<td>0.385</td>
</tr>
<tr>
<td>Preoperatif kreatinin (mg/dl)</td>
<td>0.74±0.36</td>
<td>0.57±0.12</td>
<td>0.483</td>
</tr>
</tbody>
</table>
Objective: To investigate the perinatal outcomes in pregnant women with absent or reversed end-diastolic velocity (A/REDV) waveform due to early-onset and late-onset umbilical artery doppler examination.

Methods: A total of 42 pregnant women were included in the study between 22 and 35 weeks of gestation with A/REDV in the umbilical artery doppler. 31 of them were diagnosed before 32 weeks of gestation and 11 of them were diagnosed after 32 weeks of gestation. Doppler flowmetry including A/REDV were used to predict the perinatal outcomes based on gestational age (GA).

Results: The mean GA was 28.3 and 33.5 in pregnant women with early-onset and late-onset impaired doppler findings according to the last menstrual period; the mean birth weight was 808 g and 1581 g; the mean duration of staying in the neonatal intensive care unit at 49,05 and 20,88 days, the need for intubation was 74% and 50%, respectively. Fetuses who were diagnosed before 32 GA with impaired doppler findings had higher composite adverse outcomes (62% vs 27%). Arterial pH <7.2 were 3/17 (17.6%) and 0/8 (%0), preeclampsia 48.3% and 27.2%; intrauterine growth restriction was 74% and 63%, respectively. Fetal biophysical profile score <6 was found to be 45% (14) and 27.2% (3), oligohydramnios were detected as 61.2% (19), 45.4% (5). The mean days from diagnosis to delivery was 6.68 and 2.27, respectively. Neonatal death was 45.1% (14/31) in early onset. Neonatal death was not observed in late-onset. There was no intrauterine death in the study.

Conclusion: Early-onset umbilical artery doppler investigations are associated with adverse perinatal outcomes in pregnancies with A/REDV compared to late-onset pregnancies.

Key words: Doppler; high-risk pregnancy; absent or reversed end-diastolic velocity waveform; doppler ultrasonography
### Table 1: Baseline characteristics

<table>
<thead>
<tr>
<th></th>
<th>Early onset (n=31)</th>
<th>Late onset (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>29.74</td>
<td>29.73</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primipar</td>
<td>%35 (11)</td>
<td>%27.2 (3)</td>
</tr>
<tr>
<td>Multipar</td>
<td>%64.5 (20)</td>
<td>%72.7 (8)</td>
</tr>
<tr>
<td>AMA</td>
<td>%22.5 (7)</td>
<td>%27.2 (3)</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>%48.3 (15)</td>
<td>%27.2 (3)</td>
</tr>
<tr>
<td>GDM</td>
<td>%9.6 (3)</td>
<td>%0</td>
</tr>
<tr>
<td>IUGR</td>
<td>%74.1 (23)</td>
<td>%63.6 (7)</td>
</tr>
<tr>
<td>Corticosteroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single dose</td>
<td>%21.4 (6)</td>
<td>%25 (2)</td>
</tr>
<tr>
<td>Double dose</td>
<td>%78.5 (22)</td>
<td>%75 (6)</td>
</tr>
<tr>
<td>Corticosteroid to delivery*</td>
<td>5.75</td>
<td>1.75</td>
</tr>
</tbody>
</table>

*days, GDM, Gestational diabetes; IUGR, intrauterine growth restriction; AMA: Advanced maternal age

### Table 2: Pregnancy outcomes

<table>
<thead>
<tr>
<th></th>
<th>Early onset (n=31)</th>
<th>Late onset (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA Diagnosis**</td>
<td>27.10</td>
<td>33.0</td>
</tr>
<tr>
<td>GA Delivery**</td>
<td>28.32</td>
<td>33.55</td>
</tr>
<tr>
<td>Diagnosis to delivery*</td>
<td>6.68</td>
<td>2.27</td>
</tr>
<tr>
<td>Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-section</td>
<td>%96.7 (30)</td>
<td>%100 (11)</td>
</tr>
<tr>
<td>Vaginal Birth</td>
<td>%3.22 (1)</td>
<td>%0 (0)</td>
</tr>
<tr>
<td>Fetal indications</td>
<td>%100 (31)</td>
<td>%100 (11)</td>
</tr>
<tr>
<td>Maternal indications</td>
<td>%48.3 (15)</td>
<td>%27.2 (3)</td>
</tr>
<tr>
<td>BPP ≤ 6</td>
<td>%45 (14)</td>
<td>%27.2 (3)</td>
</tr>
<tr>
<td>Oligohydramnios</td>
<td>%61.2 (19)</td>
<td>%45.4 (5)</td>
</tr>
</tbody>
</table>

**weeks, *days, GA: Gestational age; BBP: Biophysical profile
**Table 3: Neonatal outcomes**

<table>
<thead>
<tr>
<th></th>
<th>Early onset</th>
<th>Late onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean birth weight</td>
<td>808.39</td>
<td>1581.36</td>
</tr>
<tr>
<td>Mean length of stay in the NICU*</td>
<td>49.05</td>
<td>20.88</td>
</tr>
<tr>
<td>NEC</td>
<td>2/29(%6)</td>
<td>1/11(%9)</td>
</tr>
<tr>
<td>IVH</td>
<td>4/29(%13)</td>
<td>0/11(%0)</td>
</tr>
<tr>
<td>Sepsis</td>
<td>8/29(%27)</td>
<td>2/11(%18)</td>
</tr>
<tr>
<td>RDS</td>
<td>4/29(%13)</td>
<td>1/11(%9)</td>
</tr>
<tr>
<td>Composite adverse outcomes</td>
<td>18/29(%62)</td>
<td>3/11(%27)</td>
</tr>
<tr>
<td>Severe outcomes (demise, NEC, IVH)</td>
<td>17/31(%54)</td>
<td>1/11(%9)</td>
</tr>
<tr>
<td>Neonatal death</td>
<td>14/31 (%45,1)</td>
<td>0/11(%0)</td>
</tr>
<tr>
<td>APGAR Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.min</td>
<td>5.61 (17)</td>
<td>7 (%)</td>
</tr>
<tr>
<td>5.min</td>
<td>6.68 (16)</td>
<td>8.18 (%)</td>
</tr>
<tr>
<td>Intubation need</td>
<td>23/31 (%74.1)</td>
<td>4/11 (%)</td>
</tr>
<tr>
<td>Mean number of days intubated*</td>
<td>13.33</td>
<td>3.25 (%)</td>
</tr>
</tbody>
</table>

*days, NICU, Neonatal intensive care unit; NEC, Necrotizing enterocolitis; IVH, Intraventricular hemorrhage; RDS, Respiratory distress syndrome; Composite adverse outcomes, NEC, IVH, sepsis, retinopathy, gangrene in the extremity, thrombocytopenia, RDS, pulmonary haemorrhage; Severe outcomes, Demise, NEC, IVH

**Table 4: Neonatal blood gas and hemogram**

<table>
<thead>
<tr>
<th></th>
<th>Early onset</th>
<th>Late onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial pH</td>
<td>7.31 (17)</td>
<td>7.33 (8)</td>
</tr>
<tr>
<td>Arterial pH &lt;7.2</td>
<td>3/17 (%17.6)</td>
<td>0/8 (%0)</td>
</tr>
<tr>
<td>Arterial pH &gt;7.2</td>
<td>14/17 (%82.3)</td>
<td>8/8 (%100)</td>
</tr>
<tr>
<td>Bicarbonate</td>
<td>22.16 (16)</td>
<td>23.05 (8)</td>
</tr>
<tr>
<td>Bas deficit</td>
<td>2,39 (16)</td>
<td>4,34 (8)</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>12,62 (31)</td>
<td>18,33 (11)</td>
</tr>
<tr>
<td>Platelet</td>
<td>212,77 (31)</td>
<td>181,82 (11)</td>
</tr>
<tr>
<td>Neutrophil</td>
<td>8,66 (31)</td>
<td>7,33 (11)</td>
</tr>
<tr>
<td>Lymphocyte</td>
<td>2,05 (31)</td>
<td>3,71 (11)</td>
</tr>
</tbody>
</table>
OP-050 Erken başlangıçlı ve geç başlangıçlı umbilikal arter doppler flowmetride ters akım ya da diyastol sonu akım kaybı olan gebeliklerin perinatal sonuçlarının değerlendirilmesi

Esra Kartal, Özlem Ballı, Kaan Pakay, Engin Korkmazer

S.B.Ü Tıp Fakültesi, Bursa Yüksek İhtisas EAH, Kadın Hastalıkları ve Doğum Anabilim Dalı, Bursa

Amaç: Erken başlangıçlı ve geç başlangıçlı umbilikal arter doppler incelemesi sonucunda ters akım veya diyastol sonu akım kaybı bulunan gebelere perinatal sonuçları incelemek.


Bulgular: Ortalama doğum haftası; son adet tarihine göre erken başlangıçlı ve geç başlangıçlı bozuk doppler bulguları olan gebelere sırasıyla 28,3 ve 33,5; ortalama yeni doğan yoğun bakımda kalma süresi sırasıyla 49,05 ve 20,88 günken, ortalama doğum ağrılığı 808 ve 1581 gramdı; entübasyon ihtiyacı sırasıyla %74 ve %50 saptı. 32 gebelik haftasından önce bozuk doppler tanısi olan gebelerde kötü perinatal sonuç daha yüksek saptı (%62 ve %27). Arterial pH <7,2 olanlar sırasıyla %3/17 (%18) ve 0/8 %0, preeklampsi sırasıyla %48,3 ve %27,2; intrauterin gelişme geriliği %74 ve %63 saptı. Fetal biyofizik profil skoru 6’nın altında olanlar sırasıyla %45 (14), %27,2 (3) ve oligohidroamnioz sırasıyla %61,2 (19), %45,4 (5) saptı. Tanıdan doğuma kadar geçen ortalama süre sırasıyla 6,68 ve 2,27 gündür. Yenidoğan ölümü erken başlangıçlılarla %45,1 (14/31) olarak gerçekleşmiştir. Geç başlangıçlılarla yenidoğan ölümü gözlenmemiştir. İntrauterin ölüm gözlenmedi.

Sonuç: Erken başlangıçlı umbilikal arter Doppler incelemelerinde ters akım veya diyastol sonu akım kaybı olan gebeliklere, geç başlangıçlı gebeliklere göre kötü perinatal sonuçlarla ilişkilidir.

Anahtar kelimeler: Bozuk doppler; yüksek riskli gebelik; end diastolik akım kaybı; doppler ultrasonografisi
Tablo 1: Karakteristik özellikler

<table>
<thead>
<tr>
<th>Özellik</th>
<th>Erken başlangıçlı (n=31)</th>
<th>Geç başlangıçlı (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yaş</td>
<td>29,74</td>
<td>29,73</td>
</tr>
<tr>
<td>Parite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primipar</td>
<td>%35 (11)</td>
<td>%27,2 (3)</td>
</tr>
<tr>
<td>Multipar</td>
<td>%64,5 (20)</td>
<td>%72,7 (8)</td>
</tr>
<tr>
<td>İleri anne yaşı</td>
<td>%22,5 (7)</td>
<td>%27,2 (3)</td>
</tr>
<tr>
<td>Preeklampsi</td>
<td>%48,3 (15)</td>
<td>%27,2 (3)</td>
</tr>
<tr>
<td>GDM</td>
<td>%9,6 (3)</td>
<td>%0</td>
</tr>
<tr>
<td>IUGR</td>
<td>%74,1 (23)</td>
<td>%63,6 (7)</td>
</tr>
<tr>
<td>Kortikosteroid yapılanlar</td>
<td>%90 (28)</td>
<td>%72,7 (8)</td>
</tr>
<tr>
<td>Tek doz</td>
<td>%21,4 (6)</td>
<td>%25 (2)</td>
</tr>
<tr>
<td>Çift doz</td>
<td>%78,5 (22)</td>
<td>%75 (6)</td>
</tr>
<tr>
<td>Kortikosteroid doğum arası gün</td>
<td>5,75</td>
<td>1,75</td>
</tr>
</tbody>
</table>

GDM, Gestasyonel diyet; IUGR, intrauterin gelişme geriliği

Tablo 2: Gebelik sonuçları

<table>
<thead>
<tr>
<th>Özellik</th>
<th>Erken başlangıçlı (n=31)</th>
<th>Geç başlangıçlı (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanı haftası</td>
<td>27,10</td>
<td>33,0</td>
</tr>
<tr>
<td>Doğum haftası</td>
<td>28,32</td>
<td>33,55</td>
</tr>
<tr>
<td>Tanı doğum arası gün</td>
<td>6,68</td>
<td>2,27</td>
</tr>
<tr>
<td>Doğum şekli</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sezaryen</td>
<td>%96,7 (30)</td>
<td>%100(11)</td>
</tr>
<tr>
<td>NVD</td>
<td>%3,22 (1)</td>
<td>%0 (0)</td>
</tr>
<tr>
<td>Fetal endikasyonlar</td>
<td>%100(31)</td>
<td>%100 (11)</td>
</tr>
<tr>
<td>Maternal endikasyonlar</td>
<td>%48,3 (15)</td>
<td>%27,2 (3)</td>
</tr>
<tr>
<td>FBP ≤ 6</td>
<td>%45 (14)</td>
<td>%27,2 (3)</td>
</tr>
<tr>
<td>Oligohidroamnioz</td>
<td>%61,2 (19)</td>
<td>%45,4 (5)</td>
</tr>
</tbody>
</table>

FBP: Fetal biyofizik profili; NVD: Normal vajinal doğum
Tablo 3: Neonatal sonuçlar

<table>
<thead>
<tr>
<th>Doğum ağırlığı</th>
<th>Erken başlangıçlı</th>
<th>Geç başlangıçlı</th>
</tr>
</thead>
<tbody>
<tr>
<td>YDYBÜ kalış süresi*</td>
<td>808,39</td>
<td>1581,36</td>
</tr>
<tr>
<td>NEK</td>
<td>49,05</td>
<td>20,88</td>
</tr>
<tr>
<td>İVH</td>
<td>2/29(%6)</td>
<td>1/11(%9)</td>
</tr>
<tr>
<td>Sepsis</td>
<td>4/29(%13)</td>
<td>0/11(%0)</td>
</tr>
<tr>
<td>RDS</td>
<td>8/29(%27)</td>
<td>2/11(%18)</td>
</tr>
<tr>
<td>Kötü perinatal sonuç</td>
<td>4/29(%13)</td>
<td>1/11(%9)</td>
</tr>
<tr>
<td>Ağır perinatal sonuç (ölmü, NEK, IVH)</td>
<td>18/29(%62)</td>
<td>3/11(%27)</td>
</tr>
<tr>
<td>Yenidoğan ölümü</td>
<td>17/31(%54)</td>
<td>1/11(%9)</td>
</tr>
</tbody>
</table>
| APGAR Skoru | 14/31 (%45,1) | 0/11 |%
| 1.dk | 5,61 | 7 |
| 5.dk | 6,68 | 8,18 |
| Entübasyon ihtiyacı | 23/31 (%74,1) | 4/11 (%36) |
| Entübe gün sayısı | 13,33 | 3,25 |

Tablo 4: Neonatal kanganı ve hemogram

<table>
<thead>
<tr>
<th>Arterial pH</th>
<th>Erken başlangıçlı</th>
<th>Geç başlangıçlı</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial pH &lt;7,2</td>
<td>7,31 (17)</td>
<td>7,33 (8)</td>
</tr>
<tr>
<td>Arterial pH &gt;7,2</td>
<td>3/17 (%17,6)</td>
<td>0/8 (%0)</td>
</tr>
<tr>
<td>Bikarbonat</td>
<td>14/17 (%82,3)</td>
<td>8/8 (%100)</td>
</tr>
<tr>
<td>Baz açığı</td>
<td>22,16 (16)</td>
<td>23,05 (8)</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>2,39 (16)</td>
<td>4,34 (8)</td>
</tr>
<tr>
<td>Platelet</td>
<td>12,62 (31)</td>
<td>18,33 (11)</td>
</tr>
<tr>
<td>Nötrofil</td>
<td>212,77 (31)</td>
<td>181,82 (11)</td>
</tr>
<tr>
<td>Lenfosit</td>
<td>8,66 (31)</td>
<td>7,33 (11)</td>
</tr>
<tr>
<td></td>
<td>2,05 (31)</td>
<td>3,71 (11)</td>
</tr>
</tbody>
</table>

*gün; YDYBÜ, Yenidoğan yoğun bakım Ünitesi; NEK, Nekroz izlenikler; İVH, intraventriküler hemoraji; RDS, Respiratuar distres sendromu; kötü perinatal sonuç (NEK, intraventriküler hemoraji, sepsis, retinopati, ekstremite gangren, trombositopeni, RDS, pulmoner hemorajiden herhangi birini içeren grup)
Cengiz Gokcek Maternity and Child’s Health Hospital, Department of Perinatology, Gaziantep, Turkey

Objective: Presentation of intrauterine transfusions (IUT) in terms of perinatal outcomes and evaluation of the performance of middle cerebral artery peak systolic velocity (MCA-PSV) in prediction of fetal anemia in first and following IUTs.

Methods: This is a retrospective study of a continuous series of fetuses with suspected anemia undergoing IUT between 2017 and 2019. Doppler measurements, fetal hemoglobin (Hb) levels before and after the procedures were all recorded. Perinatal outcomes were characterized. MCA-PSV multiple of median (MoM) in prediction of severe fetal anemia were calculated for the first and consequent IUTs. Also daily decrease in fetal Hb levels were assessed.

Results: 29 fetuses were included in this study (one dichorionic twin pair) to whom 107 IUTs were performed. 21 of them required second IUT and 17 required third. Highest number of IUTs for the same fetus was eight (in one fetus). There were four cases ended up with intrauterine demise and another four died in the postnatal period (one diagnosed with congenital leukemia). MCA-PSV MoM was associated with severe anemia before the first transfusion, significantly compared with subsequent IUTs (p=0,004) (Table 1).

Conclusion: Intrauterine blood transfusion is a relatively safe procedure. MCA-PSV MoM prediction was more significant for severe fetal anemia in the untransfused group.

Key words: Fetal anemia, MCA PSV, prediction

| Table 1 |
|----------|-----------------|-----------------|-----------------|-----------------|
|          | Severe anemia   | MCA-PSV MoM     | Moderate anemia | MCA-PSV MoM     | p value         |
|          | (n)             | (mean±SD)       | (n)             | (mean±SD)       |                 |
| First IUT | 22              | 1,91 (0,44)     | 7               | 1,55 (0,16)     | 0,004           |
| Second IUT| 9               | 1,63 (0,14)     | 12              | 1,57 (0,22)     | 0,48            |
| Third IUT | 5               | 1,74 (0,36)     | 12              | 1,49 (0,34)     | 0,2             |
Aim: To determine the association between adverse perinatal outcomes and serum aminotransferase levels in intrahepatic cholestasis of pregnancy.

Materials and Methods: 179 patients hospitalized with the diagnosis of “Intrahepatic Cholestasis of Pregnancy” and gave birth between 2014-2018 were included in this study (patients with hypertension, insulin dependent diabetes, total bile acid levels (TBA)< 10µmol/L, liver diseases, congenital/chromosomal anomalies, multiple pregnancies were excluded).

Maternal demographic data, and information about TBA levels, aminotransferase levels were collected. Week of gestation at birth, method of birth, birth weight, presence of preterm birth, fetal distress, meconium stained amniotic fluid, admission to neonatal intensive care unit, fetal demise and APGAR scores were noted.

Results: No difference was found related to demographic information between groups of TBA and transaminase levels. Frequency of preterm birth in pregnant women with TBA ≥40µmol/L was higher than the group with TBA<40µmol/L (p=0.01). In pregnancies with serum ALT≥125IU/L, rates of preterm birth and low/very low birth weight was higher than the ones with ALT<25 IU/L (p<0.01 and p<0.05). Cut-off ALT value for preterm birth was found to be 99.5IU/L and rates of preterm birth increased above this level. Statistically significant differences were not present between the TBA and transaminase groups in terms of fetal distress, meconium stained amniotic fluid and admission to neonatal intensive care unit.

Conclusion: ICP is generally benign for the mother whereas the perinatal complications, some of which cannot be predicted, attribute the disease high significance in clinical practice. Patients who have higher levels than the stated values of TBA and ALT should be evaluated in regards of these risks.

Key words: Aminotransferase, bile acid, intrahepatic cholestasis of pregnancy
### Table 1: Perinatal complication rates in ALT level groups

<table>
<thead>
<tr>
<th>Variables</th>
<th>ALT LEVEL (IU/L)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>X²</th>
<th>p**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALT≤25</td>
<td>25&lt;ALT≤125</td>
<td>ALT&gt;125</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal Distress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>36</td>
<td>75</td>
<td>52</td>
<td>52</td>
<td>31,9</td>
<td>2,9</td>
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<tr>
<td>Present</td>
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<td>4</td>
<td>8</td>
<td>8</td>
<td>50,0</td>
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<tr>
<td>NICU Admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>3</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>40,0</td>
<td>1,9</td>
<td>0,40</td>
</tr>
<tr>
<td>Absent</td>
<td>37</td>
<td>43,5</td>
<td>50</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preterm Birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>36</td>
<td>61</td>
<td>43,5</td>
<td>43,5</td>
<td>27</td>
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<tr>
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<td>25</td>
<td>45</td>
<td>45</td>
<td>50</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear</td>
<td>38</td>
<td>77</td>
<td>45</td>
<td>45</td>
<td>32,8</td>
<td>1,4</td>
<td>0,50</td>
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<tr>
<td>Meconium stained</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td>Birth Weight</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>LBW/VLBW</td>
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<td>70</td>
<td>47</td>
<td>47</td>
<td>39,9</td>
<td>8,1</td>
<td>0,017</td>
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<tr>
<td>Normal weight</td>
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<td>9</td>
<td>13</td>
<td>13</td>
<td>21,3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Row percentage  
** Pearson Chi-square test  

### Table 2: Perinatal complication rates in bile acid level groups

<table>
<thead>
<tr>
<th>Variables</th>
<th>BILE ACID LEVEL (µmol/L)</th>
<th></th>
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<th></th>
<th></th>
<th>X²</th>
<th>p**</th>
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<tbody>
<tr>
<td></td>
<td>BA&lt;40</td>
<td>BA ≥40</td>
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<tr>
<td>Fetal Distress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>127</td>
<td>36</td>
<td>22,1</td>
<td></td>
<td>0,1</td>
<td>1,00</td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>13</td>
<td>3</td>
<td>18,8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission to NICU</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
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<td>6</td>
<td>24</td>
<td></td>
<td>0,1</td>
<td>0,77</td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>121</td>
<td>33</td>
<td>21,4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preterm birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>32</td>
<td>17</td>
<td>34,7</td>
<td></td>
<td>6,6</td>
<td>0,01</td>
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</tr>
<tr>
<td>Absent</td>
<td>108</td>
<td>22</td>
<td>16,9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amniotic Fluid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear</td>
<td>135</td>
<td>36</td>
<td>21,1</td>
<td></td>
<td>1,2</td>
<td>0,37</td>
<td></td>
</tr>
<tr>
<td>Meconium-stained</td>
<td>5</td>
<td>3</td>
<td>37,5</td>
<td></td>
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<td></td>
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<tr>
<td>Birth Weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LBW/VLBW</td>
<td>18</td>
<td>5</td>
<td>21,7</td>
<td></td>
<td>0,1</td>
<td>0,99</td>
<td></td>
</tr>
<tr>
<td>Normal weight</td>
<td>122</td>
<td>34</td>
<td>21,8</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* Row percentage  
** Chi-square test
Figure 1: ROC analyses of diagnostic value of ALT for preterm birth (p<0.05; AUC=0.70)
OP-053 Tip 1 split spinal kord malformasyonların prenatal tanısı ve gebelik sonuçları

Duygu Adıyaman¹, Melda Kuyucu², Bahar Konuralp Atakul², Öзğür Öztekin²

¹Sağlık Bilimleri Üniversitesi, Tepecik Eğitim ve Araştırma Hastanesi, Perinatoloji Bilim Dalı, İzmir
²Sağlık Bilimleri Üniversitesi, Tepecik Eğitim ve Araştırma Hastanesi, Radyoloji Anabilim Dalı, İzmir

Amaç ve Yöntem: Perinatoloji polikliniğine 2017-2019 arasında başvuran ve prenatal dönemde Tip 1 Split Spinal Kord Malformasyonu (SSKM) saptanan 5 hastanın prenatal yönetimindeki klinik tecrübemizi ve postnatal izlem sonuçlarını paylaşmaktadır.


Anahtar kelimeler: Tip 1 Split Spinal Kord Malformasyonu, prenatal tanı, fetal MR

<table>
<thead>
<tr>
<th>YAŞ</th>
<th>GEBELİK HAFTASI</th>
<th>KARYOTİPLEME</th>
<th>FETAL MR</th>
<th>DOĞUM HAFTASI</th>
<th>DOĞUM KİLOSU</th>
<th>POST-NATAL İZLEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>OLGU 1</td>
<td>18</td>
<td>22</td>
<td>Normal Karyotip</td>
<td>Lomber tip 1 SSSM diastometamyeli</td>
<td>38</td>
<td>3285</td>
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<tr>
<td>OLGU 2</td>
<td>25</td>
<td>18</td>
<td>Normal Karyotip</td>
<td>Alt torakal-lomber tip 1 SSSM</td>
<td>39</td>
<td>3380</td>
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<tr>
<td>OLGU 3</td>
<td>26</td>
<td>19</td>
<td>Normal Karyotip</td>
<td>Alt torakal-lomber tip 1 SSSM; sağa bakan rotoskolyoz</td>
<td>38</td>
<td>2935</td>
</tr>
<tr>
<td>OLGU 4</td>
<td>30</td>
<td>19</td>
<td>Normal Karyotip</td>
<td>Lomber tip 1 SSSM</td>
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<td>3100</td>
</tr>
<tr>
<td>OLGU 5</td>
<td>30</td>
<td>18</td>
<td>Pallistar Klian sendromu 47,+i(12p)</td>
<td>Torakal Tip I SSSM; torakal rotoskolyoz; spinal kanalda genişleme</td>
<td>37</td>
<td>2410</td>
</tr>
</tbody>
</table>

Bulgular: Ocak 2016- Ocak 2019 tarihleri arasında Tepecik Eğitim ve Araştırma Hastanesi Perinatoloji klinikinde tanı almış veya kliniğimize referi edilmiş 21 fetal abdominal kist öntanılı hasta değerlendirildi. Yapılan incelmelere sonucunda bu kistlerin 18 tanesi ovarian kaynaklı olduğu, 2 tanesi mezenter ve 1 tanesi intestinal duplikasyon kisti olduğu bulunmuştur. Bu hastalardan 2 tanesi (%11.1) 2. Trimestrda tanı almış olup, 16 tanesi (%88.8) 3. trimestrda tanı almıştır. Tanı anında ortalama gebelik haftası 33,6 (min 22-max 38) olarak bulunmuştur. Ortalama maternal yaş 27.4 (min 18-max 36), nullipar sayısı 8 (%44,4), ortalama kist boyutu 39,3*33,8*35,1 mm, ortalama doğum kilosu 3372 gram (min 2650- max 3670), ortalama doğum haftası 39,1 (min 38- max 41) olarak bulunmuştur. Bu hastaların 12 tanesi sezaryan ile doğmuş (%66,6) olup 6 tanesi (%33,3) normal spontan vajinal yolla doğmuştır. 2 tane over kisti ön tanıli hastanın gebelik takibi devam etmektedir. 18 over kisti olan vakânın 2 tanesinde over kistleri bilateral (%9) yerleşmiş ve unilateral yerleşimli olan kistlerin 8 tanesi sağ over (%50), 8 tanesi ise sol over (%50) yerleşmiştir. Bu hastaların 6 tanesinde (%33.3) kist boyutları 5 cm üzerindedir. Kist boyutu 5 cm üzerinde olan hastaların 3 tanesi (%50) postpartum dönemde opere edilmiş olup patoloji sonucu seröz kistadenom olarak raporlanmış, ve bu hastalardan 1’i torsiyon nedeniyle opere edilmiş olup unilateral salpingooferektomi yapılmıştır. 3 hastaya postpartum takip kararı verilmiştir. Opere edilen hastaların 1 tanesinde kist boyutu 5 cm altında olup ve patoloji sonucu lutein kisti ile uyumlu olarak rapor edilmiştir. Hastaların hizbirinde prenatal takip sırasında over kistinde rezolüsyon görmülmüştür. 12 hastaya ise postpartum takip kararı verilmiş olup, postnatal yapılan ultrason değerlendirmeleri ile over kisti tanısı doğrulanmıştır. Takip sırasında 6 hastada kistler spontan rezolüsyona uğramış, 6 hastada ise kist boyutlarında küçülme saptanmış ve takibe devam edilmektedir.


Anahtar kelimeler: over kisti, torsiyon, ultrasonografi
OP-055 Gebeliğin intrahepatik kolestazı ve genetik inceleme

Gülten Özgen, Gültekin Adanaş Aydın, Ferhan Zengin

Bursa Yüksek İhtisas Eğitim ve Araştırma Hastanesi, Bursa, Türkiye

Giriş: Gebeliğin intrahepatik kolestazı gebeliklerin ortalama 1/1000 ile 1/10000'de izlenmektedir ve tanı genellikle 3. trimesterde safra asitleri ve karaciğer enzimlerinde yükselme ve kaşıntı ile karakterizedir. İntrahepatik kolestaz mekonyumlu amniyon sıvısı, preterm doğum riski, fetal distress, anormal intrapartum fetal kalp trasesi ile ani intrapartum fetal mortaliteye sebep olabilmektedir. Etyopatogenezinde hormonal, genetik ve çevresel faktörler sluçanılmakla birlikte kesin etyoloji net olarak bilinmemektedir.


Hastanın yapılan genetik incelemelerinde PFIC (Progresif Familyal İntrahepatik Kolestazis) paneli ABCB4, ABCB11 ve ATP8B1 gen analizi Yeni Nesil Dizi Analizi ile tüm kodlanan ekzonlar, ekzon-intron bileşikleri, 5’ ve 3’ düzenleyici bölgeler incelemiştir. ATPB81(NM_005603) geninde heterozigot p.Asp70Asn (c.208G>A) değişimi saptanmıştır. Saptanan değişim literatürde bildirilmiş olup (HGMD:CM043812) gebeliğin intrahepatik kolestazı ile ilişkilendirilmiştir.

Sonuç: PFIC tip 1 hastalarında ATP8B1 geninde birçok mutasyon saptanmıştır. PFIC tip 1 otozomal resexif geçiş gösteren genetik bir hastalıktır. PFIC tip 1 hastalarında ATP8B1 geninde birçok mutasyon saptanmıştır. Son yıllarda ilerleyici ailesel intrahepatik kolestazda (PFIC) safra asit tuzlarının taşımásından sorumlu olan (BSEP ve ABCB11) ve multidrug resistsans protein 3 (MDR3) ile bağlantılı bulunmuştur. BSEP,ABC taşıyıcı ailesinin bir üyesi olup konjuğa safra asitlerinin safra kanallarının içine taşımasını sorumludur. Birkaç çalışmada BSEP gen heterozigot mutasyon ICP hastalarında saptanırken bazılarında ise diğer çalışmalarda BSEP polimorfizim bulunamamıştır.
OP-056 Karadeniz bölgesinde riskli gebelere önerilen non-invazif prenatal tarama testleri (NIPT) ve prenatal invazif tanı testlerine (PİTT) hastaların bakış açısı

Uğur Turhan
Sağlık Bilimleri Üniversitesi, Samsun Eğitim ve Araştırma Hastanesi, Kadın Hastalıkları ve Doğum, Perinatoloji, Samsun


Bulgular: Çalışma katılan hastaların demografik verilerine bakıldığında; maternal yaş 18-41 yıl (ort. 32), gebelik haftası 13-39 hafta (ort. 23). 953 hastaya (% 58) PİTT, 558 hastaya (% 34) NIPT önerildi, 131 hastaya (% 8) herhangi bir ek genetik test önermedi. PİTT önerilen 953 hastadan sadece 45 olgu (% 4,8 ) invazif prenatal tanı testi yaptırmayı kabul etti. NIPT önerilen hastalardan sadece 12 hasta (% 2.1) işlemi yaptırdı. Sonuç: Genetik tanı yöntemlerinin kullanımı artıkça, erken prenatal tanı ile sağlıklı bebeklere ulaşılması ve günden güne genetik hastalıkların önlenmesi amaçlanmaktadır. Fakat istatistikler göstermektedir ki Türkiye gibi ülkelerde hastaların genetik testlere bakış açısı, fetal anomalileri ve fetal anomaliler mevcudiyetinde bile, % 95,2 gibi büyük bir çoğunun mevcut durumu geleneksel bir bakış açısı ile değerlendirildi ve herhangi bir karyotipleme yapılmak istemediğini gösterdi.

