on the clinical course of gestational processes and its impact on perinatal outcome. Secondly, I would also like to thank my parents and friends who helped me a lot in finalizing this project within the limited time frame.

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PS014
The possibility of optimization of hemodynamics in the fetoplacental pool as a factor of influence on perinatal outcome

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Aim: To study the possibility of optimization of hemodynamics in the fetoplacental pool as a factor of influence on perinatal outcome.

Introduction: Endothelial dysfunction in uteroplacental pool is a universal response of placenta to adverse effects of hypoxia, which leads to a high percentage of obstetric complications. Recreation is a way of optimization of hemodynamics in fetoplacental complex in the interests of antenatal protection of the fetus.

Methods: The study was conducted at the 3rd Maternity hospital, Zaporozhye including 40 pregnant women with VD with age group of 21–36 years (Primapara – 52.5%, multipara is 47.5%). 40 pregnant women with chronic venous insufficiency to restore homeostasis used the IR thermo-camera, designed and implemented by the Department of Clinical Pathophysiology, Institute of physiology. Pregnant women of the main group underwent 3 sessions of IR sonotherapy (1 time per week), lasting 30 min at temperature of 35 °C.

Results: Pregnant women with VD after using sonotherapy in the infrared heat chamber in the complex sanatorium treatment, on comparison with the control group, a more pronounced therapeutic effect of lowering body weight by 22.3 ± 1.2%, and decrease of systolic 14.6 ± 0.2 mmhg and diastolic 15.1 ± 1.1 mmhg pressure. Ended pregnancy in a core group of women, the birth of full-term newborns with no signs of distress, with an Apgar score of 7–9 points, body mass 2980–4000 g, 1 in the case of birth by caesarean section for obstetric indications.

Conclusion: The research conducted in the sanatorium “Velikii Lug”, confirms the effectiveness of the use of the IR sonotherapy in optimizing antenatal protection of the fetus against the background of endothelial dysfunction.

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PS090
Bile duct injuries after cholecystectomy: A retrospective tertiary centre study comparing outcomes of different types of surgical treatment

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Aim: Evaluation of long-term outcomes after different types of surgical management of postcholecystectomy bile duct injuries (BDI).

Introduction: Cholecystectomy is one of the most routinely performed procedures in abdominal surgery. Despite the growing experience of surgeons and benefits of minimal invasive approach, BDIs still occur. The treatment of this complication is challenging.

Methods: This was a single-center retrospective study. The outcomes of 64 consecutive adult patients, surgically treated after postcholecystectomy BDI 2002–2016, were reviewed. The newest EAES ATOM classification was used to describe injuries. The anatomic characteristics of the injury and long-term treatment outcomes were evaluated.

Results: 48 (75%) BDI followed laparoscopic cholecystectomy. 26% of injuries were detected intraoperatively, 58% detected <7 days, 16% >7 days after the procedure. The injury of non-main bile duct was diagnosed in 10 (16%) cases. The injuries of main bile duct: choledochal duct 22 (34%), hepatic duct 22 (34%), bifurcation with right-left communication preserved 5 (8%), bifurcation with right-left interrupted 1 (2%), right/left hepatic duct 4 (6%), 26 (41%) patients with a cystic stump leak or partial division of duct were managed endoscopically. This treatment was successful for 7 (88%) cystic stump leaks and 8 (58%) partial divisions. 13 (20%) partial divisions of duct were closed by suture. 8 (73%) patients had complications which later required endoscopic management or hepaticojejunostomy. End-to-end anastomosis (60%) or hepaticojejunostomy (16 (25%)) was initially performed after the complete division with or without loss of substance was detected. End-to-end strategy was successful in 4 (67%) cases, others finally required hepaticojejunostomy. The complication rate after initial hepaticojejunostomy - 25%.

Conclusion: Endoscopic treatment is optimal for cystic stump leaks and partial divisions of ducts. Complete divisions with or without loss of substance may be treated by hepaticojejunostomy and end-to-end anastomosis with similar long-term outcomes. While end-to-end anastomosis is more physiological, this strategy should be considered when possible.

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PS041
Perinatal loss in multiple pregnancies

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**Aim:** The aim of the study was to analyze causes of perinatal loss in multiple pregnancies.

**Introduction:** In population rate of multiple pregnancies varies from 0.7 to 1.5%. Multiple pregnancies are complicated by perinatal loss 4–9 times more frequently than singleton pregnancies.

**Methods:** Retrospective study of medical histories was carried out. Thirty patients with twin pregnancy and perinatal loss of one or both fetuses were included. Thirteen (43.3%) twins were monochorionic (MC), 17 (56.7%) – dichorionic (DC). At 11–14 week of gestation choriocity was diagnosed by ultrasound; transvaginal measurement of cervix was performed at 19–21 week; biometry was done to identify degree of fetus’ discordance.

**Results:** Complications of DC pregnancy: discordant fetal growth – 17 (100%), fetal growth restriction – 7 (41.2%), cervical insufficiency – 4 (23.5%). Discordant fetal growth was diagnosed in 17 DC twins: 8 (47.1%) – ≤20%, 9 (52.9%) – >20%. 8 (47.1%) patients with discordance >25% had highest degree of fetal growth restriction (estimated fetal weight <5%).

Perinatal loss in patients with DC twins was 61.8% (21 of 34 children). Highest mortality [10 of 21 (47.7%)] was among newborns at 22–27 week of gestation with DC type of placentation: 7 – intrauterine death, 3 died postnatally. Seventeen cases of intrauterine death were diagnosed: 7 (41.2%) – 22–27 weeks, 3 (17.6%) – 28–31 weeks, 5 (29.4%) – 35–36 weeks, 2 (11.8%) – at term.

Complications of MC pregnancy: discordant fetal growth – 13 (100%), twin-to-twin transfusion syndrome (TTTS) – 11 (84.6%), fetal growth restriction – 9 (69.2%), cervical insufficiency – 4 (30.8%). Discordant fetal growth was diagnosed in 13 MC twins: 7 (53.8%) – ≤20%, 6 (46.2%) – >20%. Four (30.8%) patients with discordance >25% had selective fetal growth restriction.

Perinatal loss in patients with MC twins was 80.8% (21 of 26 children). Highest mortality [13 of 21 (61.9%)] was among newborns at 22–27 week of gestation: all of them died antenatally. Nineteen cases of intrauterine death were diagnosed: 13 (68.4%) – 22–27 weeks, 4 (21.0%) – 28–31 weeks, 1 (5.3%) – 35–36 weeks, 1 (5.3%) – at term.

**Conclusion:** There were 1.3 times more perinatal losses in MC twins than in DC twins (80.8% vs. 61.8%). Regardless of chorionicity, perinatal losses were observed more frequently at 22–27 weeks of gestation: DC (47.7%) and MC (61.9%) twins. Causes of perinatal loss in DC twins: prematurity – 52.9%, discordant fetal growth (≥20%) – 52.9%, fetal growth restriction – 41.2%. Causes of perinatal loss in MC twins: TTTS – 84.6%, prematurity – 76.9%, fetal growth restriction – 69.2%, discordant fetal growth (≥20%) – 46.2%.

**References**


