Perinatal Journal 2011;19(1):35-50

e-Adress: http://www.perinataljournal.com/20110191009
doi:10.2399/prn.11.0191009

The Conclusion Report of 13th National Perinatology Congress

Ayşe Kafkaslı[1], Alper Tanrıverdi[2], Yeşim Baytur[3], Özlem Pata[3], Ertan Adalı[3], Hakan Camuzcuoğlu[3], Arif Güngören[3], İlker Arıkan[3]

[1]*Head of the Congress, 13th National Perinatology Congress, İstanbul Türkiye*
[2]*Congress Secretary, 13th National Perinatology Congress, İstanbul Türkiye*
[3]*Congress Reporter, 13th National Perinatology Congress, İstanbul Türkiye*

The Conclusion Report of 13th National Perinatology Congress

13th National Perinatology Congress was held in İstanbul Military Museum and Culture Site in between 13th and 16th April, 2011.

Before the congress, 3 pre-congress courses were held on 13th April, 2011.

1. Perinatal Genetic and Postmortem Diagnosis Course

In the first session, Assoc. Prof. Serdar Ceylaner made a presentation about "Basic Genetics and Management of Genetic Diseases for the Clinician" and he explained that chromosomal analysis indications are recurrent gestational losses, intrauterine death, stillbirth of unknown etiology, neonatal death, congenital malformations, suspicious genital structure, mental-motor retardation, growth retardation, primary amenorrhea and some secondary amenorrhoea. He also suggested performing chromosomal analysis if chromosomal disorder was found in previous children, one of the spouses has balanced chromosomal disorder, fetal anomaly is detected in ultrasonographic follow-ups, if there are high risk rates in triple screen test and combined tests, history of recurrent gestational loss, history of intrauterine and postnatal death of unknown etiology, and if mosaicism is detected in CVS sample during chromosomal analysis study.

The subject of "Fetal Postmortem Examination and Chromosomal Analysis of Abortion Material" was presented by Dr. Gülay Ceylaner. According to the results of this presentation, postmortem examination should be performed on congenital anomalies, intrauterine growth retardation, non-immune hydrops fetalis, fetal-neonatal death history of unknown etiology or in fetuses with unknown death reason or maser (high frequency of chromosomal disorder). Findings should certainly be recorded during examination, photographs and X-ray should be taken and skin biopsy should be done. Fetus evaluation is really an easy and convenient examination method.

In the presentation of "Fetal Autopsy: The Influence on Perinatal Mortality", Prof. Dr. Erdener Özer emphasized the importance of perinatal autopsy and stated that perinatal autopsy is essential for verifying the results of fetal maturity and diagnostic processes, reviewing clinical approaches and establishing national perinatal death statistics.

Dr. Neşe Karadağ specified in her presentation "Placenta: The Importance of Pathological Examination" that evaluating placenta provides important information in terms of care and health of mother and baby during and after delivery as well as creating medicolegal support in terms of physician when compared to unexpected fetal or

Correspondence: Yeşim Baytur, Celal Bayar Üniversitesi Tıp Fakültesi, Kadın Hastalıkları ve Doğum Anabilim Dalı, Manisa, Türkiye
e-mail: yesim_bulbul@yahoo.com

maternal results and she emphasized that evaluating placenta is an inseparable part of autopsies for fetal and neonatal deaths.

2. Perinatal Ultrasonography Course

Assoc. Prof. Yeşim Baytur talked on "Normal Sonographic Findings in Early Pregnancy" and emphasized the importance of determining gestational age, viability and chorionicity within first three months. She stated that yolk sac had to be observed at 5th week and fetal heart beat had to be observed when the sac reached 25 mm. She emphasized that some of fetal anomalies such as anencephaly and omphalocele can be detected and she also said that fetal anatomy should be paid attention. She indicated that week 14 should be waited for heart screening and that anencephaly, omphalocele and Dandy-Walker can not be diagnosed before 11th week.

"Fetal Anatomical Examination in 11-14 Weeks Gestation" was presented by Prof. Dr. Yakup Erata. By the developed technique and the perinatology being a sub-branch, it was begun to do anatomical evaluation in earlier weeks and therefore ultrasonographic imaging became important.

"Fetal Chromosomal Anomaly Markers in 11-14 Weeks Gestation" was explained by Prof. Dr. Turgay Şener. He stated that the major anomalies among sonographic identifiers that may cause chromosomal anomalies were anatomical defects such as omphalocele, megacystitis, holoprosencephaly, and that the tests such as NT measurement, nasal bone, ductus venosus, and tricuspid regurgitation should be used for screening purposes. Though it is known that chromosomal anomaly risk increases as maternal age increases, it was remarked by him that it is possible to decrease invasive tests performed and to increase Down Syndrome diagnoses detected by various screening strategies. The importance of training was emphasized and it was also stated that it should certainly be certified for effective use of screening tests.

On the session of second trimester, Prof. Dr. Alper Tanrıverdi made a speech about "Fetal Anatomical Examination in the Second Trimester". It was stated that the examination was done from the point of fetal anatomy during ultrasonography evaluation and it was important to question patient's history and to check some systems more carefully accordingly and he emphasized the importance of systematic evaluation and the use of a check list. It was underlined that at least 20 minutes should be spared for examination and he suggested the importance of carrying on physician training and technical competency of the device. He also indicated that anomalies could be missed even in the best clinics; skeletal system and KVS defects were those mostly missed, and CNS and GUS anomalies were those easily detected. He also remarked following topics:

a. The evaluation of fetal biometry, placenta and amnion fluid, and the systematic screening of fetal anatomy should be performed.

b. If necessary, Doppler ultrasonography should be included.

c. During systematic evaluation of the anatomy, orbitas on face, lips, nasopalatine, fetal profile, extremities, 4 cardiac chambers, major vessel outlets, 3 vessel images, falx cerebri on central nervous system, ventricular system, posterior fossa, choroids plexuses, stomach, bladder, diaphragm and kidneys should be checked.

d. Indications such as heart anomaly of Down syndrome, duodenal atresia that may be seen at 2nd trimester should be paid attention.

In the same session, Prof. Dr. Lütfü Önderoğlu emphasized in his presentation "Which Fetal Anomalies Should Not Be Overlooked in the Second Trimester?" that there is confusion about who should perform the ultrasonographic evaluation due to the increase in medicolegal events and stated that there is 60% chance to detect in ultrasonography and expectation of patient should not be raised. He expressed that all those normally to be checked between 18th and 22nd weeks could be possibly found in all books and internet, and everybody who got ultrasonography training can perform standard and detailed ultrasonography. He noted that regular care of devices, reporting and image recording should be provided, and obese patients should be registered. He stated that 83% of lethal anomalies were detected; however, we can detect 54% of lethal anomalies such as

hypoplastic heart and 90% of renal agenesia, but lethal musculoskeletal anomalies can be missed. He pointed out that the actual problem is in babies with serious morbidity and chance of living. He expressed that neural tube defects, hydrocephaly, complex heart abnormalities, abdominal anterior wall defects, diaphragmatic hernia, small intestine obstructions and bladder extrophies should be detected (and also they can be missed).