Tartışma: Mevcut bu çelişki, toplumun sosyokültürel düzeyi ile de ilgili olduğu sonucunu doğurdu.

Anahtar kelimeler: prenatal invazif tanı testleri, non-invazif prenatal tarama testleri, NIPT
<table>
<thead>
<tr>
<th>Hasta grubu</th>
<th>Hasta sayısı</th>
<th>NIPT önerilen</th>
<th>NIPT yaptırılan</th>
<th>PITT önerilen</th>
<th>PITT yaptırılan</th>
<th>Herhangi bir genetik test yaptırırmak istemeyen</th>
</tr>
</thead>
<tbody>
<tr>
<td>TT yüksek risk</td>
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<td>-</td>
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<td>TT orta risk</td>
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<td>Majör fetal anomalı</td>
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<td>-</td>
<td>-</td>
<td>386</td>
<td>15 (3,8)</td>
<td>371</td>
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<td>minör/ soft bulgular varlığı</td>
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<td>476</td>
<td>4</td>
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<td>4</td>
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<td>öyküde kr. bozukluğu veya anomalili bebek öyküsü</td>
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<td>-</td>
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<td>28</td>
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<td>-</td>
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<td>1 (0,2)</td>
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</tr>
<tr>
<td></td>
<td>1644</td>
<td>736 (44,7)</td>
<td>28 (1,7)</td>
<td>934 (56,8)</td>
<td>45 (4,8)</td>
<td>1571 (95,2)</td>
</tr>
</tbody>
</table>
Amaç ve yöntem: Fetal manyetik rezonans görüntüleme (MRG), gastrointestinal sistem (GİS) malformasyonlarında doku kontrast çözünürlüğü ile tanıya önemli katkı sağlamaktadır. Çalışmamızda GİS malformasyonlarında ultrasonografi (USG) ile değerlendirme sonrası yetersiz tanı nedeniyle fetal MRG istediğimiz hastalar değerlendirilmiştir. Amacımız GİS patolojilerinde fetal MRG’nin prenatal tanıya katkısını paylaşmaktır.

Bulgular: Perinatoloji kliniğimize 2016-2018 yılları arasında başvuran ve USG sonrası GİS patolojisi endikasyonu ile fetal MRG istediğimiz 34 hastayı değerlendirildik. Maternal obezite, ileri gebelik haftası ve oligohidramnioz nedenli yetersiz değerlendirmelerde şüphede kalnan GİS bulguları için fetal MRG endikasyonu verildi. Hastaların yaş ortalaması 27,68 (± 5,8) idi. Tanı haftası 27,12 (min 17 - max 38) idi. 3 hastaya özefagus atrezisi, 4 hastaya anal atrezi, 1 hastaya jejunoileal atrezi, 1 hastaya duodenal atrezi, 12 hastaya intestinal obstrüksiyon şüphesi, 1 hastaya intestinal duplicasyon kisti, 6 hastaya mezenter kisti, 1 hastaya köledok kisti, 1 hastaya OEİS kompleksi, 2 hastaya omfalosel, 6 hastaya mezenter kisti, 1 hastaya koledok kisti, 1 hastaya hepatoblastom ön tanı ile fetal MRG istendi. Ultrasonografik değerlendirme sonrası özefagus atrezisi, intestinal ans genişliği ve köledok kisti düşünülen toplam 15 (%44,1) hastanın fetal MRG sonucu normal olarak raporlandı. Bebeklerde postpartum değerlendirildiğinde patoloji izlenmedi. Özefagus atrezi şüphesi olan 2 vakânın tanısı fetal MRG ve postnatal değerlendirildiğinde doğrulanmıştı. Abdominal hamartom ve hepatoblastom ön tanılı hastaların fetal MRG sonucu hepatik hemanjom olarak raporlandı ve tanı postnatal MRG ile desteklendi. USG’de anorektal atrezi düşünülen 2 hastada fetal MRG jejunal atrezi olarak raporlandı ve postnatal jejunal atrezi nedeni ile bebekler opere edildi. USG’de intestinal obstrüksiyon düşünülen 13 hastanın 4’ünde (%11,7) fetal MRG’de anal atrezi şüphesi olarak raporlandı ancak postnatal bebekler sağlıklı izlendi.

Sonuç: Fetusün incelemesinde temel değerlendirme yöntemi ultrasonografidir ancak fetal MRG, yetersiz ultrasonografik tanı durumlarında, tanıyı doğrulamak ve uygun gebelik yönetimi planlamak için kullanılabilir. Fetal MRG, sadece fetus santral sinir sistemi anomalilerinde değil GİS malformasyonlarının da prenatal tanısında USG’nin en önemli yardımcı olduğu yerini almaya başlamıştır.

Anahtar kelimeler: fetal GİS malformasyonları, prenatal tanı, fetal MRG
Objective: Preeclampsia (PE) is a life threatening obstetric disorder and condition for the mothers and babies which is usually cannot be controlled and prevented. The objective of this study is to demonstrate the roles of hematological markers at determine the usefulness of them at deciding the severity of PE.

Methods: This research is a retrospective and cross-sectional study performed between January 2010 and March 2018. SPSS (Statistical Package for Social Sciences) version 15.0 (SPSS Inc., USA) is used for statistical analysis. Kolmogorov-Smirnov, Anova, Kruskal-Wallis, Paired Samples and Wilcoxon tests are used for interpreting data. Test results are assessed within 95% confidence interval and statistical significance is considered if p < 0.05.

Results: 469 pregnant women were recruited into our study. 165 women delivered with severe preeclampsia, 155 with mild preeclampsia and 149 with gestational hypertension. Comparison of the hematological parameters after the diagnosis of SPE, MPE and GHT; MPV was higher in SPE subgroup with respect to MPE and GHT subgroups (respectively p=0.043, p=0.014) and that was unchanged between MPE and GHT subgroups (p=0.651). PDW, RDW, PCT, NLR, Hb ve PLR were found unchanged among three subgroups (respectively p=0.66, p=0.153, p=0.908, p=0.137, p=0.350 p=0.528). PC is significantly lower in SPE with respect to both MPE and GHT subgroups. Also, PC is significantly lower in MPE than in GHT (p=0.021).

Comparison of the hematological parameters before the diagnosis of SPE, MPE and GHT; MPV, RDW, PDW, PCT, NLR, PC, PLR and Hb parameters were found indifferent among three subgroups prior to diagnoses of SPE, MPE and GHT (respectively p=0.60,p= 0.153, p=0.388,p=0.908, p=0.443, p=0.154,p=0.103,p=0.350).

Conclusion: Platelet count and MPV may be used to determine severity of preeclampsia. As preeclampsia gets severer, MPV increases and platelet count is lowered.

Key words: Mean platelet volume, Platelet count, Severity of preeclampsia, hematologic parameter
Table 1. Comparison of hematological parameters in SPE, MPE and GHT subgroups

<table>
<thead>
<tr>
<th></th>
<th>SPE (n=165)</th>
<th>MPE(n=155)</th>
<th>GHT(n=149)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPV</td>
<td>9.42 ± 1.57</td>
<td>8.91 ± 1.51</td>
<td>8.67 ± 1.23</td>
<td>0.005</td>
</tr>
<tr>
<td>RDW</td>
<td>16.63±1.81</td>
<td>16.19±1.99</td>
<td>16.10±1.69</td>
<td>0.153</td>
</tr>
<tr>
<td>PDW</td>
<td>17.76±2.15</td>
<td>17.17±1.91</td>
<td>17.70 ± 1.56</td>
<td>0.66</td>
</tr>
<tr>
<td>PCT</td>
<td>0.203±0.10</td>
<td>0.202±0.058</td>
<td>0.218±0.06</td>
<td>0.108</td>
</tr>
<tr>
<td>NLR</td>
<td>8.19±12.04</td>
<td>5.55±7.03</td>
<td>5.38±3.24</td>
<td>0.137</td>
</tr>
<tr>
<td>Hb</td>
<td>12.16±1.60</td>
<td>12.10±1.40</td>
<td>12.18±1.42</td>
<td>0.350</td>
</tr>
<tr>
<td>PC</td>
<td>216.88±88.49</td>
<td>230.95±70.86</td>
<td>239.55±55.52</td>
<td>0.021</td>
</tr>
<tr>
<td>PLR</td>
<td>129.45±75.27</td>
<td>145.19±162.58</td>
<td>152.87±133.78</td>
<td>0.528</td>
</tr>
</tbody>
</table>

Table 2. Hematological parameters of subgroups before the diagnoses of SPE, MPE and GHT

<table>
<thead>
<tr>
<th></th>
<th>SPE (n=165)</th>
<th>MPE(n=155)</th>
<th>GHT(n=149)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPV</td>
<td>9.12±1.49</td>
<td>8,92 ± 1,56</td>
<td>8,51 ± 1,40</td>
<td>0.060</td>
</tr>
<tr>
<td>RDW</td>
<td>16.20±1.82</td>
<td>16.05±1.86</td>
<td>15.61 ± 1.59</td>
<td>0.153</td>
</tr>
<tr>
<td>PDW</td>
<td>17.44±2.07</td>
<td>17.21±2.17</td>
<td>17.66 ± 1.58</td>
<td>0.388</td>
</tr>
<tr>
<td>PCT</td>
<td>0.208±0.07</td>
<td>0.204±0.05</td>
<td>0.206 ± 0.05</td>
<td>0.908</td>
</tr>
<tr>
<td>NLR</td>
<td>9.68±48.87</td>
<td>4.59±3.31</td>
<td>5.28±4.97</td>
<td>0.443</td>
</tr>
<tr>
<td>Hb</td>
<td>12.36±1.38</td>
<td>12.10±1.40</td>
<td>12.13±1.40</td>
<td>0.350</td>
</tr>
<tr>
<td>PC</td>
<td>234.36±66.36</td>
<td>236.71±64.64</td>
<td>251.57±58.36</td>
<td>0.154</td>
</tr>
<tr>
<td>PLR</td>
<td>129.24±49.60</td>
<td>131.03±74.81</td>
<td>136.67±59.81</td>
<td>0.103</td>
</tr>
</tbody>
</table>
Amaç: Gebelikte tanı alan maternal sifiliz olgularının demografik özelliklerinin, prenatal sonografik bulgularının ve perinatal sonuçlarının incelenmesi amaçlanmıştır.

Yöntem: Haziran 2017- Aralık 2018 tarihleri arasında gebelikte sifiliz tanısı ile takip edilen 15 olgu geriye dönük olarak incelendi. Hastalara maternal sifiliz taraması amacıyla öncelikle nontreponemal VDRL (venereal disease research laboratory) testi uygulandı, serolojik tanı RPR (rapid plasma reagin) ve treponemal test olan TPHA (Treponema pallidum hemagglutination assay) ile doğrulandı.


Sonuç: Maternal sifiliz antenatal dönemde tanı konulabilen ve etkin bir şekilde tedavi edilerek maternal ve perinatal kötü sonuçların engellenebilirdileggən intrauterin enfeksiyondur. Bu nedenle risk faktörlerinden bağımsız birçok şekilde ilk antenatal vizitte rutin taraça yapılmasını yansısa fetal enfeksiyonu düşündürecek sonografik bulgular varlığında maternal sifiliz olağanı akla getirilmelidir.

Anahtar kelimeler: sifiliz, antenatal tarama, perinatal sonuçlar
<table>
<thead>
<tr>
<th>Olgu</th>
<th>Yaş</th>
<th>Tanı haftası</th>
<th>Tanı endikasyonu</th>
<th>Tanı anındaki serolojik test sonucu</th>
<th>Tedavi başlama haftası</th>
<th>Tedavi-doğum intervali &gt; 30 gün</th>
<th>Yenidoğan serolojik test sonucu</th>
<th>Lomber ponksiyon sonucu</th>
<th>Yenidoğan komplikasyonu</th>
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<tbody>
<tr>
<td>1</td>
<td>32</td>
<td>25 hf</td>
<td>Rutin tarama</td>
<td>TPHA 1/320 RPR 1/32</td>
<td>26 hf</td>
<td>+</td>
<td>TPHA 1/320 RPR 1/16</td>
<td>LP (-)</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>22</td>
<td>15 hf</td>
<td>Rutin tarama</td>
<td>TPHA 1/320 RPR 1/16</td>
<td>18 hf</td>
<td>+</td>
<td>TPHA 1/160 RPR 1/8</td>
<td>LP (-)</td>
<td>-</td>
</tr>
<tr>
<td>3 1.</td>
<td>23</td>
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<td>Plasentomegali, kardiyomegali, anemi, asit</td>
<td>TPHA 1/160 RPR 1/32</td>
<td>-</td>
<td>-</td>
<td>TPHA 1/320 RPR 1/32</td>
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<td>3 2.</td>
<td>24</td>
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<td>Maternal sifiliz öyküsü</td>
<td>TPHA 1/160 RPR 1/4</td>
<td>24 hf</td>
<td>+</td>
<td>TPHA 1/80 RPR ¾</td>
<td>LP (-)</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>34</td>
<td>35 hf</td>
<td>FGK, pleural efüzyon</td>
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<td>-</td>
<td>TPHA 1/160 RPR 1/16</td>
<td>LP (-)</td>
<td>-</td>
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<tr>
<td>5</td>
<td>20</td>
<td>25 hf</td>
<td>Erken FGK, plasentomegali, asit</td>
<td>TPHA 1/320 RPR 1/32</td>
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<td>LP (-)</td>
<td>Koryoretinit</td>
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<td>32 hf</td>
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<td>TPHA 1/320 RPR ¾</td>
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<td>-</td>
</tr>
<tr>
<td>7</td>
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<td>Taşikardi, sınırda sistolik disfonksiyon</td>
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<td>LP (-)</td>
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<td>9</td>
<td>26</td>
<td>7 hf</td>
<td>Rutin tarama</td>
<td>TPHA 1/160 RPR 1/4</td>
<td>8 hf</td>
<td>+</td>
<td>VDRL (-) RPR (-)</td>
<td>LP (-)</td>
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</tr>
<tr>
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<td>32</td>
<td>9 hf</td>
<td>Rutin tarama</td>
<td>TPHA 1/80 RPR ¾</td>
<td>9 hf</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>Gebelik devam ediyor</td>
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<td>11</td>
<td>28</td>
<td>8 hf</td>
<td>Rutin tarama</td>
<td>TPHA 1/160 RPR 1/8</td>
<td>10 hf</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>24 haftadan sonra takibe devam etmedi</td>
</tr>
<tr>
<td>12</td>
<td>23</td>
<td>7 hf</td>
<td>Rutin tarama</td>
<td>TPHA 1/320 RPR 1/16</td>
<td>9 hf</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>24 haftadan sonra takibe devam etmedi</td>
</tr>
<tr>
<td>13</td>
<td>21</td>
<td>15 hf</td>
<td>Rutin tarama</td>
<td>TPHA 1/320 RPR 1/8</td>
<td>16 hf</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>38 haftada FGK endikasyonu ile dış merkezde doğum</td>
</tr>
<tr>
<td>14</td>
<td>30</td>
<td>35 hf</td>
<td>Sol tibiada belirgin angulasyon, tibia &lt; 5 pc</td>
<td>TPHA 1/640 RPR 1/32</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Tanı sonrası takibe devam etmedi</td>
</tr>
</tbody>
</table>

FGK: fetal gelişme kısıtlılığı, TPHA: Treponema pallidum hemagglutination assay RPR: rapid plasma reagin
Hüseyin Ekici

Ege Üniversitesi Tıp Fakültesi, Kadın Hastalıkları ve Doğum Ana Bilim Dalı, İzmir

Amaç: İlk trimester ultrasonografide saptanan üriner sistem anomalileri arasında yer alan fetal megasistis tanılı olgulara karyotip sonuçları, ek ultrasonografi bulguları ve gebelik sonuçlarını hakkında tek merkez deneyimlerimizi aktarmak.


Sonuç: İlk trimesterde ultrasonografi ile tanı konabilen fetal megasistis, intrauterin tedavi seçeneği olan üriner sistem anomalilerindendir. Ek ultrason bulguları, karyotip anomalileri açısından değerlendirildikten sonra persiste olan vakalarda ciddi pulmoner hipoplazi gerçekleşeceğinden dolayı terminasyon veya fetal cerrahi seçeneği dikkatle değerlendirilmelidir.

Anahtar kelimeler: fetal megasistis, koryonik villus örneklemesi, fetal cerrahi
OP-061 Prenatal dönemde aort koarktasyonu tanısı ile takip edilen olguların postnatal sonuçları

Aylin Yılmaz¹, Tuğba Saraç Sivrikoz¹, Didar Kurt¹, Lütfiye Uygur¹, Çiğdem İşgüder¹, İbrahim Kalelioğlu¹, Recep Has¹, Atıl Yüksel¹, Rukiye Eker Ömeroğlu²

¹İstanbul Üniversitesi, İstanbul Tıp Fakültesi, Kadın Hastalıkları ve Doğum Ana Bilim Dalı, Perinatoloji Bilim Dalı
²İstanbul Üniversitesi, İstanbul Tıp Fakültesi, Çocuk Sağlığı ve Hastalıkları Ana Bilim Dalı, Çocuk Kardiyo洛i Bilim Dalı


Materyal-Metod: Çalışma sürecinde prenatal dönemde aort koarktasyonu tanısı ile takip edilen 64 olgunun prenatal bulgu ve postnatal sonuçları retrospektif olarak incelendi.

Bulgular: Ortalama tanı haftası 24.5 hafta (20-31 hafta) idi. Fetal kardiyak incelemede 54 olguda dört oda kesitinde ventriküler orantısızlık (84,3%), 47 olguda üç damar trakea kesitinde aortada darlık (73,4%) ve 19 olguda sagittal kesitte transvers aortik arkta darlık (29,6%) izlendi. Eşlik eden kardiyak anomaliler 19 olguda VSD (29,6%), bir olguda büyük arter transpozisyonu (1,5%), bir olguda hipoplastik sol kalp sendromu (1,5%), bir olguda sol izomerizm (1,5%) ve bir olguda aort stenozu (1,5%) idi. Karyotip analizi yapılan 34 olgudan 30’unda normal karyotip, 4’ünde anormal karyotip sonucu izlendi. Anormal karyotip sonuçları iki olguda Turner sendromu, bir olguda trisomi 18 ve bir olguda Di George sendromu olarak saptandı. 52 olgunun (81,2%) postnatal verilerine ulaşıldı ve ortalama takip süresi 25,1 aydı (6-42 ay). Gebelik 11 olguda terminasyon (21,1%) ile 42 (78,9%) olguda canlı doğum ile sonuçlandı. Canlı doğanın ortalaması 35,1 kaçağı (28-41 kaçağı) ve ortalaması doğum ağırlığı 3007 gramdı (1100-4100 gram). Canlı doğanın 27’si (65,8 %) yenidöğan yoğun bakım ünitesinde takip edildi. Postnatal ekokardiyografi incelemesinde 10 olguda normal kardiyak inceleme (24,3%), 31 olguda aort koarktasyonu (75,7%) saptandı. Aort koarktasyonu nedeniyle 18 olgu (43,9%) opere edildi ve 9 olgu (21,9%) postoperatif kompleksasyonlar nedeniyle kaybedildi.


Anahtar kelimeler: aort koarktasyonu, prenatal tanı, postnatal sonuç
Tablo 1: Prenatal Bulgular

<table>
<thead>
<tr>
<th></th>
<th>n = (%) veya (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tanıda GH</strong>*</td>
<td>26,28 (17-38)</td>
</tr>
<tr>
<td><strong>Ventriküler orantısızlık</strong></td>
<td>54 (84,3)</td>
</tr>
<tr>
<td><strong>RV/LV</strong> ortani</td>
<td>1,63 (1,31-2,21)</td>
</tr>
<tr>
<td><strong>3 damar trakea kesitinde aorta darlığı</strong></td>
<td>47 (73,4)</td>
</tr>
<tr>
<td><strong>Sagittal kesitte transvers arkta darlık</strong></td>
<td>19 (29,6)</td>
</tr>
<tr>
<td><strong>PSVS</strong>*</td>
<td>5 (7,8)</td>
</tr>
<tr>
<td><strong>Ek kardiyak anomali</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>VSD: 19(29,6)</td>
</tr>
<tr>
<td></td>
<td>BAT: 1 (1,5)</td>
</tr>
<tr>
<td></td>
<td>Hipoplastik sol kalp:1(1,5)</td>
</tr>
<tr>
<td></td>
<td>Sol izomerizm:1(1,5)</td>
</tr>
<tr>
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<td>Aort stenozu:1 (1,5)</td>
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<tr>
<td><strong>Karyotip sonucu</strong></td>
<td>Normal:30 (46,8)</td>
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<tr>
<td></td>
<td>Anormal:4 (6,2)</td>
</tr>
<tr>
<td><strong>Kromozomal anomali</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trisomi 18: 1(1,56)</td>
</tr>
<tr>
<td></td>
<td>Turner: 2 (3,12)</td>
</tr>
<tr>
<td></td>
<td>Di George: 1 (1,56)</td>
</tr>
<tr>
<td><strong>IUBK</strong>**</td>
<td>11 (17,1)</td>
</tr>
<tr>
<td><strong>Ek anomali</strong></td>
<td>Borderline ventriküломegali: 4 (6,2)</td>
</tr>
<tr>
<td></td>
<td>Yarık damak-dudak: 2 (3,1)</td>
</tr>
<tr>
<td></td>
<td>Asit:2 (3,1)</td>
</tr>
<tr>
<td></td>
<td>Pes ekinovarus:1(1,5)</td>
</tr>
<tr>
<td></td>
<td>Omfalosel:1(1,5)</td>
</tr>
<tr>
<td></td>
<td>Duedonal atrezi:1(1,5)</td>
</tr>
<tr>
<td></td>
<td>Korpus kallosum disgenезisi:1(1,5)</td>
</tr>
<tr>
<td></td>
<td>Clenched hand:1(1,5)</td>
</tr>
<tr>
<td></td>
<td>Multikistik böbrek:1(1,5)</td>
</tr>
</tbody>
</table>

*Gestasyonel hafta  
**Sağ ventrikül/sol ventrikül  
***Persistan sol vena cava superior  
****İnteruterin büyüme kısıtlılığı

Tablo 2: Postnatal Bulgular

<table>
<thead>
<tr>
<th></th>
<th>n = (%) veya (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gebelik sonucu</strong></td>
<td>Terminasyon:11 (21,1)</td>
</tr>
<tr>
<td></td>
<td>Canlı doğum: 41 (78,9)</td>
</tr>
<tr>
<td><strong>Ortalama doğum zamanı (hafta)</strong></td>
<td>35,1 (28-41)</td>
</tr>
<tr>
<td><strong>Doğum ağırlığı (gr)</strong></td>
<td>3007 (1100-4100)</td>
</tr>
<tr>
<td><strong>YDYBÜ</strong> ihtiyacı</td>
<td>27 (65,8)</td>
</tr>
<tr>
<td><strong>YDYBÜ</strong> kalış süresi (gün)</td>
<td>21,74(1-90)</td>
</tr>
<tr>
<td><strong>Ekokardiyografi sonucu</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Normal:10</td>
</tr>
<tr>
<td></td>
<td>Aort koarktasyonu:24</td>
</tr>
<tr>
<td></td>
<td>Aort koarktasyonu+VSD:3</td>
</tr>
<tr>
<td></td>
<td>Aort koarktasyonu+Hipoplastik sol kalp:4</td>
</tr>
<tr>
<td><strong>Operasyon</strong></td>
<td>18 (43,9)</td>
</tr>
<tr>
<td><strong>Operasyon zamanı (gün)</strong></td>
<td>6,3 (1-12)</td>
</tr>
<tr>
<td><strong>Toplam yaşam süresi (ay)</strong></td>
<td>25,1 (6-42)</td>
</tr>
<tr>
<td><strong>Neonatal ölüm</strong></td>
<td>9 (21,9)</td>
</tr>
</tbody>
</table>

*Yenidoğan Yoğun Bakım Ünitesi
OP-062 Preeklampsi olgularında nötrofil / lenfosit oranı, trombosit / lenfosit oranı ve ortalama trombosit hacim düzeylerinin değerlendirilmesi

Cihan Kabukçu, Ümit Çabuş, Babür Kaleli

Pamukkale Üniversitesi, Kadın Hastalıkları ve Doğum Anabilim Dalı, Denizli

Amaç: Bu çalışmada preeklampsi tanısı ile izlenen gebelerde nötrofil /lenfosit oranı, trombosit / lenfosit oranı ve ortalamda trombosit hacim düzeylerinin değerlendirilmesi ve bu indekslerin preeklamptik hastalarda inflamatuvar belirteç olarak kullanılabilirliği amaçlanmıştır.


Bulgular: Maternal yaş ve gebelik sayısı ile iki grup arasında anlamlı istatistiksel fark tespit edildi (p>0,05). Maternal yaş preeklampsi grubunda 29,36±6,49, kontrol grubunda 28,71±6,48 olarak bulundu. Gebelik haftası, doğum ağırlığı ve ağıp skorları kontrol grubuna kıyaslı preeklampsi grubunda anlamlı olarak düşük bulundu (p<0,05). Ortalama trombosit hacmi (MPV) değeri normal gebelerde 10,04±1,36, preeklampsi gebelerde 10,25±1,70 olarak saptandı (p=0,412). Nötrofil / lenfosit oranı (NLO) ve trombosit / lenfosit oranı (PLO) sırasıyla normal gebelerde 5,06±2,47, 118,9±48,8 preeklampsili gebelerde 4,69±3,19, 125,6±68,0 olarak bulundu (p=0,172, p=0,915). İki grup arasında MPV, NLO ve PLO oranları arasında istatistiksel anlamlı fark tespit edildi.

Sonuç: Mevcut çalışma sonucunda inflamatuvar belirteç olarak kabul edilen nötrofil /lenfosit oranının ve trombosit / lenfosit oranın preeklampsi tanısı alan hastalarda, hastalığın şiddetini gösteren etkin bir belirteç olmadığı gösterilmistiştir.

Anahtar kelimeler: Preeklampsi, Ortalama trombosit hacmi, Nötrofil /lenfosit oranı, Trombosit / lenfosit oranı
### Tablo 1: Preeklampsi ve kontrol grubunda hasta özellikleri ve doğum öncesi kan parametreleri

<table>
<thead>
<tr>
<th>Özellikler</th>
<th>Preeclampsı n=50</th>
<th>Kontrol n=52</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Yaş (yıl)</td>
<td>29,36±6,49</td>
<td>28,71±6,48</td>
<td>0,578</td>
</tr>
<tr>
<td>Parite</td>
<td>2,32±1,54</td>
<td>2,31±1,24</td>
<td>0,671</td>
</tr>
<tr>
<td>Doğum anındaki gebelik haftası (hafta)</td>
<td>34,4±3,5</td>
<td>38,9±1,8</td>
<td>0,001*</td>
</tr>
<tr>
<td>Sistolik kan basıncı (max) (mmHg)</td>
<td>153,5±18,1</td>
<td>116,8±12,0</td>
<td>0,001*</td>
</tr>
<tr>
<td>Diastolik kan basıncı (max) (mmHg)</td>
<td>95,8±12,3</td>
<td>76,1±18,0</td>
<td>0,001*</td>
</tr>
<tr>
<td>Doğum ağırlığı (gr)</td>
<td>2186±897</td>
<td>3274±503</td>
<td>0,001*</td>
</tr>
<tr>
<td>Apgar skoru (1. Dakika)</td>
<td>7,5±1,7</td>
<td>8,6±1,7</td>
<td>0,001*</td>
</tr>
<tr>
<td>Apgar skoru (5. Dakika)</td>
<td>8,9±1,2</td>
<td>9,7±0,5</td>
<td>0,001*</td>
</tr>
<tr>
<td>İdrarda total protein (24 saat- mg)</td>
<td>1371±1557</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Beyaz kan hücreleri (WBC) (x10⁹/L)</td>
<td>11,1±2,3</td>
<td>11,9±3,4</td>
<td>0,361</td>
</tr>
<tr>
<td>Nötrofil sayısı</td>
<td>8,3±2,2</td>
<td>9,1±3,3</td>
<td>0,309</td>
</tr>
<tr>
<td>Lenfosit sayısı</td>
<td>2,0±0,6</td>
<td>1,9±0,6</td>
<td>0,771</td>
</tr>
<tr>
<td>Monosit sayısı</td>
<td>0,8±1,2</td>
<td>0,7±0,8</td>
<td>0,723</td>
</tr>
<tr>
<td>Eozinofil sayısı</td>
<td>0,11±0,11</td>
<td>0,14±0,38</td>
<td>0,537</td>
</tr>
<tr>
<td>Bazofil sayısı</td>
<td>0,02±0,01</td>
<td>0,19±0,01</td>
<td>0,113</td>
</tr>
<tr>
<td>Trombosit sayısı (x10⁹/L)</td>
<td>234,7±79,3</td>
<td>217,7±65,6</td>
<td>0,290</td>
</tr>
<tr>
<td>Ortalama trombosit hacmi (MPV) (fl)</td>
<td>10,25±1,70</td>
<td>10,04±1,36</td>
<td>0,412</td>
</tr>
<tr>
<td>Nötrofil / Lenfosit oranı (NLO)</td>
<td>4,69±3,19</td>
<td>5,06±2,47</td>
<td>0,172</td>
</tr>
<tr>
<td>Monosit / Lenfosit oranı (MLO)</td>
<td>0,36±0,36</td>
<td>0,33±0,28</td>
<td>0,733</td>
</tr>
<tr>
<td>Trombosit / Lenfosit oranı (PLO)</td>
<td>125,58±68,03</td>
<td>118,93±48,84</td>
<td>0,915</td>
</tr>
</tbody>
</table>

*p<0,05
Objectives: To evaluate the distribution of fetal indications leading to termination of singleton pregnancies (TOP) in Etlik Zubeyde Hanım Women's Health Care, Training and Research Hospital.

Methods: All pregnant women with singleton pregnancies who underwent TOP due to fetal abnormalities in our institute between January, 2017 and March, 2019 were included. Maternal demographic features; gestational age at the time of the TOP procedure, mode of termination, fetal weight and sex, karyotype results (if done) and feticide status (from 22 weeks’ gestation onwards, pregnant were asked to do feticide) and fetal abnormalities leading to TOP were assessed.

Results: A total of 106 singleton pregnancy termination cases were recorded in our institute. Feticide was done in 30/106 (28.3%) of the cases. The leading indication was fetal structural abnormalities (n=68, 64.1%). The structural abnormalities were further subdivided according to the affected system and they are listed in Table 2. The most common fetal structural abnormalities were derived from central nervous system. Diagnostic invasive procedures were performed in 52 (49%) parturient women who underwent TOP. Chromosomal abnormalities were detected in 20/106 (18.8%) of the cases and listed in Table 3. Of them, trisomy 21 was the leading aneuploidy, diagnosed in 11 (10.3%) cases. Karyotype analyses were reported to be normal in 32 of the 106 (30.1%).

Conclusions: In cases of fetal anomaly detected by invasive diagnostic tests or ultrasound examination, pregnancy termination option should be offered to families in case of lack of fetal and neonatal treatment options. The distribution of fetal anomalies for which TOP was performed in our institute was: structural abnormalities (64.1%). With more effective prenatal screening, some of the late pregnancy terminations can be reduced.

