8th International Conference on

Gynecology and Obstetrics

April 27-28, 2023 | Amsterdam, The Netherlands

Day-1

Poster Presentation

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Mullerian Duct Anomaly: A case report

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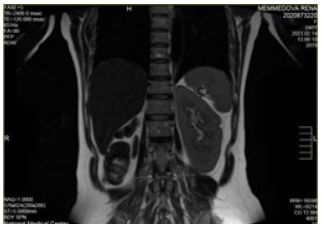
Background: Mullerian Duct Anomalies (MDAs) are congenital defects of the female genital system that arise from abnormal embryological development of the Mullerian Ducts. In embryology uterus, upper 2/3 of vagina and fallopian tubes derived from paired mullerian ducts. Crosby proposed fusion of the two Mullerian Ducts starts caudaly in Muller's tubercle, proceeds cranially up to the fundus. Failure of ducts to develop leads to types of uterine, cervical or vaginal agenesis while incomplete fusion results in uterus didelphys. These congenital anomalies occur in 1-15% of women associated with renal anomalies especially agenesis or ectopia. A didelphys uterus, also known as a "Double Uterus," is one of the least common amongst MDAs.

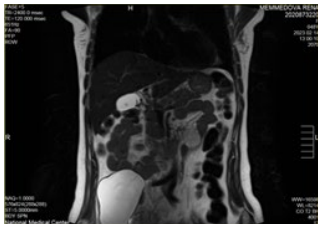
Objectives: Woman 48 years old. History of 2 normal births and 1 abortion.

Complaints: irregular uterine bleeding lasting more than 2 months. During the studies, the patient was diagnosed with:" "Didelphys uterus, Uterine fibroids, Right-sided hematosalpinx, Endometrial hyperplasia, Aplasia of the right kidney."

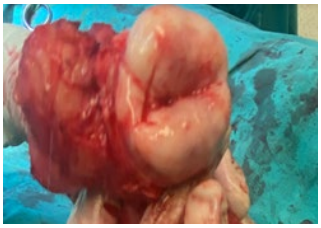
The diagnosis was confirmed by sonography, MRI, contrast CT, etc.The patient was scheduled for surgical treatment. Hysterectomy of both uterus was performed. During the operation, it was revealed: an abnormal arrangement of blood vessels, the presence of 2 cervix (the right one opens into the left cervical canal), ectocervix -1 common, 2 fallopian tubes (hematosalpix 112x67x65 in the right), 2 ovaries. The operation went without complications. The diagnosis was confirmed histologically.



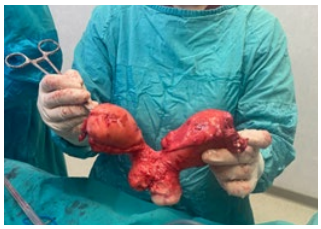
Fiq 1. MRI- of the right kidney



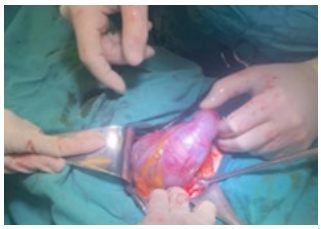
Fiq 2. Right-sided hematosalpinx



Fiq 3. Ectocervix



Fiq 4. Didelphys uterus



Fiq 5. Right-sided hematosalpinx

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Biography

Aysel Bayishova is a highly qualified and experienced Obstetrician and Gynecologist, with extensive academic qualifications and medical work experience. She completed her graduation from Azerbaijan Medical University with an MD degree in 2011. With a keen interest in Obstetrics and Gynecology, she pursued a Ph.D. in this field, which she successfully completed in March 2019 at the Scientific-research Institute of Obstetrics and Gynecology. Her thesis title was "Using of Stem Cells to Improve implantation processes." She has gained a wide range of medical work experience over the years, which has helped to shape her expertise and knowledge.

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E Poster Presentations

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A case of Intra-Partum Cervical Shock

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Cervical Shock is defined as maternal hypotension and bradycardia secondary to cervical stimulation. The pathophysiology likely involves the vagus nerve causing a parasympathetic nervous system response. It is often associated with early pregnancy loss and with cervical instrumentation. There have been no previous reported cases of cervical shock in the intra-partum period. Whilst cervical shock is a relatively uncommon phenomenon, it can contribute significantly to maternal morbidity and mortality, as persistent hypotension/bradycardia can result in end organ hypoperfusion and maternal collapse.

This case involves a 34 year old multiparous woman who presents at 39 weeks and 6 days gestation in early labour following an uncomplicated pregnancy. Her first two pregnancies resulted in uncomplicated spontaneous vaginal births at term. In early labour, she began reported increasing symptoms of lightheaded/dizziness associated with each contraction. She then had a witnessed 15 second complete syncopal event whilst in the recumbent position on the birthing bed. There was no prodrome or seizure like activity. A medical emergency call was made. Her blood pressure was 85/60 and her heart rate was 45. ECG shortly after demonstrated normal sinus rhythm with a normal PR interval and no evidence of heart block. She was placed supine, her legs were elevated and she was given an intravenous fluid bolus. She quickly regained a normal level of consciousness although had ongoing symptoms of light-headedness with each contraction. She progressed to have an epidural block and a spontaneous vaginal birth shortly after. Postnatally, a cardiology consult was conducted and a diagnosis of vasovagal syncope/cervical shock phenomenon was favoured and she is due for 6 week follow up with a transthoracic echocardiogram.

