fetal aorta and pulmonary artery were high, suggesting hyperdynamic circulation. The peak systolic velocity in the fetal MCA was 72 cm/sec (2.04 MoM) suggesting fetal anemia. Diagnosis of hydrops fetalis and fetal anemia due to huge chorioangioma was made and intrauterin fetal transfusion was planned. Before fetal transfusion chordosynthesis was performed; fetal hematocryte was 24%. 32ml radiated CMV negative, 0 Rh negative eriythrocyte suspension was transfered. After transfusion fetal hematocryte was measured as 33% and fetus was monitorized with cardiotocogram. Six hours after transfusion recurrent late decelarations occured and the pregnancy was terminated via C/S. 1100 gr female baby was delivered. The 1st minute apgar score was 5 and the 5th minute apgar score was 2. Despite agressive cardiopulmonary resucitation the baby was dead 1 hour after birth. A lobular mass measuring 90 mm x 100 mm that attached to the fetal surface of placenta with a pedicle was noted. The diagnosis of chorioangioma was made with pathological examination. Chorioangioma is usually treated with expectant management, as the majority of tumors are asymptomatic and small. In situations in which maternal or fetal complications necessitate intervention, there are several possible treatments. However, most of these cases have a dismal poor prognosis. Possible interventions include serial fetal transfusions, fetoscopic laser coagulation of vessels supplying the tumor, chemosclerosis with absolute alcohol, and endoscopic surgical devascularization. Large placental chorioangiomas are rare and the prognosis is bad when a big tumor causes fetal hemodynamic changes with NIHF. The overall prognosis is somewhat dependent on the presence and / or development of hydrops fetalis.

Keywords: Chorioangioma, fetal hiydrops.

PP-020

Alobar holoprosencephaly: a case report

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Alobar holoprosencephaly is a rare and severe congenital brain anomaly which is caused by developmental defect in the fore brain associated with non-disjunction of both hemispheres and ventricles during embryonic period. Depending on the severity of non-disjunction, holoprosencephaly can be classified as alobar, semilobar or lobar. Alobar holoprosencephaly is the most severe form and results with monoventricular cavity formation, fusion of thalami and non-development of corpus callosum, falx cerebri, optical paths and olfactory structures. Its ethiology is multifactorial, and chromosomal anomalies or monogenic defects are the major reasons with the rate of 40-50%. The patient with gravida 1 and parity 0 was referred to our clinic at 30 weeks of gestation due to lateral ventriculomegaly. There was no risk factor in the medical history of the patient. The result of combined screening test was normal. In her ultrasonography, composite lateral ventricular and monoventricular appearances were observed. Bilateral thalamic fusion was detected. Vermian agenesis was found. Interorbital length was measured as 10.6 mm and hypotelorism was observed. Median cleft was seen on the midline of upper lip. The results of the evaluation of other systems and fetal cardiac screening were normal. Fetal karyotyping was carried out by cordocentesis and karyotyping was resulted as normal. The patient was discussed at our council and the patient was informed about the progress of the pregnancy. The termination of pregnancy was offered as an option to the patient and she accepted the termination option. After the fetocide, the pregnancy was terminated vaginally. Postpartum median cleft lip and hypothelorism were confirmed. Since the family did not approved, fetal autopsy could not be performed. The diagnosis of HPE is established primarily when monoventricular structure, fusioned thalami and cavum septum pellucidum cannot be observed. Various brain anomalies and facial anomalies are frequently concomitant. In our case, we have presented an alobar holoprosencephaly case diagnosed by the presence of monoventricular structure, fusioned thalami, vermian agenesis and cleft lip.

Keywords: Alobar holoprosencephaly, cleft lipt, vermian agenesis.

PP-021

Prenatally diagnosed fetal gallbladder stone: a case report

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Objective: Fetal gallbladder stone is seen quite rarely. Its incidence rate is approximately 1/2000. Together with the increase of the use obstetric ultrasonography in clinical practice, there has been an increase in the number of cases diagnosed with fetal gallbladder stone. Our aim is to present the case diagnosed with prenatal gallbladder stone.