Key words: fetal abnormalities, termination of pregnancy, prenatal sonography
Figure 1: Distribution of parturient women who underwent termination of pregnancy (TOP) because of severe fetal malformations in a singleton pregnancy, according to the indication PPROM: Preterm premature rupture of membranes

Table 1: Baseline demographics and obstetric characteristics of the women and fetal characteristics

<table>
<thead>
<tr>
<th></th>
<th>Median (Range)</th>
<th>N</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal age (years)</td>
<td>27 (15-43)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gravidity</td>
<td>1 (1-7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td>1 (0-6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational age at the time of TOP procedure (weeks)</td>
<td>21 (11-25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feticide</td>
<td>30/106</td>
<td>28.3</td>
<td></td>
</tr>
<tr>
<td>Mode of termination (Hysterotomy/VD)</td>
<td>11/95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal weight (grams)</td>
<td>360 (20-1115)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal sex (F/M/?)</td>
<td>41</td>
<td>38.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>47.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>14.1</td>
<td></td>
</tr>
</tbody>
</table>
Table 2: Structural abnormalities not explained by chromosomal-genetic problems leading to termination of pregnancy

<table>
<thead>
<tr>
<th>The system involved</th>
<th>Number of cases</th>
<th>Gestational ages at termination (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central nervous system</td>
<td>38</td>
<td>20 (median)</td>
</tr>
<tr>
<td>Hydrocephaly</td>
<td>5</td>
<td>20,20,22,22,24</td>
</tr>
<tr>
<td>Neural tube defects</td>
<td>21</td>
<td>20 (median)</td>
</tr>
<tr>
<td>Acrania</td>
<td>4</td>
<td>11,12,13,13</td>
</tr>
<tr>
<td>Anencephaly</td>
<td>3</td>
<td>20,20,24</td>
</tr>
<tr>
<td>Holoprosencephaly</td>
<td>2</td>
<td>24,23</td>
</tr>
<tr>
<td>Agenesis of the corpus callosum</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Dandy-Walker malformation</td>
<td>2</td>
<td>21,21</td>
</tr>
<tr>
<td>Urinary tract</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Renal agenesis, bilateral</td>
<td>4</td>
<td>18,20,22,23</td>
</tr>
<tr>
<td>Megacystis</td>
<td>3</td>
<td>14,17,22</td>
</tr>
<tr>
<td>Multicystic kidney disease</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Cardiovascular system and lung</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Hypoplastic left heart</td>
<td>2</td>
<td>24,25</td>
</tr>
<tr>
<td>Truncus arteriosus</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>Lung hypoplasia</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Musculo-skeletal System</td>
<td>4</td>
<td>20,21,22,24</td>
</tr>
<tr>
<td>Multiple anomalies</td>
<td>10</td>
<td>21.5 (median)</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Hydrops</td>
<td>3</td>
<td>17,22,23</td>
</tr>
<tr>
<td>Sacrococcygeal teratoma</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>68</strong></td>
<td><strong>21 (median)</strong></td>
</tr>
</tbody>
</table>

Table 3: The chromosomal-genetic abnormalities leading to termination of pregnancy

<table>
<thead>
<tr>
<th>Chromosomal-genetic Abnormalities</th>
<th>N</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trisomy 21</td>
<td>11</td>
<td>10.3</td>
</tr>
<tr>
<td>Trisomy 18 &amp; 13</td>
<td>5</td>
<td>4.7</td>
</tr>
<tr>
<td>Turner (45,XO)</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>Triploidy</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Partial 12q Xp deletion</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>20/106 (18.8)</strong></td>
</tr>
</tbody>
</table>
Meltem Koyuncu Arslan¹, Melek Akar¹, Mehmet Yekta Öncel¹²
¹University of Health Sciences, Izmir Tepecik Training and Research Hospital, Clinic of Neonatology, Izmir
²Izmir Kâtip Çelebi University Faculty of Medicine, Department of Pediatrics, Division of Neonatology, Izmir

Objectives: The World Health Organization (WHO) describes adolescence as the ages between 10-19 years. Adolescent pregnancies cause major health problems in both developing and developed countries. In terms of maternal and fetal problems, adolescent pregnancies are in high risk pregnancy category. In this study, we aimed to investigate neonatal results of adolescent pregnancies in our hospital.

Methods: Babies born from adolescent pregnancies in Tepecik Training and Research Hospital between January 1, 2018 and December 31, 2018 were included to the study. The records of refugees were examined retrospectively, and demographic data, hospitalization rates and causes and neonatal morbidity-mortality rates were determined.

Results: Total number of 196 baby born from adolescent pregnancies were included to study. Mean age of adolescent pregnant women was 16.6±0.5 year. The mean gestational week was 34.2±4.4 weeks, the mean birth weight was 2507±946 grams, 1st minute Apgar score was 6 (1-7) and 5th minute Apgar score was 7 (1-8). Of the cases, 26.5% were born by cesarean section and 52% were male. Adolescent pregnant women of 69.8% (n=137) were Syrian. The hospitalization rate was 30.2% (n=57). Mean hospitalization day was 16.6±13.6 day. The rate of prematurity was 47% (n=94). In the causes of hospitalization, sepsis 31% (n=18) and transient tachypnea of the newborn 35% (n=20) were the leading causes. Unwanted pregnancy rate was 2.5% (n=5). One patient stillbirth and two other were lost due to immaturity.

Conclusions: In our hospital which is a perinatology center, prematurity, hospitalization rates, unwanted pregnancies and Syrian origin were high in adolescent pregnancies. For the reduction of these pregnancies and perinatal complications policies should be determined.

Key words: Adolescent pregnancies, newborn, morbidity
Adolesan gebeliklerin neonatal sonuçlar üzerine etkileri

Meltem Koyuncu Arslan1, Melek Akar1, Mehmet Yekta Öncel1,2

1 Sağlık Bilimleri Üniversitesi, İzmir Tepecik Eğitim ve Araştırma Hastanesi, Yenidoğan Kliniği, İzmir
2 İzmir Kâtip Çelebi Üniversitesi Tıp Fakültesi, Çocuk Sağlığı ve Hastalıkları Anabilim Dali, Neonatoloji Bilim Dali, İzmir


Bulgular: Bu retrospektif çalışmaya toplam 196 adolesan gebeden doğan bebek dahil edildi. Anne yaşları ortalama 16,6±0,5 idi. Olguların demografik verileri incelendiğinde ortalama gestasyonel hafta 34,2±4,4 hafta, ortalama doğum ağırlığı 2507±946 gram, 1. dakika Apgar skoru 6 (1-7), 5. dakika Apgar skoru 7 (1-8) saptandı. Olguların %26,5’si sezaryen doğum ile doğarken, %52’si erkekti. Adolesan gebelerin %69,8’si (n=137) Suriye kökenliydi. Bebeklerin %30,2’sinin (n=57) hastaneye yatışı gerektiği. Yatış süresi ortalama 16,6±13,6 gün idi. Prematüre doğum oranı %47 (n=94) olarak bulundu. Yatış nedenleri arasında sepsis %31 (n=18) ve yenidoğanın geçici takipnesi %35 (n=20) önde gelen nedenler olarak sıralandı. İstenmeyen gebelik nedeniyle sosyal hizmetlere verilen bebek oranı %2,5 (n=5) idi. Mortalite oranlarına bakıldığında bir bebek ölü doğum, 2 bebekleri derece prematürite nedenleri ile kaybedildi.

Sonuç: Perinatoloji merkezi olan hastanemizde adolesan gebeliklerin çoğunlukla Suriye kökenli olduğunu, prematür doğum, hastaneye yatış ve istenmeyen gebelik oranlarının yüksek olduğunu saptadık. Adolesan gebeliklerin azaltılmasına ve dolaysıyla perinatal komplikasyonları azalmaya yönelik politikalar belirlenmelidir.

Anahtar kelimeler: Adolesan gebelik, yenidoğan, morbidite
Peripheral perfusion index does not accurately reflect hypoperfusion in postpartum hemorrhage

İlknur Demir Karakılıç, Abdullah Cevrioğlu, Selçuk Özden

1Eskisehir City Hospital, Department of Obstetrics and Gynecology, Perinatology Eskisehir, Turkey
2Sakarya University, School of Medicine, Department of Obstetrics and Gynecology, Perinatology Eskisehir, Turkey

Objective: Antepartum and postpartum hemorrhages are one of the most common causes of maternal mortality and morbidity. Close follow-up of the signs and symptoms of hypovolemia and hypoperfusion are necessary for these patients. The peripheral perfusion index (PI) is a reliable, non-invasive, tool for detecting hypoperfusion in humans. In this study, peripheral PI variability and non-invasive hemoglobin (Hb) levels were examined in postpartum hemorrhagic patients.

Methods: 61 patients at risk of bleeding of having with no peripheral circulatory disorders or chronic diseases were included in this study. Basal and during the next 5 hours mean arterial pressure (MAP), pulse rate, laboratory Hb value and PI, non-invasive Hb monitoring (Massimo personal health) were recorded. Bland-Altman method used for statistical analysis.

Results: MAP and pulse rate, obtained basal and sequential measurements taken 1-hour interval, was compared with PI (basal and sequential measurements). There were no concordant changes (p<0.01), (A small P value (P<0.05) indicates that there is no linear relationship between the two measurements for Bland-Altman). Laboratory and non-invasive Hb values were compared. Although, Hb values of both methods are not same, changes of Hb values were concordant (y=2.500000+1.000000x) (P=0.58).

Conclusions: The peripheral perfusion index (PI) is a reliable, non-invasive, tool for detecting hypoperfusion. Conversely, it is unreliable for postpartum hemorrhagic patients. We think that the possible cause is due to physiological changes in pregnancy and further studies are needed. On the other hand, using non-invasive Hb is useful for postpartum hemorrhagic patients.

Key words: Postpartum hemorrhage, peripheral perfusion index, hemoglobin

Figure 1: Bland-Altman plot of PI-MAP and PI-Pulse rate (Repetetive measurement)
Objective: To determine the reference values of the corpus callosum at 18 to 35 weeks of gestation in Turkish women with normal singleton pregnancies.

Materials and Methods: Our retrospective study comprised total of 366 fetuses undergoing routine sonographic examinations at 18 to 35 weeks of gestation. All fetuses were free of structural and chromosomal abnormalities and homogenously dated according to their gestational age of pregnancy at scan. The corpus callosum was visualized in a midsagittal plane as an anechoic structure delimited by two echogenic lines: superiorly by the sulcus of the corpus callosum and the cingulate gyrus and inferiorly by the cavum septum pellucidi, the cavum vergae, and the lateral ventricles. The length was measured from the most anterior aspect of the genu to the most posterior aspect of the splenium, by using a straight rostrocaudal length. The thickness was measured from the same plane at the level of the anterior mid-body of the corpus callosum.

Results: The mean length of the corpus callosum was 29.31mm (standard deviation, 6.5 ; 95% confidence interval, 12.56 - 45.84) mm. Thickness of the corpus callosum was 2.86 (standard deviation, 0.7 ; 95% confidence interval, 1.8 - 5.76) mm. Normal mean lengths and thicknesses according to the parametric and nonparametric methods were defined for each week of gestation.

Conclusion: Reference values for the length and thickness of corpus callosum between 18 and 35 weeks of gestation in a Turkish population were established.

Key words: corpus callosum measurements, fetal brain, sonography

Table 1: Descriptive statistics of the study

<table>
<thead>
<tr>
<th></th>
<th>N (total)</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal age (years)</td>
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<td>19.0</td>
<td>43.0</td>
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<td>Gestational age</td>
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<td>CC length</td>
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<td>12.56</td>
<td>45.84</td>
<td>29.3139</td>
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<td>CC thickness</td>
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<td>1.18</td>
<td>5.76</td>
<td>2.8688</td>
<td>.71284</td>
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Table 2. Fetal corpus callosum (CC) length (mm) by gestational age

<table>
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<tr>
<th>Gestational age at assessment (weeks)</th>
<th>Observations (n)</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval for Mean</th>
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<tr>
<td></td>
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<td>21.4</td>
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<td>31.3</td>
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<tr>
<td>Total</td>
<td>366</td>
<td>29.3</td>
<td>6.5</td>
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</table>
Tuğba Saraç Sivrıköy, Ibrahim Kalelioğlu, Recep Has, Ezgi Karakaş, Atıl Yüksel
İstanbul Üniversitesi, İstanbul Tıp Fakültesi, Kadın Hastalıkları ve Doğum AD, Perinatoloji BD
Muğla Sıtkı Koçman Üniversitesi Eğitim ve Araştırma Hastanesi, Kadın Hastalıkları ve Doğum AD

İstanbul Üniversitesi, İstanbul Tıp Fakültesi, Kadın Hastalıkları ve Doğum AD, Perinatoloji BD

Amaç: Multifetal redüksiyon uygulanan çoğul gebeliklerde, işlemin uygulandığı gebelik haftasının ve indirgenen gebelik sayısının gebelik sonuçlarının etkisini incelenmesi.


Bulgular: 109 çoğul gebelikin %83’üne (90/109) ait verilere ulaşılmıştır, bu gebeliklerden 7’si halen devam etmektedir. Redüksiyon işlemi ortalama gebelik haftası 11 (min.9-max.14) olup, olguların %7,2’si (6/83) ikiz, %60,2’si (50/83) üçüz, %32,6’sı (27/83) ise dördüz ve üzeri çoğul gebeliklerden oluşmaktadır. Grup A(n=54), 9 – 11 6/7; grup B(n=29) ise 12 – 13 6/7 haftadaki gebeliklerden oluşmaktadır. İşlem haftası ile ortalamı doğum haftası arasında geçen süre 23 (std ±2,8) haftadır. ≥24. Hafta üzerinde devam eden genel gebelik oranı %91 (76/83), ≤34 hafta altında doğum oranı %31,5 (24/76), PPROM oranı %10,5 (8/76) olup, grup A ve B arasında ≥24 hafta edadın gebelik, ≤34 preterm doğum ve PPROM oranları arasında anlamılı fark saptanmamıştır. Gebeliklerin %68,6’sı (57/83) ikiz gebelik, %31,4’ü (26/83) ise tekil gebelikle indirgenmiştir. İkiz gebelik ise indirgenen grup ile tekil gebelikte indirgenen grup arasında ≥24 hafta geçen gebelik oranları arasındaki fark anlamılı değilken, tekile indirgenen gebeliklerdeki PPROM ve preterm doğum oranı anlamılı olarak düşük olarak bulunmuştur (p<0.01). Doğumda genel ortalama gebelik haftası 34 (std ±2,8)’tür. Toplam canlı doğum oranı %89,2 (125/140), neonatal kayıp oranı ise %1,6 (2/125) olarak bulunmuştur.

Sonuç: Multifetal redüksiyon uygulanan gebeliklerde, başlangıçtaki gebelik sayısından bağımsız olarak ikiz gebelik yerine, tekil gebelikle indirgenmesinin gebelik sonuçlarının olumlu etkisi bulunabilir.

Anahtar kelimeler: Multifetal redüksiyon, çoğul gebelik
Objectives: Cesarean section (C-section) rates in Turkey has increased in years and has reached a rate of 53% in 2016. This rate is especially high in university hospitals (69.9 %). In a comprehensive study, which includes patients admitted between 1983 and 2002, has shown that c-section rates has shown a yearly increase and were 31.58% of all births. Also the primary c-section rate was 74.6%. Aim of this study is to enlighten the reason behind the c-section rates by showing c-section indications.

Methods: Study includes year 2018. Patient data was acquired from patient files. Patient’s age, gravida, parity, gestational week and also c-section indications were recorded. Histerotomy operations carried out before 20th week were.

Results: Total number of births in 2018 was 1432 and 1127 of these were c-section. Mean age, gravida, parity and gestational week for patient who had c-section were 31.75±6 (16-52), 4.5±42.47 (1-16), 3.83±2 (0-11) and 35±4 (20-42) respectively. While the rate of primary c-section was 29%; most common c-section indication was past c-section history with %63.4. This was followed by placenta previa totalis (5.9%), severe preeclampsia (5.4%) and HELLP. Rates for malpresentations, fetal distress, multiple pregnancy, head-pelvis incompatibility and fetal anomaly were 4.9, 4.2, 2.7, 2.6 and 2.6 respectively. When we further investigate the c-section rates in patients with history of past c-section operations; while the most common indications was history of past c-section operation (72.1%); plecanta previa totalis rate was 15.1%, which is significantly higher than patients with no history of c-section operation.

Conclusions: This study shows that number and rate of c-section has increase over the years. While history of c-section has taken the top spot between c-section indications; rate of placenta previa totalis has increased in patients with a history of past c-section operations.

Key words: c-section, indications, placenta previa totalis


Bulgular: 2018 yılında toplam doğum sayısı 1432 iken bunun 1127'i sezaryen (%78.4) doğum idi. Sezaryen olan hastaların yaş ortalaması 31.75±6 (16-52), gravida 4.5±42.47 (1-16), parite 3.83±2 (0-11) ve gebelik haftası 35±4 (20-42) hafta olarak bulunmuştur. Primer sezaryen oranı %29 ise sezaryen endikasyonları içinde en yüksek oranı %63.4 ile geçirilmiş sezaryen idi. Bunu %5.9 ile plasenta previa ve %5.4 ile ağır preeklempsi, HELLP gibi durumlar takip etmektedir. Malprezantasyon %4.9, fetal distres %4.2, çoğul gebelik %2.7, baş pelvis uyumsuzluğu %2.6 ve fetal anomalili %2.6 olarak bulunmuştur. Daha önce sezaryen olmuş hastalar arasındaki sezaryen oranlarını bakımından en yüksek endikasyon oranı %72.1 ile geçirilmiş sezaryen iken, plasenta previa nedeniyle opere edilen hasta oranı %15.1 olarak gelmiştir ki; sezaryen öyküsü olmayan hastalara göre oran oldukça yüksektir.

Sonuç: Bu çalışma yıllar içinde sezaryen sayı ve oranı artığını göstermektedir. Geçirilmiş sezaryen sezaryen endikasyonları içinde ilk sıraya yükselirken, sezaryen öyküsü olan hastalarda plasenta previa endikasyonu da artış göstermiştir.

Anahtar kelimeler: Sezaryen doğum, endikasyon, plasenta previa totalis
OP-069 Gestasyonel diyabetli anne fetüslerinde kardiyak fonksiyonların değerlendirilmesi

Denizhan Bağrul

Rize Recep Tayyip Erdoğan Üniversitesi, Eğitim ve Araştırma Hastanesi, Pediyatri Kardiyoloji Bölümü, Rize


Bulgular: FGDM grubunda 16 gebe (%13) insülin tedavisi almaktayken geri kalan gebelerde diyet düzenlemesi yapılmakta idi. Fetal kardiyak incelemde aort ve pulmoner anulus çapları benzer olsa da pulmoner arter ve aort hızları FGDM grubunda kontrol grubuna göre anlamlı olarak daha yüksekti. İnterventriküller septum kalınlığı FGDM grubunda patoloji k düzeyde olmasına rağmen kontrol grubuna göre anlamlı şekilde artmış bulunuyordu (3.65 mm vs 3.05 mm, p<0.001). LV ve RV kışlama fraksiyonlarında farklılık saptanmadı. Mitral E, A ve triküspid E ve A dalga hızları FGDM grubunda kontrol grubuna göre anlamlı derecede yüksekti. Mitral E / A ve triküspid E / A oranları ise gruplar arasında farklılık saptanmamıştır. Ayrıca, sağ ve sol ventriküle ait Myokard performans indeksi (MPI) değerleri FGDM grubunda kontrol grubuna göre anlamlı olarak daha yüksekti. MPI ile birlikte IVRT’de sağ ve sol ventriküle belirgin artış görülmüştü, IVCT ve ET her iki ventrikül için de gruplar arasında benzerdir.


Anahtar kelimeler: gestasyonel diyabetes mellitus, fetal kardiyak değerlendirilme, miyokard performans indeksi
### Tablo 1: İki grubun ekokardiografik özelliklerinin karşılaştırılması

<table>
<thead>
<tr>
<th>Ekokardiografik özellikler</th>
<th>FDGM grubu</th>
<th>Kontrol grup</th>
<th>p değeri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kalp hızı (bpm)</td>
<td>146 ± 7.6</td>
<td>146.4±6.1</td>
<td>0.84</td>
</tr>
<tr>
<td>Aortik anulus (mm)</td>
<td>5.4 ± 0.37</td>
<td>5.32 ± 0.26</td>
<td>0.72</td>
</tr>
<tr>
<td>Pulmoner anulus (mm)</td>
<td>6.05 ± 0.41</td>
<td>6.09 ± 0.52</td>
<td>0.88</td>
</tr>
<tr>
<td>Aortik pik sistolik akım hızı (cm/s)</td>
<td>84.2 ± 5.6</td>
<td>94.6 ± 7.2</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Pulmoner arter pik sistolik akım hızı (cm/s)</td>
<td>75.4 ± 4.8</td>
<td>81.5± 5.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Interventriküler septum kalinliği (mm)</td>
<td>3.65±0.28</td>
<td>3.02±0.21</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sol ventrikül kalsma fraksiyonu (%)</td>
<td>34.2 ± 3.8</td>
<td>33.8 ± 3.2</td>
<td>0.108</td>
</tr>
<tr>
<td>Sağ ventrikül kalsma fraksiyonu (%)</td>
<td>32.6 ± 3.1</td>
<td>32.4 ± 2.9</td>
<td>0.72</td>
</tr>
<tr>
<td>Mitral E (cm/s)</td>
<td>41.7±4.9</td>
<td>35.6±5.6</td>
<td>0.022</td>
</tr>
<tr>
<td>Mitral A (cm/s)</td>
<td>50.3±5.6</td>
<td>46 ± 6.1</td>
<td>0.04</td>
</tr>
<tr>
<td>Mitral kapak E/A</td>
<td>0.79 ± 0.38</td>
<td>0.78 ± 0.36</td>
<td>0.206</td>
</tr>
<tr>
<td>Triküspid E(cm/s)</td>
<td>43.8 ± 4.8</td>
<td>37.2 ± 4.3</td>
<td>0.001</td>
</tr>
<tr>
<td>Triküspid A(cm/s)</td>
<td>52.6 ± 5.2</td>
<td>48.1 ± 4.6</td>
<td>0.035</td>
</tr>
<tr>
<td>Triküspid kapak E/A</td>
<td>84.2 ± 11.2</td>
<td>83.9± 10.2</td>
<td>0.188</td>
</tr>
<tr>
<td>Mitral izovolumik kontraksiyon zamanı (IVCT,ms)</td>
<td>34.4±3.12</td>
<td>33.5±3.52</td>
<td>0.308</td>
</tr>
<tr>
<td>Mitral anulus izovolumik relaksasyon zamanı (IVRT, ms)</td>
<td>45.8±3.51</td>
<td>41.2±2.58</td>
<td>0.025</td>
</tr>
<tr>
<td>Mitral anulus Ejeksiyon zamanı (ET, ms)</td>
<td>180.2±12.2</td>
<td>179.8±11.9</td>
<td>0.554</td>
</tr>
<tr>
<td>Sol ventrikül Miyokardiyal performans İndeksi(MPI)</td>
<td>0.44±0.02</td>
<td>0.41±0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Mitral annular plane systolic excursion (MAPSE,cm)</td>
<td>0.78±0.11</td>
<td>0.77±0.1</td>
<td>0.622</td>
</tr>
<tr>
<td>Triküspid anulus izovolumik relaksasyon zamanı (IVRT, ms)</td>
<td>45.8±3.51</td>
<td>41.2±3.8</td>
<td>0.02</td>
</tr>
<tr>
<td>Triküspid anulus izovolumik kontraksiyon zamanı (IVCT, ms)</td>
<td>35.2±2.9</td>
<td>34.7±3.1</td>
<td>0.686</td>
</tr>
<tr>
<td>Triküspid anulus Ejeksiyon zamanı (ET, ms)</td>
<td>178.4±12.6</td>
<td>179.2±11.1</td>
<td>0.582</td>
</tr>
<tr>
<td>Sağ ventrikül Miyokardiyal performans indeksi(MPI)</td>
<td>0.44±0.02</td>
<td>0.41±0.02</td>
<td>0.022</td>
</tr>
<tr>
<td>Tricuspid annular plane excursion(TAPSE, cm)</td>
<td>0.64±0.05</td>
<td>0.64±0.06</td>
<td>0.924</td>
</tr>
</tbody>
</table>

Bpm: beats per minute(dakikadaki atım).
Lütfiye Uygur, Tuğba Saraç Sivríkoz, Aylin Yılmaz, Didar Kurt, Çiğdem Kunt İşguder, İbrahim Kalelioğlu, Recep Has, Atıl Yüksel
İstanbul Üniversitesi, İstanbul Tıp Fakültesi, Kadın Hastalıkları ve Doğum Ana Bilim Dalı, Perinatoloji Bilim Dalı, İstanbul

Amaç: Fetal lenfanjiomalar, embriyogenezde lenfatik kesiciklerin lenfatik kanallarla bağlantısında veya lenfatik kanalların venöz sistemde drenajında defekt sonucu gelişen, kistik, benign kitlelerdir. Sıklığı 1.1-5.3/10000'dir. Kromozom anomalileriyle birlikteki görülür (%2). Boyun (%75), aksilla (%20), toraks ve karın duvarı, ekstremiteler olmak üzere tüm vücudta olabilir. Prognozları; yerleşim yer, büyüklük ve bası bulgularıyla ilgilidir.

Bu çalışmada kliniğimizde prenatal dönemde tanı konan fetal lenfanjioma vakalarının gebelik sonuçları ve postnatal prognozları araştırıldı.

Metod: 2016-2019 yılları arasında kliniğimizde prenatal dönemde lenfanjioma tanı alan 13 olgunun prenatal bulgu ve postnatal sonuçları retrospektif olarak incelendi. Ortalama postnatal izlem süresi 27 (12-41) aydır. Bulgular: Tanida ortalama gebelik haftası 23.2 (14-31 hafta) idi. İlk başvurudaki tümör büyüklüğü ortalama 49.3 mm (110-7 mm) idi. En sık boyunda (%61) ve aksilla (%30.7) saptandı (Tablo). Hastaların %61’ine genetik inceleme yapıldı ve 1 fetus kromozomal anomali (46,_,der4) saptandı.

Antenatal takiplerde fetüslerin 1 tanesinde hidrops gelişti. 3 terminasyon, 8 canlı doğum, 1 intrauterin fetal ölüm oldu. Ortalama doğum haftası 38.2 (36-39 hafta) idi. 4 yenidoğanda yoğun bakım ihtiyacı gelişti, 1 yenidoğan entübe edildi.

Postnatal izlemde hastaların %40’ında tümör boyutu sabit kalırken %20’sinde tümör boyutunda artış, %20’de de spontan regresyon izlendi. Canlı doğan bebeklerin %30’unda medikal ve/veya cerrahi tedavi gerektiri. Bu bebeklerde arımı, yutma, solunum güçlüğü, tekrarlayan dil enfeksiyonları, medikal tedaviye bağlı pansitopeni gibi morbiditeler gelişti.


Anahtar kelimeler: lenfanjioma, prenatal tanı, postnatal prognoz
Tablo 1: Fetal lenfanjiomalarda ultrason bulguları ve gebelik sonuçları

<table>
<thead>
<tr>
<th>Hasta</th>
<th>Yerleşim ve Yayılım Yerleri</th>
<th>İlk başvuruda En Geniş Tümör Çapı (mm)</th>
<th>Ek USG bulgusu</th>
<th>Gebelik Sonucu</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aksilla, toraks duvarı, toraks kavitesi, abdomen duvarı, gluteus</td>
<td>110</td>
<td>AVSD</td>
<td>Terminasyon</td>
</tr>
<tr>
<td>2</td>
<td>Aksilla, toraks duvarı, abdomen duvarı, sakroiliak eklem</td>
<td>100</td>
<td>-</td>
<td>Termde canlı doğum</td>
</tr>
<tr>
<td>3</td>
<td>Cranium: Oksipital bölge</td>
<td>40</td>
<td>-</td>
<td>Termde canlı doğum</td>
</tr>
<tr>
<td>4</td>
<td>Boyun, çene</td>
<td>36</td>
<td>Polihidramnios</td>
<td>Termde canlı doğum</td>
</tr>
<tr>
<td>5</td>
<td>Boyun</td>
<td>36</td>
<td>-</td>
<td>Termde canlı doğum</td>
</tr>
<tr>
<td>6</td>
<td>Boyun</td>
<td>43</td>
<td>-</td>
<td>Termde canlı doğum</td>
</tr>
<tr>
<td>7</td>
<td>Boyun</td>
<td>15</td>
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<td>Terminasyon</td>
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<tr>
<td>8</td>
<td>Boyun</td>
<td>40</td>
<td>Hiperekojen kardiak odak</td>
<td>Gebelik devam etmekte</td>
</tr>
<tr>
<td>9</td>
<td>Her iki aksilla</td>
<td>7</td>
<td>TOF, Nasal hipoplazi, NT artışı</td>
<td>Terminasyon</td>
</tr>
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<td>10</td>
<td>Aksilla, toraks duvarı</td>
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<td>-</td>
<td>Termde canlı doğum</td>
</tr>
<tr>
<td>11</td>
<td>Boyun</td>
<td>45</td>
<td>-</td>
<td>Termde canlı doğum</td>
</tr>
<tr>
<td>12</td>
<td>Boyun, toraks duvarı</td>
<td>36</td>
<td>Prenazal kalınlık</td>
<td>Termde canlı doğum</td>
</tr>
<tr>
<td>13</td>
<td>Boyun, toraks duvarı, batın içi karaciğer komşuluğu</td>
<td>64</td>
<td>NIHF</td>
<td>Fetal kayıp</td>
</tr>
</tbody>
</table>

USG: Ultrason, AVSD: Atrioventriküler septal defekt, TOF: Fallot tetralojisi, NT: Nukal translusensi, NIHF: Non-immun hidrops fetalis
Resim 1: Toraksa invaze lenfanjioma, AVSD
Resim 2: Boyunda lenfanjioma
Resim 3: Aksillada lenfanjioma
Objectives: The aim of this study was to determine the significance of transverse cerebellar diameter (TCD) and TCD/Abdominal circumference (AC) in reduced fetal growth.

Methods: Thirty women with IUGR were compared with 40 gestational age-matched controls by median of fetal TCD percentiles and TCD/AC values. Estimated fetal weight below the third percentile for gestational age was accepted as IUGR. TCD and other biometric parameters were measured, TCD/AC ratio were compared. The independent two-sample t-test, Mann-Whitney U test, and pearson correlation test were performed for statistical analyses.

Results: Median TCD value was lower in fetuses with IUGR (37.0 [27.0-47.2] vs. 42.7 [28.0-48.5] P = .033). There was positive, strong and significant correlation between the gestational age and TCD in the IUGR (r = 0.853, P = 0.000) and control group (r = 0.873, P = 0.000). Seventeen percent of intrauterine growth restricted fetuses had tcd measurement below tenth percentile. TCD/AC ratio was significantly higher in IUGR group and had no correlation with gestational age (0.15 ± 0.01 vs. 0.14 ± 0.01, P = .033). The TCD/AC ratio was calculated and found to be 0.15 +/- 0.01(SD) The 5th and 95th percentiles for this ratio were 0.12 and 0.17.

Conclusion: The TCD increases with advancing gestational age in IUGR. In suspicion of fetal growth restriction increased TCD/AC values may be helpfull

**Key words:** growth restriction, transverse cerebellar diameter, ratio
Table 1: Comparision of characteristics in the two study groups

<table>
<thead>
<tr>
<th></th>
<th>IUGR group (n=30)</th>
<th>Control group (n=40)</th>
<th>P value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>27.9±7.00</td>
<td>27.1±6.21</td>
<td>0.299</td>
</tr>
<tr>
<td>Gravida</td>
<td>1.0 [1.0-7.0]</td>
<td>2.0 [1.0-6.0]</td>
<td>0.616</td>
</tr>
<tr>
<td>Parity</td>
<td>0.0 [0.0-3.0]</td>
<td>0.0 [0.0-3.0]</td>
<td>0.228</td>
</tr>
<tr>
<td>Gestational age</td>
<td>32.26±3.25</td>
<td>31.97±3.03</td>
<td>0.747</td>
</tr>
</tbody>
</table>

*P < .05 indicates significant difference. Data are expressed as median, (min – max); mean ± standard deviation
IUGR : intrauterine growth restriction

Table 2: Comparison of TCD and the TCD/BPD ratio between the IUGR and control groups

<table>
<thead>
<tr>
<th></th>
<th>IUGR (n=30)</th>
<th>Control (n=40)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCD (mm)</td>
<td>37,0 [27,0-47,2]</td>
<td>42,0 [28,0-48,5]</td>
<td>Z=-2,133 p=0,033</td>
</tr>
<tr>
<td>TCD (Percentile)</td>
<td>23,0 [1,0-75,0]</td>
<td>68 [5,3-93,0]</td>
<td>Z=-4,179 p=0,000</td>
</tr>
<tr>
<td>TCD/AC</td>
<td>0,15±0,01</td>
<td>0,14±0,01</td>
<td>t=2,148  p=0,033</td>
</tr>
</tbody>
</table>

*P < .05 indicates significant difference. Data are expressed as median, (min – max); mean ± standard deviation
TCD: transvers cerebellar diameter, BPD:biparietal diameter, IUGR:intrauterine growth restriction
Aim: We aimed to investigate whether religious beliefs of pregnant women, their spouse or families have impact on their attitude towards termination of pregnancy.

Methods: This is a survey study which included pregnant women who admitted to Kirikkale University Faculty of Medicine Obstetrics outpatient clinic between January 2017 and May 2017. Their attitudes towards termination of pregnancy if they had a fetal anomaly found by prenatal screening test and confirmed with an invasive test were asked. Afterwards impact of religious beliefs on a rating scale through 0 and 10 were asked.