This case represents a Cervical Shock phenomenon based on the constellation of clinical signs and symptoms. The suspected pathophysiology is that the cervical stimulation from dilatation (and the resultant pain) caused a vasovagal syncope with a parasympathetic response and subsequent hypotension/bradycardia. The cardiotocography trace demonstrates a maternal heart rate pattern completely dropping off the trace (below 40) with each contraction. Interestingly, the woman's heartrate was up trending towards the end of the labour and following the epidural block. A proposed theory is that the epidural block effectively treated the painful stimulus and thus the resultant reflex syncope. Retrospectively, this woman had early epidural blocks in both her prior labours with no history of syncopal symptoms at those deliveries. Another proposed theory is that as the cervix progressed to fully dilated there was no longer enough cervix to "stimulate" and cause the response. This case also raises an interesting management discussion as to the threshold for cardiac monitoring in the context of a persistent bradycardia, and additionally, the potential role for atropine. It also highlights cervical shock as a potential cause of maternal intra-partum collapse that all clinicians should be aware of.

Recent publications

1. Giddey J, "A suspected case of the rare Hamman Syndrome", RANZCOG Royal Australia and New Zealand College of Obstetrics and Gynaecology Regional Annual Scientific Meeting April 2023.

Biography

Jack Giddey is a 29 year old Resident Doctor from Sydney, Australia with an interest in specialising in Obstetrics and Gynaecology. He is early in his research journey however has a deep interest in complex Obstetric care and high risk pregnancies. His previous e-Poster presentation involves a suspected case of the rare Hamman syndrome – otherwise known as Spontaneous Pneumomediastinum and subcutaneous emphysema.

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Health status of women of fertile age with Placenta Previa

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Introduction: Placenta Previa, representing abnormal placentation, is a serious, urgent, medical and social problem of modern obstetrics. Placenta Previa is considered in the literature as an abnormal location of the placenta, which contributes to the occurrence of massive bleeding, requiring radical measures up to total hysterectomy. Often placenta previa is the main cause of maternal and perinatal mortality. In this connection, the purpose of our study was to assess the health status of women of childbearing age with Placenta Previa.

Methods: The study involved n=70 women of reproductive age with central Placenta Previa, which were divided into 2 main groups: Group I consisted of n=38 pregnant women with central placenta previa - retrospective studies. Group II - prospective studies, consisted of n=32 pregnant women with central Placenta Previa. Placenta Previa was diagnosed using ultrasound (transabdominal, transvaginal) depending on the intensity of bleeding also conducted Doppler studies, MRI.

Results: In 100% of cases, according to ultrasound data, placenta attachment was detected in the lower segment of the uterus, in the region of the internal os. In the process of monitoring the migration of the placenta in women with abnormal presentation, a different nature and degree of migration was revealed. At a gestational age of 28-32 weeks, the activity of the lower segment of the uterus was detected in 18(25.7%) cases. Characterizing the menstrual function in this category of women, it should be noted that the establishment of menarche was observed at the age of 11-13 years in 41 (58.6%) cases, menstrual irregularities were noted in 32(45.7%) cases, respectively. Extragenital pathology occurred in 14(20%) patients, respiratory diseases were registered in 21(30%) cases, diseases of the gastrointestinal tract - in 9(12.8%) cases, respectively. Almost in the majority of patients n=59, which accounted for 84.3% of cases, anemia (iron deficiency, post-hemorrhagic nature) was detected. Gynecological history was aggravated by inflammatory diseases - 19(27.1%) cases. History of abortions was 21(30%), spontaneous miscarriages - 12(17.1%) cases, respectively. The leading clinical symptom in these patients was bleeding, which had the following features: bleeding was external in nature, with recurring episodes, occurring for no apparent reason. All women in labor with central Placenta Previa underwent caesarean section.

Discussion: Thus, abnormal Placenta Previa is an obstetric complication, the main risk factor of which is the occurrence of massive bleeding. The burden of obstetric and gynecological history of women in labor is a predisposing risk factor for the formation Placenta Previa.

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Biography

Aynur Gasimova is a dedicated and experienced Gynecologist who has been working in the medical field for over two decades. After completing her studies, she began working at Central Railway Hospital in Baku as a Gynecologist, where she remained from 1999 to 2005. She then moved to the Research Institute of Obstetrics and Gynecology, where she worked as a Gynecologist for the past 17 years. Throughout her time at the Research Institute of Obstetrics and Gynecology, she has demonstrated a commitment to providing high-quality care to her patients. Her duties have included conducting medical examinations, diagnosing illnesses and injuries, and performing surgical procedures as needed. In recognition of her contributions to the field, she was recently promoted to the position of Head of the Postpartum Department at the Research Institute of Obstetrics and Gynecology.