Assoc. Prof. Dr. Ebru Tarım presented the "Anomalies that can be detected during late pregnancy period" and she stated that anomaly can become apparent at 3rd trimester (diaphragmatic hernia) though it exists at 2nd trimester since anomaly appears lately and there is a pause in the development of anatomical structure (microcephalia). It was said that normal anatomic development continues during pregnancy and some anomalies such as central nervous system anomalies may arise late. It was emphasized that cerebellar vermis, ventriculomegaly, and more echogen view around ventricle at intracranial hemorrhages should be paid attention during third trimester. She indicated that transvaginal ultrasonography can be used in uncertain cases in SSS anomalies and that MR can be performed in breech delivered babies. It was said that SSS tumors and neuronal migration anomalies such as lissencephaly may appear lately. She mentioned about findings developed related to CMV infection and explained that coarctation of aorta, pulmonary stenosis, achondroplasia from skeletal dysplasia, ovarian cysts, sacrococcygeal teratoma, intestinal atresia, vesicoureteric reflux and multicystic dysplastic kidney may be diagnosed lately. She emphasized that only biometry check is not sufficient on third trimester but also the anatomy should be evaluated in terms of these anomalies.

The topic of "Sonography of the Placenta and its Adnexa" was narrated by Prof. Dr. Asım Kurjak. He expressed that placentation can be detected beginning from early gestational weeks by Doppler ultrasonography and that 3D Doppler is more advantageous than 2D Doppler. He stated that placental vessels can be imaged by "placental vascular biopsy" and that spiral arteries and placental vascular tree can be imaged by 3D, and 3D indices may change according to the parity and gestational week. He indicated that intervillous blood flow can be measured by 3D and it can be utilized in hypoxic cases. He also gave information about placental anomalies. It was talked about placental tumors, chorioangioma and placental infarcts. Though placental calcifications are accepted as physiological, it was asked to pay attention that they may be the indication of infections at early pregnancy. It was stated that there may be hyperechoic image at 0th-48th hours in ablatio placentae, isoechoic image at 3rd-7th days, hypoechoic image at 1st-2nd weeks and anechoic image after 2nd week. It was emphasized that umbilical vessels blocks servical channel at vasa praevia, it is frequent at velamentous insertion, and membrane rupture and abnormal bleeding may occur if not diagnosed. It was underlined that inferior uterine segment is formed at 28th week at placenta praevia diagnosis and therefore it should not be diagnosed before this week. It was expressed that sonoluscent areas behind placenta disappeared in placenta adhesion abnormalities, there were placental lacunas including turbulence and colored and power Doppler may help the diagnosis. It was clarified that Hyrtl anostomoses are important and that single umbilical artery may be related with chromosomal anomalies and gestational complications.

Prof. Dr. Cihat Şen presented the topic of "Sonography as a Contributory Tool in Multiple Pregnancy". It was stated that dichorionic twins can be followed up as singles and it is wrong to perform unnecessary elective cesarean. It was mentioned that Down syndrome risk calculation is different in twins compared to single pregnancies and it was also said that it is not appropriate to use biochemical tests. Checking for nuchal translucency and nasal bone is appropriate and risk will be calculated for each fetus while these risks will vary according to chorionicity. It was stated that taking one sample in monochorionics if invasive process will be performed; however, it may have rarely different genetic structures in postzygotic abnormalities. Since preeclampsia risk increases in multiples, uterine artery PI should be checked in first trimester as well as measuring blood pressure. In this way, heavy preeclampsia that occurs before 32nd week can be diagnosed at a rate of 90%. Miscarriage risk increases to 6% from 3% and early

labor risk decreases to 10% from 20% if embryo reduction is performed in triple pregnancies. It should be decided together with the family. Reduction is not performed in monochorionics, but cord coagulation should be performed. If there is any case requiring termination, it should be done at the earliest period.

In this course, after speakers presented their presentations, examples about normal fetal anatomy in point-of-care training were given by Ebru Tarım, Özlem Pata, Yeşim Baytur, and Mertihan Kurtoğlu and information was given about fetal obstructive uropathy, neural tube defect and increased NT on 3 patients at 1st, 2nd and 3rd trimesters.

3. The Course of Obstetric Emergencies

It was expressed that the real reason of early period bleedings can not be frequently determined, but the most important one is the difference between ectopic pregnancy and abortus and a good history, vaginal examination, hemogram follow-ups and ultrasonography gain importance in that case.

It was said that vaginal 70-90% success was obtained by misoprostol applications (600-800 microgram/day) in abortuses. Following opinions were shared about placenta praevia: Placenta praevia is a spectrum. Those with obstetric bleeding risk should be determined by ultrasonography at 20th-23rd weeks. Lifestyle should not be changed if cervical length is normal and placental covering is below 15 mm at 20th-23rd weeks. Placenta praevia–vasa praevia, placenta accrete–cesarean undergone–maternal age, IVF/ICSI pregnancy are associated with each other. Normal delivery can be performed under close follow up by placental tip at delivery – internal os <1.2 cm.

Placental decollement is seen generally at 3rd trimester. In most of the cases, fetal distress accompanies and its frequency is 0.3-1.6%. The diagnosis is clinical at ablation placentae. It is confirmed by showing postnatal retroplacental hematoma. Clinical findings vary according to the decollement level and bleeding amount. Placenta praevia, dystocia and rupture should be eliminated at differential diagnosis. Hemorrhage may not be observed in decollement cases ultrasonographically. Ultrasonographic diagnosis criteria are pre-placental accumulation under chorionic layers, gel-like movement of chorionic layer by fetal activity, retroplacental accumulation, marginal hematoma, sub-chorionic hematoma, heterogen increased placental thickness and intra-amniotic hematoma.

There is a clinical classification of placental decollement and it gets intensified from 0 to 3. Management of decollement in placenta includes appropriate maternal monitorization, fetal status indication, performing differential diagnosis, transfusion of proper blood and blood products, and termination of pregnancy at a suitable time. Coagulation tests should be performed and urine outgoing should be kept under control. If patient is stable during management, she can deliver. If there is fetal distress, then cesarean should be considered. It should be remembered that maternal and fetal complications increase in decollement placenta.

Can we prevent decollement placenta?

It should be prevented to drink alcohol and smoke during pregnancy, antenatal controls should be performed, pregnants with hypertension should follow treatment recommendations and folic acid should be taken.

Hypertension at Pregnancy was discussed on the first session on 14th April, 2011.

Prof. Dr. Rıza Madazlı emphasized in his presentation "Etiology and Staging of Preeclampsia" that preeclampsia is a unique formation of human placenta and it is the cost of evolution. He said that it causes 50,000 maternal deaths in the world. He talked about its common endothelial damage in the etiology caused by insufficient trophoblastic invasion. He expressed that the classification should be changed as early (<34 week) and late (>34 week). He highlighted that early preeclampsia is caused by placentation anomaly which have serious risk on mother and fetus, and late preeclampsia is caused by overreaction of mother for pregnancy.

