Neurological diseases in pregnancy

No Preference

Lymphocytic hypophysitis in pregnancy leading to diabetes insipidus a rare disease and a diagnostic challenge

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A 27 year old who was a diet controlled gestational diabetic presented with 24 h history of epigastric pain and vomiting. She was 34 weeks P1 with a normal vaginal delivery in past. She was noted to be hypernatraemic with the blood Sodium being persistently 159. Her LFT FBC potassium creatnine and urea were normal. She had a normal USS abdomen. The provisional diagnosis was dehydration. Despite adequate fluid resuscitation her blood sodium remained high. Her TSH was high but TPO antibodies were negative. On questioning she informed she was drinking 8–10l of water a day and was passing frequent urine of amount more than 31 a day. She was given dextrose saline and her blood sodium was monitored. She started running a high grade temperature whilst being admitted and had a pathological CTG and the baby was delivered with a caesarean section. She was started on a sepsis bundle. She was seen by the endocrine team. She continued with alternating dextrose and Hartmann’s. Her prolactin was high in range of 7018. A diagnosis of transient gestational diabetes insipidus secondary to a possible lymphocytic hypophysitis was made. Her serum sodium was 153 and serum osmolality was high being 313. She was started on 10 mg of desmopressin noct spray and the serum sodium showed reduction. Her MRI pituitary showed a soft tissue swelling with an enlargement of pituitary stalk. A provisional diagnosis of lymphocytic hypophysitis was made. Diabetes insipidus can complicate up to 1 in 30,000 pregnancies. Three different subtypes of Diabetes Insipidus are described: central, nephrogenic and transient. Management of central diabetes insipidus and transient diabetes insipids of pregnancy can be achieved with 1-deamino-8-D-arginine vasopressin(desmopressin acetate)(DDAVP), a vasopressin analogue. Lymphocytic hypophysitis represents an inflammatory or an autoimmune disease that involves primarily the pituitary gland and in many cases the pituitary stalk. It is most commonly diagnosed in women in the third trimester or in the post partum period and can well be associated with other autoimmune diseases. Headache may be the first and the commonest symptom. It may or may not be accompanied with visual symptoms. The symptoms of hypopituitarism include fatigue, lethargy, loss of libido amenorrhoea, nausea and vomiting and diabetes insipidus. A definite imaging is performed by MRI with or without infusion contrast. The imaging studies may show a diffuse homogenous sellar mass with both enlarged pituitary gland and enlarged pituitary stalk with a characteristic pear shape appearance. Definitive diagnosis is made by tissue biopsy and confirmed pathology. The initial management is based on the use of corticosteroids to treat the inflammation which could then be tapered depending on the extent and the duration of the response. In presence of Diabetes insipidus desmopressin should be administered and the patient should be closely monitored for fluid intake and output and the serum sodium levels. They may require lifelong therapy. Other immunosuppressant’s like azathioprine methotrexate and cyclosporine can be considered on relapse or non response to the steroid. Surgical therapy could be considered if there is lack of response to medical management or intractable symptoms. It includes the transsphenoidal resection of a part or the whole of the mass. It also provides the necessary tissue for histopathological examination.

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Successful multidisciplinary management of pustular psoriasis in pregnancy – a rare gestational dermatosis

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A 25 year old G1P0 BMI 30 was admitted to the Dermatology ward at 29 weeks with a pruritic rash. Examination revealed the patient to be unwell, but afebrile, with an extensive micro-pustular rash over the trunk, limbs and hands. She was an obstetrician led care due to being on venlafaxine for anxiety. A provisional diagnosis of pustular psoriasis was made which was confirmed on histology. She was initially treated with 30 mg oral prednisilone and topical emollients under joint obstetric and dermatology care. Her skin continued to flare, becoming more widespread for 2 days before gradually improving. She had regular growth scans and BP checks. Glucose tolerance test was equivocal and was not repeated to steroid use. She was managed by diet control. She developed pre eclampsia which was managed with labetalol. Prednisolone dose was gradually tapered. She was induced at term and labour covered with IV hydrocortisone 100 mg 6 hourly. The paediatric team was informed for a baby check and follow up. Pustular psoriasis in pregnancy is extremely rare. It mainly affects women during the third trimester but may also occur in the first trimester. It is reported to recur at an earlier gestational age during subsequent pregnancies. A disseminated spread of sterile pustules is often complicated by major general symptoms such as fever, nausea and risk of hypocalcaemia. Some cases report that pustular psoriasis may be complicated by gestational hypertension, fetal distress because of placental insufficiency, hypoparathyroidism, hyperparathyroidism, diabetes or hypoalbuminemia. Corticosteroids are usually efficacious at a low dose of 15–30 mg a day. In some severe cases, it is necessary to increase the dose to 40–60 mg a day to control symptoms. In progressive cases, oral cyclosporine is the second-line therapy and antibiotics should be administered to treat or prevent secondary infection. Besides close monitoring and aggressively controlling maternal symptoms, electronic fetal monitoring and uterine artery Doppler ultrasound are useful as screening tools to detect placental insufficiency. The final step in the treatment of resistant cases should be the early delivery of the fetus. Methotrexate, retinoids and PUVA may be helpful for treating pustular psoriasis if symptoms continue after delivery. The diagnosis is suggested by the classical pustular clinical features and confirmed by histology showing neutrophil inflammatory infiltrate, epidermal acanthosis and papillomatosis with focal parakeratosis and neutrophilic, intraepidermal, multilocular microabscesses. The current use of steroid and antibiotic therapy has reduced complications. However, the risk of stillbirth and perinatal mortality remains high due to placental insufficiency, premature rupture of membranes, preterm labour and...
Operative vaginal delivery: a feasibility study and rationale to design a new innovative medical tool for obstetric use

