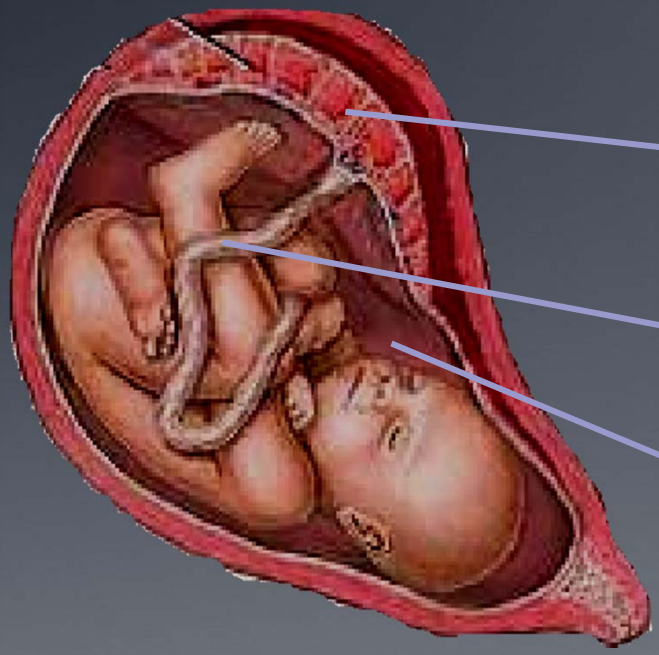
DIPARTIMENTO DI SCIENZE GINECOLOGICHE E DELLA RIPRODUZIONE UMANA
UNIVERSITA' DEGLI STUDI DI PADOVA

- ECOGRAFIA DEL III TRIMESTRE -

PATOLOGIA DEGLI ANNESSI FETALI

Gianna Bogana

ANNESSI FETALI



1 - PLACENTA

2 - CORDONE OMBELICALE

3 - LIQUIDO AMNIOTICO

ANNESSI FETALI: PLACENTA

Valutazione placentare nel III trimestre prevede:

1- sede impianto placentare: parete uterina – distanza OUI (TV)

2- controllo base di impianto placentare

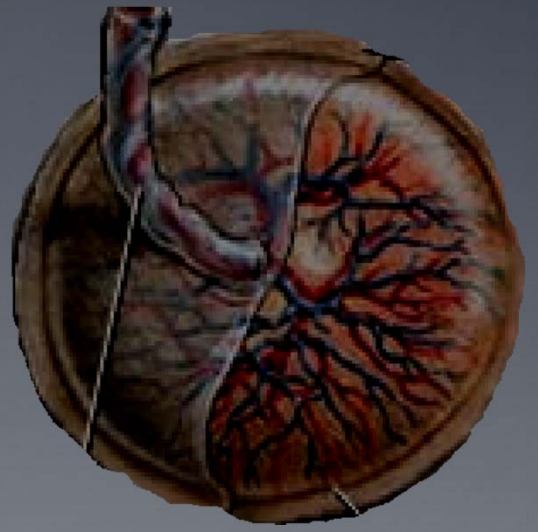
3- "aspetto" placentare: ecogenicità eterogenea

presenza di calcificazioni, lacune

spessore placentare

4- controllo sede di inserzione cordone ombelicale

5- cercare lobi placentari accessori (succenturiata)