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Twin molar pregnancy: A case report of complete hydatidiform mole coexisting with normal fetus

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Introduction: Complete Hydatidiform Mole Coexisting with Normal Fetus (CHMCF) has a rare occurrence with an incidence rate of 1/22,000 to 1/100,000 pregnancies. These uncommon cases pose several diagnostic and management challenges. During the early pregnancy it is crucial to distinguish between partial mole vs complete mole with coexisting fetus since the management of these conditions differ.

Objectives: To report a case of Twin molar pregnancy with coexistent viable fetus. To search for local incidence of Twin molar pregnancy with coexisting viable fetus and to describe the clinical, diagnostic and therapeutic aspect of complete hydatidiform mole with coexisting fetus. Lastly to discern the fetal surveillance in the case of twin molar pregnancy with coexisting viable fetus.

Case: Presented is a case of a 22-year old female with complete hydatidiform mole with coexisting fetus, with known Hyperthyroidism. Serial ultrasonographic studies and beta-human chorionic gonadotropin (β-hCG) was done to confirm presence of the complete hydatidiform mole. Pregnancy was carried up to 20 3/7 weeks age of gestation. Due to heavy vaginal bleeding and imminent abortion the fetus was delivered followed by suction curettage. Methotrexate administration was done post correction of Anemia and close follow up with serial β-hCG monitoring was done as outpatient basis. Molar pregnancy is an abnormal trophoblastic proliferation with villous stromal edema. Classified into complete and partial molar pregnancy. Histologically a complete mole has an abnormal chorionic villi that looks like a clear vesicles, while partial mole the there is a focal villous edema and often with the presence of fetal parts. Complete hydatidform mole with coexisting fetus is unusual case. Commonly presented with delayed menstruation with accompanied with high levels of β-hCG, and vaginal spotting. CHMCF is usually diagnosed during the second trimester, sonographic features of hydatidiform mole presents at 2nd trimester. But combined with high levels of β-hCG and ultrasound impression of CHMCF can be done. CHMCF predisposes many complications such as development of hyperthyroidism, theca lutein cyst, vaginal bleeding and increased risk of development of GTN. According to Imafuko et.al, continuation of pregnancy in CHMCF does not increase the risk of development of GTN. There is a 40% chance of fetal survival in patients with CHMCF thus close follow up and prenatal checkup is important. There is mother versus fetus dilemma in the management of CHMCF. Risk for mother include excessive bleeding, pre-eclampsia, hyperthyroidism and development of GTN hence, these complications have to be considered to decide whether to continue or terminate the pregnancy. Therefore, in CHMCF, the management is individualized.

Discussion

Molar pregnancy is an abnormal trophoblastic proliferation with villous stromal edema. Classified into complete and partial molar pregnancy. Histologically a complete mole has an abnormal chorionic villi that looks like a clear vesicles, while partial mole the there is a focal villous edema and often with the presence of fetal parts. Complete hydatidform mole with coexisting fetus is unusual case. Commonly presented with delayed menstruation with accompanied with high levels of β-hCG, and vaginal spotting. CHMCF is usually diagnosed during the second trimester, sonographic features of hydatidiform mole presents at 2nd trimester. But combined with high levels of β-hCG and ultrasound impression of CHMCF can be done. CHMCF predisposes many complications such as development of hyperthyroidism, theca lutein cyst, vaginal bleeding and increased risk of development of GTN. According to Imafuko et.al, continuation of pregnancy in CHMCF does not increase the risk of development of GTN.

There is a 40% chance of fetal survival in patients with CHMCF thus close follow up and prenatal checkup is important. There is mother versus fetus dilemma in the management of CHMCF. Risk for mother include excessive bleeding, pre-eclampsia, hyperthyroidism and development of GTN hence, these complications have to be considered to decide whether to continue or terminate the pregnancy. Therefore, in CHMCF, the management is individualized.

Conclusion: Complete mole with coexisting fetus in the spectrum of gestational trophoblastic disease occurs sporadically. There are limited reports and studies pertaining to the diagnosis and management of this disease. There is still no standard guideline regarding fetal surveillance, management, timing and manner of termination of pregnancies complicated with partial, complete, and mole with a coexistent fetus. Thus the treatment and management is suggested to be individualized.

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A rare case presentation: Caesarean Scar Ectopic Pregnancy

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Scar Ectopic is the rarest form of Ectopic Pregnancy, but its diagnosis has been increasing worldwide. It is the abnormal implantation of embryo within the myometrium and fibrous tissue in a previous scar on uterus. Early and accurate diagnosis with timely management can prevent life threatening complications such as haemorrhage and uterine rupture.

Exact mechanism is not known but thought to be due to migration of blastocyst through a wedge soaked myometrial scar defect, a scar dehiscence or through a microscopic tract within the scar. In this case, 30 years old women (G3P2+0 previous two caesarean) presented with on and off bleeding and spotting for 14 days but with urine pregnancy test negative with HbsAg positive status. Serum beta HCG value and TVS lead to the diagnosis followed by surgical management.

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