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SUCCESSFUL PREGNANCY AND PERINATAL OUTCOME IN PARTIAL BICORNUATE UTERUS: REPORT OF TWO CASES

P Panagopoulos[1], M Eliades[1], I Biris[2], A Economou[1], I Koutras[1], G Petrakos[1], N Kanellopoulos[1]

[1] Department of Obstetrics and Gynecology, "Tzaneio" General Hospital, Piraeus, Greece,

[2] Ultrasound Laboratory "Yperichos", Piraeus, Greece,

Congenital uterine anomalies are commonly associated with poor perinatal outcome. One of the most common abnormality is the bicornuate uterus.We describe two cases of bicornuate uterus and their successful outcome.

1st case: 26 years old, carrier of β-thalassemia with bicornuate uterus diagnosed in previous ultrasound screening. She had one previous spontaneous miscarriage and one intrauterine death at 24th week of gestation due to oligoydramnio, both in the left horn of uterus. From antenatal care we had no significant findings. Pregnancy situated in the right horn. At 24th week we recorded uterine contractions that were treated. At 28th and 32nd week of gestation we administrate steroids. At 37th week we performed cesarean section giving birth in a male of 3060gr and intraoperatively we confirmed the diagnosis of a horn-shaped branches of uterus.

2nd case: 29 years old, primipara, with ultrasound diagnosis of pregnancy in the right horn of bicornuate uterus. She was carrier of β-thalassemia, with no previous pregnancies and unknown for the abnormality of the uterus. From antenatal care we had no significant findings. Cervical cerclage was performed at 14th week. At 36th week spontaneous rupture of membranes conduct us to emergency cesarean section giving birth in a female of 3120gr. The overall fetal loss rate of women with bicornuate uteri is reported to be approximately 40% with a 30% spontaneous abortion rate. Intervention depends on whether the abnormality interferes with coitus or pregnancy. In literature modified Shirodkar cervical cerclage is recommended for the best outcome of pregnancies in bicornuate uterus especially in those women with a history of preterm delivery. Surgical correction of a bicornuate uterus has been advocated for women with recurrent pregnancy loss in whom no other etiologic factor has been identified. The Strassman metroplasty procedure was first described in 1907 and was designed for the unification of similar-sized endometrial cavities.

obgyn_tza@hotmail.com

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MATERNAL RED CELL ANTIBODIES IN PREGNANCY: REPORT OF TWO CASES WITH ANTI- M AND ONE CASE WITH ANTI- E

P Panagopoulos[1], D Hondros[1], G Petrakos[1], N Moschonisiotis[1], A Economou[1], I Koutras[1], E Paraskevopoulou[1]

[1] Department of Obstetrics and Gynaecology, "Tzaneio" General Hospital, Piraeus, Greece

[2] GP, "Tzaneio" General Hospital, Piraeus, Greece

Yet although the incidence of Rh isoimmunization has been decreasing because of prevention programs, the prevalence of blood groups other than Rh is becoming a more common cause of hemolytic diseases of the newborn (HDN). Anti-C and anti-E are the most commonly implicated non-D Rh antibodies in the pathogenesis of HDN.
Anti M is a naturally occurring IgM antibody of the MNSs system that typically presented as a cold agglutinin. An IgG type can occur rarely and be associated with HDN.
In this retrospective study we study all pregnancies managed between 1/2/1997 and 16/11/2004 in our Department. 7.864 blood samples were collected from pregnant women during their first antenatal visit. In those samples two cases with anti-M and one case with anti-E antibody were found.
Case 1: At 14th week of gestation have been detected an alloantibody anti-M with indirect antiglobulin test titer 1:2. At 39th week was born a male of 3840gr with direct antiglobulin test negative. No anti-M antibody was detected.
Case 2: At 14th week of gestation have been detected an alloantibody anti-M with indirect antiglobulin test titer 1:8 rising at 32nd week in 1:16. Gave birth at 39th week in a male of 3350gr Direct antiglobulin test of newborn was slightly positive and an anti-M antibody was detected.
Case 3: At 34th week we detected anti-E antibody with titer 1:8 and at 36th week 1:16. Gave birth at 37,4th week in a male of 2650gr. Direct antiglobulin test of neonatal negative and blood group 0/CcDEe/(k-). The prevalence of anti-M isoimmunization may be increasing. The incidence of severe hemolytic disease of the newborn due to anti-M and anti-E is extremely low. If these antibodies are detected in pregnancy, the titer is low (no more than 1:4), and there is no history of prior pregnancy complications no further testing is needed other than an indirect antiglobulin test at 28 weeks to look for the emergence of other alloantibodies, otherwise serial titers should be performed.

obgyn_tza@hotmail.com