Results: Study comprised 154 muslim pregnant subjects; 20 subjects (13%) were positive to termination, 83 subjects (54%) were negative to termination, and 51 subjects (33%) were indecisive. The mean points for religious belief and responsibilities of the subjects, religious beliefs of the spouses and families were all significantly higher in the group negative to termination than the positive ones (Table)

Conclusions: Religious beliefs of the pregnant women, their spouses and families negatively affects the attitude towards termination of pregnancies with fetal anomalies.

Key words: prenatal screening, termination of pregnancy, religious beliefs, attitude
Table: Burdens of religious beliefs on termination decision

<table>
<thead>
<tr>
<th>Attitudes towards termination</th>
<th>Group 1 Positive attitude</th>
<th>Group 2 Negative attitude</th>
<th>Group 3 Indecisive</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>My religious beliefs affected my decision</td>
<td>1.5(0-10)</td>
<td>8(0-10)</td>
<td>5(0-10)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Religious obligations affected my decision</td>
<td>1.0(0-10)</td>
<td>8(0-10)</td>
<td>7(0-10)</td>
<td>0.004#</td>
</tr>
<tr>
<td>My spouse’s religious beliefs affected my decision</td>
<td>1.0(0-10)</td>
<td>5(0-10)</td>
<td>5(0-10)</td>
<td>0.016$</td>
</tr>
<tr>
<td>My family’s religious beliefs affected my decision</td>
<td>1.0(0-10)</td>
<td>5(0-10)</td>
<td>5(0-10)</td>
<td>0.038&amp;</td>
</tr>
</tbody>
</table>

Data are given as median (minimum-maximum)
P values for difference between groups. Individual statistical details are as follows:
* p<0.001 for group 1 vs 2, p=0.026 for group 1 vs 3 and p=0.032 for group 2 vs 3
# p=0.003 for group 1 vs 2, p=0.014 for group 1 vs 3 and p=1.0 for group 2 vs 3
$ p<0.017 for group 1 vs 2, p=0.028 for group 1 vs 3 and p=1.0 for group 2 vs 3
& p<0.034 for group 1 vs 2, p=0.096 for group 1 vs 3 and p=1.0 for group 2 vs 3
Hakan Çökmez, Çağdaş Bayram

Izmir Atatürk Education and Research Hospital, Department of Obstetrics and Gynecology, Izmir

Introduction: Pituitary apoplexy occurs in 0.6% to 10% of pituitary adenomas, usually as a result of bleeding or infarction of the adenoma. Pregnancy is one of the predisposing factors for pituitary apoplexy. Usually pituitary apoplexy, which occurs suddenly in the second trimester of pregnancy, is characterized by severe headache, changes in consciousness, vomiting, and hemianopsia; it is a condition that threatens the life of the mother and the baby in cases where it is not detected early. Case: A 26-year-old woman who was 24 weeks into her first pregnancy presented with pituitary apoplexy, which included symptoms of increasing headache, nausea, vomiting, hemianopsia, and hypotensive attacks. Neurological examination was normal except for hemianopsia. Pituitary magnetic resonance imaging showed a pituitary macro-adenoma, indicating bleeding in a space that completely filled the cavities (Figure 1 and 2). Corticosteroid replacement was started as soon as the diagnosis was suspected due to the possibility that the attacks of hypotension could be fatal for the foetus. The obstetrics examination yielded normal results. Ultrasonography revealed a single live foetus that appeared 24 weeks old. Tumour excision was performed with right pterional craniotomy. On the 10th postoperative day, adrenocorticotropic hormone level was normal, cortisol level was low, thyroid-stimulating hormone level was low, thyroxine level was normal, and 75 µg levothyroxine and 15 mg hydrocortisone were prescribed to the patient. In the present case, this patient underwent caesarean section in the 39th week of pregnancy with the aim of avoiding strain that could increase intracranial pressure. By the tenth postoperative day, our patient had a healthy baby that was presenting normally and breastfeeding appropriately. Conclusion: Though rare, pituitary apoplexy should be considered in patients in the second trimester of pregnancy if they are presenting with hypotension attacks, headaches, and nausea, and vomiting.

Key words: Pituitary apoplexy, pituitary neoplasms, pregnancy
Figure 1: Sagittal T1-weighted MRI image of the pituitary gland
Figure 2: Coronal T1-weighted MRI image of the pituitary gland
PP-002 Gebelikte gelişen hipofizer apopleksi

Hakan Çökmez, Çağdaş Bayram
İzmir Atatürk Eğitim ve Araştırma Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, İzmir


Anahtar kelimeler: Hipofizer apopleksi, hipofiz neoplazması, gebelik
Resim 1: Hipofiz bezinin sagital T1 ağırlıklı MRI görüntüsü
Resim 2: Hipofiz bezinin koronal T1 ağırlıklı MRI görüntüşi
Introduction; Congenital hemoglobinopathies are among the most common inherited disease, approximately 7% of the global population is a carrier, and up to 500000 children are born with a severe hemoglobin disorder annually. Albania as a Mediterranean country has a high incidence of these diseases.

Objectives; Knowing the spread of pregnant woman with Congenital hemoglobinopathies and their outcome in Queen Geraldine Hospital, and how can the situation improve.

Methods; This retrospective cohort study was done from January 2009 to January 2019, including all the patients with Thalassemia major and intermedia, Drepanocitosis and Thalassodrepanocitosis, from 28-38 weeks of gestation, singleton pregnancy. We studied how and when they first diagnose the disease, and the treatment they had. We also studied IUGR ratio, premature delivery, S/C versus vaginal delivery in these cases, and the neonatal outcome.

Results; Among 38 patients of this group, there were 4 Thalassemia major, 26 Thalassemia intermedia, 5 Drepanocitosis, and 3 Thalassodrepanocitosis. Blood test and Hemoglobin electrophoresis were performed for the diagnosis. All the thalassemic group was diagnosed from 1 to 6 years old, and treated with blood transfusion and chelation therapy once or twice monthly. 4 of 5 Drepanocitosis patients were diagnosed before 15 years old, and one during the first trimester of pregnancy. All the 3 Thalassodrepanocitosis patients were diagnosed before 7 years old and treated with sporadic blood transfusions. The ratio of IUGR was 28%, premature delivery; 28-32 weeks 10%, 32-37 weeks 22%. S/C delivery 83% and vaginal delivery 17%. The fetal outcome was one death 28 weeks, IUGR. All the other neonates were fine. 2 cases of thalassemia major neonates were reported. The postpartum period was safe for all the patients.

Conclusions; The number of pregnant woman with congenital hemoglobinopathies has increased in the last five years. Advances in treatment have performed the average life and the reproduction capacity. Pregnancy in these cases is a high risk one, although gestation can be completed safely for mother and fetus. Albania is a high incidence country for congenital hemoglobinopathies, and thalassemia in particular. Even with the good work done for discovering, counseling and treating, further more attempts are needed.

Key words: Hemoglobinopathies, chelation therapy.
PP-004 Duodenal atresia: a case report

Miraç Özalp, Gülsün Özbay, Hidayet Şal, Mehmet Armağan Osmanağaoğlu
Karadeniz Technical University, Department of Perinatology, Trabzon

The section between the proximal and distal parts of the duodenum in the duodenal atresia is atresic. In antenatal ultrasonography, pregnant women with findings of duodenal atresia; we aimed to discuss the management and follow-up.

Case: A 42 years old G5P4 repeated cesarean section patient admitted to our clinic at 27 weeks of gestation. In the ultrasonography, double-bubble image (interconnected, significantly enlarged stomach and duodenum), persistent right umbilical vein and polyhydroamnios (single pocket 12 cm) were detected. The gall bladder was monitored. The patient did not perform the 1st and 2nd trimester screening tests and did not accept the prenatal genetic screening alternatives that we presented to her. The patient was followed up to 36th week in our clinic and this week she was taken to cesarean section after the onset of pain. 2260 gr, APGAR 6/8 female baby was delivered. No chromosomal anomaly was detected in the postpartum period. The 6th day of delivery of the infant who was admitted to the pediatric surgery service was taken into operation; annuler pancreas was observed and duodenoenterostomy was performed. She was discharged on the post-op 10th day with polyclinic follow-up recommendations.

Result: The incidence of duodenal atresia varies between 1/2500 and 1/10000 live births. The diagnosis of ultrasound is mainly based on the detection of double-bubble findings together with polyhydramnios in the late second and early third trimesters. It is closely related to Down’s syndrome. Major anomalies are associated with 40-50% of duodenal atresia. Its association with intestinal malrotation is 40%, but more severe anomalies of the biliary system and pancreatic anomalies (annuler pancreas) have an adverse effect on prognosis and are not rare.

Key words: Duodenal atresia, annular pancreas, persistent right umbilical vein, polyhydroamnios
Duodenal atrezi: olgu sunumu

Miraç Özalp, Gülsün Özbay, Hidayet Şal, Mehmet Armağan Osmanağaoğlu

Karadeniz Teknik Üniversitesi, Perinatoloji Bilim Dalı, Trabzon

Amaç: Duodenal atrezide duodenumun proksimal ve distal parçaları arasındaki bölümü atreziktir. Antenatal ultrasonografide duodenal atrezi bulguları saptanmış gebeliğin takip ve yönetiminin tarişılması amaçlanmıştır.


Sonuç: Duodenal atrezi insidansı 1/2500 ile 1/10000 canlı doğum aralığında değişmektedir. Ultrason tanı temel olarak geç ikinci ve erken üçüncü trimesterde polihidroamniyos ile birlikte double-bubble bulgusunun saptanmasına dayanır. Down Sendromu ile yakından ilişkilidir. Major anomaliler duodenal atrezilerin %40-50’si ile ilişkilidir. İntestinal malrotasyonla ilişkisi %40’ı bulur, fakat biliyer sistemin daha ciddi anomalileri ve pankreas anomalileri (annuler pankreas) prognoza kötü etki eder ve nadir değildir.

Anahtar kelimeler: Duodenal atrezi, annuler pankreas, persiste sağ umbilikal ven, polihidroamniyos
Miraç Özalp, Gülsün Özbay, Hidayet Şal, Turhan Aran, Mehmet Armağan Osmanağaoğlu

Karadeniz Technical University, Department of Perinatology, Trabzon

Aim: This is the case where the renal parenchyma is divided by a band, each is drained by the ureter, characterized by split bottom and top pol, ultrasound image of one or both renal pelvis dilated. We aimed to discuss the management and follow-up of pregnancy with hydroureteronephrosis and duplex kidney findings in antenatal ultrasonography.

Case: The patient who was 29 years old G3P2 was referred to our clinic with the preliminary diagnosis of hydroureteronephrosis at 28th week of pregnancy. In the ultrasonography, right renal pelvis anteroposterior diameter of 19 mm, renal parenchymal thickness of 7 mm, multiple renal cyst the largest with 8 × 7 mm in parenchyma were observed. The right ureter observed in tortuous and advanced dilation. The patient was followed up in our clinic, she gave birth to a baby girl with APGAR 7/8 weighting 3400 grams with normal spontaneous delivery at 37 + 4 weeks. Cystoscopy and ureterocutaneostomy were performed by postnatal 6th day pediatric surgery doctors. A small incision was opened to the structure, which was thought to be a 4 cm diameter ureter. About 250-300 cc clear water was drained of colored liquid. The patient's abdominal distention and oxygen saturation improved. When the dissection towards the bladder was extended, it was observed that the ureter draining the upper system was atresic towards the bladder. The large ureter was removed. It was seen that there was a second ureter draining the middle and lower system. The pathology result was reported as ureteral resection material with congestion and dilatation. On post-op 12th day, pediatric nephrology and pediatric surgery were discharged with polyclinic control recommendations.

Result: In unilateral obstruction cases, a decrease in the same side glomerular filtration rate, an increase in compensatory filtration in the opposite side of the kidney, is probably the expected response with near-normal global externals. For this reason, management should be limited to serial ultrasound follow-up and biochemical evaluation of renal functions should be done in the long term for at least 1 year.

Key words: Duplex kidney, ureter atresia, hydronephrosis, ureterocele
Amaç: Her biri üreter tarafından drene edilen, bölünmüş alt ve üst pol ile karakterize, ultrason görüntüsünde bir veya her iki renal pelvisin dilate olduğu, renal parankimin bir bantla bölünmüş olduğu durumdur. Antenatal ultrasonografide hidroureteronefroz ve dupleks böbrek bulguları saptanan gebelikin takip ve yönetiminin tartışılması amaçlanmıştır.


Sonuç: Unilateral obstrüksiyon olgularında, aynı taraf glomerular filtrasyon oranında azalma, karşı taraf böbrekte kompansatuar filtrasyon artış, muhtemelen normale yakın global ekskratuar fonksiyonlarla birlikte beklenir. Bu nedenle yönetim serisi ultrason takipleriyle sınırlı olmalı, böbrek fonksiyonlarının uzun dönemde en az 1 yıl boyunca biyokimyasal değerlendirmesi yapılmalıdır.

Anahtar kelimeler: Dupleks böbrek, üreter atrezisi, hidronefroz, üreterosel
Aim: Left atrial isomerism is related to the fact that the left-sided structures are double and the right-sided structures are underdeveloped or not developed at all. The aim of this study was to discuss the follow-up and management of pregnancy of left atrial isomerism findings on antenatal ultrasonography.

Case: 39 years G1P0, the patient with 20 weeks of pregnancy according to the last menstrual period was referred to us because of the suspicion of cardiac anomaly from the external center and increased risk in the combined screening test. In the detailed ultrasound of the patient, fetal biometry was found to be consistent with gestational week. In the transverse section of the upper abdomen and 4 chamber sections of the heart, double vessel sign (interrupted vena cava inferior and dilated vena azygos near the descending aorta) were observed. The stomach was seen on the left in the abdomen. The gall bladder was monitored. Although ultrasound is unreliable in the diagnosis of polysplenia in prenatal period, the observation of splenic artery in color doppler helps to classify the abnormality as left isomerism and confirm the presence of multiple spleen. Splenic artery and vein were observed in the color doppler of the patient. Both atrial appendages are hook shaped and have morphology left structure. Unbalanced AVSD was detected in fetal echo, heart block and arrhythmia were not observed. The result of amniocentesis was 46 XX, normal. The family was offered the option of termination but the family did not accept. The patient continues to follow up in our clinic.

Result: The prognosis of the right and left isomerism detected in the fetus is usually bad due to the severity of the antenatally detected cases. Patients with left isomerism and heart block are at risk of intrauterine death after hydrops development. On the other hand, prognosis is better in patients with left isomerism and mild cardiac anomalies. The position of the stomach in the abdomen is not diagnostic in heterotaxy syndrome.

**Key words:** Heterotaxy, polysplenia, avsd, vena azygos


**Anahtar kelimeler:** Heterotaksi, polispleni, avsd, azigos veni
PP-007 Sacrococcygeal Teratoma: a case report

Miraç Özalp, Gülsün Özbay, Hidayet Şal, Turhan Aran, Mehmet Armağan Osmanağaoğlu
Karadeniz Technical University, Department of Perinatology, Trabzon

Aim: Sacrococcygeal teratoma is a neoplasm, probably located in front of the coccyx, resulting from the pluripotent cells of the Hensen node. In this case report, we aimed to report our experience concerning with sacrococcygeal teratoma obstetric and neonatal management.

Case: A 31 years-old pregnant woman who had had 1 normal birth before was admitted to us at 26 weeks of gestation, fetus had a sacrococcygeal teratoma of 15×14 cm in the sacral region. No additional pathology was detected in the detailed ultrasonography. Fetal echocardiography and fetal biometry were normal. Prenatal genetic tests were proposed, but did not accepted. There were no signs of heart failure during follow-up. The last menstruel period was 38+3 weeks and 2540 gr, APGAR 7/8 female baby was delivered by cesarean section.

On the third day after the birth, sacrococcygeal teratoma excision was performed by pediatric surgery doctors. Pathology result; mature cystic teratoma Component; choroid plexus papilloma and neuroendocrine tumor. Postop 6th day baby was discharged. The baby continues to be followed by pediatric surgery.

Result: Sacrococcygeal teratoma is generally defined as having reached a very large diameter in the fetus and is mainly external. The echogenicity of the tumor varies depending on the location of calcifications and the cystic component, which is completely from the intense hyperechogenic image. Heart failure findings such as hydrops, cardiomegaly, polyhydroamnios and subcutaneous edema are often associated with solid and large tumors.

Key words: Sacrococcygeal teratoma, hensen node, cardiomegaly, choroidal plexus papilloma
PP-007 Sakrokoksigeal teratom: olgu sunumu

Miraç Özalp, Gülsün Özbay, Hidayet Şal, Turhan Aran, Mehmet Armağan Osmanağaoğlu
Karadeniz Teknik Üniversitesi Tıp Fakültesi, Perinatoloji Bilim Dalı, Trabzon

Amaç: Sakrokoksigeal teratom, koksiksin önünde yerleşen, muhtemelen Hensen nodunun pluripotent hücrelerinden kaynaklanan neoplazmdir. Biz bu olgu sunumuyla sakrokoksigeal teratomun obstetrik ve neonatal yönetim ile ilgili deneyimimizi aktarmayı amaçladık.


Sonuç: Sakrokoksigeal teratom genellikle fetusta çok geniş çapa ulaşmış olarak tanımlanır ve başlica externaldir. Yer yer kalsifikasyonlarla yoğun hiperekojen görüntüden tamamıyla kistik komponent içermesine göre tümörün ekojenitesi değişmektedir. Hidrops, kardiyomegalig, polihidroamnios ve subkutanöz ödem gibi kalp yetmezliği bulguları siklikla solid ve geniş tümörlerle ilişkilidir.

Anahtar kelimeler: Sakrokoksigeal teratom, hensen nodu, kardiyomegalig, koroid plexus papillomu
Aim: Lymphangioma, known as lymphatic malformation, is a vascular malformation that develops in the second and third trimesters of pregnancy. In this case report, we aimed to report our experience on obstetric management of fetal lymphangioma.

Case: 19 years, G1P0 according to the last menstrual period of 15 + 4 weeks of pregnancy, in the fetus's ultrasound showed a 39 × 16 × 36 mm tumoral mass under the left arm. The patient's first trimester screening test showed low risk (1/7360). Amniocentesis was performed, result 46 XY was reported as normal. At the end of 2 weeks, the mass was observed to be 51 × 25 × 44 mm., choroid plexus cyst was observed. Fetal MRI was requested. The MRI after 2 weeks was as follows; starting from the left axillary and lung apex region, multiloculated cystic mass reaching a size of approximately 110×70×75mm in the proximal part of the left arm, marked thickening of the left forearm and mild pleural effusion in the left hemithorax. Doppler ultrasound showed reverse ‘a’ wave in the ductus venosus. The family was offered a termination option. Family termination accepted and termination was performed.

Result: Lymphangioma may occur because of impaired lymphatic and venous flow, abnormal hyperplasia of the lymphatic epithelium or lymphatic obstruction. Prognosis is related presence / absence of hydrops induced by heart failure or with the presence / absence of upper airway obstruction at birth.

Key words: Lymphangioma, pleural effusion, choroid plexus cyst, amniocentesis
Amaç: Lenfatik malformasyon olarak bilinen lenfanjiyom, gebeliklerin ikinci ve üçüncü trimesterinde gelişen vasküler malformasyonur. Biz bu olgu sunumuyla fetal lenfanjiyomun obstetrik yönetimiyle ilgili deneyimimizi aktarmayı amaçladık.

Olgu: 19 yaş, G1P0 SAT'a göre 15+4 haftalık gebeliği olan hastanın yapılan ultrasonunda fetusun sol koltuk altından kaynaklanan 39×16×36 mm tümöral kitle izlendi. Hastanın 1.trimester tarama testi sonucu düşük riskli (1/7360) izlendi. Amniyosentez yapıldı, sonuç 46,XY normal olarak bildirildi. 2 hafta sonra takibe kitle 51×25×44 mm büyüümüş olarak izlendi, koroid pleksus kisti izlendi. Fetal MR istendi. 2 hafta sonra çekilen MR sonucu fetusta sol aksiller bölge ile akciğer apeiş komşuluğundan başlayarak, sol kol proksimal kesimine devam eden yaklaşık 110×70×75 mm boyuta ulaşan multiloküle kistik kitle, sol ön korda belirgin kalınlaşma ve sol hemitoraksta hafif pleval efüzyon olarak raporlandı. Doppler ultrasonında ductus venosustar ters a dalguşu izlendi. Aileye terminasyon seçeneği sunuldu ve ailenin onamıyla terminasyonu gerçekleştirildi.

Sonuç: Lenfanjiyom, bozulmuş lenfatik ve venöz akım, lenfatik epitelin anormal hiperplazisi veya lenfatik tikankanlık nedeniyle ortaya çıkabilir. Prognoz kesin tanı ve kalp yetmezliği kaynaklı hidrops varlığı/yokluğu veya doğumda üst solunum yolu obstrüksiyonu varlığı/yokluğu ile ilişkilidir.

**Anahtar kelimeler**: Lenfanjiyom, pleval efüzyon, koroid pleksus kisti, amniyosentez
Sema Tanrıverdi¹, Halil İbrahim Tanrıverdi², Esra Özer¹, Abdülkadir Genç²

¹Manisa Celal Bayar University Medical School, Department of Pediatrics, Division of Neonatology, Manisa, Turkey
²Manisa Celal Bayar University Medical School, Department of Pediatric Surgery, Manisa, Turkey

Aim: Chylothorax is a rare complication after congenital diaphragmatic hernia repair. Although the etiology is not known exactly, it is thought that it develops as a result of injury or obstruction of lymphatic vessels. In addition to the drainage of the thorax tube, enteral nutrition is cut first, then feeding with low-chain fatty acids. In resistant cases, it may be necessary to connect the ductus thoracicus with surgery. Octreotide is an anomics of somatostatin. It causes vasoconstriction in the portal vessels, reducing gastrointestinal secretions and intestinal absorption, as a result of which the chylosis current decreases. It can be used in cases of chylothorax who do not benefit from conservative treatment.

Case report: A 17-year-old G1P1 mother without any prenatal diagnosis was admitted to the hospital due to respiratory distress after delivery. The patient who had follow-up, withdrawal, moaning and cyanosis had bowel loops on the left hemithorax. On the second day of her life, she was taken to the operating room due to her stable condition. The patient did not have any problems in postoperative follow-up and increased fluid drainage from the thorax tube on the 6th day of life.

In the evaluation of pleural fluid, cholesterol was found to be 40 mg / dl, triglycerate 294 mg / dl, LDH 417 U / l, protein 0.59 mg / dl, glucose 82 mg / dl and direct leukocytes. The patient was diagnosed as chylothorax and the enteral feeding was stopped and TPN was started. On the 12th day of his life, enteral feeding was started with food containing medium chain triglyceride. Octreotide infusion was started on the 16th day. Her chylothorax regressed on the 3rd day of the treatment with octreotide and complete enteral feeding was started. On the 7th day of the treatment, the patient was discharged and a full oral diet was taken. The patient was discharged with no additional problems.

Conclusion: Chylothorax should be considered in the rare cases after repair of CHD, in cases not responding to conservative treatment, octreotide should be used before surgery.

Key words: Congenital diaphragmatic hernia, chylothorax, octreotide
Konjenital diafragma hernisi onarımı sonrası gelişen şilotoraksın tedavisinde okreotidin etkinliği:

Olgu sunumu

Sema Tanrıverdi1, Halil İbrahim Tanrıverdi2, Esra Özer1, Abdülkadir Genç2

1Manisa Celal Bayar Üniversitesi Tıp Fakültesi Çocuk Sağlığı ve Hastalıkları AD, Neonatoloji BD, Manisa
2Manisa Celal Bayar Üniversitesi Tıp Fakültesi Çocuk Cerrahisi AD, Manisa


Anahtar kelimeler: Konjenital diafragma hernisi, şilotoraks, okreotid
Aim: Van der Woude syndrome is a rare genetic syndrome with an autosomal dominant inheritance associated with cleft lip, cleft palate and lower lip. It may vary from person to person due to variations in gene expression. In patients with Van der Woude Syndrome, mutations were detected in the interferon regulatory factor 6 (IRF6) gene in the 1q32-41 region. His mother, his sister and the newborn baby were diagnosed as Van der Woude syndrome with dimples on his lower lip with bilateral cleft lip. In our mother, sister and neonatal case, heterozygote mutation of c.265A>G, p.Lys89G was detected in the IRF gene.

Case report: In a detailed examination of a 32-year-old gravida 2, parity of 1 healthy mother, a dimple was found in her lower lip outside the bilateral cleft lip (Figure 1). Other physical examination (Weight: 3830 g (90p), height: 52 cm (75-90p)), head circumference: 34 cm (50-75p) and laboratory findings were normal. On physical examination of the mother and her sister, there were dimples in her lower lip and there was an operation permit due to bilateral sided cleft lip. Three cases were diagnosed as Van der Woude syndrome due to physical examination findings of the patient who had no consanguinity and her mother and sister. Genetic examination in our mother, sister and newborn case revealed heterozygous mutation of c.1078_1081delAAAG (p.K360Dfs * 2) (p.Lys360Aspfs * 2) in the IRF gene. Genetic counseling was provided to the family.

Conclusion: Van der Woude syndrome; is an autosomal dominant disease characterized by cleft lip and/or palate. The most typical manifestations of this syndrome are the dimple on the lower lip and cleft lip. More than 200 mutations have been reported in this syndrome. We presented the heterozygous mutation of c.1078_1081delAAAG (p.K360Dfs * 2) (p.Lys360Aspfs * 2) in the IRF gene in a 2 generation family, including our case.

Key words: Dimple on the lip, cleft lip, IRF 6 gene
Figure 1: Dimple in the lower lip and bilateral cleft lip
Van der Woude Sendromu: İki kuşakta IRF geninde mutasyon

Sema Tanrıverdi¹, Dilek Biliç², Ece Şenbaykal³, Fethi Sırri Çam², Esra Özer³

¹Manisa Celal Bayar Üniversitesi Tıp Fakültesi Çocuk Sağlığı ve Hastalıkları AD, Neonatoloji BD, Manisa
²Manisa Celal Bayar Üniversitesi Tıp Fakültesi Tibbi Genetik AD, Manisa


Olgu sunumu: Yirmiçe yaşındaki gravida 2, parite 1 sağlıklı anneden zamanında doğan bebeğin yapılan ayrıntılı muayenesinde çift taraflı yarkı dudakın dışında alt dudağında çokurluklar saptandı (Resim 1). Diğer fizik muayene (Ağırlık: 3830 g (90p), boy: 52 cm (75-90p)), baş çevresi: 34 cm (50-75p) ve laboratuar bulguları olağandı. Annenin ve kız kardeşinin fizik muayenesinde alt dudağında çokurlukların olduğu ve çift taraflı taraflı yarık dudak nedeniyle operasyon izinin olduğu görüldü. Anne babası arasında akrabalık olmayan olgunun ve annesinin ve kız kardeşinin fizik muayeneleri bulgularıyla üç olgu Van der Woude sendromu olarak değerlendirildi. Anne, kız kardeş ve yenidoğân olgumuzda IRF geninde c.1078_1081delAAAG (p.K360Dfs*2) (p.Lys360Aspfs*2) heterozigot mutasyonu tespit edildi. Aileye genetik danışmanlık hizmeti verildi.


Anahtar kelimeler: Dudakta çokurluk, yarık dudak, IRF 6 geni
Resim 1: Alt dudakta çukurluklar ve bilateral yarık dudak
Objective: To address the potential risk factors related to poor maternal outcomes following cesarean section performed at full cervical dilatation

Methods: Sixty-eight women who underwent cesarean section at full cervical dilatation were enrolled in this retrospective case-control study. Women with poor maternal outcome were the cases while the women without poor maternal outcome were the controls. Poor maternal outcome included a maternal composite [composed of at least one of the following: intraoperative surgical complication (intensive bleeding, hematoma, bladder injury...etc.), blood transfusion, postoperative pyrexia or wound complication (infection, hematoma, dehiscence...etc.)]. Multivariate regression analysis determined the odds of poor maternal outcome.

Results: Of 68 women, 10 (14.7%) women constructed the case group while 58 (85.3%) women were in control group. In multivariate analysis duration of cesarean section and presence of oxytocin induction before operation were independent risk factors to be significant for the poor maternal outcome following cesarean section at full cervical dilatation (Table 1). In Receiver operating characteristics curve analysis, 1.1 hour was the best cut-off point for the duration of cesarean section at full cervical dilatation identifying the poor maternal outcome with a sensitivity of 66.8% and a specificity of 64.4%.

Conclusion: Presence of labor induction with intravenous oxytocin and longer duration of operation may increase the risk of poor maternal outcome of cesarean section at full cervical dilatation. All obstetricians should take preventive measures against adverse maternal outcome, if the duration of cesarean section at full cervical dilatation lasts more than one hour.

Key words: cesarean section, full cervical dilatation, maternal outcome

Table 1: Multivariate regression analysis of independent risk factors for poor maternal outcome

<table>
<thead>
<tr>
<th></th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal age</td>
<td>0.74</td>
<td>0.60-0.88</td>
<td>0.108</td>
</tr>
<tr>
<td>Nulliparity</td>
<td>0.90</td>
<td>0.86-0.99</td>
<td>0.153</td>
</tr>
<tr>
<td>Oxytocin induction</td>
<td>4.35</td>
<td>1.34-14.22</td>
<td>0.021</td>
</tr>
<tr>
<td>Duration at full cervical dilatation</td>
<td>1.54</td>
<td>0.90-2.91</td>
<td>0.315</td>
</tr>
<tr>
<td>Birth weight</td>
<td>0.68</td>
<td>0.41-2.12</td>
<td>0.129</td>
</tr>
<tr>
<td>Duration of cesarean section</td>
<td>7.16</td>
<td>2.35-18.29</td>
<td>0.001</td>
</tr>
</tbody>
</table>

OR: Odds Ratio; CI: Confidence Interval

p<0.05 was considered statistically significant


Sonuç: Prenatal ultrason muayenesi ile omfalosel vakaları tespit edilebilir ve herhangi bir organ sisteminde ortaya çıkabilecek anomaliler tanımlanabilir. Omfalosel tanılı tüm gebeler diğer anomaliler açısından ultrason ile değerlendirilmeli ve hastalara kromozom analizi yapılmalıdır.

Anahtar kelimeler: omfalosel, olgu, normal karyotip, karın duvari defekti

Kaynaklar
Giriş-Amaç: Hiperemezis gravidarum (HEG) patogenezinde oksidatif stresin katkısı birçok çalışmada gösterilmiştir. Biz bu çalışmada, iskemi modifiye albüminin (IMA) HEG tanısı alan hastalarda ve sağlıklı gebelerde serum düzeyini karşılaştırarak oksidatif stresin HEG'de serum IMA düzeyinde artışa neden olup olmadığını araştırmayı amaçladık.

Metot: Bu çalışma Dr. Zekai Tahir Burak Kadın Sağlığı Eğitim ve Araştırma Hastanesi’nde yapılmıştır. Gebeler, HEG tanısı konan grup(n:45) ve HEG olmayan yaş ve BMI eşleştirmiş kontrol grubu olarak sınıflandırılmış(n:45).

Bulgular: HEG hastalarının ve kontrol grubundaki gebelerin ortalama yaşları sırasıyla 27.6 (20-36), 27.4 (20-37) olarak saptanmıştır. Hastaların sosyodemografik özellikleri Tablo 1’de gösterilmiştir. Serum hemoglobin, hematokrit, beyaz küre, platelet, glukoz, ure, kreatin, aspartat transaminaz(AST), alanin transaminaz(ALT) and TSH serum düzeyleri her iki grupta istatistiksel olarak benzer saptandı(Tablo 2).

Sonuç: HEG’de yüksek olarak saptanan serum IMA düzeyleri oksidatif stresin bir yansıması olarak değerlendirilebilir.

