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Management of postpartum hemorrhage of lower uterine segment atony, posterior fornix and vaginal wall hematoma by balloon tamponade of three catheters and embolization

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Although the most common cause of postpartum hemorrhage is uterine atony, perineal and vaginal lacerations can be associated with rapid and significant loss of blood. Balloon tamponade has been used in the treatment of postpartum hemorrhage after failure of medical management. We report a case of woman with postpartum hemorrhage where ultrasound and clinical findings revealed a well contracted fundus and upper uterine segment and a ballooned out lower uterine segment, posterior fornix and vagina. A 25-year-old woman was transferred to our hospital with 16 cotton ball vaginal packing because of vaginal bleeding after vaginal delivery of 2800g female at 40 weeks and 4 days. After removing the cotton ball we could find the bleeding site on lower uterine segment, posterior fornix and vaginal wall. Three silicon Foley catheters with fluid-filled balloon were designed for tamponade function. One with a filling capacity volume of 80cc in the lower uterine segment, another with 70cc in the posterior fornix, and the other with 10cc in the vaginal wall. The balloon was effective in controlling postpartum hemorrhage originating from the lower uterine segment, posterior fornix and vaginal wall. Even though active bleeding was controlled, there was persistent bleeding draining to Foley catheters. Pseudoaneurysm originating from right vaginal artery was detected on abdomen computed tomography. And embolization of right vaginal artery using microcoil and gelfoam was done. We present a case of postpartum hemorrhage which was well controlled after balloon tamponade and embolization.

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Prenatal diagnosis of 69 XXY, triploid fetus with abnormal ultrasonographic finding at second trimester

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Chromosome abnormalities are the most common causes of early miscarriages. As much as 60% of miscarriages at first-trimester are reported to associated with chromosome anomalies, and nearly 20% of all miscarried embryos are triploidic. It often culminates in early spontaneous abortion and even if, occasionally it results in the fetal development, most triploid fetuses will die before 20 weeks. Because of this fatal outcome, early prenatal diagnosis of triploidy is the matter of concern for the obstetricians. We recently encountered the case of triploid fetus diagnosed at the 17 weeks of gestations by ultrasonography and subsequent amniocentesis. A 34-year-old Korean woman, gravida 1, para 1, at 17+3 weeks of gestation was referred to Chonnam National University Hospital for abnormal ultrasonographic findings and positive result at quad screening test with a 1:5 chance of having Edward syndrome. At referral, sonographic examinations revealed a singleton fetus with suggestive asymmetric intrauterine growth restriction, oligohydramnios and echogenic fetal bowel. At 19+3 weeks of gestation, subsequent sonography also showed abnormal fetal biometry and more decreased amniotic fluid index. Amniocentesis revealed a karyotype of 69,XXX. After intensive counseling about the poor outcomes, the parents opted to have termination at 21+3 weeks of gestation. The postmortem findings revealed a fetus of 17 to 18 weeks' size (severe asymmetrical fetal growth restriction) showing relative macrocephaly, syndactyly of finger 3 and 4 of left hand and normal looking placenta.