Assoc. Prof. Arif Güngören said in his presentation "Preeclampsia Prediction by Ultrasonography" that there is resistance increase in uterine artery of preeclampsia patients against current and that early diastolic notch may develop;

but he also added that Doppler of uterine artery has a limited value for predicting preeclampsia, IUGR and perinatal death. He expressed that its decrease in uterine artery Pulsatility Index alone or together with notching will be successful for predicting preeclampsia. It was said that there is 90% sensitivity when 1st Trimester PI and PP-13 are used together. He emphasized that it is more valuable to use biochemical markers and USG identifiers together.

In "Hellp Syndrome: Practical Management", the speaker Sanjay Gupte said that the situation develops 70% before delivery. He talked about endothelial damage caused by cytokines secreted by maternal cell immunity as a reaction against pregnancy. He stated that the early diagnosis of the syndrome may give the best chance to mother and delivery should be performed when the situation arises, no matter what happens. He highlighted that nausea or vomit developing at the second half of pregnancy would cause a high level of suspicion. He expressed that the state will regress within 48 hours in most of the cases, and it can be waited for steroid for 48 hours by stabilizing cases developed between 7th and 32nd weeks. He said that high dose of steroid use is not suggested in syndrome treatment and it does not change outcomes and also said that thrombocyte suspension should not be given when thrombocyte count is over 50,000. He emphasized that aggressive treatment should be performed in order to save the life of patient.

"Gestational Diabetes" was discussed in the next session. Gestational diabetes is a diabetes type which begins during pregnancy or appears during pregnancy for the first time. 90% of diabetes observed during pregnancy is gestational diabetes and its incidence is about 5-10%.

Even light hyperglycaemia affects prognosis. Therefore, GD should be checked at pregnancy. The screening can be performed as two-phased (50 g OGTT – 100 OGTT) or one-phased (75 OGTT).

At 75 g GTT, FBG (fasting blood glucose) threshold value is 95 mg/dL, while 1st hour threshold is used as 180 mg/dL and 2nd hour threshold is used as 155 mg/dL.

Carpenter Causton values are mostly used at 100 g OGTT. FBG, 1st, 2nd and 3rd hour threshold values are accepted as 95, 180, 155, and 140 respectively.

75 g GTT threshold values were decreased after the results of HAPO study were taken and FBG, 1st hour and 2nd hour values were determined as 92, 180 and 153 respectively.

FBG should be checked at first examination in all pregnants and FBG should be below 92 mg/dL. In diabetic pregnants, maternal and fetal complications increase. If blood glucose is above 200 mg/dL in pregnant with nausea and vomit, we should remember diabetic ketoacidosis. Management of diabetes should begin in preconceptional period. If there is type-1 diabetes and patient currently uses any cholesterol lowering drug and ACE inhibitors, they should be not be used and it should be begun to use Ca channel blockers and folic acid.

Renal function tests should be asked for patients with Type-1 DM before pregnancy, eye ground examination should be performed and consultancy should be given in terms of maternal-fetal risks.

Congenital malformation risks should be told to case who applies for bad glycemic control at first trimester, and tight glycemic control should be provided as not being hypoglycemic. During 20th-24th weeks at second trimester, it should be suggested to do detailed ultrasonography and fetal echo in terms of fetal anomalies.

At final trimester, patient should be called for weekly controls and NST and Biophysical Scoring should be done twice in a week if necessary.

Complications are lesser in gestational DM, but careful follow-up should not be forgotten. It should be paid attention to hypertension and preeclampsia. In these cases, it is not necessary to check urine routinely for ketone but it can be checked for diet control. It is suggested to do first trimester test at 11th-14th weeks, detailed ultrasonography and fetal echo at 18th-22nd weeks, ultrasonography once at every four weeks after 28th week and delivery as not exceeding 40th week.

In diabetic pregnants, shoulder dystocia rate above 4,000 g is 30%. Shoulder dystocia possibility decreases by delivery induction without causing cesarean risk to increase if pulmonary maturation is full at 38th-39th weeks in those who were treated by insulin. Classical recommendation is cesarean above 4,500 gram. ACOG, on the other hand, suggests cesarean above 4,000 gram.

It should be avoided to do long-acting insulin during labor. Fluid should be given by using neutralized insulin inside glucose solutions.

In patients with gestational diabetes, Type-2 diabetes risk increases at long-term. Therefore, 75 g GGT should be done after postpartum 6th-12th weeks.

Nutrition at Pregnancy and Diabetes

Nutrition and exercise are both first step in gestational DM treatment and are important factors among other treatments. The purpose is to keep blood glucose levels normal and to prevent macrovascular diseases. Nutrition should be personal and appropriate to nutrition style of that person. There is no extra energy need at first trimester; however, 300 calories of extra energy is needed on 2nd and 3rd trimesters. When calculating calorie need, 30 cal/kg energy according to pre-pregnancy weight should be calculated and 50% of it should be carbohydrate while the other half should be protein and fat. If BMI is higher than 30, energy can be calculated as 25 cal/kg and carbohydrate amount can be decreased to 40% if necessary. Nutrition should include 3 main meals and 2-4 refreshments.

Physical activity-exercise directly affects glucose level over insulin, and it increases insulin sensitivity. Exercises such as swimming, bike moves and chair exercises are suggested; however, tiring exercises such as step should be avoided. Daily exercises for 20-30 minutes are effective, and GD decreases in early pregnancy of those who exercise. It should not be forgotten that nutrition and exercise are one of the most important steps for following up diabetic pregnant and preventing gestational DM.

Table 1. Target blood glucose levels.

	Plasma	Capillary
FBG	70-106	60-95
1st Hour	100-155	90-140
2nd Hour	90-130	80.120

Treatment Modals in Gestational Diabetes

Planned diet, proper exercise, insulin, oral hypoglycemic agents are used in treatment. Desired targets are not reached by diet in 40% of cases with gestational diabetes. Desired target blood glucose levels are given Table 1.

The purpose in treatment is to provide glycemic control as urine ketone is negative, HbA1C is normal and there is no glycemia.

Abdominal circumference is proportional with postprandial blood glucose, so macrosomia is directly related with postprandial blood glucose.

At what doses should insulin be used?

NPH – short-rapid-acting (insulin 50% - NPH 50%) insuline can be used 1-2 times as insulin pump. Analog insulins are lispro or aspart-ins pregnancy category B and are rapid-acting. Pregnancy category of long-acting insuline analogs is C, therefore it is stopped during pregnancy and NPH insulin is used. Pregnants generally do not want this treatment due to oral hypoglycemic agents, using injection for insulin, difficulty for adaptation to treatment and hypoglycemia risk, prejudice and concern about future, and appetite and weight increase. Therefore, oral hypoglycemic agents were brought to the agenda. In GDM, glyburid can be used and given 1 hour before meal. It can be used as 1x1 and 2x1. In order to prevent high FBG, it can be given before going to bed. Insulin-like effects can be observed if glycemic control can be provided when daily glyburid dose is below 10 mg; however, risks are higher if more than 10 mg is needed.

