

recovers normally after detorsion of the organ. In these cases, if predisposing factors for torsion are present, suture of the adnexa to the posterior broad ligament of to the pelvic cavity is recommended. A possible danger after detorsion of the adnexa is embolic phenomenon due to detachment of thrombi formed in utero-tubaric circulation. When the organ is necrotic, adnexectomy is necessary. Spontaneous amputation of the rotated tube has been described on laparotomy. Finally, contralateral adnexa must always be accurately inspected to diagnose and eventually correct predisposing factors to torsion such as adherence, cysts, etc.

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INTRAVENOUS 16-PHENOXY PGE2 METHYLSULFONYLAMIDE FOR INDUCTION OF LABOR IN CASES OF FETAL DEATH

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Summary: Labor was induced via intravenous infusion of 16-phenoxy-prostaglandin-E2-methylsulphonylamide in 13 cases of missed abortion and 19 cases of intrauterine fetal death. In all cases Bishop score was less than 4. Delivery occurred within 24 hours in all cases, with a minimal frequency of side effects (six cases of erythema above the incannulated vein and 1 case of diarrhea). The interval between the beginning of the infusion and delivery was 9.42 minutes. Uterine curettage was performed in 9 cases.

The induction of labor in patients with a posterior, closed and unripe cervix is possible, effectively utilizing prostaglandins

(PGs). The Authors study the effectiveness of 16-phenoxy-prostaglandin-E2 methylsulfonylamide (PGE2) in cases of missed abortion or fetal death in patients admitted from 1982 to 1985 in the First Cli-

(1) Scherin E. Italy.

Table 1. — *Parity in 32 patients with missed abortion (13 cases) or intrauterine fetal death (19 cases).*

Nulliparous	14 cases	43.75%
Pluriparous	18 cases	56.25%

Table 2. — *Week of pregnancy.*

1st trimester	4 cases	12.5 %
2nd trimester	9 cases	28.12%
3rd trimester	19 cases	63.38%

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MATERIAL AND METHOD

32 patients, aged between 19 and 40 years, were studied, 14 of whom were nulliparous and 18 pluriparous (table 1). In no patient was there contraindication for the use of PGs, and in all cases Bishop score was less than 4.

13 patients had missed abortion while 19 patients had intrauterine fetal death, which was diagnosed via echography. A group of 4, 9 and 19 patients in the first, second and third trimester of pregnancy, respectively were treated (table 2). Labor was induced by intravenous infusion via infusion pump of PGE₂ (Nadador 500-500 mcg per ampule, Schering s.p.a., Milan, Italy), diluting 500 mcg of medication with 500 ml of physiologic solution. The initial dose was 0.25 mcg per minute and was successively increased in proportion to uterine contraction, usually every 20 minutes. The infusion of PGE₂ was determined at maximum dose of 500 mcg or with the expulsion of the placenta.

During the infusion heart and respiratory rates, blood pressure, and body temperature

were monitored, and before and after the infusion Hgb, red cell count, creatinine, BUN, blood sugar, alkaline phosphatase, total bilirubin, platelets, SGOT and SGPT were evaluated.

The frequency and gravity of side effects, the frequency of success, the interval between the beginning of infusion and the beginning of uterine contraction, the duration of intravenous infusion, the interval between the beginning of the infusion and delivery, dose of medication, and the modality of delivery of the placenta were studied.

RESULTS

Delivery occurred in all cases within 24 hours of the beginning of the infusion with an average time of 9.92 hours (9.66 in the nulliparous and 9.38 in the pluriparous). Table 3 reports the time between the beginning of the infusion and the beginning of uterine contractions, the duration of intravenous infusion, the dose of medication used and the interval between the beginning of the infusion and delivery. Contrary to what was anticipated, a shorter duration of infusion, a shorter interval between the beginning of the infusion and delivery, and a lower dose of PGE₂ are noted in the nulliparous, and these differences are statistically significant ($p < 0.01$).

Side effects including six cases (18.75%) of erythema above the incannulated vein and one case (3.12%) of diarrhea, did not cause interruption of the infusion (table 4). 9 cases (28.12%) required curettage of the uterine cavity due to retention of placental tissue. Postpartum and puerperium were normal in all patients.

Table 3. — *Interval calculated in minutes between beginning of the infusion and beginning of uterine contraction, duration of the infusion, interval between beginning of the infusion and delivery and dose of medication, respectively, in nulliparous and pluriparous after induction of labor with PGE₂.*

	Nulliparous	Pluriparous	p
Interval between beginning of infusion and beginning of uterine contraction	19.8 ± 19.3	16.54 ± 70.87	<0.01
Duration of intravenous infusion	467 ± 169.25	516 ± 229.05	<0.01
Interval between beginning of infusion and delivery	580 ± 259.87	590.81 ± 211.64	<0.01
Dose of medication (mcg)	330 ± 160.46	415.45 ± 126.80	<0.01

Table 4. — Side effects and complications in patients with missed abortion or intrauterine fetal death during and after induction of labor with PGE₂.

Erythema	6 cases	18.75%
Diarrhea	1 case	3.12%
Uterine curettage	9 cases	28.12%

There were no modifications of vital signs nor in laboratory exams performed before, during and after the infusion.

DISCUSSION AND CONCLUSION

The use of 16-phenoxy-prostaglandin-E₂-methylsulfonylamide is extremely useful in the induction of labor in cases of missed abortion or intrauterine fetal death. It is effective (100% of cases) regardless of age, parity and Bishop score, causes minimal side effects (21.87%—7 cases), and is accepted by patients. The high frequency of uterine curettage, which

occurred especially in cases in which there was a long interval between interruption of pregnancy and induction of labor, is probably due to modification of the anatomical characteristics of the chorionic tissue.

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SIMPLE ASSYMPTOMATIC ORTHOTOPIC URETEROCELE IN PREGNANCY: ANALISIS OF A CLINICAL CASE

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Summary: In the present paper the Authors, taking for a starting point the occasional recognition of an asymptomatic orthotopic urethrocele in pregnancy, refer to the present knowledge of its embryology, pathological anatomy and the form of therapeutic approach. In the light of such experience they confirm the role of clinical-instrumental diagnostic investigations of purely gynecological and obstetric pertinence in the recognition of pathologies of urological interest.

The urethrocele is a nosological entity represented by a pseudocystic submucosa dilation of the terminal extremity of the urethra (¹⁻²).

Different theories have been suggested concerning the embryogenesis of this malformation: some Authors consider it the persistence of Chwalle's membrane with