MHz convex abdominal probe. Ultrasonography findings and patient history were noted.

Case: 26-year-old primagravid patient applied to our polyclinic for detailed ultrasonography at the 20th week of her pregnancy. There was no additional feature in her anamnesis and it was learned that the first trimester screening test was reported as low risk. On ultrasonography, the gallbladder had the appearance of Phrygian cap (Figure 1,2), and right renal anteroposterior (AP) diameter: 9 mm, left renal AP diameter: 7.7 mm, it was evaluated as bilateral pelviectasis, no additional anomaly was observed. In the control examination performed at 32 weeks, right renal AP diameter: 6.3 mm, left renal AP diameter: 5.5 mm. The pregnant woman, who had no features in her follow-ups, was delivered by cesarean section at 39 weeks with an indication of breech presentation. In the postnatal period, the gallbladder was reported as Phrygian cap in the abdominal ultrasonography performed on the newborn, the anteroposterior diameter of the pelvis in the bilateral kidneys was evaluated as normal, and no problems were observed in the newborn follow-ups.

Results: Phrygian cap is the most common congenital anomaly of the gallbladder. Although this image, which is formed by the folding of the gallbladder from the fundus, is not clinically meaningful, pathologies with clinical significance such as tumoral mass in the liver or gallbladder and duplication are included in the differential diagnosis. For these reasons, making the diagnosis carefully, informing the family about other possible diagnoses, and confirming the diagnosis with abdominal ultrasonography or MRI in the postnatal period are vital for the clinical course.

Keywords: Gallbladder, pyrgian cap, ultrasound

References

1. Severn CB. A morphological study of the development of the human liver. I. Development of the hepatic diverticulum. American Journal of Anatomy. 1971 Jun;131(2):133–58.
2. Kokilavani J, Indiran V. Phrygian cap. Abdominal Radiology. 2017 Jul 15;43(5):1264–5.
3. Edell S: A comparison of the Phrygian cap deformity with bistable and gray scale ultrasound. J Clin Ultrasound 1978;6:34–35.
4. Meilstrup JW, Hopper KD, Thieme GA. Imaging of gallbladder variants. American Journal of Roentgenology. 1991 Dec;157(6):1205–8.
5. Kamp MJS van, Bouman DE, Steenvoorde P, Klaase JM. A Phrygian Cap. Case Reports in Gastroenterology. 2013;7(2):347–51.

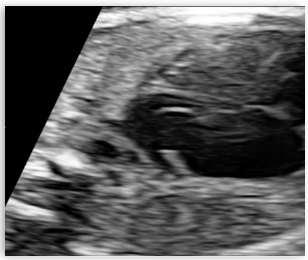
PP-02 Prenatal diagnosis of isolated redundant foramen ovale

Gökalp Şenol[1]

[1]Erol Olçok Research and Education Hospital, Çorum, Türkiye

DOI:10.59215/prn.23.031supp017

Objective: Redundant Foramen Ovale (RFO) is a rare cardiac anomaly. In this case report; Prenatal diagnosis and management of isolated redundant foramen ovale is discussed.



Case: During a routine mid-trimester cardiac examination, we found that the foramen ovale flap extended at least half way into the left atrium and was isolated. There were no arrhythmias during follow-up and right heart function was normal. After delivery, the baby has no hydrops or arrhythmia.

Discussion: Redundant Foramen Ovale (RFO) is defined as an abnormally redundant foramen ovale flap that extends at least halfway across the left atrium. It can cause right ventricular volume overload leading to fetal hydrops and subsequent heart failure. RFO usually occurs in isolation, but when associated with congenital heart disease it carries a poor prognosis

Conclusion: Redundant Foramen Ovale (RFO) is a rare cardiac anomaly. It can cause arrhythmias and right heart dysfunction. Most cases resolve spontaneously after birth.

Keywords: Cardiac anomaly, foramen ovale, redundant

References

1. Prenatal Diagnosis of Isolated Redundant Foramen Ovale: A Case Report may 2023 journal of fetal medicine 5/9

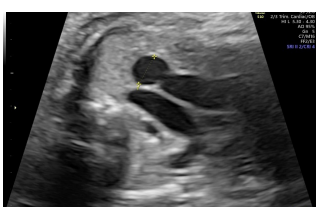
PP-03 Prenatal diagnosis of ductus arteriosus aneurysm

Gökalp Şenol[1]

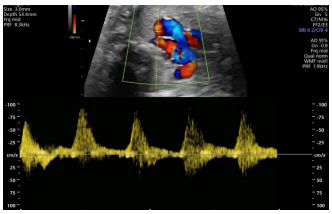
[1]Erol Olçok Research and Education Hospital, Çorum, Türkiye

DOI:10.59215/prn.031supp018

Objective: Ductus arteriosus aneurysm is a rare cardiac anomaly. In this case report; Prenatal diagnosis and management of ductus arteriosus aneurysm is discussed.