It is advantageous that metformin breaks insulin resistance, decreases hepatic glucose release and does not cause weight gain. Its disadvantages are that it passes close to the total transplacentally and generally it is not sufficient alone. It is not suggested to use for these reasons.

Treatment Manual

- If FBG is higher than 95 or 1st hour postprandial blood glucose is over 140, then insulin should be used. If FBG is 95–110 mg/dl, and 1st hour is 110–150, then treatment should be initiated by NPH as 0.3-0.4 unit/kg.
- If FBG is 110mg/dl, and 1st hour is over 200, then treatment should be initiated by 0.7 unit/kg insulin.
- Individual capillary blood glucose should be checked for 4-7 times daily in 3 days in a week.

Preterm Labor Management in Diabetic Pregnant

Iatrogenic preterm labor is frequently seen especially in diabetes. Diabetes-caused IUGR, macrosomia or bad biophysical profile can cause early labor requirement. Also bad maternal blood glucose control, noncontrollable HT caused by vascular complications may require delivery to be performed early. If blood glucose is high, then preterm labor risk is high, too. Preterm labor risk in those with good glycemic control is similar with a normal pregnant.

Fetal hyperinsulinism antagonizes cortisol effect and Type-2 alveolus cell development is delayed. Surfactant is decreased and newborn tachypnea occurs. In cases where pregnancy will be terminated before 38 weeks and 7 days, pulmonary maturation should be known for sure. Tests used in pulmonary maturation are L/S, PG, and Lamellar Body (37 thousand / microliter) counts. Sometimes lung can be RDS though it is mature according to L/S test. Therefore, PG should also be checked.

Tocolytic agents + antenatal steroid are used in preterm labor management. There are some risks about antenatal steroid use, because maternal hyperglycemia may be observed. This also may cause fetal hyperglycemia and increases fetal insulin. Fetal hyperinsulinemia delays pulmonary maturation. Checking hourly capillary blood glucose and doing insulin infusion in diabetic pregnant to whom steroid is applied are proper approaches.

Beta agonist can be given as a tocolytic agent to diabetic pregnant who has good glycemic control. Also, calcium channel blockers and oxytocin receptor antagonists should be preferred.

Gestational period is closely related with blood glucose level. Since antenatal steroid is applied, insulin infusion is the best effective method in blood glucose management.

In "Multiple Pregnancies" session, Prof. Dr. Murat Yayla gave information about "Epidemiology of Twin Pregnancies in Turkey". The incidence of multiple pregnancy increased after 1980. The major reason is the improvements in reproductive medicine. Its incidence at first periods of pregnancies is indicated as 6-12%. The rate is observed as 2-3% in deliveries. (The increase of abortus risk?). The incidence is over 30% in HT pregnancies. Vaginal delivery is suggested at vertex presentations in twin pregnancies while cesarean is suggested non-vertex presentations. Maternal mortality increases approximately 3 times. It is required to do chorionicity determination by ultrasonography at early period. It is suggested to do follow-up in perinatology clinics for pregnancies more than two and monochorionic twins. Routine cervical sonography should be performed at 22nd-24th weeks and follow-ups of pregnants who have early labor risk should be suggested doing at perinatology clinics. Less number of embryo transfer made by the new law decreased multiple pregnancy rates 4 times; however, it did not change pregnancy rates. It should be remembered that perinatal mortality and morbidity will increase in multiple pregnancies.

Assoc. Prof. Okan Özkaya then talked about "Management in Preterm Twins".

More than 50% of twin pregnancies give birth before 37th gestational week. Short cervix and fFn screening by ultrasonography is useful for determining preterm labor. There is no effective method for preventing preterm labor. Contrarily, prophylactic circlage may increase preterm labor. Hospitalization, bed rest and prophylactic progesterone are not effective. The purpose in acute preterm labor treatment is to perform antenatal steroid application and to gain time for referring appropriate center.

The last session of the day was "Turkish-Georgian Joint Meeting". In this meeting, "Cesarean on Demand" was presented by Assoc.

Prof. Mekin Sezik. He emphasized that the definition of cesarean on demand is quite difficult. He stated that the situation is complicated if it is patient who demands cesarean as it may not be a healthy decision. It should be discussed whether patient demands cesarean as her health is deteriorated or it is possible that we call it as cesarean out of indication.

Who determines cesarean indications? Should physician be determiner traditionally with his knowledge and experience or should there be instructions and regulations about it? In fact, there are many factors affecting indication determining process (ministry, SSI, societies, physician, NGOs etc.). Consequently, both patient-physician relation decreases and technician role is given to physician.

As a reflection, "increase in cesarean rates" becomes an intricate situation caused by the combination of some "interrupted" social practices and value judgments through global-scaled excessive medicalization and mechanization in obstetric practice.

Solution offers are not as easy as thought, they should cover the change of some complicated social value judgments. In fact, women are in the focus of the debate; however, everyone except women participates to the debate.

What can be done to decrease cesarean rates? First of all, transparency should be provided. Pregnant should be informed clearly about how pregnant will be prepared for labor, where labor will be performed, who will make do labor, and who will also be there.

Another topic emphasized by the speaker is if cesarean rates can be decreased. Support to labor by someone else except health personnel and people close to pregnant decreased cesarean rates about 2.5%. There should not be any places like pain room of delivery room in hospitals since such places insulate and alienate pregnant. Lithotomy position and routine episiotomy should be questioned. Importance should be attached to patient privacy.

The Ministry of Health established mother-friend hospital criteria. According to this, a close person chosen by candidate mother should stay with her during delivery; candidate mother should receive physical and emotional support regularly from an educated health employee, walking and moving freedom should be provided for her; routine lithotomy position should not be insisted and position preferred by her should be provided; induction rate should be decreased ≤10% and episiotomy rate should be decreased ≤20% (target is ≤5%). Unless required, it is not encouraged to use analgesic and anesthetic materials.

Consequently, it was stated it could not be expected to see a decrease in increasing cesarean rates without leaving male-dominated medical discourse and interiorizing the privilege of "giving birth" by women which is peculiar to women.

Dr. Nana Gvetadze spoke about "Homotoxicological Therapy of Chronic Feto-Placental Insufficiency and Fetal Growth Retardation". In this session, it was mentioned about the use of homotoxic drugs in gestational complications. The most important reasons for choosing homotoxicology in fetal medicine are that they do not have embryotoxic and teratogenic effects, they do not cause allergy and do not have any contraindications, they are more effective in treatment of chronic diseases and they are advantageous in terms of costs. These preparates are obtained by mixing various dilutions of certain natural herbs. They can be used in especially growth retardation and placental insufficiency in terms of fetal medicine.

On 15 April 2011, the second day of the congress, the first session was "High-Risk Pregnancies". The topic "From Pregnancy to the Neonatal Period" was presented by Prof. Dr. Kalbiye Yalaz. By findings at early period of high-risk pregnancies, it is not always possible to detect neurologic problems such as cerebral palsy and mental retardation that will appear on advanced ages. Babies who are delivered on time and have no risk factor (cerebral palsy 60%-70%) may have neurological problems in the future. Intrauterine or low body weight during delivery according to gestational age, small head circumference, intrauterine movement shortage, low heart beats during pregnancy, hypoglycemia during intrauterine and natal period, placenta dysfunction, and retardation at development steps are most important preliminary findings of cerebral palsy and mental retardation.

