PP-93

Oligohydramnios: A risk of adverse perinatal outcomes

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ABSTRACT

Introduction: Oligohydramnios is diagnosed when amniotic fluid index is less than 5. The incidence is between 1% and 4.4%. Although there are various maternal, fetal and placental contributory factors, the cause in the majority of cases is unknown. Most oligohydramnios cases warrant obstetric intervention. **Case Description:** A 22-year-old, Gravida 3 Parity 1+1 lady was diagnosed to have gestational diabetes at 15 weeks of gestation, which was well controlled with diet throughout pregnancy. At 34 weeks of gestation, ultrasound examination showed oligohydramnios. Ultrasound assessment confirmed both fetal kidneys were present, and bladder was seen. End diastolic flow was present in umbilical doppler and estimated fetal weight was 2.07 kilograms. After the administration of dexamethasone for fetal lung maturity, induction of labour was started with Cook's balloon catheter. After 5 hours, cardiotocograph showed fetal tachycardia with a non-reassuring tracing. The emergency lower segment caesarean section was performed and a baby of 2.07 kilograms was born with Apgar score 1 in 1 minute and 5 minutes. Umbilical cord blood pH of artery and vein were 7.35 and 7.338 respectively. The baby passed away the next day. **Discussion:** Pregnancy with oligohydramnios have a higher chance of g induction of labour which is beneficial. Pregnancies complicated with only oligohydramnios without underlying disorders may not be associated with adverse neonatal outcomes. But there is evidence that oligohydramnios cases with underlying disorders, their labours are likely to be associated with abnormal cardiotocographs, a higher rate of emergency caesarean sections and adverse neonatal outcomes.

PP-94

Astrocytoma in pregnancy

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ABSTRACT

Introduction: Astrocytoma are tumours that originate from astrocytes and are the commonest brain tumour in adults. Physiological and hormonal changes in pregnancy such as fluid retention and increased blood volume, may influence some types of brain tumour. **Case Description:** A 28-year-old, primigravida woman at 25 weeks presented with frontal headache and persistent vomiting of a month duration, with no neurological deficit. MRI brain was performed and a brain tumour was noted with features suggestive of high-grade glioma. She subsequently underwent craniotomy and tumour excision. Histopathological examination was reported as Astrocytoma WHO histological grade 4 with IDH1 mutation detected. **Discussion:** The management of astrocytoma in pregnancy requires a multi-disciplinary approach. A consensus of management should be achieved promptly as pregnancy is known to cause clinical deterioration and tumour growth. Unanswered questions include; 1) when pregnancy should be discouraged, 2) the best monitoring schedule for both mother and fetus, 3) how therapy can be safely administered during pregnancy, and 4) what is the best mode of delivery. For high-grade glioma, the treatment should be the same as that of non-pregnant patients, as the majority of them are young women and early resection and therapy initiation could improve prognosis.