IS-62 THE CORRELATION BETWEEN SEVERE PREECLAMPSIA WITH FETAL OUTCOMES AT ASTANA ANYAR MOTHER AND CHILDREN HOSPITAL IN THE PERIOD OF JANUARY 1ST-December 31st 2008

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The objective of this study: Is to know the correlation between severe preeclampsia with fetal outcomes. The method of this research: Descriptive analytic observational study with cross sectional approach. Data had been collected from medical record of Astana anyar Mother and Children during the period of 1st of January 2008 until 31st of December 2008. Statistical analysis used Chi-square (x²), correlation coefficient, prevalence ratio and p-value to examined the correlation between variables. The Result of this study: Revealed that from 3,067 postpartum women, there are 5.1% of severe preeclampsia which distributed 34.6% incidence of LBW, 99.3% incidence of asphyxia based on 1st minute APGAR score, and 7.2% incidence of stillbirth. The study showed that significant relationship only between severe preeclampsia with Low Birth Weight (p = 0.034; PR = 1.459), and Asphyxia based on 1st minute APGAR score (p = 0.000; PR = 1.148). Conclusion: There is a significant correlation between severe preeclampsia with Low Birth Weight and Asphyxia based on 1st minute APGAR score. Keyword: Preeclampsia, Fetal Outcomes, LBW, Asphyxia.

IS-63 Fatal Necrotizing Pancreatitis associated with Intrapartum Severe Preeclampsia: A Case and Review

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Objective/Context: Pancreatitis, specifically necrotizing pancreatitis, rarely occurs in pregnancy. Nearly all reported cases are in association with symptomatic cholelithiasis. We present a fatal case of necrotizing pancreatitis resulting from the microvascular changes and widespread microthrombi associated with severe preeclampsia and hemolysis, elevated liver function and low platelet (HELLP) syndrome.

Case Report: A 25 year old primigravida presented at 35 weeks with a chief complaint of decreased fetal movement and generalized malaise for 3 days. She was subsequently diagnosed with an intrauterine fetal demise and severe preeclampsia, demonstrating severely elevated blood pressures, 4 + proteinuria, thrombocytopenia, with a platelet count of 12,000, hemolysis, elevated transaminases, and renal insufficiency. After stabilization of blood pressures with IV labetalol, labor was induced with vaginal misoprostol, and delivery occurred 16 hours after admission with a postpartum hemorrhage of 700cc. Additionally, the patient was transfused with packed red blood cells and platelets both during induction and at time of delivery. Immediately post-delivery, the subject appeared stable with the exception of rising total bilirubin and creatinine, and complaints of intermittent back pain. On the first post-partum day, she suffered an acute cardiorespiratory decompensation with laboratory evidence of severe metabolic acidosis, hyperglycemia, and lactic acidemia. Within minutes of her decompensation, she developed ventricular tachycardia and then asystole. Postmortem autopsy revealed evidence of extensive pancreatic microthrombi and necrotizing pancreatitis, which ultimately was designated as the cause of death.

Conclusion: We present a tragic case of fatal necrotizing pancreatitis associated with HELLP syndrome to raise awareness and highlight the systemic effects and potentially widespread end organ damage caused by the microvascular destruction resulting from preeclampsia. We hypothesize that the pathogenesis of this subjects necrotizing pancreatitis is the direct affect of the vascular damage caused most likely by preeclampsia and HELLP syndrome.

IS-64 The Effect of Placenta Previa on Recurrent Preterm Birth

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Objective: To investigate the effect of placenta previa on the risk of recurrent spontaneous preterm birth. We hypothesized that placenta previa has a reinforcing effect on the cervix, reducing the risk of preterm birth by acting as an "internal cerclage". Methods: Retrospective cohort study of women with a history of spontaneous preterm delivery who had a subsequent delivery at our institution between 1995 and 2009. Given that previa is an indication for delivery at 36-37 weeks, the outcome of interest was defined as birth at less than 34 weeks. Multivariate logistic regression was performed to identify predictors of recurrent preterm birth and to examine the effect of placenta previa after controlling for potential confounders. Results: 964 women met the inclusion criteria. The mean gestational age of the prior preterm birth was 33.5 weeks; most women subsequently delivered at term (mean GA 38.4 weeks). 10 women were identified who had a prior preterm birth and a placenta previa in the subsequent pregnancy; only 1 of these women delivered prior to 34 weeks. The mean gestational age at delivery for women with a placenta previa was 36.0 weeks, which was significantly lower than the cohort as a whole (p<0.05), but was not significantly different from the mean gestational age that all women with placenta previa were delivered at our institution over the same time period (36.7 weeks). After controlling for potential confounders, placenta previa did not have a significant effect on the likelihood of recurrent preterm birth; as expected, gestational age of prior preterm birth, smoking, and BMI >30 all increased the odds of recurrent preterm birth (p<0.001). Conclusions: Placenta previa does not appear to have a significant impact on the risk of recurrent preterm birth; however, the small sample size limits our ability to make any definitive conclusions. At our institution, most women with a placenta previa deliver beyond 36 weeks regardless of prior birth history. This information may be useful when counseling women regarding placenta previa and the risk of preterm birth.