Prof. Dr. Neslihan Tekin explained the topic of "Prevention and Management of Perinatal Asphyxia". Perinatal asphyxia may develop at intrauterine period, during labor, during delivery or at early postnatal period. Recognizing risky cases and eliminating risk factors, referring risky patients to perinatal centers, providing sufficient antenatal care, training health personnel to enable them to evaluate and resuscitate newborns, and establishing a safe transport for risky pregnants and sick newborns are basic approaches to prevent perinatal asphyxia. Fetal heart rate, fetal blood flow rate and similar tests are important to determine proper delivery time by evaluating fetus condition. Hypothermia treatment applied as cooling head circumference or whole body of a baby about 3-4 °C who born as asphyxiating is accepted as the latest treatment method since it decreases the rate of a series of metabolic event (which will lead to secondary neuron death), decreases mortality and affects neurological prognosis positively.

"Induction and Management of Labor" was presented by Assoc. Prof. Dr. N. Ömer Kandemir. Today, obstetrics is an art in which it is required to use knowledge, skill and technology together. It was begun to use Bishop Score in 1960s for labor induction and using prostaglandins marked a new era beginning from the mid-80s. Mechanical servical dilatation is among invasive methods used on stubborn cases and it is generally used together with prostaglandins and oxytocin.

Assoc. Prof. Dr. Serdar Yalvaç talked about "Fetal Hypoxia at Labor". Nowadays, due to medicolegal issues caused by perinatal asphyxia, obstetricians and gynecologists feel themselves under pressure when they are doing their jobs. In order to detect hypoxia on time, intrauterine growth retardation, hypertension, postterm pregnancies, reduce in baby movements, breech presentation, decrease in amniotic fluid and infections are those to be paid attention in the first place. Ultrasonographic evaluation, Doppler, cord blood examination, Non-stress test, counting baby movements are major methods used for predicting asphyxia. Although none of classical-modern follow-up methods leads to certain diagnosis for predicting antepartum/intrapartum asphyxia, using proper method on chosen cases may help to reduce hypoxic encephalopathy cases.

First speech on "Postpartum Bleedings" was done by Assoc. Prof. Dr. Umut Dilek with the presentation of "PP Bleeding and Risk Factors". The speaker made the definition of PP Bleeding as the bleeding more than 500 ml in vaginal deliveries and more than 1,000 ml in cesarean deliveries. He stated that it is first reason of maternal deaths in Turkey, it has a rate of 4-6% and about 125-140 women die every year in the world for that reason. He expressed that its most frequent reason is atonia (70-90%) and that it is preventable clinical situation with 50% chance. He talked about 4 T factors in the etiology of PP Bleeding (Toe 70%, Tissue 10%, Trauma 20%, and Thrombin 1%). He indicated that extended 3rd phase, preeclampsia, episiotomy, PP bleeding history, multiple pregnancy, arrest of descent, delivery induction, and operative deliveries are risk factors. He emphasized that clinics mostly overlook and diagnosis is delayed.

"Clinic and Hypovolemic Shocks in PP Bleeding" was presented by Assoc. Prof. Dr. Selahattin Kumru and he classified the shock under 4 topics: 1- 15% (900 ml) loss of blood (no symptom), 2- 20-25% (1,200-1,500 ml) loss of blood (tachycardia, tachypnea, orthostatic changes), 3- 30-35% (1,800-2,100 ml) loss of blood (hypotension, distinctive tachycardia, cold moist skin), 4- 40% (>2,400 ml) loss of blood (oliguria-anuria, no peripheral pulse). He expressed that active management type in which loss of blood will diminish should be a routine approach by giving uterotonics at third phase of delivery, removing placenta by clamping cord. Consequently, life can be saved by recognizing risky cases, determining bleeding amount, managing third phase actively and with a good team work.

Assoc. Prof. Dr. Ahmet Yalınkaya made a speech on "Medical and Surgical Approaches in PP Bleeding". He stated that early breast-feeding, nipple massage, uterine massage and bimanual uterine compression are medical treatments in PP bleeding. He indicated that anti-shock treatment should be performed by doing blood and blood product transfusion. He also mentioned that tamponade, compression suture techniques, artery lig-

ations and artery embolization are among the options as surgical techniques. He expressed that 0.05% hysterectomy is required and he suggested doing it to save life. He stated that success rates of these methods are about 80-90%. As result, he emphasized that treatment should be done aggressively and effectively.

"Postpartum Bleeding: Preventive Measures of Maternal Death" was presented by Prof. Dr. Özgür Deren. The speaker stated that uterotonic agents should be administered rapidly in postpartum bleeding and that the biggest problems are DIC (disseminated intravascular coagulation) and myocardial ischemia developed due to delay. He specified that oxytocin should be preferred rather than oral misoprostol.

In "Screening Tests" session, the presentation on "First Trimester Screening on Aneuploidies" was made by Giovanni Monni. In the beginning of the presentation, Dr. Monni emphasized that many scannings (gestational diabetes, preeclampsia risk, preterm labor risk etc.) together with chromosomal anomalies should be performed at first trimester. Fetal biometry (CRL, microcephaly etc.), functional evaluation (decreased or increased heart beat, increased UA PI, pulsatility in umbilical vein), soft markers (choroid plexus, caliectasis, echogenic focus, hyperechogenic intestine etc.) and other markers which are popular these days (nasal bone, facial angle, ductal current, tricuspid regurgitation, mitral gap etc.) can be evaluated in the ultrasonography used in the first trimester aneuploidy screening.

The importance of detecting chromosomal anomaly especially in nuchal translucence measurement was emphasized and advantages and disadvantages of semi-automatic NT measurement of late years were mentioned.

Finally, it was stated at the end of this session that scanning only maternal age does not have any meaning; scanning first trimester is more effective than second trimester; consecutive scanning may work in patients with intermediate risk; step-wise scanning would be more useful in patients with low risk; additional markers would decrease the requirement for second trimester scanning, contingent scanning performed by checking nasal bone-tricuspid regurgitation-ductus venosus current would contribute to obtain best results.

"Fetal Heart Scanning" was presented by Prof. Dr. Cihat Şen. The speaker began his speech by emphasizing the incidence rate of fetal cardiac anomalies among the society and he stated that cardiac malformations constitute a major part of neonatal deaths. It would be possible to keep many newborns alive by doing fetal echo evaluation especially risky patients and performing delivery in senior centers due to existing pathology. He expressed that checking only four chambers when screening fetal heart cause us to miss much pathological stuff, but it would be possible to catch many existing pathologies by checking especially major vessel outlets. Therefore, it was emphasized that gynecologists should certainly check major vessel outlets when screening fetal heart and it was said that it would be useful for physicians to attend courses held for their trainings related with this topic.

