

international statistics and standardize of autopsy report. Also, these benefits obtain more information to clinicians, families, pathologist and science for healthier babies in the world.

## L129

### EVALUATION OF OXIDATIVE STRESS

**M. Arif Akşit**, Neonatology Department of Osmangazi University Medical Faculty, Eskişehir, Turkey

Background: The main structure of living bodies is human cells. To evaluate the function of the cell (especially mitochondria) is nowadays indirectly estimated from the perspective of blood. The values are differentiated in arterial, capillary, venous blood and in intercellular structure. In order to make an exact estimation, all blood values have to altogether discuss under the patronage of clinical evaluation (including neurological, respiratory and other organ system functions, also concerning gut/liver, immune response).

Objectives: Blood gases are classified as; a) Blood gases; pH, pCO<sub>2</sub>, pO<sub>2</sub>, b) Oxygenation: ctHb (Total blood hemoglobin concentration = cO<sub>2</sub>Hb-oxy + cHHb-deoxy + cCOHb-carboxy + cMetHb-met), Hctc, sO<sub>2</sub> (Make correlation with ctHb, oxygen saturation = cO<sub>2</sub>Hb/cHHb + cO<sub>2</sub>Hb), FO<sub>2</sub>Hb (Oxyhemoglobin ratio = cO<sub>2</sub>Hb / cO<sub>2</sub>Hb + cHHb + cCOHb + cMetHb), FHHb, FmetHb, FetalHb, c) Electrolytes: Na, K, Ca, Cl, d) Metabolic values: Glucose, lactate, bilirubin, mOsm, d) Status of oxygen: ctO<sub>2</sub> (Content = Hb (g/dl) x 1.34 ml O<sub>2</sub> / g Hb x saO<sub>2</sub> x (0.003 ml O<sub>2</sub>/mmHg/dl), p50, e) Acid-base status: cBase, cHCO<sub>3</sub>, ABE, SBE, AG (Anion gap = [Na + K] - [Cl + HCO<sub>3</sub>]).

Design: The values will be taken arterial and venous simultaneously. After the treatment the values can be effect between 2-5 minutes. If you'll obtained no response, than change your approach. Don't just give intravenous fluid, but make reperfusion, prevent the baby from ischemic perfusion complications and edema.

Subjects: The values are not taken alone. We have to discuss the correlations with the concerning parameters. E.g. baby A with paO<sub>2</sub> 85 mmHg, saO<sub>2</sub> 95%, Hb 7 g/dl, is more hypoxemic than the other baby B with paO<sub>2</sub> 55 mmHg, saO<sub>2</sub> 85%, Hb 15 g/dl. CtO<sub>2</sub> is 8.9 in baby A, but 17.1 mlO<sub>2</sub>/dl in baby B.

Conclusion: All for one, one for all will be the main topic for evaluation of blood gases. All the components will be systematically examined and must make a correlation with the clinical findings.

## L132

### RISK APPROACH TO INTRAPARTUM CARE

**Narendra Malhotra, Jaideep Malhotra, Prabha Malhotra, R.M. Malhotra**, Dr. Amrita Singh, Dr. Samiksha Gupta Malhotra Test tube Baby Centre, Agra

Today obstetric practice has been totally revolutionised the advances in technology and their wide spread clinical application to the antenatal care has led to a drastic decrease in maternal and perinatal mortality and morbidity in the western world.

But inspite of all the new procedures at the disposal of an obstetrician undesirable complications still occur and more so in the developing countries. Almost 10% of such events can be diagnosed and predicted and 48% of these are avoidable.

To reduce the undesirable events a risk approach to pregnancy during the antenatal period and during the intrapartum period is recommended.

We at our tertiary obstetric care centre in Agra have evaluated the Risk approach in 1000 obstetric cases and have compared our figures with the primary health care delivery system in India.

The results have shown a maternal mortality of 1 in 1000, perinatal mortality of 10 in 1000 and a morbidity rate of 5 per 1000 as compared to our national figure of maternal mortality of 10/1000, 110/1000 perinatal deaths and a morbidity of 150/1000.

Today a Risk approach to all antenatal and intrapartum cases is strangely advisable.