Case: Twenty-year-old, foreign woman who had no prenatal follow-up referred to our clinic with the complaints of pain and water-breaking. In the obstetric US performed, it was

found that she was at 38 weeks of gestation which was her first pregnancy, her placenta was at anterior position, had sufficient amnion fluid and the presentation was breech type. NST was evaluated as reactive. In the measurement at AC transverse plane, an appearance consistent with single hyperechogenic stone in the gallbladder was observed. The patient delivered 3230 g female baby with 9/10 Apgar score by vaginal spontaneous delivery. The mother and the baby who had no problem on postpartum first day were discharged from the hospital. No etiological risk factor was found in the anamnesis of the case, and it was considered as idiopathic fetal gallbladder stone and she was followed up.

Conclusion: Although the ethiology of the fetal gallbladder stone is not known well, maternal and fetal reasons are considered. Among the maternal reasons, there are ablation placenta, increased estrogen level, narcotic use, diabetes mellitus, and drug use (ceftriaxone, furosemide and prostaglandin E2). The fetal reasons are Rh or ABO inconsistency, congenital anomalies (cardiovascular, gastrointestinal, urogenital), genetic anomalies (Trisomy 21), growth retardation, oligohydramnios, hepatitis, prenatal leukemoid reaction, and idiopathic reasons. Fetal gallbladder stones are generally benign, and most of them usually disappear spontaneously in the first months or within a year at the latest after the delivery.

Keywords: Prenatal diagnosis, fetal gallbladder stone.

PP-022

Prenatally diagnosed Fryns syndrome

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Fryns syndrome is a rare condition which characterized by autosomal recessively inherited multiple congenital anomalies. Its incidence rate is 0.7/10,000 births. Our aim was to present the case diagnosed with Fryns syndrome. Twenty-five-year-old foreign woman referred to our clinic with the complaints of pain and water-breaking. It was her first pregnancy and it was found that she did not had her antenatal follow-up regularly. It was seen in the obstetric US of the patient who had one finger sized orifice that amniotic fluid increased and there was advanced level of polyhydramnios with 15 cm single pocket vertical measurement. In the fetal biometric measurements, single fetus with breech presentation consistent with BPD: 34w1d, HC: 34w2d, AC: 29w4d and FL: 33w5d. In the fetal ultrasonographic examination, low ear and micrognathia were observed. In the transverse cross-section examination of abdominal region, collapse was observed on the anterior wall which was not in a normal regular structure. Compared to the previous measurements of AC, it was about 4 weeks smaller. Diaphragmatic hernia was seen where abdominal organs moved towards thorax cavity. In the extremities, there was pes equinovarus deformity in the right foot, and the toe of left foot had advanced flexion deformity. In the hands, the fingers were contracted in the flexion. Since the pains of the patient increased, cesarean section was carried out due to breech presentation. With the c-section, 1450 g – 41 cm baby was delivered, and intubated just after the birth. On the 13th postnatal day, baby has still been followed-up and treated in the newborn intense care unit as being intubated. In the examination carried out after the birth, highly arched palate, hypertelorism, undescended testicle, micro-penis, shortness of hand fingers and hypoplasia in the nails were observed in addition to the prenatal findings. The most significant and classical findings of Fryns syndrome are congenital diaphragmatic hernia, craniofacial dysmorphism, cleft palate and lip, extremity anomalies, nail hypoplasia and various internal variations. It is a syndrome generally with fatal progress. In its differential diagnosis, Pallister-Killian syndrome, trisomy 18, Cornelia de Lange syndrome and isolated diaphragmatic hernia should be considered. Frnys syndrome should be remembered in the differential diagnosis of cases found to have diaphragmatic hernia or extremity anomaly, and additional anomalies that may accompany should be investigated.

Keywords: Prenatal diagnosis, Fryns syndrome.

PP-023

Amniotic band syndrome: a case report

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Amniotic band syndrome (ABS) is a condition which occurs due to the constrictive bands formed by the early rupture of amnion membrane, and may cause different disorders depending on the organ involved. It is especially characterized with the deformation, malformation, amputation and craniofacial anomalies in the extremities. Its incidence rate varies between 1/1234 and 1/15,000 live births in different series. Although the etiopathogenesis of ABS is not known well, there have been many theories. In the etiology, infection, ischemia, trauma, amniocentesis, vasoconstrictive substance use decreasing uterine blood flow, antimitotic drug