

and many women may thus find it easier to 'let nature take its course'. The relatively low acceptance rate for termination for serious cardiac abnormalities may reflect lack of understanding of the impact that multiple operations at a young age may have on the child and the family. All of these reasons need further study and elucidation.

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## **FETAL ANOMALIES – A SONOPATHOLOGICAL CORRELATION**

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Ultrasound has proved to be an excellent modality in the antenatal diagnosis of fetal anomalies. However, the accuracy of ultrasound in detecting anomalies varies according to the skill of the operator and the equipment used and the variable fetal and maternal conditions.

While an accurate diagnosis is possible in major structural defects, the detection of minor or associated abnormalities is less accurate. A precise diagnosis is essential to predict prognosis and the risk of recurrence future pregnancy. A postnatal evaluation of the baby is mandatory to arrive at a final diagnosis. In cases where the couple has opted for termination of the pregnancy after an abnormal ultrasound, a detailed pathological examination of the fetus and placenta may help to modify the counselling for future pregnancy management. Based on the results of the autopsy, in some cases, appropriate pre-pregnancy investigations can be decided and the possibility for early exclusion of a similar problem in the subsequent pregnancy can be explored.

A retrospective study was done from Jan to Dec 2006 at Mediscan systems, Chennai. A total of 606 cases had autopsy during that period. Among them, 484 had structural anomalies. Out of these, 317 had both USG and autopsy at our institution. Of these, 28% had single system anomalies and 72% had multi system/syndromic anomalies. Among single system anomalies CNS and FACE anomalies were most common. Out of 317 who had autopsy and USG, 220 had complete match, 92 had partial match and 5 had no match.

Autopsy gave more information in 30.6%. Among those anomalies wherein there was no match, ultrasound had missed the findings due to poor visibility on account of oligohydramnios, maternal obesity and multiple fibroids. Surface abnormalities were more often missed than internal defects.

Ultrasound had the best sensitivity for CNS anomalies. In the skeletal system, though the sensitivity of the ultrasound was high, the specificity was low. In

Cardiovascular system, there was discrepancy in outflow tract abnormalities.

However, there are some limitations in the autopsy with regard to diagnosis of functional and karyotypic abnormalities. In the presence of autolysis, a pathological opinion may not be possible.

In conclusion, the sonologist, perinatal pathologist and geneticist should work as a team to give the most accurate diagnosis of an anomaly, which will help the couple to realize their dream of having a normal healthy child.

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## **MORAL AND ETHICAL ISSUES IN MONITORING A FETUS IN A WOMAN WITH ADVANCED STAGE HIV INFECTION**

**Keymanthrie Moodley**

Advanced maternal HIV infection is characterized by a low CD4 count and a high viral load in a woman with compromised health. Such a situation may be due to natural progression of disease as a result of lack of HIV testing and antiretroviral treatment, failed treatment due to drug resistance or treatment refusal by the mother. Irrespective of the proximate cause of advanced disease, the risk of vertical transmission to the fetus in this setting is likely to be higher than in the case of early stage or treated HIV infection.

Globally, the vertical transmission risk is approximately 30% and this is reduced to less than 1% with treatment. In developing countries such as South Africa, the risk of transmission with treatment during pregnancy is 8-15%. Given these statistics, it is also possible that viral transmission may not occur in such a setting and then, one is faced with an ill mother and a healthy baby or an HIV negative baby whose health is otherwise compromised.

This scenario raises important ethical questions about balancing maternal interest against fetal interest. In the setting of an ill mother, with a distressed fetus, the treating doctor may be faced with a choice between saving the life of the mother at the expense of the fetus. The option of termination of pregnancy may thus arise either as a suggestion from the treating doctor or as a request from the mother on the basis of an autonomous choice. In the scenario where the fetus is healthy and the mother is ill with a poor prognosis, should the baby be prioritized?