stage of fetal kidneys if there is severe enough bladder outlet obstruction. Sometimes it will be necessary to put a shunt into pelvis of the kidney in case of severe bilateral or unilateral hydronephrosis due to uretero-pelvic junction obstruction or reflux (6). Amnio-drainage and laser coagulation can be performed in twin to twin transfusion syndrome. Also amnio-infusion can be instilated into amniotic cavity in case of severe oligohydramnios to delineate and easily visualise the fetus during ultrasound examination, and sometimes to replace the amniotic fluid. It should be kept in mind that there is a complication rate about 3-5% with invasive fetal therapy techniques. These procedures should be performed in experience hands and centers.

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L20

MEDICOLEGAL ASPECTS OF OBSTETRICS

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The main subject in medicolegal aspect of obstetrics is the medical malpractices. Medical malpractices is a growing problem in many countries including Turkey.
Usually Obstetrics 's core business is aphysiological process which usually ends successfully without medical intervention. When it does not medically , emotionally and financially consequences can be disastrous. The risks involved in pregnancy and childbirth have changed over the years and are continually being reassessed.
At Turkey there are malpractices like in other countries including obstetrics. Between years 1990-2000 theer were 103 cases which State Institute of Forensic medicine of Ministry of Justice of Turkey has given opinion as expert witness. 69 % of the cases were performed by Obstetrics and 22 % of them were performed by widwives.
In this paper I will try to give some details about legislations, procedures and situation of malpractice cases in Turkey.

L22

NEW TECHNOLOGIES FOR INTRAPARTUM MONITORING

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The poor specificity of cardiotocography has stimulated the research on complementary fetal intrapartum monitoring techniques. In addition to analysis of fetal heart rate variation, there are three different approaches to evaluate fetal response to labour.
The first is represented by the assessment of intrapartum fetal acid-base status with the use of fetal blo-

od sampling (FBS). FBS can reduce operative intervention but it requires additional expertise, is dependant on appropriate interpretation of CTG patterns, is time consuming and give only intermittent information and thereby it is not widely used.
The second is represented by pulse oximetry. This procedure allow the continuous evaluation of fetal O2 saturation and can help in differentiating abnormal CTG patterns. Recent clinical studies have shown a reduction of 50% in the rate of caesarean section for suspected fetal distress. However the current literature holds somewhat diverging views on the information available from fetal pulse oximetry during labour in particular regarding the ability of CTG + pulse oximetry to provide diagnostic capacity on fetal metabolic acidosis.
The third is focused on evaluation of function of a high priority organ like the heart, based on the analysis of the ST waveform of the fetal electrocardiogram. ST waveform elevation reflects compensated myocardial stress and a switch to anaerobic metabolism. Persistent biphasic or negative waveform changes indicate myocardial decompensation as a result of direct myocardial ischemic hypoxia. Extensive experimental work indicate that analysis of changes in ST waveform provide continuous information on metabolic events occurring within myocardial cells which allow cardiac function to be maintained during hypoxia. This information is available from the same source from which we obtain the fetal heart rate. Large clinical studies have shown that ST analysis of the fetal ECG provide useful information on fetal reaction to labour and can safely reduce the number of obstetric operative intervention with a parallel improvement in fetal outcome.
Improvement of intrapartum fetal monitoring however require also the capacity of making the appropriate use of the information available.

L23

ELECTIVE CESAREAN SECTION: IS IT ABUSED?

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Cesarean section (CS) still remains the most common operation, being performed in the world. Although The World Health Organization suggested a limit of 15% for cesarean section rate, it has grown markedly in recent years. In Turkey , there are not healthy records regarding the rate of caesarean section but as far as we know in private hospitals it reaches 90%.
The reasons for this unacceptable rate are not understood exactly. Advanced maternal age, widely use of electronic fetal monitoring, breech presentation, concern for malpractice litigation, socioeconomic/cultural factors and "maternal request" might be the possible reasons.
In this presentation, the aspects of cesarean section mainly performed by maternal request and the following questions will be discussed.
What is the exact reason for a physician to perform CS in the case of advanced maternal age, poor obstetric history, infertility history, or a history of ovulation induction/ART?
Does CS really carry more morbidity than vaginal delivery? Or
Is it safer for the fetus/mother?
Is it more comfortable than a vaginal delivery?
Is CS cause less complications than vaginal delivery concerning pelvic floor disorders, stress incontinence and sexual disorders?
Who makes the decision to made CS? The physician? The patient? Or both of them?
Has the woman have a right to chose the mode of delivery? Is it a human right or not?
Should physicians perform an elective CS on request?