Assoc. Prof. Dr. Ertan Adalı talked about "New Approaches for Screening of Gestational Diabetes". The concept of Gestational diabetes mellitus (GDM) is used for defining abnormal glucose tolerance which is either first noticed during pregnancy or appeared at various levels. However, the number of patients increases who previously have diabetes during pregnancy but not diagnosed yet due to type-2 diabetes frequency throughout the world. These patients have different risks than those of whom diabetes begin with pregnancy. Therefore, IADPSG (International Association of Diabetes and Pregnancy Study Groups) offered a change in this terminology in 2010. According to this, diabetes diagnosed during pregnancy is classified into two groups as "gestational" and "overt-preexisting diabetes".

In this terminology, overt diabetes diagnosis should be established at first prenatal visit for women from risk group. Accordingly, if diagnosis of FBG is ≥126 mg/dl or of hemoglobin is ≥ 6.5% or randomly checked blood glucose is found as ≥ mg/dl (later on, it should be confirmed by FBG and hemoglobin A1C levels), then pregnant is diagnosed as overt diabetes.

According to the new terminology, gestational diabetes mellitus is diagnosed when FBG is ≥92 mg/dl but <126 mg/dl at first prenatal visit or high abnormal values (FBG ≥ 92, 1st hour; ≥ 180, 2nd

hour ≥153) high by 75 g one phased test at 24th-28th gestational weeks. ADA 2011 also adopts this approach. However, ACOG 2001 recommendations offer to do scanning on all pregnants by two phased test (first 50 g GCT, then 100 g OGTT to abnormal ones).

In the Manual of Diabetes Mellitus and Diagnosis, Treatment and Follow-up its Complications published by The Society of Endocrinology and Metabolism of Turkey in 2009, it is asked to do risk evaluation (GDM history, obesity, glycosuria, DM in first degree relative) at first prenatal visit for GDM screening and to do screening at next trimester if risk is negative. The manual recommended doing screening (50 g GCT) to all pregnants at their 24th-28th gestational weeks.

Another issue to emphasize is that there is no consensus in the world on performing diagnosis and screening of gestational diabetes. The conclusion obtained from HAPO study is to apply 75 g one-phased screening and diagnosis test by using new diagnostic criteria. However, professional organizations should decide based on their local risk factors.

In the "Ultrasonography" session, Thomas Everett made a speech about "New Studies about Preeclampsia". He expressed that preeclampsia can not be treated efficiently though it is an important health problem and that treatment approaches are very old. He emphasized that preeclampsia is not only hypertension. He mentioned about studies performed with newly developed drugs such as "Digoxin binding antibody fragments, relaxin, sildenafil, recombinant active protein C".

In the same session, Prof. Dr. Asım Kurjak presented "The 4d Assessment of Fetal Brain Function in Preeclampsia". He expressed that cerebral palsy mostly (80%) develops related with intrauterine reasons, but its diagnoses appear at a later period after delivery and that the cerebral palsy risk is higher in multiple pregnancies. He stated that evaluating moves of fetus at intrauterine period provides benefit in evaluating fetal brain functions. There are six different facial expressions that should be analyzed in ultrasonography: blinking, yawning, lip sucking, sticking tongue out, grimacing and swallowing. Head and head moves to be evaluated are retroflexion, rotation and anteflexion of head, taking hand to head, eye, face and ear. KANET score system has been developed for scoring these moves in antenatal period. He, however, emphasized that more studies are required to evaluate normal levels for evaluating brain functions. He said that positions of hand fingers and thumb standing apart can be determined by intrauterine 4D ultrasonography when evaluating brain functions at neonatal period by Amiel-Tisson.

Prof. Dr. Turgay Şener made a speech about "Ultrasonographic evaluation of placenta, umbilical cord and membranes". He spoke of placental anomalies. Placenta circumvallate is membrane twisting onto placenta and may be confused with adhesion and tapes. Placenta succentriata may cause complication since accessory lobe stays behind after placenta is removed. This is why it is important to evaluate by ultrasonography and to know it at delivery. Battledore (Racket) placenta is more in twins and insertion is more marginal. Placenta membranacea is thinner than normal placenta and it covers whole uterus. Vessel structures also may be less. Chorioangiomas are tumors which have high vascular content and may cause intrauterine hydrops, growth retardation and death. Doppler helps diagnosis. Lipomas are the structures which are more hypoechoic and do not include Doppler signal, and they do not have effect on prognosis very much. Placental cysts do not affect obstetric approach. Placental lacunas (ponds) are the structures which need more attention clinically. They have motion inside. Thrombosed infarct areas seem hyperechogenic. Placenta praevia and vasa praevia can be defined by using Doppler and vaginal ultrasonography. We may meet placenta edema Rh incompatibility in infections. The thickness is above 4 cm. He also mentioned about evaluating molar pregnancies and membranes.

Prof. Dr. Yakup Erata talked about "Perinatal Doppler". He stated that Doppler can be used in preeclampsia and IUGR prediction by using it as a uterine artery screening test and that fetal Doppler can be used in order to evaluate fetuses with IUGR. He said that preeclampsia may be predicted by applying uterine artery Doppler on high risk group and it would not be useful on low risk group. He expressed that it is not necessary to

apply Doppler on all pregnants and it should be used only in cases such as preeclampsia and IUGR. He explained that the non-existence of diastole end blood flow in umbilical artery is normal, because diastole end blood flow is formed after 15th week and it increases as pregnancy proceeds while PI decreases. Depending on the MCA brain protective effect, diastole blood flow increases under hypoxia case, and cerebro-umbilical rate goes below 1.08 accordingly. In such case, the decision of giving birth can be given depending on descendant aorta blood flow. If arterial Doppler diagnoses are corrupted, then venous Doppler should be performed. If ductus venosus diagnoses are corrupted, then delivery should be performed. There is adverse flow which does not exist in ductus in inferior vena cava, and being deepening is the diagnosis of hypoxia. Pulsation in umbilical vein is the worst diagnosis which appears lately.

Assoc. Prof. Dr. Yeşim Baytur made a presentation entitled as "IUGR on Single Fetus in Twins: Diagnosis Management". sIUGR in twins is a rare but significant problem. Management in DC is not so different than singles. It should be acted according to the classification made depending on UA diagnoses in MC twins, and delivery should be performed at 34th week in fetuses with normal UA diagnoses. In Type-2 and Type-3 MC sIUGR, the management varies according to family request, frequency of weight difference and gestational week. Cord occlusion should be considered in bad prognoses that are diagnosed early.

On the third day of the congress (16th April, 2011), first session was "IUGR and Preterm Labor". The first speaker Prof. Dr. Lütfü Önderoğlu presented "IUGR and Preterm Labor: Antenatal Strategies". Gestational complications expected antenatally should be detected early, preventive processes should be performed, and maternal and fetal health should be considered together. When doing this, all health personnel should work together and the awareness of families should be raised. The most frequent reasons for losing baby are preterm labor, IUGR and preeclampsia. Instead of traditional monthly approach, screening tests at 11th-14th week, anatomy and uterine artery, cervix evaluation by ultrasonography at 20th-22nd week, and growth follow-up at 32nd week should be performed. Evaluation at 12th week will give us an idea about follow-up frequency at next period. Uterine artery evaluation should be performed at high-risk group; if there is bilateral notch and resistance increase, then preeclampsia risk is high. Cervix measurement should be done twice in a week at 14th-18th week and 18th-22nd week in high risk cases, and at 20th-22nd week in low risk cases. Mud-like structure around cervix orifice may be related with preterm labor. When cervix is contracted, preterm labor prevention strategies change. Progesterone may be used. If cervix is below 20 mm, tocolysis indication may occur. Circlage use should be discussed.

