Patient's vitals: TA:135/70 mmHg, Pulse:170/min, Fever:39C, Spo2:91. Laboratory results were: D-dimer: 10520 ng/ml, Procalcitonin: 2.68 ng/dl. Celestone(1x2 amp), Rocephin(1 gr IV), Diltiazem(100cc/hour) were applied to the patient. Oxygen was started at 4lt/min. Sinus tachycardia was seen on ECG and EF was 65% on ECO. No significant dilatation was observed in the right heart structures. Considering the clinical and laboratory evaluation of the patient, it was thought to be compatible with the preliminary diagnosis of pulmonary embolism. The patient was started on Clexane 2x0,6. Due to that the patient's vital signs were unstable, the partial oxygen pressure was at the intubation limit, and the maternal-fetal tachycardia did not improve, the patient was taken to cesarean section. Postoperative vitals and general condition was good. As a result of thorax CT angiography, there were thickenings in the interstitial septas and frosted glass densities in the bilateral lungs, and the patient was transferred to the chest diseases service with a preliminary diagnosis of alveolar hemorrhage. There was an appearance compatible with thrombosis in the left tibial artery's branch. On the 14th postoperative day, the patient's vital signs were stable, the laboratory values were Troponin- negative(less than 0,04 ng/ml), D-dimer (less than 500 ng/ml) Procalcitonin:0.14 ng/dl. One week after discharge, the patient presents to the emergency department again with complaints of fever and flank pain. Sepsis was suspected in the patient who had fever(39C), tachycardia(130/min) and Spo2: 89. After further investigations(CT imaging), the Urinoma secondary to renal pelvis laceration due to nephrolithiasis was considered as the cause of sepsis. Double J stent was inserted to the patient by the urology team under cystoscopy. As soon as the patient's urinoma and sepsis regressed after antibiotic therapy, the stent was removed on the postoperative 30th day.

Discussion: Considering similar complaints during pregnancy, sepsis and other pulmonary diseases of pregnancy must be ruled out. Urosepsis is a common cause of septic shock during pregnancy. Genitourinary tract infections can often be asymptomatic. It may be accompanied by nephrolithiasis.

Conclusion: The risk of thrombosis and pulmonary embolism increases during pregnancy and puerperium. Especially pregnant women with a history of thrombosis should be questioned and anticoagulant treatment should be started.

Keywords: Pregnacy, pulmoner embolism, thrombosis

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PP-01 Phrygian cap of gallbladder a case report

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Objective: The gallbladder is an organ that resembles a pear in shape and serves to store bile. Numerous anomalies and variations have been described regarding the location, shape, number and size of the gallbladder. Starting from the 4th week of pregnancy, the liver, gallbladder and bile ducts emerge as ventral buds from the most caudal part of the foregut.[1] In the embryological period, the folding of the fundus of the gallbladder causes the appearance of an image called the Phrygian cap on ultrasound. Phrygian cap is the most common congenital anomaly of the gallbladder and can be confused with a liver mass or gallbladder duplication ultrasonographically. The frequency of the Phrygian cap has been reported as 1-6%.[2-4] The Phrygian cap is not pathologically significant, but it is important to distinguish it from other possible diagnoses ultrasonographically in the antenatal period.[5] We aimed to share our case diagnosed with ultrasonography in the antenatal period, accompanied by bilateral pelviectasis, and the management of the case.

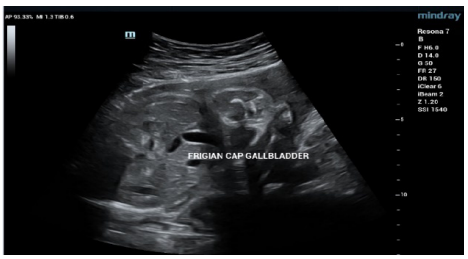

Fig 1. Ultrasonographic view of the Phrygian cap gallbladder

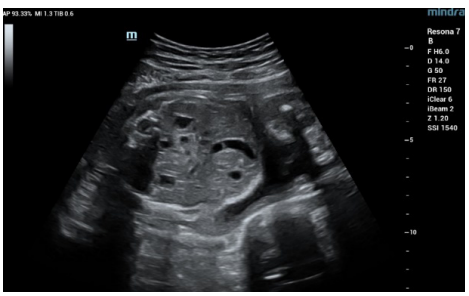

Fig 2. Phrygian cap gallbladder

Methods: Computer-based and ultrasonography records of the case with Phrygian cap and pelviectasis, who applied to the Perinatology outpatient clinic of Prof. Dr. Cemil Taşçıoğlu City Hospital at the 20th week of pregnancy, were scanned retrospectively from the hospital system and the history of the ultrasonography device. Fetal ultrasonography examination and abdominal ultrasonography during the neonatal period were performed using Mindray Resona 7 device and its 1.2-6

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

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PP-02 Prenatal diagnosis of isolated redundant foramen ovale

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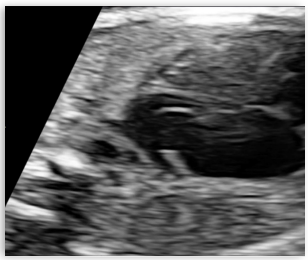
Objective: Redundant Foramen Ovale (RFO) is a rare cardiac anomaly. In this case report; Prenatal diagnosis and management of isolated redundant foramen ovale is discussed.



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

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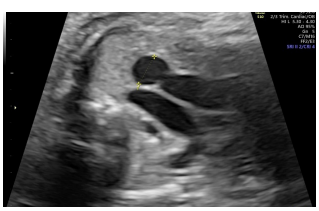
Objective: Ductus arteriosus aneurysm is a rare cardiac anomaly. In this case report; Prenatal diagnosis and management of ductus arteriosus aneurysm is discussed.



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