to 1.5% - 4% in recent studies, possible due to changes in diagnostic criteria. Higher rates in Araucanian Indian origin women living in Chile were identified. The incidence of ICP in U.S.A is about 0.3%, based on a small number of studies. At the same time, recent study on a Latina population in Southern California determined a prevalence in this ethnic subgroup of 5.6%, which is considerably higher than previously reported. The incidence of ICP in Europe is lower - 1% ranging insignificantly for many years. It is more common for Finland, Sweden and Portugal population, where incidence of ICP varies between 1 and 2%, comparing with France, where prevalence has been reported to be around 0.2%. At the same time it has been reported an overall incidence of 0.7% in the South Birmingham area of UK. In this study, it was found a significantly higher incidence of ICP in Asian women of Pakistani (1.46%) and Indian (1.40%) origin. A retrospective clinical audit review undertook in Australia, sample size - 43 557 pregnancies reported the overall prevalence of ICP being 0.7% (319 cases). Also high rates of ICP in Caucasian (53.6% cases) and South Asian (22.6% cases) ethnicity were registered. In general, population a higher incidence is observed in twin pregnancies (20%-22%) and in women who took in vitro fertilization medication (2.7% vs 0.7%). At the same time, authors suggest that obstetric cholestasis is more common in women over the age of 35 years.

Conclusions. Despite the fact that the global incidence of ICP is up to 1% the researches presented in this review draw special attention to wide variation due to different geographical location and ethnicity, further research is needed with detection of patients at high risk.

Key words: ICP, intrahepatic cholestasis of pregnancy

191. OVARIAN TUMORS IN MAYER-ROKITANSKY-KÜSTER-HAUSER: A CASE SERIES

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Background. Mayer-Rokitansky-Küster-Hauser syndrome (MRKH) presents a multiethiological congenital abnormality of Müllerian's ducts and it is characterized by: agenesia of the 2/3 superior part of vagina and uterine anomaly, functional and normally developed ovaries and fallopian tubes and normal secondary sexual characteristics and female karyotype. Ovarian tumors in case of this syndrome are very rare, being described in literature as unique clinical cases.

Case report. Case #1: A 35 y.o. woman with MRKH syndrome was admitted to institute with lower abdominal pain and deep dyspareunia. Her previous gynecological history included the creation of a peritoneal neovagina (Davydov's procedure) 10 years earlier. Exploration of the abdomen: a huge (20x15x10.5 cm), solid and lobular tumor of the left ovary; the band-like uterus and a normal right ovary. Laboratory studies revealed an elevated CA 125 (127 U/ml) and β-hCG (53 mIU/ml). Resection of the mass, bilateral salpingo-oophorectomy, and omentectomy were performed. Microscopic examination of surgical specimen confirmed the diagnosis of dysgerminoma. The postoperative recovery was uneventful and four courses of chemotherapy were performed. Case #2: A 38 y.o woman with history of MRKH syndrome and Davydov's procedure 17 years earlier, was admitted to hospital with constant lower

abdominal pain for 4 months. Gynecological examination: neovagina with a good anatomical result (length 7 cm) and an elastic, painful mass in the projection of left annexes. At CT: a 107x87x93 mm cystic tumor. Laboratory studies revealed a normally CA 125 and b-hCG levels. A laparoscopic removal of tumor and left annexes was performed. Exploration showed a cystic mass on the left ovary, and left ovariectomy was performed. Microscopic examination of surgical specimen confirmed the diagnosis of Sertoli-Leydig cell tumor. The postoperative recovery was uneventful and she continued the treatment at oncological department. Case #3: A 14 y.o patient was admitted to the surgery department with hypogastric pain, increased abdominal volume and primary amenorrhea. At MRI: a solid mass in the pelvic cavity with intraabdominal spread with dimensions 115.3×75.2×82mm. A diagnostic laparoscopy was performed and determined the lack of the uterus (two uterine rudiments), the left ovarian tumor and follicular cyst (5×5 cm) on the right site. Conversion with bilateral ovariectomy was performed. The light microscopy data and the immunohistochemical profile revealed ovarian dysgerminoma. The postoperative period was without any particularities. Further the patient followed six chemotherapy courses

Conclusions. Ovarian tumors in MRKH syndrome refer to a very rare gynecological pathology and should be considered in the differential diagnosis of abdominal cavity volume formations in case of this malformation. Long term clinical and radiological monitoring of patients with MRKH syndrome should be considered justified.

Key words: Mayer-Rokitansky-Küster-Hauser syndrome, ovary, ovarian tumors

192. INTRAHEPATIC CHOLESTASIS OF PREGNANCY. DIAGNOSIS.MATERNAL AND FETAL COMPLICATIONS

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Introduction. Intrahepatic cholestasis of pregnancy (ICP) is a cholestatic disorder characterized by pruritus, elevated serum aminotransferases and bile acid levels with onset in the second or third trimester of pregnancy, and spontaneous relief of signs and symptoms within two to three weeks after delivery. ICP has been observed in almost all ethnic groups, but there is relevant geographical variation in the incidence of ICP varying from less than 1% to 27.6%. It is important to diagnose it in time because of its effects on pregnancy outcome.

Aim of the study. This review was undertaken to find the criteria of diagnosis and to evaluate the possible maternal and fetal complications.

Materials and methods. To identify relevant articles, NCBI and ScienceDirect databases were searched using the Key words: “intrahepatic cholestasis of pregnancy”, “Idiopathic jaundice of pregnancy”, “Pruritus gravidarum”, “diagnosis of intrahepatic cholestasis of pregnancy”, “outcome on intrahepatic cholestasis of pregnancy”.

Results. This study concluded that Pruritus is the primary clinical symptom of ICP. It usually presents in the third trimester, after 30 weeks of gestation, but rare cases developing early. The diagnosis of ICP is based on pruritus of cholestasis, elevated fasting serum bile acids > 10 μmol/L (± and elevated serum transaminases), spontaneous relief of signs and symptoms within two to three weeks after delivery and absence of other diseases that cause pruritus and jaundice. Mild jaundice with serum levels of conjugated bilirubin only moderately elevated occurs in 10