with distrophic calcification. Ovarian intracystic bleeding raises the suspicion of adnexal torsion though it may occur spontaneously without torsion - as in this case. Some reports advocate conservative treatment for fetal complex ovarian cysts; however it may not be completely safe to leave a gangrenous ovary within the abdomen because of the actual risk of adhesion of the necrotic tissue to the bowel with resultant occlusion or perforation and of a possible misdiagnosis (teratomas, etc).

Supporting information can be found in the online version of this abstract

P12.17
Abstract Withdrawn

P12.18
Fetal obstructive uropathy of solitary kidney complicated by urinary ascites
J. Cortejo1, A. Gasalla1, M. Cosme1, L. Cortiñas1, S. Gutiérrez2, A. Sánchez2
1Servicio de Obstetricia y Ginecología, Hospital Clínico Universitario de Valladolid, Valladolid, Spain; 2Servicio de Cirugía Pediátrica, Hospital Clínico Universitario de Valladolid, Valladolid, Spain

Prenatal sonographic diagnosis of fetal obstructive uropathy is relatively common. However, the complication of spontaneous rupture of the urinary tract in utero causing fetal urinary ascites is extremely rare. Case report. A 33-year-old patient, gravid 2 para 1, comes to the realization of the morphological ultrasound in the second trimester of gestation. We identify a single fetus with biometry that corresponds to the gestational age and massive hydronephrosis of the left kidney with pielocalciciar system significantly dilated. It was not possible to identify the right kidney, not finding left ureteral dilatation and being the bladder normal. The only additional finding was a single umbilical artery. Before these findings, we perform a genetic amniocentesis being its result normal (46, XX). In a subsequent exploration carried out at 26 weeks of gestation there is a severe fetal ascites, without criteria of hydrops. The diagnosis can be done in the first trimester due to increased nuchal translucency and edema that extends the body. However it may be delayed to an advanced stage of pregnancy when the joint contractures become more evident. As differential diagnosis, it should be excluded Turner Syndrome, Noonan Syndrome (which leads to cystic hygroma), arthrogryposis (a result of fetal aquinæsia) and Pena-Shokeir’s Syndrome (which may have joint contractures).

Hygromas can have multifactorial origin. Therefore the precise diagnosis is important for a thorough genetic counselling in future pregnancies.

P12.19
Lethal Multiple Pterygium Syndrome: prenatal ultrasonographic and postmortem findings – a case report
L.C. Bussamra1,2, F. S. B. Barros1, G. Tedesco1, F.M. Andrade1, S.S. Herbst1, J. Aldrighi1
1Obstetrics, FCMSC-SP, Sao Paulo, Brazil; 2Obstetrics, EPM - UNIFESP, Sao Paulo, Brazil

The Lethal Multiple Pterygium Syndrome is characterised by hydropsy accompanied by severe and early cystic hygroma and joint contractures. The incidence is rare and unknown and its etiology is autosomal recessive, in some cases suggesting transmission connected to X. Patient Q.S.T, 22 years, primigravida. Cystic hygroma (figure 1), scoliosis, non visualisation of fetal stomach, flexion contracture of multiple joints - legs and arms (figure 2) and lack of fetal movements were detected by ultrasound (Medison Sonoace X8, Korea) in the first examination in our clinic, at 22 weeks. In the face of multiple malformations, amniocentesis was carried out to search for fetal karyotype with 46XX as a result. Based on the ultrasound findings and the karyotype, the diagnostic hypothesis of Lethal Multiple Pterygium Syndrome was made. The fetus developed progressive hydrops (figure 3) and pleural effusion, polyhydramnios and intrauterine fetal dismiss was diagnosed at 27 weeks. The autopsy confirmed the ultrasound findings and diagnosis.

The diagnosis can be done in the first trimester due to increased nuchal translucency and edema that extends the body. However it may be delayed to an advanced stage of pregnancy when the joint contractures become more evident. As differential diagnosis, it should be excluded Turner Syndrome, Noonan Syndrome (which leads to cystic hygroma), arthrogryposis (a result of fetal aquinæsia) and Pena-Shokeir’s Syndrome (which may have joint contractures).

Hygromas can have multifactorial origin. Therefore the precise diagnosis is important for a thorough genetic counselling in future pregnancies.

P13: NORMAL AND ABNORMAL GROWTH

P13.01
Hemodynamic pattern of ophthalmic artery in pregnant women with appropriate-for-gestational-age fetuses and fetal growth restriction: Doppler study
N.B. Melo1, A.L. Diniz2, T.M. Helfer1, A.P. Zamarian1, A.R. Caetano1, A.F. Morón1, L. Nardozza1
1Obstetrics, Universidade Federal de São Paulo - UNIFESP, São Paulo, Brazil; 2Obstetrics, Universidade Federal de Uberlândia - UFU, Uberlândia, Brazil

Objectives: The aim of this study was to compare ophthalmic artery (OA) Doppler indexes between normotensive pregnant women carrying appropriate-for-gestational-age (AGA) fetuses, and those with fetal growth restriction (FGR).

Methods: A cross-sectional study with 54 normotensive women after 32 weeks gestation, 28 with FGR (weight prediction below 10th percentile for gestational age, Hadlock et al.) and 16 carrying AGA fetuses (weight prediction between 10th and 90th percentile for gestational age, Hadlock et al.) were undertaken. Color Doppler was used to obtain the OA Doppler waveform, with insonation angle less than 20 degrees, 50 Hz filter, pulse repetition frequency of 125 kHz and 2 mm sample volume. The following Doppler parameters were assessed: pulsatility index (PI), resistance index (RI), peak systolic velocity (PSV), peak diastolic velocity (PDV), end-diastolic velocity (EDV) and peak ratio (PR), mean peak velocity. The Mann-Whitney or T-student test was used to assess the artery Doppler indexes.