diagnosis is possible in large number of skeletal anomalies. By careful examination, it is possible to notice number, form and movement disorders of hands and feet as well as fingers and toes. Prenatal diagnosis includes ultrasound examinations and prenatal invasive diagnostic methods. Anomalies of the hand may be associated with triploidy and trisomy of 13,18 and 21 chromosome.

Objective: Our aim was to present case of prenatally diagnosed fetal malformation-abnormal development of the right hand and the importance of ultrasound diagnosis in the decision to end a pregnancy.

Methods: Case of pregnant women in 21 week of gestation (WG) was presented, where the ultrasound diagnosis of fetal anomalies was set (malformation of fetal hand) which was promptly interrupted by inducing abortion.

Results and Case: During ultrasound examination (3D) in 21 WG, in patient P.K. 25 years old, it was established pregnancy with anomalous development of the right hand-the thumb has two phalanges, missing index finger, and there is only a part of the upper phalanx of the middle finger and the little and ring fingers have two phalanges. During ultrasound examinations movements of the wrist were normal. The rest of the morphology of the fetus looked normal. From history data patient states only hiperemesis symptoms in the first trimester of pregnancy. After signing the informed conset, under ultrasound control amniocentesis was performed and obtained 20 ml of clear amniotic fluid, which is sent to the cytogenetic testing. Analysis of amniotic fluid cells showed normal female karyotype 46,XX. Analysis was performed from two flasks on 16 metaphases. After reviewing the medical records-the ultrasound findings, the Ethics Commission of the Department of Gynecology and Obstetrics in Novi Sad made the decision to terminate the pregnancy.The patient was admitted to the Clinic of Gynecology and Obstetrics, Clinical Center of Vojvodina for abortion (registration number 3169/2014 in case history). Pregnancy is completed by induction of abortion with the use of 2 Prepidil gel and application of Prostin 15M. Extraction of the fetus was performed and instrumental revision of the uterus. Antibiotic therapy and therapy with uterotonics was administered. At autopsy confirmed the ultrasound diagnosis of these anomalies. On follow up after induced abortion ultrasound examinations showed normal uterine findings.

Conclusion: A case report shows the importance of 3D ultrasound as a reliable method for prenatal diagnosis of abnormalities of the skeletal system, careful antenatal fetal testing with the application of cytogenetics and off associated disorders and timely completion of pregnancy. Prenatal diagnostics today necessitates a multidisciplinary approach and thus prevent the birth of children with anomalies which are burden not only for their families, but also for whole society.

Keywords: Prenatal diagnosis, fetal skeletal system anomalies, 3D ultrasound.

PP-006

Placentomegaly with acute chorionitis: case report

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Objective: Placentomegaly is enlargement of placenta with 2 standard deviation from mean values. A placental thickness of >40 mm at term is associated with gestational diabetes, intra uterine infections and hydrops fetalis.

Case: A 16-year-old women, gravidity 1 with 23 weeks pregnancy was reffered to as placentomegaly. Her blood type was A Rh positive. There was single, alive and anatomically normal fetus with 23 week biometric measurement in her ultrasonographical exam. Cervical dilation with 3cm and 80% effacement was found in clinical exam. Placental thickness was 6 cm and measured from cord insertion as a perpendicular to uterine wall. Placenta has occupied nearly whole part of uterine cavity and fetus located on one side because of placenta. She delivered a 530 gr, male, dead fetus by spontaneous vaginal way. Acute chorionitis and fibrinoid necrosis were found in histo-pathological evaluation of placenta. Placentomegaly might be result of hydrous fetalis, placental bleeding, eritroblastosis fetalis, intrauterine infections (e.g. syphilis), chromosomal abnormality, molar pregnancy, chorioangioma of placenta. Increased placental thickness was associated with maternal mortality and fetal anomaly furthermore ıt was a predictor for LGA infants. Placentomegaly was accompanied with acute chorionitis in our case. However exact etiology of acute chorionitis could not found.

Keywords: Placentomegaly, acute chorionitis.