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Operative Vaginal delivery is considered an obstetrical emergency which entails the extraction of the fetus from the vagina with the use of forceps or a vacuum extractor. This instrumental emergency presents a high risk of maternal and neonatal complications and carries an important risk of failure.

**Objectives:** Our aims is to understand the forces involved in an operative vaginal delivery during the extraction of the fetal head in order to evaluate the technical features required to design an innovative medical device which could ideally lower the incidence of complications and failures of an instrumental vaginal delivery with forceps and vacuum.

**Study design:** Trials have been carried out with devices used in operative vaginal delivery like the Omnicup vacuum produced by Kiwi and the Neagele and Simpson forceps and the “Sophie and Mum” trainer, produced by “Med model international which reproduce the maternal pelvis and fetus. The compression force exerted by the blades of the forceps on the head of the fetus was calculated with the help of a dynamometer, whereas a triaxial accelerometer produced by “PCB” was used to analyse the force exerted along the Cartesian axes applied by the operator during extraction with forceps and obstetrical vacuum.

**Results:** The compression force exerted by the two blades of the forceps on the head of the fetus varies between 120–170 N for the vacuum extractor and 120–155 N for forceps. The calculated coefficient of static friction is 0.1866.

**Conclusions:** The results obtained from the present feasibility study must be kept in mind designing this new obstetrical device. To reduce the failure rate for operative vaginal deliveries (i.e. detachment of the suction cap and/or failure to extract the head of the fetus), the device should be able to support greater forces of traction than those found in the simulations.

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Minimally invasive surgery

**Oral Presentation**

Feasibility and surgical outcomes of Conventional and Robot-Assisted Laparoscopy for Early-Stage Ovarian Cancer: preliminary data from a retrospective, multicenter study

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**Objective:** We aimed to investigate the safety, adequacy and oncological outcomes of laparoscopic surgery (LS) and robot-assisted laparoscopic (RALS) approach for the treatment of early-stage ovarian cancer.

**Patients and methods:** We performed a multicenter, retrospective cohort study. Data from patients who underwent laparoscopic management for early-stage ovarian cancer between 2006 and 2014 were retrospectively reviewed in two oncology service databases. Surgical, pathologic and oncologic outcome data were analyzed to compare LS and RALS performances for early-stage ovarian cancer management.

**Results:** A total of 39 patients underwent laparoscopic management of early-stage ovarian cancer. Of these, 23 women underwent LS and 16 underwent RALS. As showed in Table 1, the mean operative time was 281 ± 81 min (LS 288 ± 88 min; RALS 270 ± 72 min; p = 0.49). No conversion to laparotomy occurred, and one patient had intraoperative hemorrhage requiring blood transfusion. Four patients (10.2%) experienced postoperative complications of grade 3 according to the Clavien-Dindo classification. The median hospital stay was 3 days (1–15); the differences were not statistically significant between two groups [LS = 4 (1–15); RALS = 3 (1–7); p = 0.43]. During a mean follow-up period of 19.4 months, tumor recurrence occurred in 3 patients: 2 (8.7%) in the LS group and 1 (6.25%) in the RALS group. Overall survival and disease-free survival for the entire cohort were 97.4% and 92.3%, respectively. Conclusion. LS and RALS seem to be adequate and feasible for the treatment of early-stage ovarian cancer in terms of the surgical outcomes and oncological safety. Furthermore, in our experience, perioperative outcomes are comparable between LS and RALS making them an acceptable approach in selected patients.

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