Anahtar kelimeler: Ischemi-modifiye albumin (IMA), Oksidatif Stres, Hiperemezis gravidarum(HEG)
Tablo 1: Hastaların sosyodemografik özellikleri

<table>
<thead>
<tr>
<th></th>
<th>Kontrol (n:45)</th>
<th>HEG (n:45)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yaş (Yıl)</td>
<td>27 (20-37)</td>
<td>27 (20-36)</td>
<td>0.682</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>28.84 (21.3-37.3)</td>
<td>28.1 (21.9-36.7)</td>
<td>0.294</td>
</tr>
<tr>
<td>Gestasyonel yaş (hafta)</td>
<td>10.24±1.09</td>
<td>10.28±0.94</td>
<td>0.238</td>
</tr>
<tr>
<td>Gravida (range)</td>
<td>2 (1-4)</td>
<td>2 (1-5)</td>
<td>0.825</td>
</tr>
<tr>
<td>Parite (range)</td>
<td>1(0-2)</td>
<td>1 (0-23)</td>
<td>0.764</td>
</tr>
</tbody>
</table>

BMI: Body mass index, HEG = Hyperemesis gravidarum

Tablo 2: Hastaları laboratuvar bulguları

<table>
<thead>
<tr>
<th></th>
<th>Kontrol (n:45)</th>
<th>HEG (n:45)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBC (x10⁹/L)</td>
<td>8.2±1.95</td>
<td>8.6±1.81</td>
<td>0.283</td>
</tr>
<tr>
<td>Hemoglobin (g/L)</td>
<td>12.4±0.98</td>
<td>12.6±0.87</td>
<td>0.581</td>
</tr>
<tr>
<td>Hematocrit (%)</td>
<td>37.74±2.60</td>
<td>38.31±2.8</td>
<td>0.318</td>
</tr>
<tr>
<td>Platelet (x10⁹/L)</td>
<td>238±63</td>
<td>243±50</td>
<td>0.578</td>
</tr>
<tr>
<td>Ure (mg/dL)</td>
<td>17±5.6</td>
<td>18±5.5</td>
<td>0.146</td>
</tr>
<tr>
<td>Kreatin (mg/dL)</td>
<td>0.63±0.12</td>
<td>0.60±0.13</td>
<td>0.226</td>
</tr>
<tr>
<td>TSH (µIU/mL)</td>
<td>1.34±0.77</td>
<td>1.27±0.74</td>
<td>0.063</td>
</tr>
<tr>
<td>AST (IU/dL)</td>
<td>18±6</td>
<td>17±7</td>
<td>0.659</td>
</tr>
<tr>
<td>ALT (IU/dL)</td>
<td>13±10</td>
<td>14±8</td>
<td>0.542</td>
</tr>
<tr>
<td>Glukoz</td>
<td>84±8.7</td>
<td>85±8.7</td>
<td>0.844</td>
</tr>
<tr>
<td>IMA</td>
<td>87</td>
<td>103.59(56.8-460.8)</td>
<td>0.027</td>
</tr>
</tbody>
</table>

WBC: Beyaz Küre, TSH: Tiroid Stimulan Hormon, 
AST: Aspartat Transaminaz, ALT: Alanin Transaminaz, IMA: Ischemi Modifiye Albumin
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PP-014 Monokoryonik diamniyotik ikiz gebelikte tek fetüste 2. trimesterde saptanan duodenal atrezi; Olgu sunumunu

Ayşe Açıkel, Pınar Tokdemir Çalış

Dr. Sami Ulus Kadın Doğum, Çocuk Sağlığı ve Hastalıkları Eğitim ve Araştırma Hastanesi

Giriş: Tüm doğumların % 3,4’ ünü, çoğul gebeliklerin ise %96’sını ikiz gebelikler oluşturumaktadır ve bunların da %20’si monozigotiktir(1). Erken dönemde ortaya çıkan malformasyonlar monozigotik ikizlerde daha sık görülür ve vakaların çoğunda bu malformasyondan sadece bir ikiz etkilenir (2).


Anahtar kelimeler: Duedonal Atrezi, 2. Trimester, Prenatal Tanı

1-Neonatal complications, outcome, and management of multiple births
Author:George T Mandy, MD
2- Twin pregnancy: Prenatal issues Authors:Stephen T Chasen, MD Frank A Chervenak, MD.
Aim: We aimed to report a case of 13q deletion prenatally detected which is a rare cause of parietal encephalocele.
Case: A 32 year old multigravida referred to our perinatology unit for hydrops fetalis as a preliminary diagnosis. Pregnancy was 14 weeks and 5 days according to her last menstrual date. In ultrasonographic examination CRL was 12 weeks and 3 days and there was an approximately 3.5 cm in diameter parietal encephalocele which contains brain tissue. We informed the family about growth restriction, chromosomal abnormalities and neurodevelopmental problems in the postnatal period in case of encephalocele. We suggested CVS for karyotype analysis. Family opted amniocentesis. Amniocentesis performed in 16th gestational week. OF-PCR result was normal, but 13q deletion detected in cytogenetics analysis. After genetic consult we offered pregnancy termination. Medical termination done at 21th gestational week. After termination, the fetus weighing 196 grams sent to pathologic examination. Flat nose, wide mouth, long philtrum, webbed neck, ambiguous genitalia and absent of bilateral thumb was detected in external examination.
Conclusion: It is possible to diagnose 13q deletion by chromosomal analysis done for ultrasound abnormalities but it is difficult. Because most of the cases of 13q deletion result with miscarriage or fetal demise in the early stages. In our case we detected 13q deletion done for parietal encephalocele. As a result it is very important to perform chromosomal analysis for pregnancies in which ultrasonographic growth restriction and malformations detected.

Key words: 13q deletion syndrome, encephalocele, prenatal diagnosis
Figure 1. Ultrasonography image of parietal encephalocele.
Figure 2. Parietal encephalocele, Enlarged nose, wide mouth, long filtrum and mane neck and oligodactyl appearance in hands and feet.
PP-015 Parietal ensafalosel ile tanı konulan 13q delesyon sendromu olgusu

Süreyya Sarıdaş Demir¹, Mehmet İrfan Külahçioğlu¹, Erkan Çağlayan¹, Erdener Özer², Sabahattin Altunyurt³

¹Dokuz Eylül Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı Perinatoloji Ünitesi, İzmir
²Dokuz Eylül Üniversitesi Tıp Fakültesi Tibbi Patoloji Anabilim Dalı, İzmir

Amaç: Prenatal döneminde parietal ensefalosel saptanan olgularda, 13q delesyon sendromunun da ayırıcı tanıda düşünülmesi gerektiğini ortaya koymak amacıyla olgumuz sunulmaktadır.


Anahtar kelimeler: 13q delesyon sendromu, ensefalosel, prenatal tanı
Şekil 1. Parietal ensafaloselin ultrasonografi görüntüsü.
Şekil 2. Parietal ensefalosel, Başık burun, geniş ağız, uzun filtrum ve yele boyun ve el ve ayaklarda oligodaktili görünümü
Objective: To present non immune hydrops fetalis due to parvovirus 19 infection

Case: A 28-year-old woman, who has 21 weeks pregnancy, was referred to our perinatology clinics (fetal medicine department?) for hydrops fetalis. Prenatal combined first trimester was low risk. Obstetrics ultrasonographic examination revealed 21 weeks viable fetus. In detailed ultrasonography we have found that scalp was edematous, abdominal ascites, pleural and pericardial effusion. There was no other obvious fetal defect. In Doppler ultrasonography MCA PSV was 2.6 Mom, there was no risk factor and Rh-incompatibility for fetal anemia. It was revealed at fetal echocardiography cardiomegaly, pericardial and pleural effusion also systolic dysfunction. We performed TORCH and parvovirus, blood type and indirect Coombs test and cordocentesis. We took 7 cc blood for performing fetal hemogram, blood type, karyotype analysis and parvovirus PCR. Fetal hemoglobin was 2 gr/dl and we calculated the amount of transfused blood and transfused 0 rh negatif washed red cells. The result of Parvovirus PCR test was 696 IU/mL (sensitivity analysis 30 IU/mL). We evaluated this case as a non-immune hydrops fetalis in consequence of parvovirus infection. We intended second intrauterine blood transfusion. Before second transfusion, we noticed that fetal death in ultrasonographic evaluation. We were delivered 510 gram male fetus with medical abortion.

Conclusion: Parvovirus B19 infections are responsible from 8-10 percent of Non immune hydros fetalis. PV-B19 can lead to fetal anemia by eritroid precursor disintegration, non immune hydros fetalis and fetal demise. Lower than 2 g/dl hemoglobin amount can cause high output heart failure, on occasions, virus direct effect on myocardial cells cause hydrops.

In our case, we consider that severe fetal anemia and hydrops fetalis with systolic dysfunction, in addition parvovirus damage on myocardial cells can lead to fetal death.

Key words: parvovirus B19, non immune hydrops fetalis
Parvovirus enfeksiyonu bağlı gelişen non-immun hidrops fetalis olgusu

Süreyya Sarıdaş Demir, Mehmet İrfan Külahçıoğlu, Güülce Babacan, Erkan Çağlıyan, Sabahattin Altunyurt
Dokuz Eylül Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı Perinatoloji Ünitesi, İzmir

Amaç: Parvovirus enfeksiyonu bağlı gelişen non immun hidrops fetalis olgusunu sunmak


Sonuç: Non immün hidrops fetalis vakalarının, % 8 -10 dan parvovirus B 19 sorumludur. Parvovirus B 19, fetal eritroid öncü seri hücrelerini parçalayarak fetal anemi, non immün hidrops fetalis ve fetal ölüm yol açabilir. 2gr/dl ve satınaki hemoglobin düzeyleri yüksek debili kalp yetmezliğine neden olmakla beraber, bazen virüs myokardial hücreler üzerine doğrudan etki ederek hidrops ve fetal ölüm yapabilir. Bizim olgumuzda da; tespit edilen ciddi fetal anemi ve hidrops fetalise ilave, fetal ekokardiografi de saptanan sistolik disfonksiyon, parvovirusun myokardial hücreler üzerine direk etki ederek fetal ölüm neden olduğunu düşünmüştür.

Anahtar kelimeler: Parvovirus B 19, non immün hidrops fetalis
PP-018 Presentation of Turner syndrome with cystic hygroma and holoprosencephaly in the second trimester

Havva Sütcü1,2, Işıl Uzun Çilingir1,2, Cihan İnan1,2, Selen Gürsoy Erzincan1,2, Cem Yener1,2, Sinan Ateş1, Füsun Gülizar Varol1,2, Niyazi Cenk Sayın1,2

1Department of Obstetrics & Gynecology, Faculty of Medicine, Trakya University, Edirne, Turkey
2Division of Perinatology, Faculty of Medicine, Trakya University, Edirne, Turkey

Objective: Turner syndrome, also known as monosomy X, is one of the most common sex chromosomal abnormalities in females caused by loss of a part or all of an X chromosome. Its incidence is approximately 1 in 2500 live female births. Turner syndrome can be suspected due to presence of some abnormalities on prenatal ultrasound, including cystic hygroma, hydrops, renal anomalies, cardiac defects or short femur but the definitive diagnosis is by karyotype analysis. We present a case of Turner syndrome with holoprosencephaly.

Methods: A case report of Turner syndrome with cystic hygroma and holoprosencephaly.

Results: A 23-year-old woman, gravida 1 was referred at 18th weeks due to suspicion of fetal anomaly. The patient did not have a first or a second trimester screening test. Her medical history was uneventful except the consanguineous marriage. Detailed ultrasound examination revealed a 16-week fetus with septated cystic masses on the neck indicating cystic hygroma, diffuse skin edema and alobar holoprosencephaly. Termination of pregnancy was recommended, because of major lethal anomaly. Medical abortion was performed and postmortem genetic investigation revealed Turner syndrome (Figure 1).

Conclusion: The presence of cystic hygroma increases the probability of a chromosomal anomaly, namely Turner syndrome, but the association of the syndrome with holoprosencephaly is rare.

Key words: Turner syndrome, ultrasound examination, chromosomal anomaly, cystic hygroma
Figure 1: a. Postmortem view of the fœtus

Figure 1: b. Postmortem view of the fœtus
Objective: Cystic hygroma (CH) is a congenital abnormality of the lymphatic system characterized by abnormal fluid accumulation in the fetal neck. The prenatal diagnosis is made by the presence of bilateral cystic lesion with or without septations in the fetal occipitocervical region. It is associated with structural malformations, chromosomal abnormalities (ie., Trisomy 21, trisomy 18 and Turner syndrome being the most common numerical chromosomal anomalies) and poor prognosis. In one third of fetuses with normal karyotype, major structural anomalies including heart defects or skeletal dysplasia, can be detected. Here, we present a case of CH with skeletal dysplasia.

Methods: A case report of fetal CH with skeletal dysplasia.

Results: A 25-year-old woman, gravida 2 abortion 1, was referred at the 12th weeks of gestation with suspicion of fetal CH. Her medical history was uneventful. Ultrasound examination revealed CH diagnosed with typical septations on the neck. We recommended genetic counseling and chorionic villus sampling was performed which revealed an euploid karyotype. On ultrasound examination at the 16th week, fetal head was in an extension position, fetal thorax was narrow and scoliosis was present (Figure 1). Detailed counseling was given to the future parents about the poor prognosis and termination of the pregnancy was recommended. After the parents concluded to terminate, medical abortion was performed. Postmortem findings were consistent with CH and skeletal dysplasia (Figure 2).

Conclusion: Further evaluation is mandatory after the diagnosis of CH. Detailed ultrasound examination in the second trimester should be performed following karyotype analysis.

Key words: Cystic hygroma, prenatal diagnosis, fetal karyotyping, structural anomalies
Figure 1: A sagittal image of the fetus

Figure 2: a. Postmortem view of the fetus

Figure 2: b. Postmortem view of the fetus
Aort koarktasyonu (Aok), hastaların% 95’inde isthmus seviyesinde yer alan aort lümeninin lokal daralmasıdır. Aok tüm doğumsal kalp hastalarının% 4-6’sını oluşturur ve yaklaşık 4/10000 doğumda görülür. Erkeklerde, kadınlardan sık gözlenir ve genellikle sporadiktir. Tanımlanan iki teorisi mevcuttur. Bunlardan ilk duktal doku yayılım hipotezidir; duktus arteriosus kapanırken, aktif duktal doku aort içine migrasyon göstererek fibrozisin yayılmasını sağlar ve aortun düktüsa yakın bölgelerinde darlık oluşturur. İkincisi; akım teorisidir, duktal doku anomalisi nedeniyle akım bozulmuş ve bu akım azlığıyla aort hipoplazisi gelişmektedir. Ultrasonografi, fetal aort koarktasyon varlığını ortaya çıkarabilir. Bu durumda, ilişkili anormallikler araştırılmalıdır (karyotip dahil), çünkü prognozu etkiler ve doğumun pediatrik kardiyoloji olan bir merkeze gerçekleşecek gerçekleşmeeyeceğini gösterir. Aok cerrahi veya endovasküler teknilerle tedavi edilebilir.


Key words: Fetal, antenatal, aort koarktasyonu, kardiyak anomali
Distal kesimde sol subklavían dali verdikten sonra en dar yerı 3,7 mm
Ahmet Erol, Filiz Halıcı Öztürk, Doğa Öcal, Betül Yakıştıran, Ali Taner Anuk, Ayşe Kırbaş

Department of Perinatology, University of Health Sciences Zekai Tahir Burak Women’s Health Practice and Research Center, Ankara, Turkey

Meckel-Gruber syndrome is an unusual and lethal autosomal recessive disorder defined by occipital encephalocele, polydactyly and bilateral dysplastic cystic kidneys. Antenatal ultrasound examination can determine the correct diagnosis by identifying at least two of the major features described. We report a case in which the diagnosis of Meckel-Gruber Syndrome was feasible by ultrasonography in the first trimester.

Case: A 31-year-old gravida 2, parity 1 patient, without consanguinity, was referred to our hospital at 13 weeks of gestational age with a suspicion of encephalocele. Her first trimester screening results were having low risk. We demonstrated an encephalocele involving a large posterior fossa cyst protruding from the occiput on ultrasonography (Figure 1). The kidneys were echogenic, enlarged suggesting cystic dysplasia (Figure 2), and there was evidence of polydactyly of the hands (Figure 3). There was no oligohydramnios, but the fetal urinary bladder was not visualised. Based on these findings, the diagnosis of Meckel-Gruber Syndrome was considered. Karyotype analysis was suggested and termination of the pregnancy choice was offered but the patient did not accept both of them.

The incidence of Meckel-Gruber Syndrome worldwide varies from 1:3000 to 2.6 per 100,000 live births. It is an autosomal recessive disorder with a 25% recurrence risk. A significant number of cases show mutations at chromosome 17q21–24, but the genetic heterogeneity is high. The reported incidence of renal cystic dysplasia in this syndrome varies from 95% to 100%. Occipital cephalocele is present in 60% to 80% of fetuses. Post-axial polydactyly is present in 55% to 75%. Other limb anomalies like bowing or shortening may also be present. A karyotype analysis should be ensured when Meckel syndrome is suspected, to exclude chromosomal disorders. If the diagnosis is accomplished, termination can be offered. Parents should be counseled of the likely recurrence of Meckel-Gruber syndrome for future pregnancies.

Key words: Encephalocele, polydactyly, dysplastic kidney
Figure 1: Occipital encephalocele

Figure 2: Dysplastic cystic kidneys

Figure 3: Polydactyly
PP-024 Posterior urethral valve: A case report

Süreyya Sarıdaş Demir, Mehmet İrfan Külahçıoğlu, Samican Özmen, Erkan Çağlıyan, Sabahattin Altunyurt

Division of Perinatology, Department of Obstetrics and Gynecology, Dokuz Eylül University School of Medicine, Balcova, Izmir, Turkey

Objective: To present a case of posterior utethral valve(PUV) which diagnosed prenatally.
Case: A 31 year old patient with 18 weeks and 6 days of pregnancy, gravida 2, has one living child, was referred to our hospital with oligohydramnios and fetal multicystic dysplastic kidney. Fetal examination showed a highly dilated bladder and the keyhole sign was seen. Bilateral ureters were seen dilated and the kidneys were multicystic and dysplastic. Due to severe anhydramnios, vesico synthesis was performed to evaluate prenatal genetic diagnosis and fetal kidney functions. As the result of vesico synthesis osmolality: 235, Beta2 microglobulin 17.6, Na 117, Ca 11.4 was detected and the patient was referred to pediatric nephrology. It was decided that the kidney functions of the fetus was severely impaired. The result of the genetic examination was normal. The termination of pregnancy was recommended to the patient by the perinatology council. 24 hours after the termination of pregnancy, the patient was discharged with healing. The family did not accept the detailed internal pathological examination. In the external pathological examination, a severely distended abdomen, retrognatia and low-set abnormal ears were seen.
Result: PUV, which is one of the most common causes of bladder outflow obstruction, is mostly observed in male fetuses, but can be seen in both sexes. The incidence is one in 8000-25000 live male births. PUV is a congenital pathology characterized by infravesical obstruction that can cause damage and dysfunction in the entire urinary tract. Ultrasonography shows a large bladder with thickened wall and the posterior urethra is seen as a protrusion at the base of the bladder. This is called the keyhole sign. In patients with severe megalistitis and oligoanhydroamniosis, PUV should be considered for bladder outflow obstruction. If there is severe oligo-anhydramnios in patients who are thought to habe PUV, vesico synthesis can be done to evaluate the kidney functions and genetic examination.

Key words: Posterior urethral valve, anhydramnios, vesico synthesis
The keyhole sign in ultrasound examination
PP-024 Posterior üretral valv olgu sunumu

Süreyya Sarıdaş Demir, Mehmet İrfan Külahçioğlu, Samican Özmen, Erkan Çağlıyan, Sabahattin Altunyurt
Dokuz Eylül Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı Perinatoloji Ünitesi, İzmir

Amaç: prenatal tanı konulan posterior üretral valv (PUV) olgusu sunmak


Sonuç: Mesane çıkış yolu obstrüksiyonlarının en sık görülen sebeplerinden biri olan PUV neredeyse tamamı erkek fetüslerde izlenmekle beraber her iki cinsten de görülebilir. Görüleme skliği 8000-25000 canlı erkek doğumda biridir. PUV tüm üriner sistemde hasar ve disfonksiyona sebep olabilen infravesikal obstrüksiyona karakterize olduğunu bir patolojidir. Ultrasonografi incelemesinde geniş ve kalın duvarlı mesane ve mesane tabanında bir çıkıntı şekilde görülen posterior üretra izlenir bu anahtar deliği görünümü denir. İleri derecede megasistit ve oligoanhidroamnios saptanan olgularda mesane dış yolu obstrüksiyonları PUV düşündülmeli. PUV düşünülün hastalarda ileri derecede oligo-anhidroamnios mevcutsa, böbrek fonksiyonlarını değerlendirmek ve genetik inceleme yapmak için vesikosentez yapılıp aileye fetal böbrek fonksiyonları ve kromozomal değerlendirmeye yapılarak antenatal danışmalık verilebilir.

Anahtar kelimeler: Posterior üretral valv, Anhidroamnios, Vesikosentez
Ultrasonografide anahtar deliği görünümü
Objective: To present a case of congenital hairy polyp which diagnosed prenatally.  
Case: A 27 year old patient with 28 weeks and 3 days of pregnancy, gravida 2, has one living child, was referred to our hospital with a mass in the fetal face. Antenatal screening tests were found to be low risk, and there was no systemic diseases except hypothyroidism. Detailed ultrasound examination in our clinic showed that in addition to normal fetal growth, a 20x12 mm homogenous mass without a blood flow in doppler examination was detected, which originated from the oral cavity. There was no change in the size of the mass during the follow-up of the patient. She had a previous history of cesarean section, so cesarean section was done on 37th weeks of pregnancy due to rupture of membranes. A female neonate weighing 3400 g was delivered with Apgar scores of 7 at 1 min and 9 at 5 min. Pediatrics and otorhinolaryngology physicians were present at birth due to the need for possible emergency tracheostomy. The infant was admitted to the neonatal intensive care unit and had feeding and breathing difficulties. The maxillofacial MRI showed a well-circumscribed mass lesion of approximately 3x1 cm in size, extending from the nasal cavity to the oral cavity. The mass was surgically excised on the third day of labor by the ENT department. The patient was discharged with healing and the postoperative pathology resulted as hairy polyp.

Results: Hairy polyp is a rare, benign congenital tumor and may also occur in the adulthood. The average incidence is 1/40000. Hairy polyps are originated from both ectoderm and mesoderm and the ethiology is not fully known. In females, hairy polyps are 6 times common than males, and are frequently observed in the nasopharynx and oropharynx. Neuroblastoma, teratoma, dermoid, glioma, hemangioma, epidermoid cysts, meningoencephalocele and coanal atresia should be considered in the differential diagnosis of hairy polyps, which are also seen with difficulty in breathing and swallowing. Treatment is the total excision of the tumor, recurrence rates are very low and malignant transformation has not been reported.

Key words: congenital hairy polyp, prenatal diagnosis
PP-025 Prenatal tanı alan konjenital hairy polip olgusu

Erkan Çağlıyan, Süreyya Sarıdaş Demir, Samican Özmen, Sabahattin Altunyurt

Dokuz Eylül Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı Perinatoloji Ünitesi, İzmir

Amaç: Prenatal tanı konulan konjenital hairy polip olgusunu sunmak


Anahtar kelimeler: konjenital hairy polip, prenatal tanı

Ultrasonografide nasofarenksten köken alan fetal konjenital hairy polip
PP-027 Effect of pilates during pregnancy on delivery outcomes

Selen Yaman¹, Özlem Banu Tulmaç¹, Yasemin Sert¹, Büşra Kılınç², Necati Hançerlioğulları¹

¹Zekai Tahir Burak Woman’s Health, Education and Research Hospital, Department Obstetrics and Gynecology, Ankara
²Zekai Tahir Burak Woman’s Health, Education and Research Hospital, Department Physiotherapy, Ankara

Introduction: The aim of this study was to investigate the effect of clinical Pilates on delivery outcomes in pregnant women.

Materials and Methods: Eighty-three pregnant women were included in the study. The study comprised pregnant women who voluntarily agreed to perform Pilates (n:26, age:28.77±4.43 years) and a control group (n:57, age:28.18±4.69 years) that didn't perform Pilates. Pilates training was provided by a physiotherapist two days a week (1 h/session). Height, weight, weight gained during pregnancy, hemoglobin level, education level, duration of labor, type of delivery, birth week, induction requirement and duration, birth weight of infants, and APGAR scores were retrospectively recorded from the patient files.

Results: It was found that Pilates didn’t have a negative effect on gestational age, birth week, birth weight of infants, and APGAR scores. Pregnant women who performed Pilates gained less weight during pregnancy compared with those in the control group (p<0.05).

Conclusion: In conclusion, clinical Pilates can be a suitable exercise model when applied to pregnant women within an appropriate period of pregnancy because they have a positive effect on pregnant women and infants. We believe that this exercise model should be given more importance by obstetricians and physiotherapists in Turkey.

Key words: Pregnancy, Delivery, Pilates
## Table 1: Demographic characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pilates Group (n=26)</th>
<th>Control Group (n=57)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Years)(mean±SD)</td>
<td>28.77±4.43</td>
<td>28.18±4.69</td>
<td>0.574</td>
</tr>
<tr>
<td>Initial BMI(kg/cm²)</td>
<td>25.70±1.75</td>
<td>26±2.54</td>
<td>0.432</td>
</tr>
<tr>
<td>Weight Gain(kg)</td>
<td>10.69±2.24</td>
<td>14.11±4.39</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gestational age (weeks)</td>
<td>39.35±1.23</td>
<td>38.88±1.40</td>
<td>0.157</td>
</tr>
<tr>
<td>Gravida</td>
<td>1.54±0.72</td>
<td>1.84±0.80</td>
<td>0.21</td>
</tr>
<tr>
<td><strong>Education (N, %)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>2(%7.7)</td>
<td>34(%59.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>High School</td>
<td>7(% 26.9)</td>
<td>17(% 29.9)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>University</td>
<td>17(%65.4)</td>
<td>6(% 10.5)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Demographic data: age, initial body mass index, gestational age, gravida, education

## Table 2: Clinical characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pilates Group (n=26)</th>
<th>Control Group (n=57)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal Birth (N, %)</td>
<td>22 (%84.6)</td>
<td>42 (%73.7)</td>
<td></td>
</tr>
<tr>
<td>Cesarean</td>
<td>4 (%15.4)</td>
<td>15 (%26.3)</td>
<td>0.272</td>
</tr>
<tr>
<td>Labor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latent Phase (h)</td>
<td>7.92±2.46</td>
<td>9.35±4.5</td>
<td>0.313</td>
</tr>
<tr>
<td>Active Phase (h)</td>
<td>3.54±1.33</td>
<td>4.19±1.49</td>
<td>0.042</td>
</tr>
<tr>
<td>Induction Time (h)</td>
<td>5 h(2-11)</td>
<td>11 h (6-20)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hb (gr/dL)</td>
<td>12.57 (10.20-14.10)</td>
<td>12.08 (9.20-13.9)</td>
<td>0.045</td>
</tr>
<tr>
<td>Infant weight (g) (SD)</td>
<td>3454± 73.9</td>
<td>3378±66.6</td>
<td>0.498</td>
</tr>
</tbody>
</table>

Note: Values are presented as mean±standard deviation, median(min,max) (p < 0.05).
Introduction: Congenital diaphragmatic hernia (CDH) is characterized by protrusion of abdominal organs from a diaphragmatic defect to the thoracic cavity. The incidence is 1 in 2200 live births and it is associated with high mortality and morbidity. Double outlet right ventricle is a ventriculo-arterial connection anomaly which is defined as pulmonary artery and aorta origin morphologically from right ventricle. This anomaly is usually accompanied by ventricular septal defect (VSD) and pulmonary stenosis. Various clinical findings could be seen according to additional congenital cardiac anomalies.

Case: G 3, P 2, 28 years of age, 22 weeks pregnant women, who did not have any antenatal care was admitted for 2. trimester ultrasonographic screening. She was diagnosed with multiple anomalies at the ultrasonographic examination. Left diaphragmatic hernia was detected in the patient. Stomach and intestines were observed in the thorax. The heart was dextroposed depending on the pressure. Inferior vena cava was dilated. Cardiac examination revealed that the aorta was located behind the pulmonary artery and originated from the right ventricle. A narrowing of the aortic isthmus was observed. The left ventricular was hypoplastic. Mitral valve atresia was detected. Also single venous return detected. Partial venous return anomaly was also considered. Detailed information was given to the family and prognosis was explained. However, the patient rejected the options of termination and invasive diagnosis. The patient’s pregnancy continues.

Discussion: Additional cardiac defects are common in congenital diaphragmatic hernias. Therefore, careful cardiac examination is also necessary in these cases. Close follow-up and delivery should be recommended in tertiary centers when these cases are not terminated.

Key words: congenital diaphragmatic hernia, double-outlet right ventricle
Figure 1: diaphragmatic hernia

Figure 2: double-outlet right ventricle
Introduction: Sirenomelia is a very rare congenital malformation, seen 0.8 - 4 in 100,000 pregnancies. As sirenomelia’s appearance resembles the mythical creature Mermaid, it was called Mermaid syndrome. It is characterized by partial or complete lower extremity fusion, comcomitant gastrointestinal anomalies, single umbilical artery, urogenital anomalies, absent genitalia and neural tube defects. The etiology of sirenomelia is not clear. Some of the risk factors are maternal diabetes, maternal age(<20 years or >40 years), exposure to retinoic acid, cadmium, cyclophosphamide, cocaine.

Case: A 18 years old woman, G3P0A2, was referred to our perinatology clinic for oligohydramnios. She is a Syrian citizen, with no other health problems. Patient was 23 weeks pregnant according to last menstrual date and 18 weeks 1 day according to 39mm of biparietal diameter. The combined and triple tests were not in high risk group. By ultrasonic examination bilateral kidneys and bladder couldn’t be seen, hypoplasia of thorax, pleural effusion, anhydroamniosis were present. Vertebral scanning revealed kyphoscoliosis and hemivertebra. Single femur and iliac bones have been observed. We informed the parents about sirenomelia and the other anomalies and termination of the pregnancy was proposed. The pregnancy was terminated with parents’ consent. Cleft lip, bilateral four fingers and single umbilical artery have been observed after termination (Figure 1). X-Ray scans were consistent with the prenatal diagnosis (Figure 2). The parents did not accept autopsy and chromosome analysis.

Discussion: Mermaid syndrome is a lethal malformation. Estimatedly half of sirenomelia cases are terminated as fetal anomalies and other half are either intrauterine exitus cases or born alive. On the first days after delivery, neonates with sirenomelia die due to urogenital anomalies and lung hypoplasia. If it is diagnosed in early weeks, parents should be informed about the prognosis and life expectancy of sirenomelia and choice of early termination.

We presented a case with sirenomelia and bilateral renal agenesis in a fetus with oligohydramnios. We conclude that when renal agenesis is diagnosed, caudal regression should be kept in mind and vertebral and urogenital systems should be scanned carefully.

Key words: Sirenomelia, Mermaid syndrome, renal agenesis
Özge Yücel Çelik, Gülşah Dağdeviren, Ayşe İstek Keleş, Dilek Şahin, Aykan Yücel

University of Health Sciences Etlik Zübeyde Hanım Women’s Health Care, Training and Research Hospital, Perinatology Department, Ankara

Introduction: Bilobate placenta is characterized by two nearly equal lobes, seen in 2-8% of all pregnancies. It is associated with velamentous umbilical cord insertion which lays in intermembranous, inserted site of placenta with no Wharton’s jelly. Velamentous umbilical cord insertion is seen in 1% of singleton pregnancies, usually associated with placenta previa which may cause adverse outcomes.

Case: A 18-year old woman, G2P1, was referred to our perinatology clinic at 28 weeks of gestation for vaginal bleeding and contractions in nonstress testing. She had a history of cesarean section in previous pregnancy. Her first admission to our hospital was when vaginal bleeding occurred. By first ultrasonographic examination with Doppler imaging, vasa previa and bilobate placenta have been diagnosed, two placental lobes were present in both of sides of the internal os. Betamethasone for lung maturation, indomethacin for tocolysis, MgSO4 for neuroprotection were administered. She was followed up until 35 weeks 4 days of pregnancy. During this period vaginal bleeding was minimal and IUGR was observed in fetal biometry. At 35 weeks 4 days, elective C-section was performed. A 2150-grams female infant was delivered with an APGAR score of 6 and 8 at 1 and 5 minutes. No abnormal bleeding was observed during the operation and post-delivery. Neonatal examination was reported as normal. She was discharged two days after delivery. Bilobate placenta with velamentous umbilical cord insertion was confirmed postpartum via histopathology.

Discussion: Bilobate placenta, velamentous umbilical cord insertion and vasa previa can be observed concomitantly and each of them are related to adverse pregnancy outcomes. If either of them is observed, ultrasonographic examination with Doppler imaging should be performed in detail for placental or cord insertion abnormalities and timing of delivery should be planned carefully.