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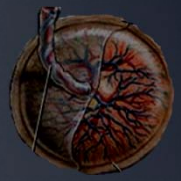
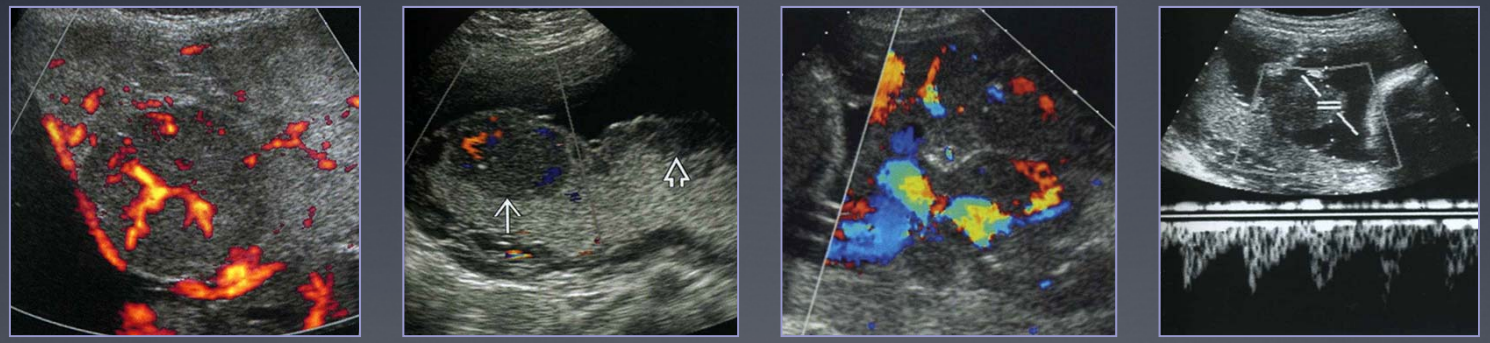


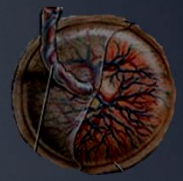
1- CORIONANGIOMA



- Tumore placentare benigno più frequente
- Sede più frequente: lato placentare vicino all'inserzione del cordone
- Generalmente ipoecogeno, ben definito, ben vascolarizzato
- Se > 5 cm può dare complicanze: polidramnios, insufficenza placentare, idrope (da shunt A-V o anemia fetale da emolisi)

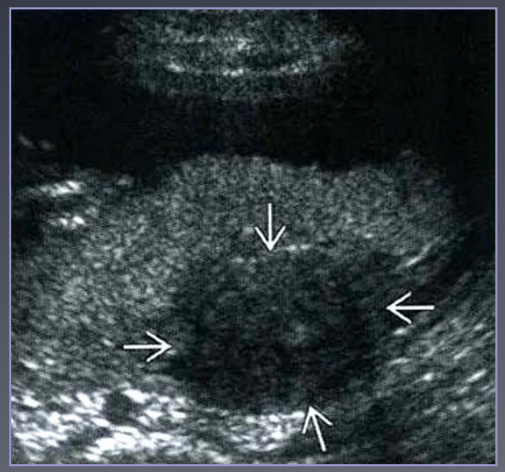
- ***Generalmente non necessario trattamento***
- ***No idrope: prognosi eccellente***
- ***Idrope: considerare intervento***
- ***Polidramnios: amnioriduzione***

ANNESSI FETALI: PLACENTA

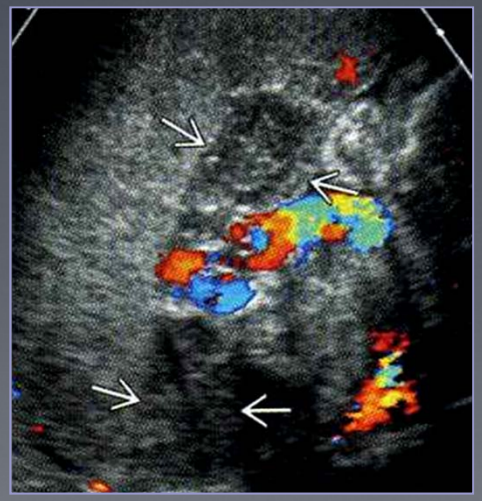


1- CORIONANGIOMA

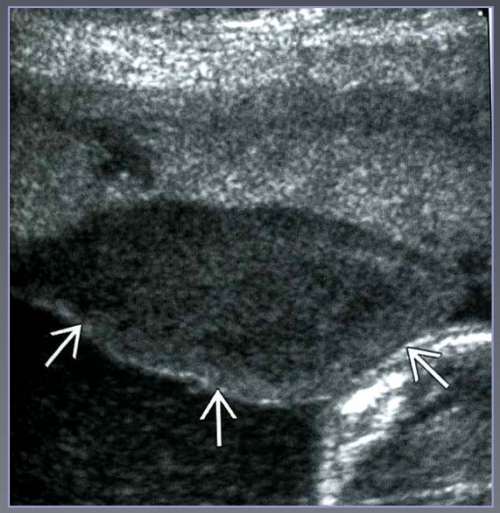
DIAGNOSI DIFFERENZIALE



FIBROMA

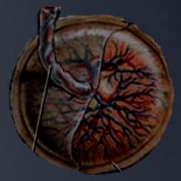


EMATOMA RETROP.



