loss. The case who had 22W2D pregnancy according to early USGs had fetus competible to 19 weeks of gestational age in the USG performed. The case was followed up weekly with the diagnosis of oligohydramnios + IUGR (AC: 18W, FL: 20W) and diastolic flow loss. Placenta was low-lying and no clear relationship with cervix was established. The patient had normal results for first trimester combined test in her history, no rupture of membrane was described and there was no remarkable characteristic in the TORCH panel. The patient who refused vaginal examination was called for control. The patient came one week later and fetal cardiac activity was not seen in the ultrasonography. Fetal abdominal circumference was compatible with 18W4D. She was diagnosed with 23W1D oligohydramnios, intrauterine fetal death, transverse presentation, and previous 1 C/S. In the USG, fundus was observed as empty and in postpartum appearance. Fetus was observed around isthmic area. So it was suspected of servical ectopic pregnancy. The patient was hospitalized and applied laparotomy after preoperative evaluation. The abdomen was entered by epigastric and hypogastric incisions. The diagnosis of cervical ectopic pregnancy was confirmed by the laparotomy. In order to prevent possible severe bleeding, it was decided to apply Infrarenal Aorta occlusion. The aorta was suspended from Aorta bifurcation level by the consultant cardiovascular surgery physician. Double J catheters were placed on both ureters together with cystoscopy by consultant urologist. Also tourniquet was applied by Penrose over isthmic region. 1 cc heparin was administered and the aorta was clamped 2 minutes later. First the bladder was dissected. Just below the isthmus on the front side of uterus, fetus and its attachments were delivered by opening 3 cm transverse incision. Fetus was 240 g, 20 cm and male. Placenta and its attachments were cleaned. Intracervical foley condom was placed. It was inflated by 300 cc SF. Aorta clamp was opened. The procedure took about 25 minutes. One foley drain was placed into Douglas. Bleeding was checked. The case was taken to her bed in the unit with stable findings.

Conclusion: The diagnosis of servical ectopic pregnancy is generally limited with the first trimester cases in the literature. In cases referring at advanced weeks of gestation, prioritized evaluation of uterine fundus and fetus localization is essential to prevent delays in diagnosis.

Keywords: 2nd trimester, cervical ectopic pregnancy.

PP-012

Edward syndrome: a case report

Sevcan Arzu Arınkan, Resul Arısoy, Emre Erdoğdu, Oya Demirci, Oya Pekin, Mesut Polat, Murat Muhcu

Maternal Fetal Medicine Department, Zeynep Kamil Women and Children Diseases Research and Training Hospital, Istanbul, Turkey

Objective: Edward syndrome, is the second common autosomal trisomy and most of the cases are lost during their first year of life because of severe cardiac pathologies. We aimed to present a case of Edward syndrome which is prenatally diagnosed and to discuss the management in these cases.

Case: A 35-year-old gravida 2, para 1 patient was referred to our clinic at 17 weeks gestation. A detailed ultrasound scan was revealed that alobar holoprosencephaly, proboscis, hypotelorism, polydactyly and midfacial cleft palate-lip. Parents were informed about the fetal prognosis and termination of pregnancy was put forward as an option. Karyotype analysis was performed.

Conclusion: Edward syndrome can include holoprosencephaly and midfacial defects. Karyotype analysis should be performed and termination of pregnancy should be offered as an option for these cases.

Keywords: Edward syndrome, trisomy 18, prenatal diagnosis.

PP-013

Prenatal diagnosis of right aortic arch and aberran left subclavian artery anomalies: a case report

Şebnem Erol Türkyılmaz[1], Gürcan Türkyılmaz[2], Resul Arısoy[1], Emre Erdoğdu[1], Oya Demirci[1], Oya Pekin[1], Pınar Kumru[1], Murat Muhçu[1]

[1]Perinatology Clinic, Zeynep Kamil Training and Research Hospital, Istanbul, Turkey; [2]Obstetrics and Gynecology Clinic, Beykoz State Hospital, Istanbul, Turkey

Objective: İt's aimed to present a case of right aortic arch and aberran left subclavian artery anomalies which is prenatally diagnosed, and to discuss the managment of the case.

Case: A 29-year-old, gravida 2, parity 1 patient was refered to our clinic because of high risk of Edward syndrome in triple aneuploidy screening test. Detailed fetal ultrasonography and fetal echocardiography performed. Right aortic arch and aberran left subclavian artery anomalies were detected. No additional anomaly was detected during the examinations of other systems. Cordosentesis was performed to patient. Normal karyotype was detected and Di George syndrome microdelesyon was not identified. Pregnancy follow-up was continued and at 39. week of gestation a healty 3240 gr male infant was delevered by vajinal delivery.

Conclusion: Karyotype analysis and the other associated syndromes should be evaluated and a detailed ultrasonography examination should be performed in fetuses which right aortic arch and left subclavian artery were diagnosed. The prognosis for isolated right aortic arch and aberran left subclavian artery anomailes are good.