Key words: Bilobate placenta, velamentous umbilical cord insertion, vasa previa, bleeding
Olgu sunumu: Plasenta previa totalis tanısı bulunan Yahova Şahidi hastasında doğumda otolog kan transfüzyonu prosedürü

Tuğba Saraç Sivrkoz1, Çiğdem Kunt İşgüder1, Melis Cantürk2, Mukadder Orhan Sungur3, İbrahim Kalelioğlu1

1İstanbul Üniversitesi İstanbul Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı, Perinatoloji Bilim Dalı, İstanbul, Türkiye
2İstanbul Üniversitesi İstanbul Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı, İstanbul, Türkiye
3İstanbul Üniversitesi İstanbul Tıp Fakültesi Anesteziyoloji ve Reanimasyon Anabilim Dalı, İstanbul, Türkiye

Otolog kan transfüzyonu sistemi hastanın kendi vücutunda bulunan kırmızı kan hücrelerin bir filtreden ve santrifüjden geçirildikten sonra otolog olarak transfüzyon edilmesi esasına dayanır. Genel olarak kardiyovasküler cerrahiye ve traumatoloji uygulanırken, obstetri ve jinekoloji ameliyatlarında nadir kullanılmaktadır. Anütonomik sıvı embolisi, izoimmunizasyon ve hiperkoagulabilite gibi riskle bulunması nedeniyle bu sistemin obstetrik nedenlerle transfüzyon ihtiyacı bulunan ancak kan transfüzyonunu kabul etmeyen hastalarda kullanılması kabul edilen görüşler arasındadır.


Anahtar kelimeler: Plasenta previa totalis, Yahova Şahidi, otolog kan transfüzyonu
Hasan Eroğlu, Harun Egemen Tolunay, Nihal Şahin, Dilek Şahin, Aykan Yücel
Health Sciences University Etilik Zübeyde Hanım Gynecology Training and Research Hospital, Ankara

Goal: Presentation of an acute and chronic subchorionic hematoma case detected by ultrasound in third trimester

Case: 20 years old, G2P1Y1 patient was admitted to our hospital with vaginal bleeding complaint. The patient admitted to the maternity hospital; in abdominal ultrasonography, biometric measurements of fetus were consistent with gestational week. The chronic subchorionic hematoma, which reached a diameter of approximately 7 cm from the upper end of the plesanta towards the anterior, was observed. Doppler ultrasonography revealed no flow in the mass. The patient was followed up with these findings with the preliminary diagnoses of subchorionic hematoma.

Acute bleeding was performed 24 hours after hospitalization. Ultrasonography showed a well-defined acute subchorionic bleeding area just above the chronic subchorionic hematoma seen one day earlier (Figure 2). Due to rapid growth in hematoma area and decreased hemogram values during ultrasonography, delivery was made by emergency cesarean section. When the placenta was removed, small area of placenta next to the subchoronic hematoma was observed as decolated.

Discussion: Pregnancy complications and perinatal adverse outcome are not expected in small subchorionic hematoma cases. But sometimes large subchorionic Hematomas are associated with severe pregnancy complications such as intrauterine growth retardation, fetal distress and fetal death. Therefore, these cases should be closely monitored by other fetal well-being tests and Doppler ultrasonography.

Conclusion: The most important criterion for correct diagnosis in bleeding detected during pregnancy is the relationship between bleeding and placenta. It should be kept in mind that antenatal hemorrhage and intrauterine fetal death may occur in subchoric hematoma cases. As in our case, Fetus should be delivered immediately when fetal distress or worsening of maternal condition is concerned. The correct diagnosis for the right approach is important for pregnancy outcome.

**Key words**: Plesanta, Subchorionic hematoma, Fetal Distres
Figure 1: The area of the chronic subchorionic hematoma with the newly formed acute hematoma area. Doppler examination on hematoma revealed no flow.
Figure 2: Acute hematoma is seen on the edge of the placenta
PP-036 Fetal galen vein aneurysm: A case report

Kemal Sarsmaz, Hasan Eroğlu, Nazan Vanlı Tonyalı, Nihal Şahin Uysal, Dilek Şahin, Aykan Yücel

Etlik Zübeyde Hanım Woman’s Health Care, Training and Research Hospital/Perinatology Department, Ankara, Turkey

Introduction: Aneurysms of the vein of Galen (AVG) is a rare congenital vascular malformation that shunts the arterial blood flow into an enlarged vein. AVG are representing less than 1% of all intracranial arteriovenous malformations. Here we present a prenatal diagnosed case of AVG with the main findings based on conventional ultrasonography as well as postnatal outcome.

Case: A 31 year-old-woman gravida 3, para 2, had an uneventful pregnancy until 28 weeks of gestation when an ultrasound scan revealed severe ventriculomegaly with fetal hydrops. The patient had been referred our hospital for further investigation. During our ultrasound examination we detected anechoic, supratentorial, median mass, with a keyhole shape and regular borders (Figure 1). Color Doppler revealed turbulent arterial and venous flows suggesting the diagnosis of AVG (Figure 2, 3). Generalised scalp edema, ascites, cardiomegaly with tricuspid regurgitation and increase in placental thickness were also noticed (Figure 4, 5, 6).

After a multidisciplinary discussion, delivery by cesarean section at 28 weeks was decided because of the absence of end-diastolic flow of umbilical artery and the reverse A wave of ductus venosus Doppler. A 1590 g female infant with Apgar scores of 3 and 7 at 1 and 5 min respectively was delivered. The baby died due to a high-output cardiac failure on day two.

Discussion: The etiology of AVG is unknown, and there is no described familial inheritance. Prenatal diagnosis of AVG has become easier with the improvement of sonographic Doppler techniques that demonstrate the turbulent arterial and venous flows within the mass. Magnetic resonance imaging is important to exclude associated brain anomalies and also reveals complications such as hemorrhagic injury in the white matter of the brain. Differential diagnosis includes arachnoid, porencephalic or choroids plexus cysts, pineal tumors, choroid papilloma and intracerebral hematoma.

Heart failure is the most common symptom in the neonatal period, but seizures and other neurological signs may also be observed. Embolization is the main therapy for AVG. Prenatal cardiomegaly and cerebral injury at birth have been proposed as contraindications to vascular intervention. The best gestational age for delivery of these fetuses must be carefully considered. Vaginal delivery is suggested in cases of AVG without signs of heart failure. In cases complicated by cardiac insufficiency cesarean section does not seem to reduce the mortality rate and should only be performed for obstetrical reasons. Because AGV is associated with high rates of neonatal death, its prenatal diagnosis is essential for parent counseling and follow-up at tertiary care institutions.
Objective: To present ultrasound finding, associated anomalies and prognosis of right aortic arch (RAA) abnormality

Case: A 32 years old, multiparous woman was referred to our perinatology clinic upon detection of RAA in fetal ultrasound screening performed at 24 weeks of gestation. In the ultrasound examination, no other abnormalities were found except RAA and the case was accepted as isolated RAA (figure 1-2). Amniocentesis for genetic analysis was recommended but the patient did not accept it. No additional problems were observed in antenatal follow-up, she was delivered vaginally at 38th week. 1 and 5 minutes apgar scores were 7 and 9 respectively. There were no symptoms of respiratory obstruction like stridor or dyspnea in the infant and there were no problems until he was discharged from hospital. Now the baby is 1 month of age and he is healthy.

Discussion: RAA is usually diagnosed in three-vessel tracheal section during a detailed ultrasonographic scan of 20-24 weeks. In fetal echocardiography, aortic arch is seen on the right side of the trachea and additional cardiac pathologies should be screened especially for conotruncal anomalies. When a diagnosis of RAA, a karyotype analysis should be recommended to patients due to the possibility of chromosomal anomaly (22q11del, trisomy 21 etc). Symptoms in infancy are related to congenital heart anomalies or to compression of mediastinal structures such as the trachea or the esophagus. The prognosis depends on whether RAA is associated with cardiac and extracardiac anomalies. The prognosis is relatively good for isolated RAA.

Key words: right aortic arch, fetal echocardiography, prenatal diagnosis
Figure 1

T:trachea  VCS: vena cava superior
Figure 2

DA: duktus arteriozus  VCS: vena cava superior  T:trachea  R:right.  L:left
Introduction: Small bowel atresia can occur in any small bowel segment from Treitz's ligament to ileocecal valve level and its frequency is 0.06%. It is thought that atresia develops due to obstruction of the intestinal lumen with ischemia caused by deterioration of mesenteric vascular feeding in early weeks. 13% of ileal atresia is detected in proximal and 36% in distal ileum. In 90% of cases, atresia is single and in 5-10% more than one (multiple atresia). The ultrasound finding of jejunoileal obstruction is the increase of enlarged bowel segments with a diameter of more than 7 mm and sometimes with the accompanying peristalsis. Although chromosomal anomalies are common in duodenal atresia, chromosomal anomaly is present in less than 1% of atresia involving more distal bowel segments.

Case: A 35 years old G2P1 pregnant patient was referred to perinatology clinic at the 35nd weeks of gestation. She had no additional co-morbidity and prenatal care. Ultrasound measurements were consistent with 36 week, amniotic fluid was normal, there were no additional anomalies. Monitoring of the anal mucosa in the ultrasound allowed us to rule out anal atresia (Figure 1, 2, 3, 4). In the follow-up, cesarean section was planned as a result of non-reactive nst monitoring and 2960 g live baby girl was delivered by cesarean at 38 weeks of gestation. Surgical correction was performed shortly within few days after birth (Figure 5)

Discussion: The incidence of ileojejunal atresia at live birth is 1 / 2500-5000. In the ultrasound, dilatation proximal to the obstruction and late-onset polyhydroamnios can be seen. The risk of chromosomal and non-chromosomal anomalies are low and the prognosis is generally good. In our case, no additional anomaly was found. In the ultrasound, an increase of more than 7 mm in the intestinal segment, increase in fetal intestinal echogenicity, increased peristalsis and end-abdominal calcification due to meconium ileus are the findings. Polyhydramnios are usually present in fetal small bowel obstructions, but this does not occur until the third trimester. As a general rule, as far as the obstruction is, the polyhydramnios will appear as late and less severe. In our case, polyhydroamnios was not observed.

As a result, it is important to consider the importance of antenatal ultrasonography in the diagnosis of small bowel obstruction during the antenatal period, to direct the newborn without planning for postpartum complications and general condition and to allow treatment planning.
PP-041 Epignatus: A rare teratoma blocking fetal airway

Gökçe Naz Küçükbaş, Filiz Akyol, Onur Karaaslan, Erbil Karaman, Hanım Güler Şahin

Yuzuncu Yil University, Obstetrics and Gynecology and Perinatology Department

A 25 year old nulliparaous woman with a 24 weeks old gestational aged singleton pregnancy was referred to perinatology clinic. There was a mass originated from face especially from maxilla and mandibula reaching orbits with no nasal bone observed and face distorted. The mass included three lobules, cystic and solid. On MRI imaging, mass blocked oesaphagus and nasopharynx. Parents were informed and decided on pregnancy termination. Karyotype was 46, XX and pathological survey diagnosed mature teratome.
Gökçe Naz Küçükbaş¹, Gürcan Türkyılmaz², Hanım Güler Şahin³

¹Yüzüncü Yıl Üniversitesi, Perinatoloji Bölümü
²Van Devlet Hastanesi, Perinatoloji Bölümü


Figür 1: Terminasyon sonrası torakopagus ikizler
Figür 2: Torakapagus ikizlerin ultrasonografide ortak tek kalbi
PP-043 Wolf hirschhorn syndrome: A rare case report

Bülent Demir, Süreyya Sarıçar Demir, İbrahim Üğraş Toktaş, Fatma Silan, Öztürk Özdemir, Mesut Abdülkerim Şunsal

1Çanakkale Onsekizmart Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı Çanakkale
2Dokuz Eylül Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı Perinatoloji Ünitesi, İzmir
3Çanakkale Onsekizmart Üniversitesi Tıp Fakültesi Tibbi Genetik Anabilim Dalı Anabilim Dalı Çanakkale

Aim: We aimed to present a rare case of Wolf-Hirschhorn Syndrome, presenting with severe intrauterine growth retardation and oligohydroamnions, and note the importance of prenatal genetic evaluation in patients with intrauterine growth retardation and oligohydroamnions.

Case: A 32-years-old G2 P1 pregnant was referred to our clinic on the 17th week of gestation due to high risk in first trimester screening test. Ultrasonography showed a live fetus with mean 15w-2d-old of age, and a significantly decreased amniotic fluid. Amniocentesis was recommended for the patient who had a combined risk of 1/40 in the first trimester test and was considered to be early onset intrauterine growth retardation. The family did not accept the genetic diagnostic test. In the following weeks and routine controls, severe retardation (<3) in AC and FL and oligohydroamnions were observed, no pathology was found in fetal Doppler analysis. At 35 weeks and 4 days of gestational age, due to severe amniotic fluid reduction and severe growth retardation, a female infant with 1680 g, 40 cm length and 6/8 Apgar score was delivered by caesarean section, as the mother had a previous cesarean section, and the newborn was taken to the neonatal intensive care unit. In her physical examination, she had a plain occipital bone, protruding forehead, a broad and flat nasal bridge, hypertelorism, preauricular tags with low set ears, short philtrum, micrognathia and fish-type mouth. The body and extremity tone were decreased. Genetic evaluation revealed 4p16.3 microdeletion detected with Array-CGH (Agilent,180K) method from peripheral blood DNA, and this chromosomal region contains CPLX1, FGFRL1, CTBP1, LETM1 genes. Patient diagnosed as Wolf Hirschorn Syndrome and referred for genetic counselling.

Discussion: WHS is a rare (1/50.000 - 100.000 live birth) multipal congenital anomalies spectrum resulted. Severe intrauterine growth retardation, oligohydramnios, kraniofasial dismorfizm, Hypotonia, psikomotor retardation, seizures were >75% and short limbs, heart defects, Cleft lip/palate and genitourinary anomalies were present 25%-50% of patients. Our newborn presented with plain occipital bone, protruding forehead, a broad and flat nasal bridge, hypertelorism, preauricular tags with low set ears, short philtrum, micrognathia and fish-type mouth as shown in Picture 1, and it had a severe intrauterine growth retardation and oligohydramnios at prenatal age. WHS may presented with many ultrasonographic abnormalities according to the literature. In cases without fetal anomalies where severe IUGR and oligohydramnios are present without uteroplacental insufficiency, the family should be informed and invasive prenatal diagnostic test should be recommended.

Picture 1
Amaç: Ciddi intrauterin gelişme geriliği ve oligohidroamnios ile bulgu veren nadir görülen Wolf-Hirschhorn Sendromu (WHS) olgusunu summerayı ve ciddi intrauterin gelişme geriliği olan oligohidramniosu olan gebeliklerde prenatal genetik değerlendirme önerildi.


Tartışma; WHS, MSX1 genini kodlayan 2. Kromozomun kısa kolunda mikrodelesyon (del 4p16.3) sonucu oluşan konjenital bir hastalık spektrumudur. WHS insidansı 1/50.000-100.000 canlı doğum durumundur. Genellikle ciddi intrauterin gelişim geriliği, oligohidroamnios, kraniofazial dismorphizm, hipotoni, kısa uzun kemikler, psikomotor geriliğ ortaya çıkabilmesi, kardiak defektiler ile bulgu verirler. Olgumuzda da belirgin alın, burun kökü basılığı, hipertelorizm, kısa filtrum, mikrognati ve balık ağzı gibi tipik fetal bulguların (Resim 1) yanı sıra antenatal dönemde ciddi IUGR ve oligohidramnios saptanmıştır. WHS literatüründe birçok ultrasonografik bulgu ile karşılaşma çıkmaktadır. Uteroplensal yetmezliği bağlı olarak ciddi IUGR ve oligohidramniosu olan olgularda başka fetal anomaliler eşlik etmese bile aile bilgileri ile invazif prenatal tanı testi önerilmelidir.
Bülent Demir¹, Süreyya Sarıداş Demir², Nihat can Demircioğlu³, Furkan Kemal Paksoy¹, Faruk Demir⁴

¹Department of Obstetrics and Gynecology, Çanakkale Onsekiz Mart University, Çanakkale
²Division of Perinatology, Department of Obstetrics and Gynecology, Dokuz Eylul University School of Medicine, İzmir
³Şanlıurfa Training and Research Hospital, Division of Pediatric Allergy and Immunology, Department of Pediatrics, Şanlıurfa
⁴Şanlıurfa Training and Research Hospital, Division of Pediatric Allergy and Immunology, Department of Pediatrics, Şanlıurfa

Aim: To present Rusty Pipe Syndrome which occurs with bloody nipple discharge in a postpartum lactating women.

Case: 26 years old primigravide woman was admitted to Emergency Room at 38 weeks’ gestation with a Preterm Rupture of the Membranes. Obstetric examination shown healthy, breech presented singleton gestation. The baby was delivered via Cesarian section which was uneventful. The newborn weighed 3050gr and the APGAR score was 6-8, respectively. After the delivery, baby was admitted to NICU because of Transient Tachypnea of the Newborn. The symptoms regressed after 48 hours and the baby was discharged. During the time baby was in NICU the mother was milking with breast pump at the first 48 hours. She had bilateral painless bloody milk discharge from the breasts (Picture 1). Examination of the breasts did not reveal any tenderness, engorgement, mass lesion, cracks or fissures. The ultrasound scan did not find any pathology such as breast mass or dilated ducts. The mother was consulted to General Surgery department and cytological examination of the discharge was negative for neoplasm. She was advised to continue milking by pump, and the bloody discharge resolved spontaneously after 4 days and did not reoccur. Thereafter, the patient breastfed properly.

Conclusion: Rusty pipe syndrome is a benign physiologic condition that occurs on mothers on the first week of lactation. It spontaneously regresses within 3 to 7 days without any pain or permanent effects. Rusty pipe syndrome is caused by the rapid growth of the alveola and growing vascularization of the blood vessels in that area. The fragile arterioles are easily traumatised and causes bloody nipple discharge. If that happens the mother should simply keep breastfeeding.

Despite its dramatical symptoms it is considered as a benign condition, therefore awareness of medical personnel dealing with lactating mothers is very important for proper management of this condition, and also to avoid unnecessary investigations and to reduce anxiety in the mothers.

Key words: Rusty Pipe Syndrome, Bloody nipple discharge, Breastfeeding
Rusty pipe sendromu: Olgu sunumu

Bülent Demir¹, Süreyya Sarıdaş Demir², Nihat can Demircioğlu³, Furkan Kemal Paksoy⁴, Faruk Demir⁴

¹Çanakkale Onsekizmart Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı Çanakkale
²Dokuz Eylül Üniversitesi Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim Dalı Perinatoloji Ünitesi, İzmir
³Çanakkale Onsekizmart Üniversitesi Tıp Fakültesi Fizyoloji ve Bitki Tıbbiği Anabilim Dalı Yenidoğan Ünitesi, Çanakkale
⁴Şanlıurfa Eğitim ve Araştırma Hastanesi Çocuk Hastalıkları Allerji ve İmmünoloji Birimi, Şanlıurfa

Amaç: Doğum sonrası bebeğini emziren annenin memesinden kanlı akıntı ile ortaya çıkan Rusty pipe sendromu (paslı boru sendromu) olgusunu sunmayı amaçladık.


Anahtar kelimeler: Rusty pipe sendromu, Kanlı meme akıntısı, Emzirme
"Fetal trigonosefali: olgu sunumu"

Ülkü Mete Ural, Dilara Boztaş, Aybike Uysal

Abant Izzet Baysal Üniversitesi, Tıp Fakültesi, Kadın Hastalıkları ve Doğum Anabilim Dalı, Bolu


Olgu: 26 yaşında, ilk gebeliği olan hastanın 12. gestatsyonel haftasında yapılan ultrasonografik incelemesinde, mesane çapı 8.9 mm olarak ölçüldü. Ense saydamlığı ve ikili tarama testi sonucu normal olan hasta genetik inceleme yapmayı reddetti. İkinci trimesterde yapılan ultrasonografik muayenede bilateral minimal pelviektazi ve trigonosefali tespit edildi (Şekil 1). Takiplerinde intrauterin gelişme geriliği tanısi konulan hasta 38. gebelik haftasında ilerlemeyen eylem nedeniyle sezaryene alındı. 2245 gr ağırlığında, 7-8 APGAR’lı erkek bebeğ doğurtuldu. Fizik muayenesinde; hipospadias, inmemiş testis, düşük kulak, düşük ense saç çizgisinin olması, trigonosefalinin sendromik olabileceği düşündü (Şekil 2).


Anahtar kelimeler: kraniosinostoz, trigonosefali, tedavi
Şekil 1: İntrauterin trigonosefali görünümü

Şekil 2: Doğum sonrası yüz görünümü
Giriş: Gebelik, kalp kapak cerrahisinin ciddi bir komplikasyonu olan protez kapak trombozu açısından artmış risk ile ilişkilidir. Bu hastaların yeniden operasyonu, %6-69 oranında mortaliteye sahiptir. Birinci basamak strateji olarak trombolitik tedavi son yıllarda başarılı ve güvenli bir şekilde uygulanmaya başlanmıştır.

Olgu: 10 yaşında ventriküler septal defekt nedeniyle primer onarım ve 11 yaşında aort yetmezliği nedeniyle mekanik aort kapak replasmanı yapılmış olan 21 yaşındaki hastanın 30. gestasyonel haftasında yapılan EKO'da ciddi aort darlığı ve ortalama gradientin 60 mmHg üzerinde olduğu tespit edildi. Transözefajial ekokardiyografide > 10 mm boyutlarında trombüsler izlendi. Aortik kapaklardan birisinde tam stuck diğerinde ise yarı stuck görünümü tespit edildi. Düşük doz ve ultra yavaş infüzyon şeklinde (25 mg/25 saat; saatte 1 mg infüzyon, Alteplaz) trombolitik tedavi başlandı. Tedavi sonrası ciddi iyileşme tespit edilmesine rağmen halen 7-10 mm büyüklüğünde trombüslerin görülmesi üzerine ikinci bir 25 mg / 25 saat infüzyon ile trombolitik tedavi uygulandı. Kontrol transözefajial ekokardiyografide total trombüs büyüklüğünde > % 75 azalma olduğu tespit edildi. Yakın takip altında tutulan hasta 38. gebelik haftasında genel anestezi altında sezaryen ile 3000 gr ağırlığında Apgarlı erkek bebek doğdu. Postpartum kontrollerinde maternal veya fetal komplikasyon izlenmedi.

Appendiceal neuroendocrine tumor during pregnancy

Gizem Durmazoglu, Bilgesu Çetinel, Zeynep Cankaya, Simge Tezel Yozgat, Arzu Avci, Aykut Ozcan

Department of Obstetrics and Gynecology, Katip Celebi University School of Medicine, Izmir, Turkey

Introduction: The diagnosis of the appendiceal carcinoid tumor during pregnancy is a rare situation. The acute appendicitis picture caused by the tumor needs to be differentiated in a complicated or uncomplicated pregnancy. These cases are extremely rare.

Case report: A 24-year-old gravida 1 para 0, 21nd week pregnant woman presented at our emergency room with symptoms of acute appendicitis. The patient was complaining of vomiting and pain on the right iliac fossa. On physical examination there was tenderness in the right abdomen and rebound in the right paraumbilical region.

Gynecological examination showed no abnormal findings. A live fetus of about 21 weeks and 3 days with normal amniotic fluid and fetal weight was 512 g was seen on ultrasound. An enlarged McBurney incision was performed. The appendix was inflammatory, especially on its peripheral part. A typical appendectomy was performed. The resected specimen was about 7×1 cm. The pathological exam revealed a tumor smaller than 1 cm in diameter, at the tip of the appendix, with no base or middle portion invasion. The immunohistochemistry unveiled a positive reaction for chromogranin A, synaptophysin. The Ki-67 proliferation index was 1%. The mitotic activity was insignificant (Fig. 1).

The postoperative period was uncomplicated and the patient was discharged on the 2th postoperative day with no clinical symptoms and with good laboratory exams. The patient had a normal delivery at the 39th week of gestation. The infant’s weight and height were 3300 g and 50 cm, respectively.

Discussion: There are only few similar cases were found in the literature reporting appendiceal carcinoid tumor during pregnancy.

Key words: Appendix, Neuroendocrine Tumor, Pregnancy
Figure: Carcinoid of the appendix.

a) Hematoxylin and eosin stained sections (original magnification x2). The tumor was composed of nests and/or groups of round cells with a wide rim of normal-appearing tissue. No mitotic figures were seen. The tumor involved the entire appendix wall thickness, appendicular space with residual normal-looking mucosa by the appendiceal lumen at the left side, and the carcinoid tumor spreading at the right side with solid sheets, trabecular and rosette formations of variable size. Hematoxylin-eosin, x20. b) Chromogranin A immunohistochemical stain (original magnification x20) was strongly positive in the tumor cells and negative in residual mucosal cells. c) Pan-cytokeratin immunohistochemical stain (original magnification x20) were strongly positive.
Persistent right umbilical vein diagnosed in the third trimester

Gülşah Dağdeviren, Ayşe İstek Keleş, Özge Yücel Çelik, Aykan Yücel, Dilek Şahin

Universty Of Health Sciences, Etilik Zübeyde Hanım Women’s Health Care, Training And Research Hospital, Perinatology Department, Ankara, Turkey

Embryologically, obliteration of the right umbilical vein (UV) begins at the 4th gestational week and it disappears at week 7. Persistent right umbilical vein (PRUV) is an altered embryonic development, in which the left umbilical vein regresses and the right vein remains open.

Two variants of PRUV are described in the literature:

Intrahepatic type (PRUV-I): The most common type and 95% of cases have been reported. In PRUV-I, the UV passes lateral to the right side of the gallbladder, connects to the right portal vein, and then bends toward the stomach. The ductus venosus (DV) is usually present.

Extrahepatic type (PRUV-E): UV connects directly to the right atrium or the inferior vena cava. PRUV-E is associated with DV agenesis and a poorer prognosis.

Case: A 39-year-old multiparous patient had no significant features. At the 35th gestational week, she was referred to perinatology department with the diagnosis of fetal growth restriction. Intrahepatic type persistent right umbilical vein was detected. The other anatomic evaluations of the fetus and fetal echocardiography were normal. At the 37th gestational week, 1900 g of live male baby was delivered. There was no problem detected during the neonatal follow-up.

Discussion: PRUV is an uncommon prenatal finding and may be an isolated anomaly. A diagnosis of PRUV should be followed by a fetal morphology scan in order to exclude any other malformations, especially those of the cardiovascular system. Clinical significance of PRUV depends on its type and concomitant malformations.

Key words: anomalous venous system, persistent right umbilical vein, prenatal diagnosis
PRUV is trackt in the right lateral side of the gallbladder

Visualitation of the DV

The aberrant course of the right umbilical vein towards the stomach
Giriş: Omuz distosisi bağlı olarak yenidöğanda görülen en sık komplikasyonlar brakijal pleksus zedelenmesi ve klavikula kıırıklarıdır.


Sonuç: Omuz distosisinin farkedilmediği olgulara kalvikula fraktürü izole ise, takipte nörolojik sekeliz iyileşme mümkün olabilir.

Anahtar kelimeler: Klavikula kıırığı, brakijal pleksus hasarı, omuz distosisi
PP-054 The effect of bed position on respiratory outcomes in neonates receiving respiratory support with Ncpap

Sema Tanrıverdi, Esra Arun Özer

Manisa Celal Bayar University Medical School, Department of Pediatrics, Division of Neonatology, Manisa, Turkey

Aim: nCPAP is the most commonly used application for respiratory support in neonatal intensive care units. During nCPAP, there is no clear view of the baby's ideal bed position during follow-up. The aim of this study was to evaluate the effects of supine and prone positions on respiratory support and complications in neonates who received respiratory support with nCPAP.

Material and methods: Forty-five neonates who were admitted to the neonatal intensive care unit due to respiratory distress and who had nCPAP were enrolled in the prospective, randomized controlled study between 01.01.2018-01.01.2019. Cases with major congenital anomalies, congenital pulmonary and cardiac disease, who were referred to our clinic in another neonatal unit after birth were not included in the study. The patients were randomized by closed-envelope procedure and followed during supine or prone position during nCPAP during hospitalization. All patients were treated according to clinical protocol. Demographic characteristics, blood gas and other respiratory parameters, mortality and short-term morbidities were recorded.

Results: A total of 42 newborn infants were randomly assigned to the supine or prone position. There was no difference between the demographic characteristics of the study groups and antenatal risk factors. Although the duration of respiratory support was shorter, reintubation requirement and atelectasis frequency were less in the Prone group, the difference was not statistically significant (Table 1). Neonatal mortality, intraventricular hemorrhage, bronchopulmonary dysplasia, retinopathy of prematurity, sepsis and nutritional intolerance were not different.

Conclusion: In infants who are treated with nCPAP, there is a need for research involving more patients with less need for atelectasis and reintubation, and shorter respiratory support.

Key words: nCPAP, bed position, newborn
<table>
<thead>
<tr>
<th></th>
<th>Supine Group (n=21)</th>
<th>Prone Group (n=21)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilation time*</td>
<td>4.0 ± 6.4</td>
<td>2.3 ± 8.9</td>
<td>0.07</td>
</tr>
<tr>
<td>CPAP time*</td>
<td>8.4 ± 11.5</td>
<td>7.1 ± 11.7</td>
<td>0.26</td>
</tr>
<tr>
<td>Oxygen treatment time*</td>
<td>11.9 ± 13</td>
<td>10.3 ± 13.4</td>
<td>0.27</td>
</tr>
<tr>
<td>Surfactan requirement</td>
<td>7</td>
<td>4</td>
<td>0.29</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>2</td>
<td>1</td>
<td>0.54</td>
</tr>
<tr>
<td>Pulmonary bleeding</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PDA</td>
<td>3</td>
<td>2</td>
<td>0.63</td>
</tr>
<tr>
<td>PDA treatment</td>
<td>3</td>
<td>1</td>
<td>0.29</td>
</tr>
<tr>
<td>Cafein treatment (day)*</td>
<td>16.7 ± 14.8</td>
<td>17.1 ± 19.8</td>
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</tr>
<tr>
<td>Bronkopulmonary dysplasia</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Atelectasis</td>
<td>2</td>
<td>0</td>
<td>0.14</td>
</tr>
<tr>
<td>Reentubation</td>
<td>5</td>
<td>1</td>
<td>0.07</td>
</tr>
</tbody>
</table>

*Data are given as mean ± standard deviation.
PP-054 nCPAP ile solunum desteği alan yeniden doğanlarda yatış pozisyonunun solunumsal sonuçlara etkisi

Sema Tanrıverdi, Esra Arun Özer

Manisa Celal Bayar Üniversitesi Tıp Fakültesi Çocuk Sağlığı ve Hastalıkları AD, Neonatoloji BD, Manisa

Amaç: Günümüzde yeniden doğan yoğun bakım unitelerinde solunum desteği olarak en yaygın kullanılan uygulama nCPAP’dir. nCPAP’da izlem sırasında bebeğin en ideal yatış pozisyonu konusunda kesin bir görüş yoktur. nCPAP ile solunum desteği alan yeniden doğanlarda supine ve prone pozisyonlarının solunum desteği ve komplikasyonları üzerine etkilerinin değerlendirilmesi amaçlanmıştır.


Bulgular: Çalışmaya dahil edilen toplam 42 yeniden doğan bebek randomize olarak supine veya prone pozisyonunda izlendi. Çalışma gruplarının demografik özellikleri ve antenatal risk faktörleri arasında fark bulunmadı. Prone grubunda solunum desteği süresi daha kısa, reentübyüson ihtiyacı ve atelektazi sikliği daha az olmasına karşın ardadaki fark istatistiksel olarak anlamlı değişildi (Tablo 1). Neonatal mortalite, intraventriküler kanama, bronkopulmoner displazi, premature retnopatisi, sepsis ve beslenme intolleransı açısından farklılık bulunmadı.

Sonuç: Prone pozisyonunda nCPAP tedavisi alan bebeklerde atelektazi ve reentübyüson ihtiyacı daha az, solunum desteği daha kısa olmakla birlikte bu gözlemi kantlayacak daha fazla sayıda hastayı içeren araştırmalara ihtiyaç vardır.

