malous lethal aberration in one fetus, (2) twin-twin transfusion syndrome (TTTS), and (3) adverse consequences on the surviving fetus after the fetal death of its co-twin. The incidence of TTTS is 15-30% in monochorionic monozygotic twins. Obstetric risks, survival and neurological outcome associated with interventions for treating TTTS (serial amnioreduction, fetoscopic laser ablation of placental vascular anastomoses, amniotic septostomy, and selective feticide) have been reported, and several randomised controlled trials are in progress.

**L75**

**MULTIFETAL PREGNANCY REDUCTION**

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This study was undertaken to evaluate the pregnancy outcome in women who underwent multifetal pregnancy reduction

The data reported here reflect the multifetal pregnancy reduction experience of Hacettepe University Hospital Dept of Ob/Gyn, Division of Perinatology from 1995 through 2002.

Pregnancy records were retrospectively reviewed.

In the absence of any abnormal findings, the fetuses most readily accessible were chosen for reduction, usually those most fundal in location. All multifetal pregnancy reduction procedures were performed between 9 and 14 weeks gestation via intrathoracic injection of potassium chloride under ultrasonographic guidance.

The fetus chosen for reduction was the one with suspicious ultrasonographic findings such as increased nuchal translucency thickness or delayed growth in comparison with others.

122 procedures were performed on 83 pregnancies. Of these pregnancies 53 (63,85%) were triplets, 20 (24,09%) were quadriplets, 6 (7,22%)were quintuplets and 4 (4,81%) were sextuplets.

Mean age of patients was 31,8±4,2, mean gestational age at MFPR was 11,2±1,2, mean starting number was 3,4±0,8 (3-6) and finishing number was 2.

Fetal loss rates according to starting number of fetuses are summarised in Table 1.

| | Loss<20 weeks | Loss btw 20-28 weeks | Total loss |
|---|---|---|---|
| 3-2 (53) | 1 (1,88%) | 2 (3,76%) | 3 (5,66%) |
| 4-2 (20) | 1 (5%) | 2 (10%) | 3 (15%) |
| 5-2 (6) | 1 (16,6%) | 2 (33,3%) | 3 (50%) |
| 6-2 (4) | 1 (25%) | 1 (25%) | 2 (50%) |
| Total loss | 4 (4,81%) | 7 (8,43%) | 11 (13,25%) |

**L76**

**WEIGHT GAIN IN PREGNANCY: DEFINITIONS AND CONSEQUENCES OF ABNORMAL PATTERNS**

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The weight gain of the pregnant women is the end result of many, usually physiologic metabolic changes occuring during pregnancy and is prone to wide induvidual variation. Strict control of weight gain during pregnancy as praticed worldwide until mid seventies gave way to a more liberal approach following reports revealing a direct relationship with suboptimal weight gain and low birth weight and prematurity. Currently recommendations of weight gain during pregnancy are based on the prepregnacy body mass index . Roughly a gain of less than 10 kg is associated with an abrupt increase in the incidence of low birth weight infants whereas a gain of more than 16 kg is associated with an increase in macrosomia and cesarean section rate.Another late sequele of excessive weight gain during pregnancy is the the retainment of the weight gain after delivery, which occurs more frequently among black race. Though the meta-analysis of mostly observational studies done so far suggests optimum maternal and

fetal outcome for pregnancies with weight gains within the recommended limits, the recognition of a real causative relationship and definition of abnormal patterns in temporal and compositional terms still needs large scale, well designed, prospective comparative studies.

**L79**

**IRON SUPPLEMENTATION IN PREGNANCY**

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Iron deficiency anemia is the most common nutritional deficiency in the world. Pregnant women are at especially high risk for iron deficiency and iron deficiency anemia. A considerable proportion of pregnant women in both developing and industrialized countries become anemic during pregnancy. The prevalence of anemia in pregnant women has remained unacceptably high worldwide despite the fact that routine iron supplementation during pregnancy has been almost universally recommended to prevent maternal anemia especially in developing countries over the past 30 years. The major problem with iron supplementation during pregnancy is compliance. Despite many studies, the relationship between maternal anemia and adverse pregnancy outcome is unclear. However, there is now sufficient evidence that iron supplements increase hemoglobin and serum ferritin levels during pregnancy and also improves the maternal iron status in the puerperium, even in women who enter pregnancy with adequate iron stores. Recent information also suggests an association between maternal iron status in pregnancy and the iron status of infants postpartum. The necessity of routine iron supplementation during pregnancy has been debated in industrialized countries and routine supplementation is not universally practiced in all these countries. In view of existing data, however, routine iron supplementation during pregnancy seems to be a safe strategy to prevent maternal anemia in developing countries, where traditional diets provide inadequate iron and where malaria and other infections causing increased losses are endemic.

Key words: Iron supplementation, pregnancy, anemia.

**L80**

**VITAMIN SUPPLEMENTATION IN PREGNANCY**

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The prescribing of vitamin supplements during pregnancy has become standard in obstetric practice. It is obvious the growth and development of the fetus depend on maternal supply of essential nutrients, e.g vitamins. In some studies it was reported that vitamin deficits during pregnancy might result in megaloblastosis, neural tube defects, placental and fetal defects, low birth weight and premature delivery. But these subjects are still being studied because the recommendation, which suggest that these supplements improve maternal and fetal outcome, however are often based on studies with serious deficiencies. Moreover, the increase in vitamin requirements during pregnancy usually can be more than adequately provided by dietary sources, assuming appropriate caloric intake and the consumption of animal protein. Much knowledge regarding transport of vitamins across the placenta is derived from animal studies and simple case reports. The animal data are generally obtained using study designs in which vitamins are totally excluded or administered to excess. This type of study design has little potential application to the human experience, even in a severely malnourished mother or a mother who is taking "megadose" vitamins. Human studies of pregnancy complications associated with vitamin deficiencies are generally uncontrolled; frequently they are performed in populations of patients with generally poor nutrition and multipl vitamin and mineral deficencies. For this reason, it is difficult to extrapolate from these data to populations of pregnant women with well-balanced and nutritionally complete diets. Finally, there is no agreement on what constitutes normal serum levels of vitamins during pregnancy. Normal values for nonpregnant states do not correspond to values in the pregnant state. All maternal serum vitamin levels decrease as pregnancy progresses and hypovitaminemia compared to non-pregnant women seems to be a normal status even in pregnant women who is using vitamins. This is because of the nor-