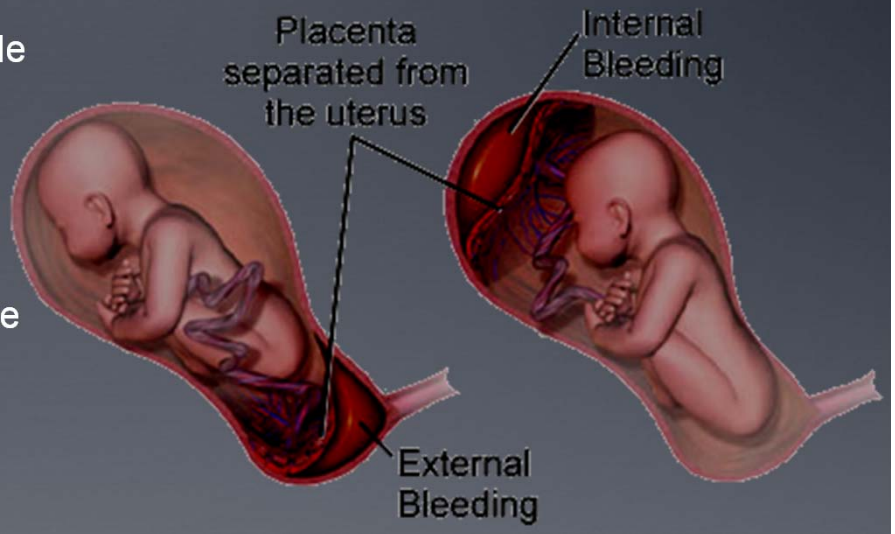
LACUNA VASCOLARE

ANNESSI FETALI: PLACENTA



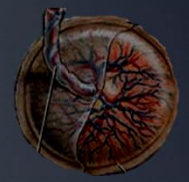
2- DISTACCO PLACENTARE

- Distacco della placenta prematuro dall'utero: 1% delle gravidanze
- Area ipoecogena (sangue ± coagulato)
- Marginale (+ comune), retroplacentare, preplacentare
- 50% distacchi placentari NON VISIBILI in ecografia
- Stimare la superficie placentare staccata
- Controllare frequenza cardiaca e benessere fetali



POWER DOPPLER utile per diagnosi: flusso assente!!!

ANNESSI FETALI: PLACENTA



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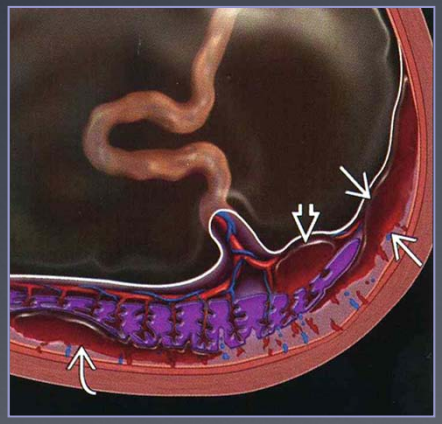