Anahtar kelimeler: nCPAP, yatış pozisyonu, yeniden doğan
Tablo 1. Çalışma grubunda solunum desteği ile ilişkili morbidite ve komplikasyonların karşılaştırılması

<table>
<thead>
<tr>
<th></th>
<th>Supine Grubu (n=21)</th>
<th>Prone Grubu (n=21)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilasyon süresi*</td>
<td>4.0 ± 6.4</td>
<td>2.3 ± 8.9</td>
<td>0.07</td>
</tr>
<tr>
<td>CPAP süresi*</td>
<td>8.4 ± 11.5</td>
<td>7.1 ± 11.7</td>
<td>0.26</td>
</tr>
<tr>
<td>Oksijen tedavisi süresi*</td>
<td>11.9 ± 13</td>
<td>10.3 ± 13.4</td>
<td>0.27</td>
</tr>
<tr>
<td>Surfaktan gereksinimi</td>
<td>7</td>
<td>4</td>
<td>0.29</td>
</tr>
<tr>
<td>Pnömotoraks</td>
<td>2</td>
<td>1</td>
<td>0.54</td>
</tr>
<tr>
<td>Pulmoner kanama</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PDA</td>
<td>3</td>
<td>2</td>
<td>0.63</td>
</tr>
<tr>
<td>PDA tedavisi</td>
<td>3</td>
<td>1</td>
<td>0.29</td>
</tr>
<tr>
<td>Kafein tedavisi(gün)*</td>
<td>16.7 ± 14.8</td>
<td>17.1 ± 19.8</td>
<td>0.80</td>
</tr>
<tr>
<td>Bronkopulmoner displazi</td>
<td>1</td>
<td>1</td>
<td>0.14</td>
</tr>
<tr>
<td>Atelektazi</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Reentübasyon</td>
<td>5</td>
<td>1</td>
<td>0.07</td>
</tr>
</tbody>
</table>

*Veriler ortalama ± standart sapma olarak verilmiştir.
Objective: Our purpose was to reveal whether maternal copeptin levels are useful in prediction of preterm birth.

Methods: The study group comprised 44 women from Kırıkkale University Faculty of Medicine Obstetrics and Gynecology outpatient clinic between 04/12/2016 and 07/30/2017, and 104 women from high risk pregnancy unit and obstetrics outpatient clinic of Zekai Tahir Burak Women’s Health Education and Research Hospital between 10/09/2017 and 07/01/2018. Patients were classified as low-risk or high-risk according to preterm birth possibility after clinical assessment. A control group comprised of healthy pregnant at similar gestational weeks without pain. Eventually 6 groups were formed. Group 1: subjects at low risk for preterm birth in 7 days (n=51), group 2: subjects at high risk for preterm birth in 7 days (n=59), group 3: control group (n=38). After birth patients were classified in one of the following groups; group A: women who gave birth in 7 days after admission (n=41), group 5: women who gave birth later than 7 days after admission (n=33), and group 6: women who gave birth at term (n=66).

Results: Median copeptin levels for groups 1-3 were not significantly different 7.8(0.39-35.62) ng/ml, 7.02-25.74) ng/ml, 6.1(0.35-36.88) ng/ml, respectively). Copeptin levels did not differ between groups 4 to 6 (7.7(0.69-25.7) ng/ml, 8.0(2.73-35.62) ng/ml, 7.69(0.39-22.38) ng/ml respectively). However, in subgroup analysis copeptin levels significantly differed between control group and patients with cervical dilatation more than 3 cm (p<0.006).

Conclusion: Eventually we did not find any difference in copeptin levels between different stages of birth. These findings revealed that copeptin levels are not useful to predict preterm birth.

Key words: preterm labour, prediction, copeptin, preterm birth
Table 1: Characteristics of control and patient groups

<table>
<thead>
<tr>
<th></th>
<th>Group1</th>
<th>Group2</th>
<th>Group3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low Risk</td>
<td>High Risk</td>
<td>Control</td>
</tr>
<tr>
<td>N:51, 35 %</td>
<td>26(18-39)</td>
<td>27(17-38)</td>
<td>30(18-48)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>23.3(15.8-33.7)</td>
<td>20.6(14-38)</td>
<td>24.2(17.4-38.1)</td>
</tr>
<tr>
<td>Pre-pregnancy body mass index (BMI; kg/m²)</td>
<td>0.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight gain during pregnancy (kg)</td>
<td>0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smokers</td>
<td>5 (9.8 %)</td>
<td>11(20.4 %)</td>
<td>2(5.3 %)</td>
</tr>
<tr>
<td>Gestational week (week)</td>
<td>0.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nulliparous</td>
<td>21(42 %)</td>
<td>30(51 %)</td>
<td>12(31 %)</td>
</tr>
<tr>
<td>Primiparous</td>
<td>14(28 %)</td>
<td>16(27 %)</td>
<td>17(45 %)</td>
</tr>
<tr>
<td>Multiparous</td>
<td>15(30 %)</td>
<td>11(22 %)</td>
<td>9(24 %)</td>
</tr>
<tr>
<td>History of caesarean delivery in previous pregnancies</td>
<td>0.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of preterm labour in previous pregnancies</td>
<td>0.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of preterm labour in ongoing pregnancy</td>
<td>0.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal steroid application during ongoing pregnancy</td>
<td>0.41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>47(94 %)</td>
<td>51(88 %)</td>
<td>Yok</td>
</tr>
<tr>
<td>Bleeding</td>
<td>3(6 %)</td>
<td>7(12 %)</td>
<td>0.00</td>
</tr>
<tr>
<td>Cervical evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical length, mm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;30 mm, N, %</td>
<td>28(20-51)</td>
<td>17(6-26)</td>
<td>35(32-44)</td>
</tr>
<tr>
<td>20–30 mm, FFN positive, N, %</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–30 mm, FFN negative, N, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20 mm, N, %</td>
<td>30(58.8 %)</td>
<td>N/A</td>
<td>38%(100)</td>
</tr>
<tr>
<td>Cervical dilatation, cm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0(0-2)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Days until delivery</td>
<td>33(0-106)</td>
<td>3(0-90)</td>
<td>44(3-89)</td>
</tr>
</tbody>
</table>

Table 2: Patient characteristics based on the timing of delivery

<table>
<thead>
<tr>
<th></th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm within 7 days N: 41, 28.6 %</td>
<td>7, (17.1 %)</td>
<td>15, (45.5 %)</td>
<td>25, (37.9 %)</td>
</tr>
<tr>
<td>Preterm after 7 days N: 33, 23.6 %</td>
<td>33,(80.5 %)</td>
<td>11, (33.3 %)</td>
<td>14, (21.2 %)</td>
</tr>
<tr>
<td>Term birth N: 66, 47.1 %</td>
<td>1, (2.4 %)</td>
<td>7, (21.2 %)</td>
<td>27, (40.9 %)</td>
</tr>
<tr>
<td>Days until delivery</td>
<td>1.0(0-6)</td>
<td>19.5(6-49)</td>
<td>45.0(17-106)</td>
</tr>
<tr>
<td>Birth weight, g</td>
<td>1980(700-2895)</td>
<td>2515(1510-3300)</td>
<td>3040(1035-4010)</td>
</tr>
</tbody>
</table>
Objective: Making a decision through the prenatal diagnostic steps are affected by many factors in pregnant women. The purpose of this study is to explain which choices Turkish women prefer for prenatal diagnosis more frequently and to find out if there is any association between temperament and decisions through the prenatal diagnostic steps or consistency of decision.

Methods: This is a descriptive study on pregnant women who admitted to our outpatient clinic based on the responses to a self-administered questionnaire at the time of combined test or triple test as the first prenatal screening test. 198 pregnant completed self-administered questionnaires comprising 131 questions including Temperament Evaluation of Memphis, Pisa, Paris and San Diego questionnaire (TEMPS-A). Informed women answered 4 questions on their attitudes on prenatal diagnosis continuum.

Results: Overall, 88.4% of women were willing to learn if there was an anomaly, whereas 4.5% did not; 7.5% were uncertain. Of the included patients, 87.9% would decide on the screening tests to be performed, 23.2% had a positive attitude on diagnostic tests, and only 13.1% were in favour of termination. No association was found between the temperament scores and positive, negative and indecisive attitudes of the patients. In addition, there was no relation between being decisive and indecisive, and the temperament scores. Decision groups and temperament scores had no significant difference.

Conclusion: we found that affective temperaments measured by the TEMPS-A are not related with the attitudes about prenatal screening or diagnostic tests or termination.

Key words: prenatal screening, temperament, TEMPS-A, Turkish women, preferences, decision-making
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total, n = 199</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (year)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17–34 years</td>
<td>164</td>
<td>82</td>
</tr>
<tr>
<td>&gt;35 years</td>
<td>35</td>
<td>18</td>
</tr>
<tr>
<td><strong>Education (year)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domestic education</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>School ≤5 years</td>
<td>39</td>
<td>20</td>
</tr>
<tr>
<td>School ≤8 years</td>
<td>100</td>
<td>50</td>
</tr>
<tr>
<td>School &gt;8 years</td>
<td>54</td>
<td>27</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nulliparous</td>
<td>66</td>
<td>33</td>
</tr>
<tr>
<td>1</td>
<td>66</td>
<td>33</td>
</tr>
<tr>
<td>≥2</td>
<td>66</td>
<td>33</td>
</tr>
<tr>
<td><strong>Relationship status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a relationship</td>
<td>196</td>
<td>99</td>
</tr>
<tr>
<td><strong>Gestational age (week)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;14 weeks</td>
<td>174</td>
<td>87</td>
</tr>
<tr>
<td>15–18 weeks</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td><strong>Body mass index (kg/m²)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underweight</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Normal</td>
<td>93</td>
<td>47</td>
</tr>
<tr>
<td>Overweight</td>
<td>62</td>
<td>32</td>
</tr>
<tr>
<td>Obese</td>
<td>34</td>
<td>17</td>
</tr>
<tr>
<td><strong>Family Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;Minimum wage</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Minimum wage</td>
<td>66</td>
<td>33</td>
</tr>
<tr>
<td>&gt;Minimum wage</td>
<td>121</td>
<td>61</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>187</td>
<td>95</td>
</tr>
<tr>
<td><strong>Beginning of prenatal care (week)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;8 weeks</td>
<td>156</td>
<td>80</td>
</tr>
<tr>
<td>8–10 weeks</td>
<td>25</td>
<td>13</td>
</tr>
<tr>
<td>11–14 weeks</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>&gt;14 weeks</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Have you had a screening test for Down syndrome in any previous pregnancy?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>98</td>
<td>49</td>
</tr>
<tr>
<td><strong>Have you had an invasive test in any previous pregnancy?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Do you have a child with Down syndrome or any other anomaly?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td><strong>Passed time since child desire</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>101</td>
<td>51</td>
</tr>
<tr>
<td>&gt;1 year</td>
<td>33</td>
<td>17</td>
</tr>
<tr>
<td>IVF pregnancy</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 2: Attitudes of study population

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes, N%</th>
<th>No, N%</th>
<th>Uncertain, N%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want to know the anomaly?</td>
<td>175 (88)</td>
<td>9 (5)</td>
<td>14 (7)</td>
</tr>
<tr>
<td>Do you wish screening test?</td>
<td>174 (88)</td>
<td>15 (8)</td>
<td>9 (5)</td>
</tr>
<tr>
<td>Would you wish invasive test after a positive screening test?</td>
<td>46 (23)</td>
<td>101 (51)</td>
<td>51 (26)</td>
</tr>
<tr>
<td>Would you terminate pregnancy if invasive test is positive?</td>
<td>26 (13)</td>
<td>102 (52)</td>
<td>70 (35)</td>
</tr>
</tbody>
</table>

Values are given as frequency(percentage)

Table 3: Relation between the decisions and temperament scores

<table>
<thead>
<tr>
<th></th>
<th>Depressive</th>
<th>Cyclothymic*</th>
<th>Hypertimic**</th>
<th>Irritable *</th>
<th>Anxious *</th>
</tr>
</thead>
<tbody>
<tr>
<td>All pregnant</td>
<td>5 (0–14)</td>
<td>7 (0–17)</td>
<td>10.1 ± 4</td>
<td>2 (0–13)</td>
<td>6 (0–18)</td>
</tr>
<tr>
<td>Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would N:174</td>
<td>5 (0–14)</td>
<td>7 (0–17)</td>
<td>10.4 ± 4</td>
<td>2 (0–13)</td>
<td>6 (0–18)</td>
</tr>
<tr>
<td>I would not N:15</td>
<td>6 (0–8)</td>
<td>5 (0–16)</td>
<td>8.1 ± 5.1</td>
<td>2 (0–12)</td>
<td>5 (0–15)</td>
</tr>
<tr>
<td>Indecisive N:9</td>
<td>4 (1–14)</td>
<td>7 (2–16)</td>
<td>9.2 ± 4.9</td>
<td>1 (0–11)</td>
<td>7 (1–16)</td>
</tr>
<tr>
<td>P</td>
<td>0.982</td>
<td>0.369</td>
<td>0.102</td>
<td>0.755</td>
<td>0.863</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would N:46</td>
<td>5 (0–14)</td>
<td>7 (0–16)</td>
<td>10.2 ± 4.2</td>
<td>3 (0–13)</td>
<td>5 (0–18)</td>
</tr>
<tr>
<td>I would not N:101</td>
<td>5 (0–12)</td>
<td>6 (0–17)</td>
<td>9.7 ± 4.1</td>
<td>2 (0–11)</td>
<td>6 (0–18)</td>
</tr>
<tr>
<td>Indecisive N:51</td>
<td>5 (1–14)</td>
<td>8 (1–16)</td>
<td>11 ± 4.1</td>
<td>3 (0–13)</td>
<td>5 (0–17)</td>
</tr>
<tr>
<td>P</td>
<td>0.766</td>
<td>0.657</td>
<td>0.188</td>
<td>0.094</td>
<td>0.841</td>
</tr>
<tr>
<td>Termination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would N:26</td>
<td>5 (1–12)</td>
<td>5 (1–13)</td>
<td>10.5 ± 4.4</td>
<td>2 (0–13)</td>
<td>4 (0–18)</td>
</tr>
<tr>
<td>I would not N:102</td>
<td>5 (0–14)</td>
<td>7 (0–17)</td>
<td>10.1 ± 4.2</td>
<td>2 (0–13)</td>
<td>6 (0–18)</td>
</tr>
<tr>
<td>Indecisive N:70</td>
<td>5 (1–14)</td>
<td>8 (0–16)</td>
<td>10.1 ± 4</td>
<td>3 (0–11)</td>
<td>6 (0–17)</td>
</tr>
<tr>
<td>P</td>
<td>0.869</td>
<td>0.1</td>
<td>0.896</td>
<td>0.795</td>
<td>0.174</td>
</tr>
</tbody>
</table>

*Kruskal–Wallis test

**One-way analysis
Table 4: Relation between the decisions and temperament scores

<table>
<thead>
<tr>
<th></th>
<th>Depressive</th>
<th>Cyclothymic</th>
<th>Hypertimic</th>
<th>Irritable</th>
<th>Anxious</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decisive</td>
<td>5 (0–14)</td>
<td>7 (0–17)</td>
<td>10.4 ± 4</td>
<td>2 (0–13)</td>
<td>6 (0–18)</td>
</tr>
<tr>
<td>Indecisive</td>
<td>5.5 (0–14)</td>
<td>6 (0–16)</td>
<td>8.5 ± 5</td>
<td>2 (0–12)</td>
<td>6.5 (0–16)</td>
</tr>
<tr>
<td>P</td>
<td>0.939</td>
<td>0.305</td>
<td>0.093</td>
<td>0.592</td>
<td>0.783</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decisive</td>
<td>5 (0–14)</td>
<td>7 (0–16)</td>
<td>10.2 ± 4.2</td>
<td>3 (0–13)</td>
<td>5 (0–18)</td>
</tr>
<tr>
<td>Indecisive</td>
<td>5 (0–14)</td>
<td>7 (0–17)</td>
<td>10.1 ± 4.1</td>
<td>2 (0–13)</td>
<td>6 (0–18)</td>
</tr>
<tr>
<td>P</td>
<td>0.946</td>
<td>0.935</td>
<td>0.905</td>
<td>0.184</td>
<td>0.606</td>
</tr>
<tr>
<td><strong>Termination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decisive</td>
<td>5 (1–12)</td>
<td>5 (1–13)</td>
<td>10.5 ± 4.4</td>
<td>2 (0–13)</td>
<td>4 (0–18)</td>
</tr>
<tr>
<td>Indecisive</td>
<td>5 (0–14)</td>
<td>7 (0–17)</td>
<td>10.1 ± 4.1</td>
<td>2 (0–13)</td>
<td>6 (0–18)</td>
</tr>
<tr>
<td>P</td>
<td>0.759</td>
<td>0.036</td>
<td>0.64</td>
<td>0.666</td>
<td>0.147</td>
</tr>
</tbody>
</table>

Figure 1: Paths women prefer more frequently
Objectives: The aim of this study was to determine whether or not gestational diabetes is a risk factor for carpal tunnel syndrome (CTS).

Methods: This prospective cross-sectional study was included patients who were in the 3rd trimester of pregnancy and had undergone gestational diabetes screening in the 24th-28th gestational week. All patients were questioned about symptoms of CTS in respect of whether or not they had complaints of pain, numbness and tingling in the hand and wrist. Patients with these complaints were administered the Boston Carpal Tunnel Syndrome Questionnaire (BCTSQ). Then the presence of CTS was investigated in an orthopaedic consultation.

Results: The study population consisted of 201 pregnant women without gestational diabetes and 150 pregnant women with gestational diabetes. The results of the study showed the frequency of CTS to be 12.5% of the total patient population and no difference in patients with and without gestational diabetes. (12.1%, 13.1% respectively)

Conclusion: CTS, which is widely encountered in pregnancy, is a condition that has a significantly negative effect on the quality of life of the pregnant patient. This is an important problem in the patient group with diabetes mellitus. However, the results of this study did not show gestational diabetes to be a risk factor for CTS.

Key words: gestational diabetes mellitus, pregnancy-related carpal tunnel syndrome, Boston Carpal Tunnel Syndrome Questionnaire
Table 1: Demographic characteristics

<table>
<thead>
<tr>
<th></th>
<th>Pregnant patients without gestational diabetes n:201 (57.2%)</th>
<th>Pregnant patients with gestational diabetes n: 150 (42.7%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>26.0(17-43)</td>
<td>31.0(16-42)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Prepregnancy BMI(kg/m²) (miss:13)</td>
<td>23.80(16.4-47.0)</td>
<td>27.1(15.9-50.0)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gestational week (weeks) (miss:1)</td>
<td>37(30-41)</td>
<td>36(31-40)</td>
<td>0.033</td>
</tr>
<tr>
<td>Gestational weekly weight gain (kg/week) (miss:4)</td>
<td>0.34(±0.17)</td>
<td>0.27(-0.17-1.09)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Smoker</td>
<td>16 (8.0%)</td>
<td>8 (5.3%)</td>
<td>0.425</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Nulliparous</td>
<td>84(41.8%)</td>
<td>37 (24.6%)</td>
<td></td>
</tr>
<tr>
<td>How to control diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle modification</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Insulin therapy</td>
<td>N/A</td>
<td>86(57.7%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Characteristics of the patient

<table>
<thead>
<tr>
<th></th>
<th>Pregnant patients without gestational diabetes n:201 (57.2%)</th>
<th>Pregnant patients with gestational diabetes n: 150 (42.7%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTS present</td>
<td>N:193</td>
<td>N:146</td>
<td>0.696</td>
</tr>
<tr>
<td></td>
<td>27 (13.4%)</td>
<td>17 (11,3%)</td>
<td></td>
</tr>
<tr>
<td>Complaints</td>
<td>53(26.4%)</td>
<td>30 (20%)</td>
<td>0.296</td>
</tr>
<tr>
<td>Affected side</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td>N:27(13.4)</td>
<td>N:17(11,3)</td>
<td>0.613</td>
</tr>
<tr>
<td></td>
<td>10(5.0)</td>
<td>6(4,0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6(3.0)</td>
<td>2(1.3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11(5.5)</td>
<td>9(6.0)</td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilateral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTS history present</td>
<td>N:182</td>
<td>N:141</td>
<td>0.356</td>
</tr>
<tr>
<td></td>
<td>7(3.8%)</td>
<td>8(5.7%)</td>
<td></td>
</tr>
<tr>
<td>Side of complaint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td>N:51(25.4%)</td>
<td>N:25(16,6%)</td>
<td>0.171</td>
</tr>
<tr>
<td></td>
<td>14(7.0%)</td>
<td>12(8.0%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9(4.5%)</td>
<td>2(1.3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>28(13.9%)</td>
<td>11(7.3%)</td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilateral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCTSQ score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S score</td>
<td>N:51(25.4%)</td>
<td>N:30(20%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,9(1,1-4,2)</td>
<td>2,4(1,1-4,3)</td>
<td>0.066</td>
</tr>
<tr>
<td></td>
<td>1,4(1,0-3,5)</td>
<td>1,5(1,0-4,4)</td>
<td>0.306</td>
</tr>
</tbody>
</table>

Variables are given as ‘median (min-max)’, mean±SD or ‘count(%)’ where appropriate.
Table 3: Logistic regression analysis of independent risk factors for KTS

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Wald</th>
<th>OR (95CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt; 25 years</td>
<td>1.774</td>
<td>0.57 (0.25-1.29)</td>
<td>0.183</td>
</tr>
<tr>
<td>Parity &gt; 1</td>
<td>0.447</td>
<td>0.74 (0.31-1.76)</td>
<td>0.504</td>
</tr>
<tr>
<td>BMI &gt; 25 kg/m²</td>
<td>1.09</td>
<td>0.68 (0.33-1.39)</td>
<td>0.294</td>
</tr>
<tr>
<td>Gestational Diabetes</td>
<td>0.96</td>
<td>1.41 (0.70-2.82)</td>
<td>0.32</td>
</tr>
</tbody>
</table>

BMI: body mass index

Figure: Flow chart of subject selection

All pregnant patients presenting at the outpatient for examination in the 3rd trimester (n=492)

Patients included in the study (n=351)

Exclusions (n=141)
- Those who did not have OGTT in weeks 24-28 (n=101)
- Those with thyroid disease (n=32)
- Those with pregestational diabetes (n=3)
- Those with pregestational CTS (n=4)
- Those with twin pregnancy (n=2)

Patients with gestational diabetes (n=150) (miss: 4)

Patients with CTS (n=17)

Patients without CTS (n=137)

Patients without gestational diabetes (n=201) (miss: 8)

Patients with CTS (n=27)

Patients without CTS (n=166)
Cardiac arrest after atrial fibrillation with fast ventricular response in second trimester pregnancy: A case report

Mustafa Şengül, Ayşegül Gülbahar, Seda Akgün Kavurmacı

Introduction: Almost 75% of the heart diseases during pregnancy are composed of congenital heart diseases. Most of the congenital heart diseases are tolerated during pregnancy, however, some of the cardiac diseases could get worse due to hemodynamic changes occurring in pregnancy.

Case: A 36-year-old patient with G:1P:0 whose pregnancy is compatible with a single live fetus of about 23 weeks was admitted to the emergency service with palpitation. Patient had atrial fibrillation with fast ventricular response in ECG. ECO results showed; severe pulmonary hypertension, 2nd degree mitral insufficiency, 4th degree tricuspid insufficiency, severe coarctation defect in the tricuspid valve and thickening of the aortic valves. Doppler ultrasonography of the lower extremity venous system showed no signs of deep vein thrombosis, but cardiac pulsations were seen on both sides secondary to tricuspid regurgitation. The patient was followed-up in the coronary intensive care unit with medical therapy. During follow-up, the patient had atrial fibrillation and had cardiac respiratory arrest. The patient was entubated and a hypotensive pulse was taken after 5min CPR. Dopamine and dobutamin infusion has been applied. As a result of transesophageal echocardiography, both atrium were highly dilated. According to control obstetric ultrasonography 23 week, single fetus with negative heart rate has been observed. After hemodynamic stabilization, cervical foley balloon dilatation has been applied with abdominal ultrasound guidance. Then, oxytocin infusion was performed and vaginal abortion is executed. It was observed that the general condition of the patient improved during follow-up. Coumadin treatment has been started for atrial fibrilation. Patient was called for control after discharge for mitral balloon valvulaplasty and INR follow-ups.

Discussion: Despite the advancements in the congenital heart disease diagnosis and treatment; pregnancy is contra-indicated and termination is recommended in some of them. Therefore, pre-pregnancy counseling should be given to prevent maternal mortality and fetal anomalies.

Key words: Atrial fibrillation, congenital heart diseases, pulmonary hypertension
İkinci trimester gebelikte hızlı ventriküler yanıtlı atrialfibrilasyonu sonrası kardiyak arrest: Olgu sunumu

Mustafa Şengül, Ayşegül Gülbahar, Seda Akgün Kavurmacı

İzmir Katip Çelebi Üniversitesi Atatürk Eğitim Araştırma Hastanesi Kadın Hastalıkları ve Doğum Kliniği İzmir

Giriş: Gebelikte görülen kalp hastalıklarının yaklaşık %75’ini konjenital kalp hastalıkları oluşturmaktadır. Konjenital kalp hastalıklarının çoğu gebelik esnasında iyi tolere edildiken bazı kardiyak hastalıklar (kapak darlıkları) gebelikte ortaya çıkan hemodinamik değişiklikler nedeni ile gebeliği daha da kötüleştirebilir. Bu gibi durumlarda pulmoner hipertansiyon (PH) gelişme riski %4 oranındadır ve hastalarda yüksek mortalite riski (%17-%50) vardır.


Anahtar kelimeler: Atrialfibrilasyon, konjenital kalp hastalıkları, pulmoner hipertansiyon


Bulgular: Postnatal depresyon semptomları annelerde daha fazla (% 25) olmakla birlikte babalarda da %6,5 sıklığında görülmektediydi. Bağlama örüntüleri anne ve babalarda benzerdi (p=0,292). Nörogelişimsel sonuçlar benzer olmakla birlikte, orta-prematüre grubunda (103,5±10,5) erken (98,9±8,8) ve geç (96,8±7,8) prematüre grubuna göre düzeltilmiş 6. ayda bilişsel gelişimin daha iyi olduğu bulundu (p=0,015). Çok değişkenli analizde prematüre derecesi ve nörogelişimsel sonuçlar ile anne-baba depresyonu ve bağlama örüntüleri modele konuldu. Hastaların düzeltilmiş altıncı ayda bilişsel gelişimi baba depresyonu ile (p=0,030, $R^2$=0,080, $B$=0,283), dil gelişimi ise anne güvensiz bağlama örüntüsü ile (p=0,011, $R^2$=0,108, $B$=0,329) ilişkilidi.

Sonuç: Erken dönem baba depresyonu ve anne güvensiz bağlama örüntüsü, prematüre derecesinden bağımsız olarak gelişimsel sonuçları etkilemektedir. Bu nedenle destek sistemlerinin erken dönemde itibaren düzenlenmesi gerekmektedir.

Anahtar kelimeler: prematüre, gelişim, depresyon, bağlama
Amaç: İnterstisyel ektopik gebelik(İEG) nadir bir ektopik gebeliktir(EG). Erken tanı, uygun tedavi bu hastalarda hayat kurtarıcı, fertiliteyi koruyucu olabilmektedir. Tanısında ultrasonografi(USG), seri insan koryonik gonodotropin(β-hCG) ölçümleri yardımcıdır. Sunumumuzda laparoskopi uygulanan İEG olgusuna yer verilmiştir.


Sonuç: Laparaskopide sağ kornuda yaklaşık 4cm boyutunda İEG materyali, batın içi minimal hemorajik mayı izlendi. Kornual bölge bipolar koter ve makas yardımıyla koterize edilerek kesildi, İEG materyali boşaltılırak patolojiye gönderildi. Sağ tüpün İEG’ye yakın izlenmesi üzerine sağ salpinjektomi ve ardından probe-c uygulandı. Postoperatif 2.-6.-12.-96. saat kontrol Hb değerleri sırasıyla 12,7-12,6-12,2-12,8g/dl; 12.-36.-96. saat kontrol β-hCG değerleri sırasıyla 5132-2743-1132mIU/ml ölçüldü. Postoperatif genel durumu iyi, vital bulguları stabil olan hasta taburcu edildi.

Tartışma: İEG yanlış/geç tanı konulabilen, nadir(%2) ancak tehlikeli bir ektopik gebeliktir. Gebeliğin erken dönemindeki maternal morbide, mortalitenin önemli nedenlerindendir. İEG’de erken tanı; medikal tedavi seçeneği sağlanması, morbidade ile mortaliteyi azaltması yönüyle prognostik açıdan önemlidir. β-hCG takibi, USG(boş uterus kavite ve gestasyonel kese etrafında ince myometrial tabakanın görülmesi) ve renkli doppler USG(ateş halkası görüntüüsü, peritrofoblastik yoğun kanlanma) bulguları İEG tanısında değerlidir. İG’de hastanın hemodinamisi, USG bulguları ve β-hCG düzeyleri değerlendirilerek tanı konulup, tedavi şekillendirilmelidir. Sistemik metotreksat EG tedavisinde kullanılmaktadır; ancak İEG tedavisinde literatür sınırlıdır. Ağır uterin hasarlı oğularda interstisyel rezeksiyon, histerektomi gibi yöntemler uygulanabilmektedir. Günümüzde laparoskopi, hemodinamisi stabil hastalarda laparotomiye iyi bir alternatiftir; postoperatif erken mobilizasyon, kısa hospitalizasyon avantajlarıyla ön çıkmaktadır.

Anahtar kelimeler: İnterstisyel ektopik gebelik, β-hCG, ultrasonografi, laparaskopi
Resim 1: USG’ de sağ istimk bölgede 33*28 mm boyutlarında kistik görünümde interstisyel ektopik gebelik bulgusu

Resim 2a: Interstisyel ektopik gebeliğin laparaskopik görünümü

Resim 2b: Laparoskopik olarak interstisyel ektopik gebelik kesesinin çıkarılması

Resim 2c: Defektin onarılış halinin görüntüü
Aicardi sendromu korpus kallosum agenezisi ile ilişkili bir sendromdur. Yalnızca kız bebeklerde görülür veya 47, XXY karyotipindedir. Intrakranial kistler ve göz bulguları siklikla eşlik eder.

Olgu: 31 yaşında G5P1A3Y1 hasta tarafımıza 32. gebelik haftasında MRI da korpuskallosum agenezisi, multiple interhemisferik kistler, serebral hemisferlerde asimetri, lateral ventriküller sol lateral ventrikül daha belirgin olmak üzere dilate izlendi. Tarafımızda yapılan ultrason incelemesinde orta hatta yakın en geniş yerinde 25x22 mm interhemisferik kist, korpuskallosum agenezisi, sol kolposefali, serebellar asimetri izlendi. Doğum sonrası yapılan göz dibi muayenesinde bilateral korioretinal lakünler izlendi. Genetik inceleme sonucu normal karyotip olarak raporlandı.


Anahtar kelimeler: Aicardi sendromu, korpuskallosum agenezi, interhemisferik kist
Objective: In perineal lacerations, morbidity rates increase after 3rd and 4th degree. The aim is to review the management of perineal lacerations in three cases in our clinic.

Method: Three cases with 3rd-4th degree laceration were evaluated in 2018 in our clinic. The degree of perineal lacerations were defined according to ACOG 2014 (Table 1). All patients were operated by general surgery; The external sphincter was repaired with 2/0 vicryl in the form of overlapping and internal sphincter was repaired with 2/0 vicryl primary separate suture method.

Results: The first case was admitted to our hospital as a 27-year-old, G1P0 and 40 + 2 weeks pregnant woman with pelvic pain. Dilatation period of the case was completed in 5 hours. Upon completion of the dilatation, the baby was delivered with a right mediolateral episiotomy. The birth weight of the girl baby was 3200 grams and the first-fifth-minute APGAR scores were 7-8. Postnatal pelvic examination revealed external sphincter’s full-thickness laceration. Our second case was a 29-year-old, G4P3 and 40 + 1 weeks pregnant woman with pelvic pain. The dilatation period of the case was completed in 10 hours. Upon completion of the dilatation, the baby was delivered with a right mediolateral episiotomy. The birth weight of the boy baby was 3800 grams and the first-fifth-minute APGAR scores were 7-8. Postnatal pelvic examination revealed external sphincter’s full-thickness laceration and distal part of internal sphincter laceration. Our third case was a 22-year-old, G1P0 and 37 weeks pregnant woman who was water breaking early. Dilatation period of the case was completed in 6 hours. Upon completion of the dilatation, the baby was delivered with a right mediolateral episiotomy. The birth weight of the boy baby was 3400 grams and the first-fifth-minute APGAR scores were 7-8. Postnatal pelvic examination revealed full-thickness laceration of 5-6 cm in the vagina 1/3 lower posterior wall. Cases were followed postpartum period until discharge to gaita. The treatment and feeding were arranged to prevent constipation. Fecal incontinence or fistula formation was not observed during following.

Conclusion: The 3rd and 4th degree lacerations may not be foreseen. Without a multidisciplinary approach in treatment and follow-up, chronic pain, sexual dysfunction, fecal incontinence and fistula formation may be associated with morbidity.