Prof. Dr. Serdar Ural mentioned about "Short Cervix: Diagnosis and Management" as the second speaker. The most important one among risk factors for preterm labor is the contraction of cervix. Contraction in cervix is important especially between 16th and 24th weeks. When cervix is taken as 3 cm, labor rate increases four times while it increases 6 times when it is taken as 25 mm. Cervical length evaluation should be done by transvaginal ultrasonography. If cervix is shorter than 25 mm and there is no history of preterm labor more than one, close follow-up can be recommended; but if there are two pregnancy losses or more, then circlage can be suggested. Steroid can be applied after 24th week to short cervix if there are preterm labors more than two. This is the standard approach in the USA. It was reported that pregnancy might be elongated 15% when circlage is done if short cervix limit is taken as 15 mm. The most important value of cervical length measurement is negative predictive value. When it is used together with the fetal fibronectin, unnecessary interventions would be prevented. In the recent studies, using vaginal progesterone gel beginning from 24th week when short cervix is between 10 and 20 mm decreased the rate of delivery before 33rd week about 45%. As a result of evaluating benefits of progesterone use together with other studies, it seems that it can be suggested to apply alone or with other treatments to groups which had losses at second trimester, had only short cervix or had preterm labor history. Cervix measurement can also be suggested in terms of decreasing health expenses.

Jason Gardosi talked about "New Concepts in IUGR Diagnosis". He stated that most of the deaths in the womb are related with IUGR and they also cause neonatal deaths. It was said that cerebral palsy risk increases in term IUGR. Making these babies intrauterinely with a non-functional placenta may increase this risk. It was emphasized that the physiological parameters affecting birth weight such as gender, maternal weight, height and race etc. should be taken into consideration and using customized growth cards are important. It was stated that these cards have not been developed for Turkey yet; however, they can be done soon. He said that SGA and IUGR distinction can be done better by customized cards. It was emphasized that more proper information can be obtained by using growth curves in IUGR diagnosis, fundal height, serial ultrasonography measurements and Doppler. There is "selection bias" in randomized studies about the time for carrying out the labor. GRIT study was criticized and it was expressed that patients who had IUGR beginning from 26th week and patients who had IUGR beginning from 29th week can not be same, also the results of preferring to wait against delivery are evaluated in the short period and the long-term status of these babies are not known. Patients rather in good condition during randomization were chosen but delivery might be done in patients in bad condition. Consequently, it was highlighted that the issue of delivery timing is critical and each patient should be evaluated separately.

Alex Vidaeff talked about "Risks and Benefits of Antenatal Corticosteroid Therapy Prior Preterm IUGR". It was stated that antenatal steroid use decreases RDS about 34% and neonatal death about 30%. It should be considered well whether the metabolic speed increased by corticosteroid use on IUGR fetus would be harmful or not, especially on hypoxic fetuses. There are studies reporting that results of steroid use are better in IUGR babies between 25th and 30th weeks as well as reporting useless and also ineffective in short term in acute IUGR babies. It was shown in some animal experiments that genomic effect of steroids increased maturation and its nongenomic effect suppressed liver and lung increase. This effect of dexamethasone is much more compared to betamethasone. Growth and CNS development are suppressed in recurrent doses. Steroid endogeny is increased in IUGR babies, and 11-beta hydroxysteroid dehydrogenase is decreased in placenta. This enzyme is neuroprotective. It has a great role in normal development of HPA axis. If this barrier is broken as in IUGR, the transformation of cortisol into cortisone is decreased and hypertension may develop in progressive years. Vasoconstriction and decreased cardiac output are seen when antenatal steroid is given to a healthy baby of sheep, but vasodilation and increased cardiac output are seen when it is given to IUGR fetus. Antenatal steroid does not create great effect in human IUGR and babies with normal umbilical artery Doppler; however, in IUGR fetuses with AEDF have effects similar to sheep and this may be dangerous in terms of fetus. 62% of babies with IUGR and AEDF who were applied antenatal steroid had progress in Dopper diagnoses within 24 hours. It is related with the removal of MCA dilation and disappearance of cerebral protective effect. Though results are better in cases that have diastolic flow returned, acute worsening may occur at a rate of 40% in these cases. Brains of IUGR babies may reach half of their neuronal development. Steroid use may cause this situation to be worsened much. Re-increase of reduced blood flow of IUGR fetus may cause oxidative damage. Consequently, steroid should not be applied without doing Doppler. If AEDF exists, fetus should be followed up closely for 3 days after steroid application, steroid may damage in worse cases; betamethasone should be preferred when nongenomic effects are less. In light of current information, it can not be forbid to apply steroid on IUGR fetuses, however it should be paid attention.

The final speaker of the session was Thomas Everett and he made a speech entitled as "Perinatal Management in Extreme Preterm Labor". He stated that preterm labors between 23rd and 27th weeks are accepted as extreme preterm. He explained that deaths related with preterm labor in England decreased and survival rates in births between 29th and 32nd weeks were close to term births by the improvements in newborn care. He mentioned that cerebral palsy rates were about 50% though survival rates increased in labors before 25th week. He expressed that preterm labors after 32nd week

are not a problem in developed countries. It was emphasized that long term handicaps should be taken into consideration while efforts are made to keep fetus alive in labors before 25th week.

In the session of "Neonatal Problems", Prof. Dr. Neslihan Tekin made a presentation about "Prevention and Management of Perinatal Asphyxia". Perinatal asphyxia can be defined as hypoxia, hypercapnia and acidosis development in newborn or fetus as a result of insufficient gas exchange. It typically occurs in intrapartum antepartum period. The most significant way to prevent or protect against perinatal asphyxia is to determine risky cases beforehand, and to refer patients to advanced perinatal centers by using required dispatch and transport mechanisms. Tests used to detect antenatal hypoxia are biophysical score, modified biophysical score, umbilical artery Doppler, cardiotacography, scalp pH, and NIRS (near infrared spectroscopy). All organ systems, especially central nervous system, can be affected by asphyxia.

In the efficient management of asphyxia, substructure should be prepared for required resuscitation and stabilization. Various neuroprotective treatment methods are used for decreasing the effect of asphyxia (hypothermia, magnesium, adenosine, vitamin C and E, indomethacin etc.). There are some recent promising developments in the use of prophylactic barbiturate and giving erythropoietin.

Consequently, perinatal asphyxia maintains its importance in terms of early and late morbidity and mortality. It is important to determine compensation potential of fetus by antenatal tests. Supportive treatment is required after successful resuscitation. First hours are significant for neuroprotective treatment. Nowadays, the most promising results have still been obtained by hypothermia; however, multi-centered studies are needed to obtain the effects of future periods.