PP-007

One sided upper extremity amputation related to amniotic band syndrome: a case report

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Amniotic band syndrome anomalies is a syndrome that is caused premature rupture of amniotic membranes and results

a broad spectrum of fetal anomalies. Syndrom can result various anomalies in a wide spectrum caused by a simple band construction, ranging from major craniofascial visceral defects and fetal demise. In this syndrome various malformations can be seen but most effected parts are extremities. Prognosis is related to severity of anomalies and involvement of the organs. 19 years old, gravisy 1, parity 0, 16 weeks pregnant patient according to the last menstrual period was referred to our clinic because of non visulation of right upper extremity. There was no significant features in the patient's history. Ultrasonographic measurements of gestation was consistent with gestational age. She had no history of previous operation and additional systemic disease.There was no history of consanguineous marriage and drug use. First trimester screening test was not avaliable. There was not sufficient information about first-trimester nuchal thickness on the 11-14 week scan. In the fetal anatomical scan, on the right upper extremity distal radius and ulna were observed absent from 1/2 part. The left upper extremity and both lower extremities were normal. Fetal echocardiographic examinations were normal. In anatomical scan no additional anomalies were detected. The patient was recommended to karyotyping and amniotic fluid sampling for prenatal diagnosis by amniocentesis was performed. Without waiting the result of karyotyping, the case was discussed in the council and she were offered the option of pregnancy termination. With the request of the patient, pregnancy was terminated vaginally. At the macroscopic appearance of abortion material, the 1/2 part of distal radius and ulna on the right extremity were amputated. At the right forearm amputation level, a thin amniotic membrane fold that could not be visualised on ultrasound was observed that was wraping right forearm very hard and the other part of it was attached to left parietal bone on cranium and that caused a 3-4mm defection cranium. Any other gross anomalies was not observed. Fetal amniotic band was confirmed in the autopsy examination and the diagnosis of the right forearm amputation due to the amniotic band syndrome was confirmed. In amniotic band syndrome complications of upper and lower extremities are frequently observed but may also cause visceral anomalies. Amniotic bands are structures that are very difficult to be select on the ultrasound but can be determined in case of detection of abnormalities of the extremities with a more careful examination. But like in our case, an amniotic band that is so tightly wraping the limb may not be displayed in ultrasonography. Like in our case, other cranial structures and organs can have deformations together with limb amputations by the advancement of gestational age.

Keywords: Amniotic band syndrome, fetal amputation.

PP-008

An unusual cause of isolated fetal ascites; fetal ovarian cyst rupture

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Fetal ascites can be recognized as a symptom of fetal hydrops, which arise in response to numerous etiologic factors. In contrast, the causes of primary isolated fetal ascites are unclear. Most cases of isolated fetal ascites progress to hydrops fetalis only a bit can resolve spontaneously. In female newborns, ovarian cysts are frequently seen abdominal masses. Usually they are not symptomatic and resolve spontaneously. However, they are rarely symptomatic and they have no clinical significance. A 34-year-old woman, gravity 2, parity 0, abortion 1 is referred to our clinic at 32 weeks of gestation because of fetal intraabdominal cystic formation. She had an unremarkable prenatal course until this week. In the 32 weeks ultrasonography fetal biometric measurements were compatible with gestational age, amniotic fluid volume was in normal limits. In ultrasonography, we detected a 15 mm spheric cystic formation on the left lower side of fetal abdomen. The cystic formation was not related with renal structures and bladder. In Doppler sonography, we did not determine intracystic blood supply. Because the fetus is female and had no accompanying genitourinary and gastrointestinal abnormalities primarily suggested us an ovarian cyst. Patient was called for a new visit two weeks later. In the 34th week, ultrasonography fetal growth was compatible with 34 weeks and amniotic fluid was in normal limits again. Only abdominal circumference was measured as 99% for this week because of fetal intraabdominal fluid. In fetal abdomen, a widespread fluid accumulation was observed. Ovarian cyst on the left fetal ovary was regressed and was measured 14mm with an ellipsoid shape. Intestines were floating in this fluid. Fetal thorax was normal and hydrothorax was notdetermined. We did not observe any edema in subcutaneous tissue and we evaluated as primary fetal ascites even so we performed an assessment about hydrops fetalis. Hemogram, HbA1c, VDRL, TORCH screening, Parvovirus B-19 screening, indirectcoombs test and anticardiolipin IgM and IgG studies were performed for the patient. Karyotyping recommended to patient. However, patient did not accept karyotyping. All screenings were evaluated normal. Fetal echocardiography was normal. Patient was called for a visit two weeks later again. Onthe next examination in the 36th weeks of pregnancy, fetal ultrasonography was completelynormal. We have not observed any fetal ovarian cyst and fluid in fetal abdomen was completelyregressed. Patient had a 3400gr healthy baby on the 40th weeks of her pregnancy. No abnormal finding determined in postnatal abdominal ultrasonography. Fetal ovarian cyst rupture should be evaluated as an etiological factor in isolatedfetal ascites cases.