Key words: Perineal laceration, sphincter repair
Table 1: Classification of Perineal Lacerations

<table>
<thead>
<tr>
<th>Degree Laceration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Degree Laceration</strong>: The injury is only on the skin of the perineum.</td>
</tr>
<tr>
<td>2. <strong>Degree Laceration</strong>: Injury includes perineal muscle layer but should not contain anal sphincters</td>
</tr>
<tr>
<td>3. <strong>Degree Laceration</strong>: Injury contains anal sphincter complex</td>
</tr>
<tr>
<td>3a: Less than 50% of the thickness of the external anal sphincter is torn</td>
</tr>
<tr>
<td>3b: More than 50% of the external anal sphincter is torn</td>
</tr>
<tr>
<td>3c: Both external and internal anal sphincters were ruptured</td>
</tr>
<tr>
<td>4. <strong>Degree Laceration</strong>: Injury includes anal sphincter complex (external and internal anal sphincters) and anal mucosa</td>
</tr>
</tbody>
</table>

Doğum sırasında perineal laserasyon (tip 3 ve tip 4) oluşan 3 olgunun sunumu

Ebru Yılmaz

Sağlık Bilimleri Üniversitesi Tepecik Eğitim ve Araştırma Hastanesi, Kadın Hastalıkları ve Doğum, İzmir

Amaç: Perineal laserasyonlarda üçüncü ve dördüncü dereceden sonra morbidite oranları artmaktadır. Amacımız kliniğimizde görülen 3 olgu ile perineal laserasyonlara yaklaşım ve yönetimi gözden geçirmek.

Yöntem: Kliniğimizde 2018 yılında 3.-4. derece laserasyonu olan üç olgu incelenmiştir. Perine yirtıklarının derecesi ACOG 2014’e göre tanımlandı (Tablo 1). Olguların hepsi genel cerrahi tarafından; eksternal sfinkter 2/0 vicryl ile overlapping şeklinde, internal sfinkter 2/0 vicryl ile primer separ separe sütüre edilerek tamir edildi.


Sonuç: 3.-4. derece yirtıklar öngörülememeyebilir. Tedavi ve takiplerde multidisipliner yaklaşım olmazsa kronik ağrı, cinsel disfonksiyon, fekal inkontinans ve fistül formlasyonu gibi morbiditeler ile ilişkili olabilirler.

Anahtar kelimeler: Perineal laserasyon, sfinkter onarımı
<table>
<thead>
<tr>
<th>Derecede Yırtık</th>
<th>Açıklama</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Derecede Yırtık</strong></td>
<td>Yaralanma yalnızca perine cildindedir.</td>
</tr>
<tr>
<td><strong>2. Derecede Yırtık</strong></td>
<td>Yaralanma perine kas tabakasını içerir ancak anal sfinkteri içermemelidir.</td>
</tr>
<tr>
<td><strong>3. Derecede Yırtık</strong></td>
<td>Yaralanma anal sfinkter kompleksini içerir.</td>
</tr>
<tr>
<td><strong>3a:</strong></td>
<td>Eksternal anal sfinkterin kalınlığı olarak %50'den azı yırtılmıştır.</td>
</tr>
<tr>
<td><strong>3b:</strong></td>
<td>Eksternal anal sfinkterin kalınlığı olarak %50'den fazla yırtılmıştır.</td>
</tr>
<tr>
<td><strong>3c:</strong></td>
<td>Eksternal ve internal anal sfinkterlerin her ikisi de yırtılmıştır.</td>
</tr>
<tr>
<td><strong>4. Derecede Yırtık</strong></td>
<td>Yaralanma anal sfinkter kompleksini (eksternal ve internal anal sfinkterleri) ve anal mukozayı içerir.</td>
</tr>
</tbody>
</table>


Hastalar ve Yöntem: Çalışmamız prospektif ve gözlemelik bir araştırma olup; Ocak 2017 - Aralık 2017 tarihlerinde İzmir Dr. Behçet Uz Çocuk Hastanesi YYBU’ne solunum sıkıntısı nedeni ile sevk edilen, 32 gebelik haftası ve/veya ≤1500 gram olan preterm bebekler alınarak, bebekler antenatal steroid uygulanmasına göre tek doz uygulanmış, tam kür yapılmış ve hiç yapılamadan gelenler olarak üçe ayrıldı. Yetersiz doz steroid yapılan gruba, doğumdan en geç 6 saat öncesine kadar steroid tedavisi alanlar dahil edildi. Major konjenital anomaliler, letal malformasyonlar, maternal yaş, maternal tıbbi durumlar ve hastaların üniteye kabulündeki solunumsal durumlar ve antenatal özellikleri açısından farklılık yoktu (p>0,05). Ciddi RDS, surfaktan gereksinimi, surfaktan doz sayısı, intüübanjoz oraneları, İVK ve evre 2 ≥ ROP, evre 2 ≥ NEK ve hemodinamik anlamlı PDA(hsPDA) durumları primer sonuçlar olarak belirlendi. Taburculukta mortalite, total invaziv/noninvaziv mekanik ventilasyon süresi, total oksijen alış süresi, taburculukta BPD ve 18. Ay BAYLEY III durumları ise sekonder sonuçlar olarak belirlenerek, gruplar karşılaştırıldı.

İstatistiksel analizlerde SPSS 20.0 bilgisayar programında, ki-kare testi ve t testi kullanıldı, p<0,05 değeri anlamlı kabul edildi.

Sonuçlar: Çalışmaya belirlenen tarihler arasında 276 bebek başvurdu, 39 bebek postnatal 72. Saatden sonra gelmesi, 84 bebekin steroid uygulandıktan sonra yeterli sürenin olması, ve 6 bebek eşlik eden ek anomalilerin olmadığı dolayısıyla çalışma dışarı bırakıldı. Çalışmaya alınan 54 bebekin tek doz sonrası, 55 bebek tam doz steroid ile ve 38 bebekin ise hiç steroid uygulanmadan doğmuş ve hiç uygulanmadan gelenler olarak çalışmaya alınmamıştır. Çalışmaya alınan tüm bebeklerin RDS evresi, surfaktan gereksinimi, surfaktan doz sayısı, pnömotoraks, ilk 72 saatteki inotrop gereksinimi, ilk 96 saatteki intüübanjoz oraneları, İVK, evre 2 ≥ ROP, evre 2 ≥ NEK ve hemodinamik anlamlı PDA(hsPDA) durumları primer sonuçlar olarak belirlendi. Taburculukta mortalite, total invaziv/noninvaziv mekanik ventilasyon süresi, total oksijen alış süresi, taburculukta BPD ve 18. Ay BAYLEY III durumları ise sekonder sonuçlar olarak belirlenerek, gruplar karşılaştırıldı.

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Can Benlioglu, Mehmet Seckin Ozisik, Ceren Y. Karaoglu

Ankara University, Department of Obstetrics and Gynecology, Ankara, Turkey

Objectives: This retrospective cohort study intended to enlighten literature and in light of this information future prospective trials will be conducted to compare success rates of cervical stitch based on different indications.

Methods: 87 patients treated with cerclage selected retrospectively based on different indications. Univariate analysis and Pearson Chi-square test used for three subgroups.

Results: In our subgroup analysis based on both indication of cervical stich and gestational age at delivery there is no statistically significant difference but both deliveries before 28 weeks and 34 weeks there are more patients at short cervix with a history group.

Conclusions: There are still conflicts at literature whether cerclage is necessary or not and indications of cerclage and success rates. Future randomised controlled trials still be neccesary after all exhaustive research in this field.

Key words: short cervix, preterm birth, cerclage
Case Report: 36 years old pregnancy applied our hospital because of toxoplasmosis seropositivity. The date was 5/10/2018 and she was pregnancy for 24 weeks. The second trimester laboratory result was Toxoplasma IgM: (+) and IgG avidity is at the border. They started Rovamycin 3 MIU 3*1. At 24/10/2018 in 24. week of pregnancy we did amniosynthesis and until the PCR result we continued Rovamycin. At 8/11/2018 Toxo PCR reported positive so we started Bactrim+Azitromycin. After the result we applied to Turkey Drug and Pharmacy Instution for Primetamine+Sulfadiazine. At 15/11/2018 we started Primetamine loading dose 2*50 mg and then 1*50 mg, sulfadiyazine 75 mg/kg/day loading dose and 2*50 mg/kg/day and folinic acid 15 mg/day. But the patient could not tolerate sulfadiyazine and started vomiting. AST, ALT, alcaline phosphatase and GGT elevated so sulfadiyazine interrupted and contiunued wit primetanine+folinic acid. At 22/01/2019 due to last menstrual date 38 weeks 3/7 the patient had a cesarean section. 7-9 Apgar 3210 gr 50 cm male baby was borned.

The infant was admitted to our intensive care unit with a preliminary diagnosis of congenital toxoplasmosis. TORCH panel from the baby was requested.TOXO IgM: + (2,02), IgG: + (460), CMV IgM: -, IgG: +, Serum TOXO PCR: negative, CSF TOXO PCR: negative, CSF protein high, cell count was normal reported as. Eye examination revealed no evidence of toxoplasma chorioretinitis. Abdominal ultrasound and echocardiography showed no pathology. Hearing test did not reveal any pathology. Whole blood and liver function tests were normal. In cranial USG, Grade 1 periventricular hemorrhage and left choroid plexus anterior 3 mm simple cyst were detected. Cranial CT: Frontal and parietal paramedian localizations showed two hyperdensities (calcification?) At the right cerebral centrum.

The baby was consulted to the infant's department with the present findings. Sulfadiyazine + Primetamine + Folinic acid was recommended for 1 year.

Key words: Toxoplasmosis, case, pregnancy
Şevki Çelen, Serpil Ünlü, Sinem Eldem

Dr. Zekai Tahir Burak Kadın Sağlığı Eğitim ve Araştırma Hastanesi, Ankara, Türkiye


Anahtar kelimeler: Toksoplazmozis, vaka, gebelik

Anahtar kelimeler: İskelet displazisi, Akondrogenezis, Tanatoforik Displazi
PP-072 Twin gestation with complete hydatidiform mole and coexisting live fetus after in vitro fertilization treatment: A case report

Verda Alpay Türk, Didem Kaymak, Hakan Erenel, Rıza Madazlı

Istanbul University-Cerrahpasa, Cerrahpasa Medical Faculty, Department of Obstetrics and Gynecology, Perinatology Division

Introduction: Twin gestation consisting of complete hydatidiform mole and coexisting live fetus occurs rarely, but is encountering more often due to increasing use of assisted reproductive techniques. These pregnancies are associated with severe complications for both mother and fetus, such as preeclampsia, thromboembolic disease, hemorrhage and persistent trophoblastic disease. We report a case of twin pregnancy with complete hydatidiform mole and coexisting live fetus after in vitro fertilization treatment and diagnosed at 12 weeks of gestation.

Case: A 33-year-old patient with a history of one spontaneous abortion underwent in vitro fertilization treatment and she conceived successfully. Ultrasound at 12 weeks of gestation revealed a single fetus with findings suggestive of coexistent complete hydatidiform mole. The family was counseled about potential outcomes and complications and they decided to the continuation of the pregnancy. The patient was closely followed up with serial hCG measurements and ultrasound examinations. At 24 weeks of gestation, she developed preeclampsia and oligohydramnios was detected on sonographic assessment and she was admitted to the hospital. Because of severe preeclampsia, she delivered by caesarean section at 25 weeks of gestation, a live infant was born and admitted to neonatal intensive care unit. The operation and postoperative period were uneventful. Postpartum weekly hCG measurements are still performing in collaboration with gynecological oncology division.

Discussion: Twin gestations with complete hydatidiform mole and coexisting live fetus are rare events which carry severe risks for both mother and fetus, so that the management is challenging. In the past, termination of the pregnancy was the only known way of management, but currently continuation of the pregnancy is also an option and is associated with detailed counseling of the family about potential outcomes and good management of complications. In the conservative management of such pregnancies, the patient has to be monitored closely, but even in optimum conditions, the rate of a viable live birth remains under %50. After the delivery, the follow-up in the term of persistent trophoblastic disease is crucial. As the management of twin pregnancies consisting of complete hydatidiform mole and coexisting live fetus is complicated, these pregnancies should be followed-up in the referral centers by experienced perinatal and oncology teams.

Key words: Twin pregnancy, complete hydatidiform mole, live fetus
PP-072 In vitro fertiliyasyon sonrası komplet mol ile canlı fetusun bir arada bulunduğu ikiz gebelik olgusu

Verda Alpay Türk, Didem Kaymak, Hakan Erenel, Rıza Madazlı

İstanbul Üniversitesi-Cerrahpaşa, Cerrahpaşa Tip Fakültesi, Kadın Hastalıkları ve Doğum Anabilim Dalı, Perinatoloji Bilim Dalı

Giriş: Komplet hidatiform mol ile eşlik eden canlı fetusun bir arada bulunduğu ikiz gebelik, geçmişte daha nadir görülen ancak嚷ndaki üreme tekniklerin artması ile artan bir durumdur. Bu gebelikler, preeklampsii, tromboembolik hastalık, kanama ve persistan trofoblastik hastalık gibi maternal ve fetal komplikasyonlar açısından yüksek risk taşmaktadır.

Biz bu sunumda, IVF uygulaması sonrası oluşan ve 12. gebelik haftasında komplet hidatiform mol ile eşlik eden canlı fetusun bir arada bulunduğu ikiz gebelik tanısı alan bir olguyu ele aldık ve böyle bir olgunun yönetimini tartışmayı hedefledik.


Anahtar kelimeler: İkiz gebelik, komplet hidatiform mol, canlı fetus
Didem Kaymak, Verda Alpay, Hakan Erenel, Rıza Madazlı

Istanbul Üniversitesi-Cerrahpaşa Cerrahpaşa Medical Faculty, Department of Obstetrics and Gynecology, Perinatology Division

Introduction: Cri du Chat syndrome caused by partial deletion the short arm of chromosome number 5. It was first described in 1963 by Lejeune. Low birth weight, microcephaly, facial dysmorphism and a cat like cry is the postnatal findings in infants with Cri du chat syndrome. Prenatal diagnosis is rare and findings is variable. In this presentation, we discussed the management and results of the case by discussing the sonographic markers of Cri du Chat Syndrome and the additional imaging methods that can be used.

Case report: A 26 year-old gravida 2 para 1 woman with one previous healthy child at the 22nd gestational week was referred to our clinic from an external center with the diagnosis of cerebellar hypoplasia. Ultrasound measurements were as following: cerebellum 19 mm (<5 centile), lateral ventricle 10.9 mm, anterior posterior length of pons 4.51 mm (<5 centile), vermis superior inferior length 10.2 mm (<5 centile) (Achiron 2004). In fetal anatomic examination there was no additional major anomaly. Prenatal findings were confirmed via MRI and cortical atrophy, increased of subdural distance were reported. Amniocentesis and karyotype-microarray were performed and reported as 5p15.33p14.3 microdeletion.The pregnancy was terminated at the parents’ request. Prenatal findings were confirmed by postnatal autopsy.

Discussion: The incidence of Cri du Chat syndrome is 1 / 15000-1 / 50000. The prenatal diagnosis of this rare syndrome is highly variable in the literature. Encephalocele, isolated mild ventriculomegaly, microcephaly, 1.trimester low maternal serum PAPP-A, 2nd trimester high maternal serum HCG, cerebellar hypoplasia are some of them. In our case, pontocerebellar and vermian hypoplasia and mild ventriculomegaly were observed. These were confirmed by fetal MRI, in addition to cortical atrophy and an increase in subdural distance. In 5p deletion syndrome, cortical atrophy and lack of myelinization are frequent findings in postnatal diagnoses, but it is not always possible to evaluate them with prenatal ultrasonography. We also received support from fetal MRI in this case.

Conclusion: Pontocerebellar hypoplasia, vermian hypoplasia can be used as a marker for prenatal diagnosis for Cri du Chat syndrome. In these cases, the cortex can be evaluated using MRI. Currently in the literature there are no cases of Cri du Chat syndrome with prenatal findings of cortical atrophy confirmed by fetal MRI.

Key words: Cri du Chat, pontocerebellar hypoplasia, vermian hypoplasia, fetal MRI, 5p deletion
İstanbul Üniversitesi-Cerrahpaşa Cerrahpaşa Tıp Fakültesi Kadın Hastalıkları ve Doğum Anabilim dalı, Perinatoloji Bilim Dalı


Anahtar kelimeler: Cri du Chat, pontoserebellar hipoplazi, vermis hipoplazisi, fetal MRI, 5p delesyon
Introduction: Diastematomyelia is a split cord anomaly in which there are two hemicords separated by a cartilaginous or bony septum, and the two hemicords are contained in separate dural sacs. Hood and colleagues reported a series of 60 patients with diastematomyelia, with approximately one-half of cases occurring at thoracic level and one-half occurring at lumbar levels. Diastematomyelia should be distinguished from diplomyelia, another split cord anomaly in which two separate cords are contained in one dural sac without an intervening cartilaginous or bony septum.

Pang and coworkers proposed a unified theory of split cord malformations (SCMs), further classifying them into two types. Type I SCMs have two hemicords, each in separate dural tubes, and an intervening osseocartilaginous septum. Type II SCMs have two hemicords in a single dural tube that may be separated by a nonrigid, fibrous septum. Both types of SCMs may arise from one embryologic error at the time of neural closure, but the phenotype depends on further stages of spinal column/cord development.

Case: 22 year old G2P1Y1 21 weeks and 4 days pregnancy was referred to our hospital with the diagnosis of neural tube defect from another center. In the ultrasound examination of the patient; In addition to the findings of severe hydrocephalus, lemon and banana sign, at thoracolumbar level the neural tube defect of 9x6 cm was present. There was also an osseocartilaginous septum dividing to cord into two. So the fetus was diagnosed as SCM Type 1. The family was informed about the course of the disease and post-amniocentesis termination was recommended. Postmortem examination of the fetus was consistent with prenatal ultrasonographic diagnosis. The diagnosis was confirmed by the direct x-ray of the fetus.

Discussion: Hood and colleagues reported a series of 60 patients with diastematomyelia, with approximately one-half of cases occurring at thoracic level and one-half occurring at lumbar levels. Diastematomyelia should be distinguished from diplomyelia, another split cord anomaly in which two separate cords are contained in one dural sac without an intervening cartilaginous or bony septum.

Diastomatomyelia cases is associated with 15-20% Chiari2 malformation. Since it is usually associated with spinal defects (80%), it should be evaluated in cases with vertebral and spinal cord anomalies.

Key words: Diastematomyelia, hemicords, Chiari2 malformation
Image 1: In an axial plane (right) three posterior ossification center are seen, the central one protruding both posteriorly and anteriorly towards the spinal canal.

Image 2 shows coronal scan of the same region with the bony spur dividing the spinal canal.
Image 3: 3D imagination of the lumbar spine showing the bony spur in the midline projecting posteriorly

Images 4: 22 weeks; transverse scans of the fetal head showing dilated lateral ventricles
Images 9, 10: Postmortem images showing the thoracolumbar spinal defect with diastematomyelia. Bony spur is visible in the midline.
Aim: Aplasia cutis congenita (ACC) is a rarely heterogeneous group of diseases that are associated with the absence of skin or subcutaneous tissue at birth. We aimed to present a case of isolated Aplasia cutis congenita in the scalp.

Case: The patient was 39 years old, G5 P0 A4. cervical insufficiency and Hashimoto’s thyroiditis were presented. She was taking levothyroxin for hypothyroidism. In the obstetric examination of the patient, she had an average 12-week-old live singleton pregnancy, she had an 12 week, live, pregnancy. First trimester screening test revealed as low risk, NIPT test was performed due to advanced maternal age, which resulted as negative. Prophylactic cervical cerclage was performed at 14th weeks of pregnancy. The patient who had no problem in antenatal follow-up and was hospitalized for labor due to the onset of pain and rupture of membranes in 38 weeks. Upon the development of fetal distress, the male baby was delivered with cesarean section with 7-8 APGAR. After birth, it was realized that the neonate had a star shaped, isolated non-membranous skin defect of approximately 6x5 cm in the right parietooccipital region of the scalp (Picture 1). The newborn was taken to the intensive care unit, and the defect was primarily repaired by pediatric surgery. No additional anomaly was detected in the patient whose genetic results were normal. The patient was discharged on Day 5. Subsequent follow-ups revealed the skin defect in the scalp was improved after primary surgical suturing (Picture 2-3).

Conclusion: ACC is a rare congenital skin defect that is characterized by the absence of skin (epidermis, dermis and subcutaneous tissue) and, more rarely, by subcutaneous tissue (bone, periosteum and dura). The prevalence of the disease, first described by Cordon in 1976, is 1/10000 and the rate of familial transmission is higher. Although the etiology is multifactorial, genetic and exogenous causes may play a role. Exogenous causes include placental infarct, teratogenic substances such as methimazole, intrauterine infections, trauma, and neural tube defects. Our patient had no known intrauterine teratogen exposure and used levothyroxine only for hypothyroidism. Although no specific gene is defined for ACC, a mutation in the BMS1 gene involved in skin morphogenesis is defined. ACC may be presented isolated or may accompany some syndromes. A conservative approach including topical silver sulfadiazine or antibiotic ointments is recommended for its treatment. Most lesions may heal spontaneously, but depending on the size of the defect, treatment options may vary by surgery or conservatively. Genetic counseling is recommended due to the likelihood of occurrence of the disease in children born, who may be born as a result of subsequent pregnancies.

Key words: Newborn, scalp, skin defects, aplasia cutis congenita
Picture 1

Picture 2

Picture 3


Anahtar kelimeler: Yenidoğan, skalp, cilt defekti, aplazia kutis konjenita
Resim 1

Resim 2

Resim 3
Aim: We aimed to present a case of convulsion after cesarean section operation with spinal anesthesia resulting subacute subdural hematoma.

Case: A 35 years-old, G3 P2 patient was admitted to the hospital at 39 weeks of gestation, with no abnormalities neither in her past medial history nor laboratory tests. Elective cesarean delivery was planned due to repeated caesarean delivery indication. After spinal anesthesia since the patient felt pain, general anesthesia induction was performed. On the second postoperative day, patient complaint headache and it was evaluated as postspinal headache and oral caffeine, analgesic and fluid intake was recommended. The patient was discharged on the postoperative 2nd day. She was brought to our emergency department on the 3rd postoperative day after she had convulsion at home and diagnosed as late postpartum eclampsia initially, and magnesium sulfate treatment was started. Despite of magnesium sulphate treatment, she had two more consecutive repeated convulsions, and she was intubated under general anesthesia. Cranial computed tomography revealed an acute late-stage subdural hematoma in the frontal region (Figure 1). Magnesium sulfate was discontinued 24 hours after the patient had no high arterial blood pressure and the laboratory findings were normal. The patient was diagnosed with subacute subdural hematoma developing after spinal anesthesia and treated with anti-edema and anticonvulsant therapy for 3 days under general anesthesia. Later she was transferred to the neurosurgery service, conscious and cooperative. Her EEG was normal, and the patient’s repeated computerized tomography revealed absence of new onset hemorrhage and resolution of the of the initial lesion. On the 9th day, the patient was discharged and called for follow-up visit.

Discussion: The most common complication of spinal anesthesia is postdural puncture headache. Cerebrospinal fluid (CSF) leakage may occur after spinal anesthesia. When this leakage is high, it causes bleeding due to stretching and tearing in the meningial vessels between the cortex and the dural sinuses due to stress. Subdural hematoma which develops after spinal anesthesia is quite rare (its incidence in obstetric anesthesia is 1/500000) but a life-threatening complication. In cases of subdural hematoma; neurological symptoms such as disorientation, tinnitus, dizziness and convulsion may occur. The most common symptom is headache. The headache is very common after dura puncture, making it difficult to make a timely diagnosis. The headache due to dural injury is usually postural which passes within a mean of 48 hours with fluid intake, bed rest, caffeine intake and administration of analgesic. In case of resistant headache for a long time and which does not relief through the rest, intracranial hematoma should be suspected.

**Key words:** Spinal anesthesia; postdural puncture headache, subdural hematoma, convulsion
Figure 1: Cranial computed tomography revealed an acute late-stage subdural hematoma in the frontal region.
PP-076 Spinal anestezi sonrası gelişen subakut subdural hematom: Olgu sunumu

Bülent Demir¹, Kübra Özkan Karacaer¹, İbrahim Uğraş Toktaş¹, Mehmet Nuri Duran¹, Mesut Erbaş², Tarık Akman³, Mesut Abdulkerrımızlar Dali Çanakkale
Çanakkale Onsekizmart Üniversitesi Tıp Fakültesi Kadın Hastalıkları Ve Doğum Anabilim Dali Çanakkale
²Çanakkale Onsekizmart Üniversitesi Tıp Fakültesi Anesteziyoloji ve Reanimasyon Anabilim Dali Çanakkale
³Çanakkale Onsekizmart Üniversitesi Tıp Fakültesi Beyin ve Sinir Cerrahisi Anabilim Dali. Çanakkale

Amaç: Sezaryende spinal anestezi sonrası subakut subdural hematoma bağlı konvülziyon geçiren olguyu sunmayı amaçladık


Anahtar kelimeler: Spinal anestezi; post dural ponksiyon baş ağrısı, subdural hematom, konvülzyon
Resim 1: Kranial BT frontal bölgede akut geç dönem subdural hematom
The effect of skin to skin contact on hormones and the timing of delivery of the placenta

Betül Püsküllüoğlu¹, Aslı Göker², Funda Kosova¹

¹Manisa Celal Bayar University Faculty of Health, Midwifery, Manisa
²Manisa Celal Bayar University Faculty of Medicine, Obstetrics and Gynecology, Manisa

Purpose: Skin-to-skin contact (SSC) is defined as the placement of the newborn over the mother’s bare chest at the time of birth and many positive effects have been shown such as early adaptation to breastfeeding, thermoregulation of the infant, adaptation to extrauterine life, meeting maternal flora, enhancing maternal-neonatal bonding, regulation of newborn’s blood sugar and increasing levels of oxytocin. In this study we have aimed to investigate the effect of early SSC on the timing of placental separation and levels of oxytocin, beta endorphine and catecholamines after delivery.

Method: A total of 40 healthy, adult, singleton pregnancies at term who were willing to participate were included in the study. Women who were admitted for vaginal delivery were randomly assigned to the study or control group. The study group was approached by one of the researchers (midwife) and informed about SSC and informed consent was obtained. Immediate SSC was performed in the study group. The time from delivery until separation of placenta was recorded in study and control groups. Pre and postpartum maternal blood levels of oxytocin, beta endorphine and catecholamine were determined biochemically.

Results: The time needed for placental delivery was found as 16.53 minutes and 24.48 minutes in study and control groups, respectively and this was a statistically significant result (p<0.05). There was no difference between oxytocin and catecholamine levels in study and control groups in respect to pre and postterm measurements. Beta endorphine was found to be higher in the study group in prepartum period when compared to the control group (p<0.05).

Conclusion: Oxytocin and catecholamine levels in the mother were not affected by SSC, however prepartum levels of endorphine were higher in the study group which shows that even a one-to-one communication between the pregnant woman and the midwife has a positive effect on the woman’s wellbeing. The shorter duration of placental separation in the SSC group may be explained by the natural massage of the baby on the mother’s body and uterus. The risk of postpartum hemorrhage will decrease as the placenta separates sooner, therefore SSC may be accepted as protective at this point as well.

Key words: skin to skin contact, oxytocin, endorphine, catecholamine, placenta
Ten tene temas ile salgılanan hormonların plasentanın ayrılma süresine etkisi

Betül Püsküulloğlu¹, Aslı Göker², Funda Kosova¹

¹Manisa Celal Bayar Üniversitesi Sağlık Bilimleri Fakültesi, Ebelik, Manisa
²Manisa Celal Bayar Üniversitesi Tıp Fakültesi, Kadın Hastalıkları ve Doğum AD, Manisa

Amaç: Doğumdan sonra anne ile bebeğin çıplak tenlerinin teması olarak tanımlanan ten tene teması (TTT), anne ve bebek üzerinde pek çok olumlu etkisi gösterilmiştir. Emzirmeye daha kolay başlama, termoregülasyon, ekstrauterin yaşamaya adapasyon, maternal florayı tanışma gibi yararlı etkilerin yanı sıra maternal-neonatal bağlanmayı kolaylaştırdığı, yenidoğan kan glukoz regulasyonu yaptığı ve oksitosin salınımını artırdığı öne sürülmektedir. Bu çalışmada amaç doğum sonrası ten tene temasın plasenta ayrılma süresi ve oksitosin, beta endorfin ve katekolamin hormon düzeyleri üzerine olan etkisini incelemektir.


Bulgular: Ten tene temas sağlanan vaka grubunda plasenta ayrılma süresi 16,53 dakika olarak ölçülürken, kontrol grubunda süre 24,48 dakika olup arada istatistiksel olarak anlamlı fark saptanmıştır (p<0.05). Oksitosin ve katekolamin değerleri arasında vaka-kontrol arası doğum öncesi ve sonrası fark yokken, beta endorfin değeri vaka doğum öncesi ile kontrol doğum öncesi arasında anlamlı olarak vaka grubu lehine artış göstermiştir (p<0.05).

Sonuç: Ten tene temas anne kanındaki oksitosin ve katekolamin değerini etkilemiyorken beta endorfin değerlerinin vaka grubunda doğum öncesiinde kontrol grubuna göre yüksek bulunması gebeve konu hakkında bilgi verilmesi ve birebir ebe görüşmesi yapılmamasının dahili endorfin seviyeleri üzerindeki olumu etkisini göstermektedir. Plasenta ayrılma süresinin TTT grubunda anlamlı olarak kısa sürmesi bebeğin anne göğsünde yatarken doğal bir uterus masajı görevi görmesiyle açıklanabilir. Postpartum kanama riski plasentanın erken ayrılmasıyla azalacağı için TTT bu açıdan da koruyucu kabul edilebilir.

Anahtar kelimeler: ten tene temas, oksitosin, endorfin, katekolamin, plasenta


Anahtarl kelimeler: trizomi 9, ultrasonografi, kordosentez
Resim 1: Ventrikülomegali, kolposefali

Resim 2: Konjenital vertikal talus
Resim 3: Ex fetüs
Thalassemia is an inherited disease of faulty synthesis of hemoglobin. It is most spread among the population living near the Mediterranean sea, but also prevalent in Africa, The Middle East and Asia. The severity of symptoms depends on the type and the number of genes deficient synthesis. Pregnancy in thalassemia is a high risk for both mother and fetus. Although advances in treatment led to aging of thalassemic patients and consequently concern about reproductive outcome is augmented.

Case Report; 30 years old woman with thalassemia major came to our unit for preconception advice on May 2016. She was diagnosed since 3 months old and till 7 years was treated with sporadic transfusions. She had Splenectomy in 2004. The rhythm of transfusions was each 3 to 4 weeks. She started chelation therapy in 1995. Once in our hospital she had the Genetic consulting, which revealed that his partner was not a carrier. We started the cardiac control with ECG, echo, 24 hour Holter and MRI, Infection tests, liver function and endocrine tests. We prescribed Vit D, Folic Acid and Calcium. After 5 months she was 7 weeks pregnant, single pregnancy, no hematomas, and normal heart rate. We interrupted the chelation therapy. She continued Folic Acid and Vit D and at 13 weeks we prescribed 75 mg Aspirin per day. She did the ultrasound every 2 weeks till 24 weeks of gestation and monthly after that. At 38 weeks after a multidisciplinary consultation we decided to do a CS for cephalopelvic disproportion. A 3000g healthy baby was born. During postpartum stage Enoxaparin subcutaneous was administered for 3 days and after those 6 weeks regimen. She was referred to the cardiologist and encouraged to breastfeed. After 6 months she started the chelation therapy and interrupted breastfeeding.

On May 2017, after 2 weeks delay, she did the ultrasound and resulted 8 weeks pregnant with twins. She decided to continue the pregnancy despite the short period of time from the last one. We interrupted the chelation therapy and prescribed Folic Acid, Vit D and Calcium. After 2 weeks the ultrasound revealed missing heart rates in one embryo and normal in the other one. We prescribed low dose Aspirin at 13 weeks and did the ultrasound every 2 weeks. She had blood transfusions twice per month to maintain the Hb over 9 gdl. At 37 weeks we did a SC and she had his second healthy baby boy 2950g. After the intervention 0.4cc Enoxaparin was given subcutaneous for 3 days. Blood tests revealed high infection ratio. She was given Cefasoline 3 g per day IV for 3 days. She left the hospital after 5 days in good conditions.

Key words: thalassemia, chelation therapy, CS