PP-06 Unicornuate uterus accompanied by unilateral tubal-agenesis in pregnancy a case presentation

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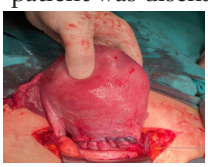
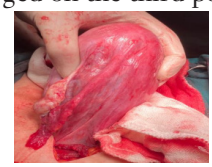
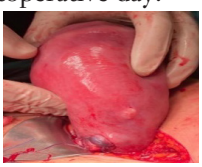
DOI:10.59215/prn.23.031supp021

Objective: Fusion of the Müllerian ducts occurs during weeks 6-11 of pregnancy. Disruptions in this fusion process can lead to Müllerian duct anomalies. Among these anomalies, unicornuate uterus is the most common and is associated with pregnancy complications such as preterm labor. In this case presentation, we aim to present a patient with a diagnosis of unicornuate uterus and pelvic kidney, accompanied by unilateral tubal-ovarian absence, who gave birth at our clinic.

Case: A 26-year-old, G2P0A1 woman presented to the clinic at 33+4 weeks of gestation with high blood pressure. Upon reviewing the patient's medical history, it was revealed that her first pregnancy ended in a miscarriage during the first trimester, and pelvic ultrasound detected an ectopic pelvic kidney. Further inquiry into the patient's family history indicated that her mother also had an ectopic pelvic kidney. The patient was being followed up in our clinic with the threat of preterm delivery due to high blood pressure and contractions in the non-stress test .Considering the potential risk of preterm birth, the patient was administered two doses of betamethasone 24 hours apart for lung maturation. As high blood pressure and uterine contractions persisted during follow-up, a decision was made for delivery. The patient underwent a cesarean section. A live baby weighing 2180 grams with an 8-10 APGAR score and umbilical cord blood gas pH of 7.40 was delivered. Intraoperatively, a unicornuate appearance of the uterus without a rudimentary horn was observed, and the left fallopian tube and ovary were not seen. No complications arose during the operation. The patient was discharged on the third postoperative day.

Conclusion: Mullerian duct anomalies are observed in approximately 1-5% of the general population. The prevalence increases to around 13-25% in patients with a history of recurrent miscarriages. Unicornuate uterus is the most commonly encountered type among müllerian duct anomalies. The variation without a rudimentary horn accounts for approximately 35% of all unicornuate uteri. Kidney anomalies accompany approximately 40% of patients with unicornuate uterus. Patients with unicornuate uterus are often asymptomatic, and ultrasound alone might not be sufficient for diagnosis. Complications related to unicornuate uterus primarily manifest during pregnancy. Pregnant individuals with unicornuate uterus are at an increased risk of preterm birth, first and second-trimester miscarriages, intrauterine fetal death, and cesarean delivery. Pelvic kidney generally remains asymptomatic and is incidentally diagnosed. Its prevalence is approximately 1-10/10,000. In cases where a pelvic kidney is detected in female patients, the possibility of müllerian duct anomalies should be considered, and patients should be informed about potential pregnancy complications, especially in the context of such anomalies.

Keywords: Unicornuate uterus, pelvic kidney, preterm birth

References

1. (Caserta, Mallozzi et al. 2014)
2. (Reichman, Laufer, & Robinson, 2009)

PP-07 TAR Syndrome case report

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DOI:10.59215/prn.23.031supp022

Objective: "Thrombocytopenia - absent radii Syndrome" (TAR) is characterized by hypo-megakaryocytic thrombocytopenia and bilateral absence of the radius bones despite the presence of both thumbs. It is rare and follows an autosomal recessive inheritance pattern. In individuals with TAR syndrome, skeletal, cardiac, gastrointestinal, hematological, renal, and genital abnormalities can also accompany the condition. Skeletal anomalies include varying degrees of ulnar hypoplasia, as well as hypoplasia of phalanges and carpal bones. Thumbs are always present. Thrombocytopenia improves with age and usually resolves by school age. It is associated with a deletion in the proximal region of the gene locus 1q21.1. The syndrome, first described in 1929, has an estimated prevalence of 0.42/100,000. In this case presentation, we aim to discuss the diagnosis and management of TAR syndrome.

Case: A 28-year-old woman, gravida 4, parity 1, abortion 1, was placed under routine pregnancy surveillance. During first-trimester screening, the absence of bilateral forearm segments and an increased nuchal translucency (3.8mm) were detected, prompting further monitoring. Amniocentesis was performed for the patient. In the second trimester, an obstetric ultrasound revealed the absence of the right forearm during upper extremity examination. Only a single bone consistent with the ulna was observed on the left side. Throughout the ultrasound examination, limited hand movement, significant wrist extension, and flexion contractures at the knees were noted. Additionally, there was pes equinovarus observed on the left foot. Differential diagnoses considered TAR syndrome, Roberts syndrome, and Fanconi syndrome. The amniocentesis yielded a normal fetal karyotype. At 40+1 weeks gestation by last menstrual period, the patient underwent a normal vaginal delivery with a birth weight of 3070g (19th percentile) and an 8-9 APGAR score. In the