"Neonatal problems in multiple pregnancies" was presented by Prof. Dr. Nilgün Kültürsay. Due to the increase in reproductive techniques especially in recent years, there has been an increase in prematurity due to multiple pregnancies and in miscarriages. As known, fetal mortality is four times higher in twins than singles and neonatal mortality is 6 times higher. Also other neonatal complications are higher in multiple pregnancies. Cerebral palsy rate increases in death of twin of monochorionic baby in twin pregnancies, TTTS, and SGA cases in discordant twins. Especially the monochorionicity is an independent bad prognostic factor. Studies done to show that selective fetocide decreases cerebral palsy risk are not reliable due to small sample group. Especially reducing embryo number (transferred during ART – assisted reproductive techniques) to one was found effective for having a living and healthy baby as well as reducing health expenses. It was found that 75% of multiple pregnancies in our country were obtained by ART applications. In pregnancies obtained by ART, increased antenatal complications are met as well as increased maternal complications.

Consequently, the multiple pregnancies have increased risk in terms of neonatal mortality, preterm labor, miscarriage weight, cerebral palsy and neurocognitive disorders. Multiple pregnancies place physical, psychosocial and financial burdens on whole society, especially on mother-father and children. Our target should always be single healthy baby.

"Premature baby mortality and morbidity in Turkey and World" was presented by Prof. Dr. Asuman Çoban. Though newborn baby death rates decelerate, it is still not at a desired level. In Turkey, we lose 22,000 babies every year before they reach their first age. Most of the newborn deaths occur in low-income countries. 50% of babies are lost within first 24 hours. The most important reason for newborn deaths is the prematurity (low birth weight), it is 13 times higher than those born in risk term. Deaths in preterm labors gradually decrease in especially developed countries and the most significant reasons are technological developments and increase in newborn care opportunities.

There may be neurodevelopmental sequelas in preterms and difficulties in rough-thin motor function. Also behavioral and emotional problems in them are stated. Eye and hearing problems are high according to the terms. Besides, metabolic disorders such as diabetes are frequently met.

In conclusion, it is important to cure prognosis in preterm babies. In order to do that, approaches

such as antenatal steroid in preterm labor, antibiotics in EMR, K vitamin, neonatal sepsis treatment, clamping cordon lately, early breast feeding and surfactant treatment gain importance.

Prof. Dr. Saadet Arsan presented "Very Premature Births: Substantial Perinatal Management for a Healthy Life". Integrated approach means to manage patients by perinatology team, newborn team and follow-up team and the collective work of these teams. Perinatologic part of the approach includes healthy pregnancy planning, decrease of assisted multiple pregnancies, use of antenatal steroid and antibiotics, tocolysis, intrauterine transport and delivery type. Neonatological approach includes delivery room stabilization, oxygen targets, surfactant treatment, respiration support and antibiotic treatment. Antenatal steroid treatment contributes lung development as well as neurological development. Antibiotic treatment at extended EMR is useful for elongating delivery. Tocolysis is used to gain time in antenatal steroid applications and transport.

In low premature, cesarean is protective at a low rate; however, patients should be evaluated in terms of maternal morbidity.

It was found that autologous blood transfusion (late clamping of the cord) during delivery did not cause increase in blood pressure of newborns, increase in urine amount, decrease in transfusion need, decrease in oxygen need and increase in the risk of polycythemia and hepatitis. Resuscitation and stabilization processes are significant in delivery room. Providing improper oxygen to premature babies would do more harm than good. CPAP applications and non-invasive ventilation use rather than mechanical ventilation should be provided as respiratory support.

Maintaining body temperature, sufficient fluid replacement, total parenteral nutrition and early full enteral nutrition can be deemed as supportive care.

Consequently, premature babies with low birth weights benefit from integrated prenatal approach and non-invasive care applications. In that way, bronchopulmonary dysplasia, necrotising enterocolitis and premature retinopathy are decreased and the development is positively affected.

In the last session of the congress, "Medicolegal Aspects" were spoken. Prof. Dr. Seyfettin Uludağ made a speech about the topic of "What Is Malpractice? What Is A Complication?". Performing irregular processes, not obeying requirement rule, not performing those which can be done by anyone or not preventing a preventable complication can be deemed as malpractice. Being unable to predict possible danger can also be deemed as malpractice. In order to accept it as a malpractice, there should be damage due to medical process. Not performing things that should be done before operation, not checking pathological results, not performing things that should be done during delivery follow-up, forgetting gas compress etc. can be given as the examples of causing injury and death as a result of negligence and recklessness. In a complication case, everything which should be done as a standard is done, but unpredictable results occur. It is physician's responsibility to keep all kinds of medical records. Also informed consent should be taken. These consents should be conformed to ethics and medical rules and should include complications. Explaining what screening tests mean and not saying "everything is ok" may protect physician. Overlooking presentation, overlooking preeclampsia by not checking tension, overlooking fetal asphyxia reasons and not following up normal delivery process carefully are the examples of malpractices made during delivery. Malpractice and complication may be together in cases such as fetal macrosomia. Though macrosomia is frequent in shoulder dystocia, it also may be in babies with normal weight. It is not possible to predict. If physicians feel themselves competent in breech presentation, baby should be about 2,000-3,000 gr, pure breech and head is in flexion. If there are broken bones in patients with these conditions, then it is complication. If first baby in twins is breech, then cesarean should be done. If vacuum and forceps are applied unnecessarily, it can be deemed as malpractice; injuries in applications performed by proper indication can be deemed as complication.

Nezih Varol presented the speech "Building Physicians Strategy in Medicolegal Cases". The speaker expressed that medicolegal problems generally appear as a result of complaints and patient dissatisfaction. It should be established that who

will provide solution and who will meet financial liabilities when a problem appears. When patient is accepted to hospital, an admittance agreement is done first. As physicians, we have employment contract with hospital and also a patient treatment agreement. First of all, health legislation should be sufficient. Turkish Criminal Code gives physician the right of intervening to patient, therefore, applications done within standards are complications. Surveyors pay attention whether standards are followed or not. The frequent legal case examples shoulder dystocia, bleedings, prenatal diagnosis, and organ injuries. This can be protective if participative treatment is done, in other words informed consent is taken. The basic o health service is to carry out a team work in compliance with laws and legislations, by using initiative and also expecting the same from other service units. Parties are liable to prove their claims; therefore, records should be kept properly.

Prof. Dr. Alper Tanrıverdi made a speech about "Up-to-date Practice Standards". He emphasized that it should be paid attention that standards have to be applicable in everywhere when putting them forth. He mentioned manuals established by the Ministry of Health briefly. The Manual of "Prenatal Care Management" can be given as an example. Tests and examinations specified here should be performed and patient should be referred to an upper step if there is something significant. If patient is referred to an upper step, it should be checked whether she went or not. Ultrasonographic examinations are recommended but they are not compulsory. Also, "Labor Management Guide" can be used as a standard for labor.