Results: There was no significant difference in median maternal serum IL-2R and IL-8 levels within the three groups. In healthy pregnant patients, serum levels of IL-1b and IL-6 were significantly higher than that in the non-pregnant women. Median (range) TNF-a levels were significantly higher in hyperemesis group than the levels in healthy pregnant and non-pregnant women [25.8 pg/ml (4.9-140) vs.10.85 pg/ml (4.1-35.8); 25.8 pg/ml (4.9-140) vs. 12 pg/ml (4.3-68.2)].
Conclusion: We found significantly elevated TNF-a levels in patients with hyperemesis gravidarum compared the levels in healthy pregnant and non-pregnant women. Elevated TNF-a levels may play a role in the etiology of hyperemesis gravidarum.

FCP106

HEPATIC PORPHYRIA – ILLUSTRATIVE EXAMPLE OF DIAGNOSTIC ERROR

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Background: Porphyries represents hereditary diseases, in which there is enzyme deficit, having as a consequence the disturbance in hem synthesis, protopophyrin with building Fe.
Hem is synthesised in liver and bone marrow and beginning of its synthesis controls DALA enzyme, which is very unstable and often suprimized or stimulating by many endogenous and exogenous factors. Porphyries can be primary (erythropoetic and hepatic) and secondary (with diseases of liver and bone marrow). Hepatic porphyries account for half of all porphyries and in more than 2\3 of cases first time appears during pregnancy. Maternal mortality accounts for 20% hepatic porphyry is inherited autosomal dominant but the most important is the enzyme deficit in uroporphobilinogen synthetasa, which leads to increase production of porphyrin precursors (DALA and PBG) its increase excretion by urine. The Clinical picture includes abdominal symptoms, neuropsyhic symptoms, and disturbance of autonomous nerve system. In the diagnosis very important is the personal and family history, screening tests and confirmation of the diagnosis is made by quantitative determine of DALA, PBG in urine, stools and erythrocytes. In therapy primary we must avoid drugs which induct DAL or provoke degradation of hepatic hem. In therapy of acute attack we administrate hemarginin, large quantities of glucose and symptomatic therapy.
Review of case: Patient I. S. born in 1964, from Pristine. Diagnosis of acute hepatic porphyry is made after a numerous of diagnostic – therapeutic neglects which start after the first delivery, when she was hospitalised because of epic attacks first in the Neuropsychiatric Clinic in Pristine. Because of worsening symptoms and intensive abdominal pain and a suspicion for acute pancreatitis she was transferred in our clinical centre. After complete diagnostic procedures and confirmation of diagnosis, continue with the administration of adequate therapy which lead to significant subjective condition and normal findings and the patient was released home with a list of contraindicated drugs.
Because of the previous events, risk and fear of the patient for relapse of the disease her next delivery was controlled in our Clinic. During the pregnancy, delivery and puerperium precipitated medicines were avoided.
Conclusion: The described case indicates that delivery and puerperium is a possible declarative factor in the appearance of acute act of porphyry. Non – diagnosed porphyry in this case, it led to inadequate therapy-contraindicated, which lead to aggravation of the clinical picture.

FCP107

IV ADMINISTRATING AMOXICILLINE TO PREGNANT WOMEN, COLONIZED WITH STREPTOCOCCUS GROUP B – POSITIVE OUTCOME TO NEWBORNS OF NEXT DELIVERIES

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Introduction: SGB vaginal colonization of pregnant and newborn infection (early-late syndr.) is frequent. These newborn have an increased risk of serious illness, high mortality rate in first hours-days of life,

and seriously ill after 2nd week. Women remain colonized for life and SGB infection risk it for next fetuses. Aim: To intervene to the pregnant for mild newborn infection, mild early syndr, to have time to intervene to the newborn without late syndr, for healthy newborn in new pregnancies.
Material-Method: For 6 years, 203 women were studied (positive vaginal, anal cultures), 123 (60,59% group a) with regular obstetric observation took peros ampiciline in pregnancy and before delivery 2gr iv, 21 (10,34% group b) were found positive culture due to ill newborn. The rest 56 (27,58% group c) positive-38 primepare-took iv amoxiciline for 7days (1grx3) and 7days peros. Same therapy to 3 subgroup c1 out of pregnancy with SGB due to preterm deliveries. Therapy started in age 20-22 weeks, in delivery amoxiciline once iv 2gr From c group 2nd pregnancy 35(59,3%), 3rd 26(44,07%) and 1c1 woman delivered for a 2nd time. We observed 85 women a&b group in their next pregnancies, they took iv-peros amoxiciline in the same manner.
Results: a&b newborns all from birth hospitalized; 1group & 2 b deaths, 11 late grave syndr in total. From c 12 needed hospitalization, 0 late syndr. Next births of all groups no death, mild newborn infection a&b group, without c group infection.
Conclusion: Amoxiciline IV administration for 7 days to SGB pregnant helps to have mild newborn infections, without late syndr. And no deaths; in next pregnancies newborns have almost no infection, without need for hospitalization.

FCP108

POSITIVE TRIPLE SCREENING TEST RESULTS AND CHROMOSOMAL ABNORMALITIES IN WOMEN LESS THAN 35 YEARS OF AGE

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Triple screening test has a significant predictive value for detection of fetal Down's syndrome cases. In this study we evaluated the results of triple screening test for chromosomal abnormalities in women less than 35 years of age. We had 201 screen positive women for trisomy 21 at a cut off level 1/270 and 12 screen positive cases for trisomy 18 at a cut off level 1/100. Amniocentesis was performed for all. In cases with positive screen for trisomy 21 we detected two cases of fetal Down's syndrome and 4 cases with normal chromosomal aberrations. In cases with with positive screen for trisomy 18 we detected a case with fetal Turner's syndrome. We concluded that using a lover cut off level unnecessary amniocentesis might be decreased.

FCP109

SERUM URIC ACID MEASUREMENTS IN HYPERTENSIVE DISORDERS OF PREGNANCY

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Relation between serum uric acid levels and hypertensive disorders of pregnancy was suggested by some authors. In this study we investigated serum uric acid levels and clinical findings of pregnant women with hypertensive disorders. The study population consisted of 46 healthy pregnant women as a control group, 122 women with pregnancy induced hypertension (PIH), 25 women with chronic hypertension and 31 women with chronic hypertension and superimposed preeclampsia. Mean age and parity were significantly lower in control and PIH groups. Mean gestational age and mean birth weight were significantly higher in the control group than the others, because of pregnancy interruptions in the hypertensive pregnant due to fetal distress. Serum uric acid and creatinin levels were significantly elevated in hypertensive pregnant. There was no significant difference in mean uric acid levels between various hypertensive disorders.
As a conclusion, serum uric acid levels may be useful in follow up of pregnant with hypertensive disorders but can not be used for differentiating various hypertensive disorders of pregnancy.