

is a risk factor for the development of pelvic organ prolapse and is correlated to recurrence after reconstructive surgery.

DTPUS has been shown to demonstrate rectocele, enterocele, and rectal intussusception with images comparable to defecography. The extent of a rectocele is measured as the maximal depth of the protrusion beyond the expected margin of the normal anterior rectal wall. On sonographic imaging, a herniation of a depth of greater than 10 mm has been considered diagnostic. The rectal intussusception may be observed as an invagination of the rectal wall into the rectal lumen or the anal canal during maximal Valsalva maneuver. Enterocele is ultrasonographically visualized as downward displacement of abdominal contents into the vagina, ventral to the rectal ampulla and anal canal. Small bowel may be identifiable due to its peristalsis. The extent of an enterocele is measured against the inferior margin of the symphysis pubis. Pelvic floor dyssynergy can be documented during Valsalva maneuver because the anorectal angle (ARA) becomes narrower, the levator hiatus (LH) is shortened in the anteroposterior dimension and the puborectalis (PR) thickens in evidence of a contraction. The most relevant utility of EAUS applies in the detection of localized EAS and/or IAS defects in patients with obstructive defecation disorders.

The configuration of perianal sepsis and the relationship of abscesses or fistulae with IAS and EAS are the most important factors influencing the results of surgical management. Preoperative identification of all loculate purulent areas and definition of the anatomy of the primary fistulous tract, secondary extensions, and internal opening plays an important role in adequately planning the operative approach in order to ensure complete drainage of abscesses, to prevent early recurrence after surgical treatment, and to minimize iatrogenic damage of sphincters and the risk of minor or major degrees of incontinence. EAUS has been demonstrated to be a very helpful diagnostic tool in accurately assessing all fistula or abscess characteristics. It can be easily repeated while following patients with perianal sepsis to choose the optimal timing and modality of surgical treatment, to evaluate the integrity of or damage to sphincters after operation, and to identify recurrence of fistula. It also gives information about the state of the anal sphincters, which is valuable in performing successful fistula surgery. A fistula tract affecting minimal muscle can be safely excised, but where the bulk of external sphincter muscle is affected, it is best treated by seton drainage or mucosal advancement flap.

KÖ-14 [18:00]

What is future of perinatal imaging?

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Understanding the structure and function of the fetal nervous system has been the dream of physicians for centuries.

The pioneering efforts of Ian Donald in obstetric ultrasound in the latter part of the twentieth century have permitted this dream to become a reality.

The initial contribution of obstetric ultrasound focused on the normal and abnormal structure. As first neuro-sonographic diagnose, anencephaly was described, followed later by increasingly subtle central nervous system abnormalities such as agenesis of the corpus callosum. Now, 4D sonography in the functional evaluation of the fetal brain has become the challenge for investigators in obstetric ultrasound. There are many functional neurological abnormalities, with cerebral palsy (CP) as one of the most important, whose causes are still poorly understood. This etiological uncertainty makes CP a rewarding medico-legal field. Attorneys throughout the world want to relate neurological abnormalities exclusively to intrapartum events associated with suspected hypoxemia, such as usage of oxytocin, forceps or vacuum delivery, and failure to perform a timely Cesarean delivery.

While during the last two decades obstetricians have become a risk group in regards to medico-legal complications, there have been substantial advances in understanding the etiology of cerebral palsy: only 10% of later diagnosed CP are caused by intrapartum asphyxia. But many questions still remain open. The final goal of prevention may be more achievable after scientific comprehension of many collaborative factors involved in the origination of CP, this still mysterious entity. The new field of fetal neurology with the latest diagnostic tool KANET offers a professional challenge. With 4D sonography it is now possible to define reproducible parameters for the assessment of normal neurobehavioral development. There is urgent need for further multicentric studies until a sufficient degree of normative data is available and the predictive validity of specific aspects of fetal neurobehavior to child developmental outcome is better established. The role of obstetrician in the antenatal detection of CP is new exciting challenge.

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KÖ-15 [08:30]

IUGR: the past, the present, the future

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To know the past can make more complete the understanding of the present and facilitate the possible future. Intrauterine growth restriction represent also today an important issue in perinatal medicine. In fact this clinical condition is present in about 8% of the pregnancies and is the second cause of peri-