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THE IMPORTANCE OF PRENATAL DIAGNOSIS IN FETAL ANOMALIES

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Objective: To evaluate fetal anomalies subject of pediatric surgery, diagnosed at second trimester of pregnancy or later.
Methods: Of the 207 fetuses with anomalies from 3891 labor or abortion, 69 fetuses associated with pediatric surgical anomalies between January 2000 and August 2002 were retrospectively evaluated.
Results: Median delivery time was 37 weeks. Of the 69 fetuses, 38 underwent normal vaginal delivery, 17 cesarean section, and 14 medical abortions before 20 weeks' gestation. Forty-seven fetuses were male and 22 were female. Fifty-six fetuses had diagnosis of at least one anomaly prenatally, while the remaining 13 fetuses all associated with gastrointestinal or genital anomaly had diagnosis postnatally. Of the 69 fetuses, 61% had urinary anomaly, 19% gastrointestinal, 9% genital, 7% thoracic anomaly, and 4% had sacrococcigeal teratoma. The median birth weight was 3548gr (range, 1320-3750gr) in viable births, while it was 762gr (range, 467-1330gr) for non-viable fetuses. Prenatal ultrasound had 98% accuracy and 81% sensitivity in diagnosing detectable fetal organ system anomaly.
Conclusions: Thirty-four percent of fetal anomalies were subject of pediatric surgery in our institution. Urinary anomalies cover nearly two-third of pediatric surgical anomalies. Certain prenatal diagnosis of genital anomalies is quite difficult. If gastrointestinal anomalies are not diagnosed prenatally, postnatal management may delay, which may cause unfavorable outcome in neonates. Antenatal diagnosis of fetal anomalies and prompt prenatal and/or early postnatal treatment in selected patients may significantly decrease neonatal morbidity and mortality. Multidisciplinary team effort is essential in the management and follow-up of fetal anomalies.

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CHORANGIOMA AND CHORANGIOSIS: AN IMPORTANT PLACENTAL SIGN OF CHRONIC FETAL HYPOXIA. A CASE REPORT

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Chorangioma and chorangiosis are incompletly understood and overlapping villous capillary lesions believed by some to be related to hypoxia.The incidence of both pathologies are significantly higher in congenital malformations, preeclampsia, IUGR,premature delivery and gestation at high altitudes. Chorangioma, one of the most frequent tumors is seen %1 of the fullterm pregnancy. In histopathological examination of placentas with chorangiomas are found chorangiosis in neighbor villous. %5 of the newborns hospitalized in neonatal intensive care unit,have chorangiosis.
We presented a 27 years old primigravid with placental mass , placentomegaly and IUGR at 27 th gestational weeks by prenatal ultrasound screening. Color Doppler imaging was revealed 7x9cm avascular solid placental mass, probably chorangioma, and without any anomalies in the fetus. Chorangioma resolved during pregnancy and occured fetal hypoxia. In this reason,at 38 weeks of gestation, Caessarean section was performed, baby was 2100g weight. Histopathological examination of placenta was chorangioma, chorangiosis and hemorrhagic infarc.
We suggest that placental examination are important for diagnosis and following up of villous capillary lesions and their unpredictable outcomes.