Fig 3. Ultrasound demonstrating two hypoechogenic symetric masses measuring 30 mm transvers lenght

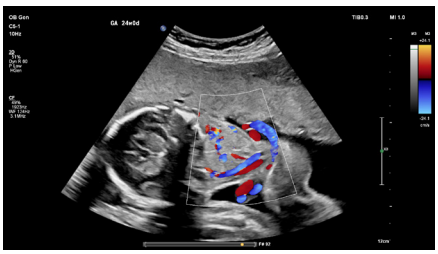

Fig 4. Color Doppler of the fetal goiter, hypervascularization of the fetal thyroid gland

Conclusion: Our case highlights the importance of timely diagnosis and management of fetal goiter to prevent potential obstetric complications . While antenatal detection and treatment options were limited in our case due to patient preferences, postnatal assessments showed positive outcomes, including the resolution of fetal goiter and normal bilateral hearing tests.

Another point we want to emphasize with this study is that clinicians and healthcare providers should carefully review the medications and supplements used by patients and ensure they are being used at the correct dosage. Improper use of any medication can lead to teratogenic effects.

Keywords: Hypothyroidism, intrauterine treatment, euthyroid, fetal goiter, iodine supplementation

OP-003 Labour induction in obese patients

Anna Miskova[1], Agnese Pridane[1], Dace Rezeberga[1]
[1]Riga Stradins University, Department of Obstetrics and Gynaecology, Riga, Latvia

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Objective: The practice of induced labour has risen to approximately 33% of all pregnancies. It is essential to know what the outcome will be for patients with higher BMI, as it is a high-risk pregnancy, and this would help avoid surgical interventions and related complications in the future. This study aimed to see how a woman's BMI affects the outcome of induced labour.

Methods: This retrospective study used data from Riga Maternity Hospital and included 8759 women presenting with induced labour from 2016 to 2022. The data was processed using IBM SPSS Statistics version 28, comparing induction outcomes in two main groups: first-primiparas and second-multiparas. Next, these two groups were divided by BMI and studied separately — Group A or control group with BMI<25; Group B – BMI 25-29; Group C – BMI 30-39; Group D – BMI > 39.

Results: Primiparas with normal BMI in 23% had a CS, and in 77% had a vaginal birth. Group B primiparas in 31% had a CS, so OR to have a CS is 1.5 (95% CI 1.3-1.8). Group C primiparas in 41% had a CS, so OR is 2.3 (95% CI 1.8-2.8). Group D primiparas in 43% had a CS, so OR to have a CS is 2.6 (95% CI 1.5-4.6). Multiparas with a normal BMI in 7% had a CS, and 93% had a vaginal birth. Group B multiparas in 11% had a CS, so OR is 1.8 (95% Ci 1.4-2.4) Group C multiparas had CS in 13%, so OR is 2.1 (95% CI 1,5-3). Almost all group D multiparas had vaginal birth (95% CI 0.3-2.7).

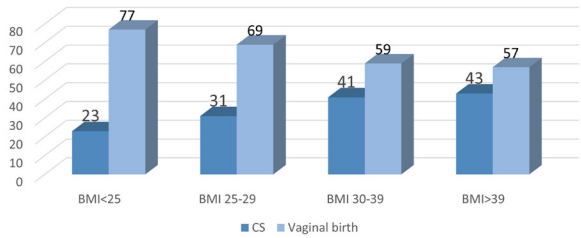

Fig 1. Primiparas CS and vaginal birth ratio depending on BMI

Conclusion: Primiparas with obesity have a high CS rate. CS risk increases with the primipara BMI. Multiparas with obesity, despite the BMI, have a high chance of delivering vaginally. Having a normal BMI to deliver the first baby is highly recommended.

Keywords: Abour induction, obesity, bitrh, cesarean section

OP-004 Reversing the reversed: successful case of early-onset fetal growth retardation

Valerie Tiempo Guinto[1]
[1]University of the Philippines-Philippine General Hospital, Philippines

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Abstract: A fetus that has failed to reach its growth potential due to a pathologic process has fetal growth restriction. Fetal growth restriction is said to be of early-onset if it is diagnosed before 32 weeks. Many interventions were investigated, but when there is a high-risk for fetal death, the only management option of significance is iatrogenic preterm birth, with corticosteroids and magnesium sulfate to improve outcome. However, early delivery