XI. TÜRK ALMAN JİNEKOLOJİ KONGRESİ

TAJEV
TÜRK ALMAN JİNEKOLOJİ
EĞİTİM, ARAŞTIRMA ve HİZMET VAKFI

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and Turkish People were as follows; 43.7 and 27.5, respectively and there was statistically difference between them ($p<0.05$).

Conclusion: The numbers of Syrian refugees are decreasing day by day in our city due to the border of Syria. For Syrian refugees, especially, pregnant women have a lot of problems such as lack of nutrition, bad hygiene in terms of water and sanitation. So they are susceptible to the infection like toxoplasma. The ministry of healthy of Turkey should take into account this measures for both Syrian refugee pregnants and Turkish population pregnants.

Keywords: Avidity, seroprevalance, toxoplasma

[PP-250]

Spontaneous uterine rupture due to placenta percreta in second trimester of pregnancy: A case report

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Introduction: Placental invasion anomalies are life threatening complications of pregnancy, which occur when placenta does not separate from the uterine wall completely following delivery. The prevalence is known to be approximately 1/500 to 1/2500 pregnancies. Because of the worldwide increasing cesarean section rates, frequency of abnormal placentation have raised in recent years. Other predisposing factors for abnormal placentation are placenta previa, advanced maternal age and history of uterine surgery. The grade of abnormally invasive placenta is defined according to depth of invasion. Placenta percreta is the most severe form, in which placental villi penetrate through the uterine serosa and sometimes into neighbor organs such as cervix, bladder or bowel. Uterine rupture is one of the catastrophic complications of placenta percreta which may lead shock, peripartum hysterectomy, cystotomy, intensive care unit admission, infection and prolonged hospitalization. Uterine rupture due to placenta percreta mainly occurs during the third trimester at the time of labor-type uterine contractility. Based on our review of medical literature, there are only a few isolated case reports in the second trimester.

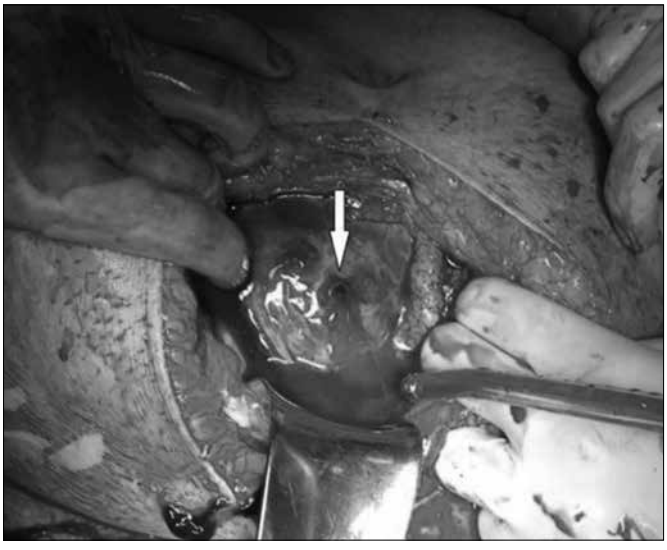

Figure 1. Intraoperative view of uterine rupture caused by placenta percreta (arrow)

Here, we presented an unusual case of massive intraperitoneal hemorrhage in the second trimester of pregnancy owing to uterine rupture secondary to placenta percreta.

Case: A 26-year old pregnant woman at 27 gestational weeks with a history of two previous cesarean sections admitted to our center because of abdominal pain and vaginal bleeding. The symptoms were started approximately 3-4 hours before admission. On physical examination, mild abdominal tenderness was detected in the umbilical region. Ultrasound examination revealed placenta previa with moderate amount of intraperitoneal fluid. The border between myometrium and placenta was not differentiated. A paracentesis under ultrasound guidance was performed in the right upper quadrant and yielded heavily blood stained fluid, suggestive of a possible intraperitoneal active bleeding. An urgent laparotomy was performed due to suspected uterine rupture. There was 1500 ml of blood in the peritoneal cavity and placenta was protruding through a bleeding full thickness uterine defect (Figure 1). A male fetus with Apgar scores of 6 and 9 at 1 and 5 min, respectively, weighing 1370 g was delivered by vertical fundal İncision. The placenta was found to be densely adherent to the anterior uterine wall. The patient became hemodynamically stable and thus, it was decided to continue conservative management. The placenta was removed completely by piecemeal excision as close as possible to the uterine lining. The defect in the uterus closed rapidly and hemorrhage was controlled. Both uterine arteries were ligated. During the operation, 3 U erythrocyte suspension were transfused. The patient was discharged on the 3th day after surgery without complications.

Conclusion: Placenta percreta induced spontaneous uterine rupture is difficult to diagnose in second trimester of pregnancy. The possibility of uterine rupture should always be kept in mind when a patient with a suspicion of adherent placenta admitted with signs of abdominal pain and free fluid in the peritoneal cavity. A state of alertness for prenatal diagnosis of cases at risk and prompt surgical management is essential to reduce perinatal mortality and morbidity.

Keywords: Placental invasion abnormality, placenta percreta, uterine rupture

[PP-251]

Atypical glandular cell on cervical cytology may be the first sign of primary peritoneal cancer

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Background: By cervical cytology, it is possible to obtain malignant cells arising from abdominal or pelvic cavity and refluxing through genital tract.

Case: A 54 year old woman presenting with postcoital pain. Cervicovaginal smear pointed atypical glandular cells suggesting endometrial