type gall bladder deformity, biliary stasis, hepatosplenomegaly (on ultrasonography non-homogeneous aspect of parenchyma with mild to moderate increased echogenicity). At the age of 10, she was diagnosed with left nephroptosis, secondary chronic pyelonephritis and chronic cystitis. She was diagnosed with adenoiditis and chronic sinusitis, episodes of otitis. On July 20, 2015, patient presented with jaundice. The hemoleucogram revealed mild anemia (hemoglobin was 112 g/l, erythrocyte 3.8 mln/mcl). The biochemical examination revealed increased bilirubin levels, mainly on the basis of free bilirubin: total bilirubin was 36.0 mmol/l, conjugated bilirubin was 9.0 mmol/l, free bilirubin 27.0 mmol/l. Serum glucose was at normal level (4.9 mmol/l), thymol test - 1.0 (normal value). The transaminase levels were normal (ALT 13.6 IU, AST 20.1 IU). From the history, serum bilirubin levels were normal until adolescence. At the age of 17, the level of bilirubin increased considerably, leading to suspected viral hepatitis, which could be present considering that hepatitis was present in the family. For differential diagnosis purpose, markers of viral hepatitis were tested: anti-HBs antibodies <2 m UI/mL (negative). Immunological tests indicated normal values: qualitative C reactive protein <6 mg/L; qualitative ASLO <200 IU; rheumatoid factor <8. Given the exclusion of the infectious factor, Gilbert's syndrome diagnosis was suspected, and was confirmed later by molecular genetic testing: a homozygous insertion of a TA dinucleotide in the region of the UGT1A1 gene promoter (genotype UGT1A1 7/7) was identified in the patient.
Conclusions. The clinical and evolution features of the case present clinical interest for the differential diagnosis of jaundice and accumulation of unconjugated (free) bilirubin in the serum.
Key words: Gilbert's syndrome, hyperbilirubinemia, jaundice, gene mutation

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

14. INTRAVENTRICULAR HEMORRHAGE WITH SUBSEQUENT VENTRICULOMEGALY IN PRETERM INFANTS

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Background. Preterm infants are at risk for developing many perinatal complications such as intraventricular haemorrhage (IVH) and subsequent ventriculomegaly. Babies born before 32 weeks of pregnancy present an even higher risk for IVH, an important cause of severe cognitive and motor neurologic impairment in very low birth weight infants. The risk of IVH is inversely related to gestational age and birth weight.
Case Report. A male neonate was admitted to the neonatal intensive care unit of Mures County Emergency Hospital. He was delivered by a cesarean section at 30-31 weeks of pregnancy. Birth weight was 1300 grams, the cranial perimeter was 29 cm and Apgar score was 7/8 at 1 and 5 minutes respectively. The primary physical examination revealed mild respiratory distress that evolved in the next two days to bilateral pneumothorax, which was successfully drained. Other abnormalities were found such as hypertrophic cardiomyopathy, atrial septal defect (2 mm) and mild mitral insufficiency. Psychomotor agitation was observed and treated with Midazolam, which caused paralysis of the respiratory center. The newborn was intubated. On the 10th day of life, transfontanellar ultrasound showed intraventricular hemorrhage in resorption and secondary ventriculomegaly. Hypotonia, feeding issues and postprandial vomiting was noted, also high levels of procalcitonin and lactate dehydrogenases were found. On the 16th day of life, bacteriological examination identified an infection with Candida Albicans and Enterococcus Faecium. Treatment with Teicoplanine was initiated. On the 19th day of life, articular pain was observed and the pediatric surgery examination revealed left humeral and forearm fractures,

which were successfully treated. On the 25th day of life, the newborn was transferred to the neurosurgical unit for reservoir implant, cerebrospinal fluid (CSF) drainage and further treatment. Due to the favorable evolution, after 20 days he was transferred back to the premature care unit.

Conclusions. Recognition of early signs of intraventricular hemorrhage with catastrophic or saltatory pattern, proper prenatal and neonatal care is essential in order to reduce mortality among preterm newborns.

Key words: intraventricular Hemorrhage, ventriculomegaly, preterm infants

15. CLINICAL MANAGEMENT IN PREGNANCY COMPLICATED WITH HELLP SYNDROME. CLINICAL CASE PRESENTATION

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Background. Preeclampsia complicates 2-3% of all pregnancies (5-7% in nulliparous women) and remains a leading cause of maternal and perinatal mortality and morbidity. HELLP syndrome is a rare manifestation of hypertensive diseases of pregnancy and represents the most severe end of the pre-eclampsia spectrum. It occurs in 0.5 to 1% of all pregnancies and in 10-20% of cases with severe preeclampsia. Although variable, the onset of the HELLP syndrome is usually rapid.

Case report. Patient X, 31y.o, primigesta, 39 w.g. was admitted to the maternity unit complaining of amniotic fluid leakage. She was not in labor on admission and her vital signs were normal: blood pressure (BP) was 130/80 mm Hg, pulse - 76/min. Her antenatal history was uneventful before this admission. Physical examination revealed peripheral edema, pathological weight add + 17 kg. Vaginal delivery according to the protocol was established. Over one hour, suddenly, the patient accused pronounced epigastric pain, occipital headache associated with high BP 180/110 mm Hg. Laboratory investigations included: thrombocytopenia - 120×109 g/l, leukocytosis - 12.4×109g/l. Liver function tests included increased concentrations of alkaline phosphatase - 126 u/l, LDH - 4886 u/l, ALAT - 317 u/1, ASAT - 500 u/1. Urinalysis for protein - 4.32 g/l. On the background of hypotensive therapy, the 150/100 mm Hg BP and symptoms of organ damage persisted. At this stage a diagnosis of HELLP syndrome was considered. In view of the rapid progression of the disease and the gestational age, it was decided to proceed to urgent delivery by caesarean section. One infant was delivered, with intrauterine growth restriction (weight - 2390g). In dynamics, hemolysis syndrome is also associated (haemoglobin - 90 g/l, erythrocytes - 2.9×1012g/l, haematocrit - 0.27%). Postoperative period was complicated by CID syndrome and acute renal failure. Clinical management was performed according to the protocols and patient was discharged in satisfactory condition at 11th postpartum day.

Conclusions. HELLP syndrome is a severe complication of pregnancy, fulminant evolution being frequently evaluated in primiparous without pre-existing medical conditions. Due to maternal and fetal impact, HELLP syndrome needs an urgent delivery by caesarian section, which is the essential method indicated in the severe form.

Key words: HELLP syndrome, pregnancy.

16. MANAGEMENT OF GIANT OVARIAN CYST IN PREGNANCY. CLINICAL CASE REPORT

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