Case: Our patient was referred to our clinic with fetal growth restriction at 39 weeks gestation. During a routine fetal cardiac scan, we found the ductus arteriosus to be larger than normal diameter. Right heart function was



normal and there was no tricuspid regurgitation. Postnatal cardiac evaluation was normal. Follow-up was uneventful and the ductus arteriosus closed within 3 days.

Discussion: Ductus arteriosus aneurysm is usually diagnosed in the third trimester. Ductus arteriosus aneurysms resolve spontaneously; however, a small group of infants present with complications such as connective tissue disorders, thromboembolism, compression of surrounding thoracic structures, and life-threatening spontaneous rupture requiring surgical correction.

Conclusion: Ductus arteriosus aneurysm is a rare cardiac anomaly. When a ductus arteriosus aneurysm is diagnosed, the function of the right heart needs to be assessed. After birth, the ductus arteriosus must be assessed for premature closure.

Keywords: Aneurysm, ductus arteriosus, ultrasound

References

1. **Tseng JJ, Jan SL. Fetal echocardiographic diagnosis of isolated ductus arteriosus aneurysm: a longitudinal study from 32 weeks of gestation to term. Ultrasound Obstet Gynecol. 2005;26:50-56.**

PP-04 Pheochromocytoma in pregnancy

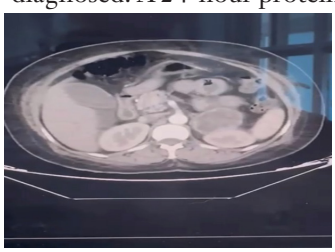
Masum Kayapınar[1]

[1]Mersin City Hospital, Mersin, Türkiye

DOI:10.59215/prn.23.031supp019

Objective: Pheochromocytoma is a neuro-endocrine tumor which secretes catecholamine. It is rare in pregnancy.. In this case report; Diagnosis and management of pheochromocytoma in pregnancy is discussed.

Case: Our patient was referred to the emergency clinic at 33 weeks of pregnancy with preeclampsia. The blood pressure was measured at 190/100 mmHg and could not be controlled. Fetal growth restriction was also diagnosed. A 24-hour proteinuria test showed a result of 2



grams per day.We delivered via C-section due to fetal distress and uncontrollable blood pressure.The baby passed away in the neonatal intensive care unit due to complications arising from fetal growth restriction and died after 3 days.

Discussion: Pheochromocytoma is a neuro-endocrine tumor which secretes catecholamine. It is rare in pregnancy. Misdiagnosis as gestational hypertension or preeclampsia may cause delays in diagnosis. Increased catecholamine cause hypertension and life threathining complications.

Conclusion: Pheochromocytoma should be taken into consideration as a possible factor in cases of uncontrolled blood pressure during pregnancy.

Keywords: Hypertension, nueroendocrine tumor, pheochromocytoma, pregnancy

References

1. **Pheochromocytoma in Pregnancy A Case Series and Review Raymond Oliva et all. Hypertension. 2010;55:600–606**

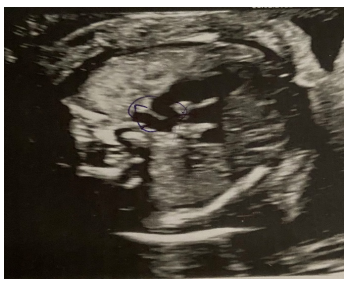
PP-05 Prenatal diagnosis of S-shaped ductus arteriosus

Zafer Bütün[1]

[1]Eskişehir City Hospital, Eskişehir, Türkiye

DOI:10.59215/prn.23.031supp020

Objective: S-shaped ductus arteriosus is a variant, but cardiac function must be evaluated at 2-3 week intervals. In this case report; Prenatal diagnosis and management of S-shaped ductus arteriosus is discussed.



Case: The patient was referred to our clinic due to an abnormal view of the three-vessel trachea at 32 weeks. We identified an S-shaped ductus arteriosus, but there is no tricuspid valve regurgitation observed, and the right heart function appears normal.

Discussion: The DA can be classified as straight, mildly curved (C-shaped banding) markedly curved, or S-shaped . During middle gestation, percentage of S-shaped ductus arteriosus can increase.After 32 weeks, the S-shaped ductus arteriosus can cause tricuspid valve insufficiency and dysfunction of the right heart.

Conclusion: When an S-shaped ductus arteriosus is diagnosed, it is important to avoid using ductal constricting agents. S-shaped ductus arteriosus is a variant, but cardiac function must be evaluated at 2-3 week intervals.

Keywords: Curved, ductus arteriosus, ductal constriction, S-shape, tricuspid valve insufficiency

References

1. **Mielke G, Peukert U, Krapp M, Schneider-Pungs J, Gembruch U. Fetal and transient neonatal right heart dilatation with severe tricuspid valve insufficiency in association with abnormally S-shaped kinking of the ductus arteriosus. Ultrasound**