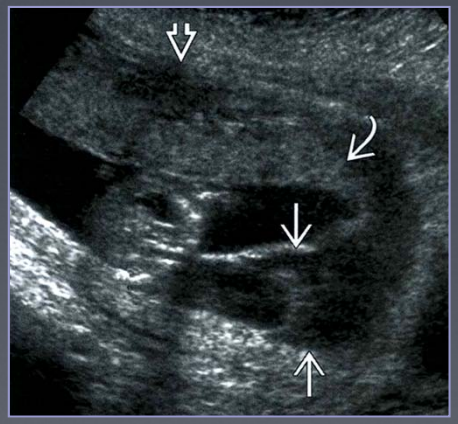

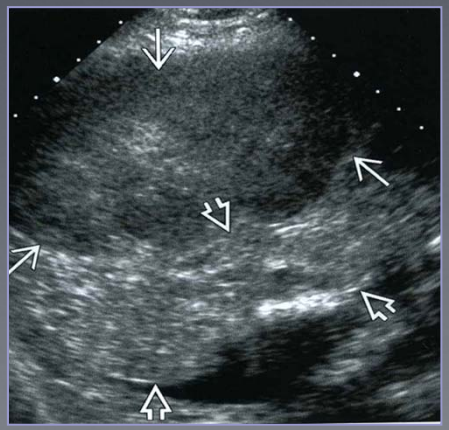

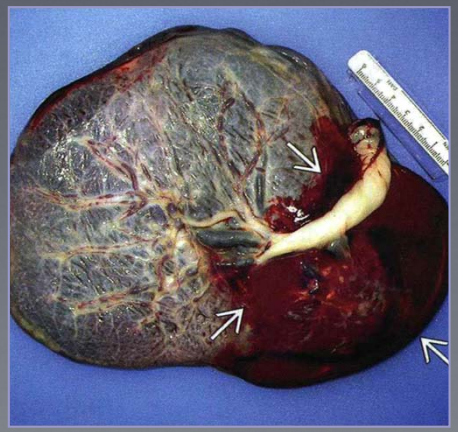

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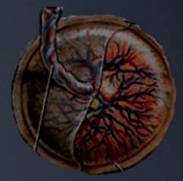
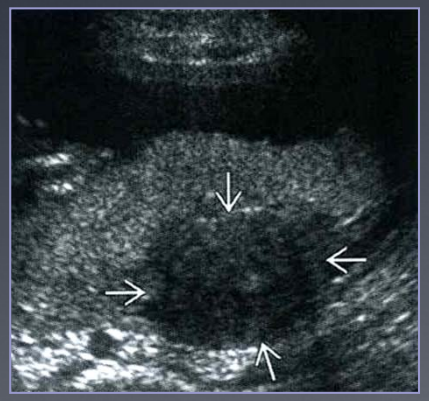


2- DISTACCO PLACENTARE

DIAGNOSI DIFFERENZIALE



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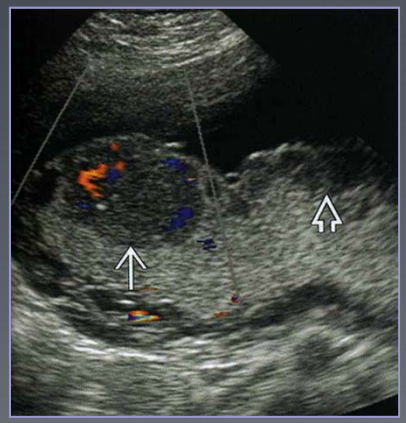
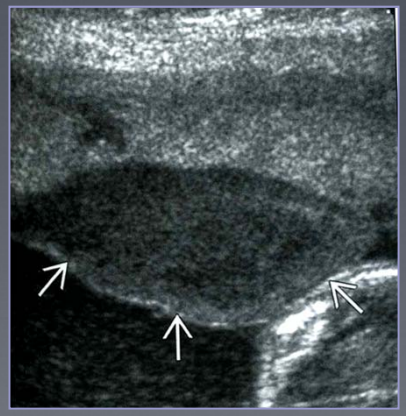


CORIONANGIOMA



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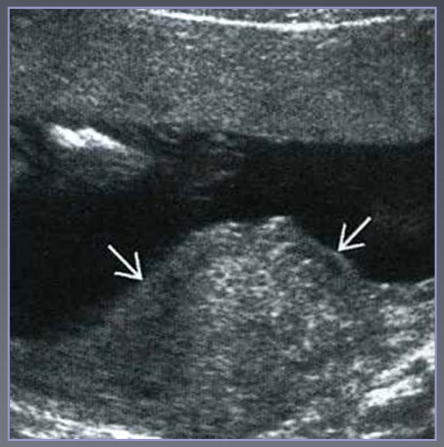
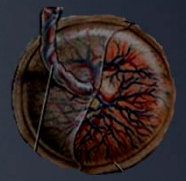


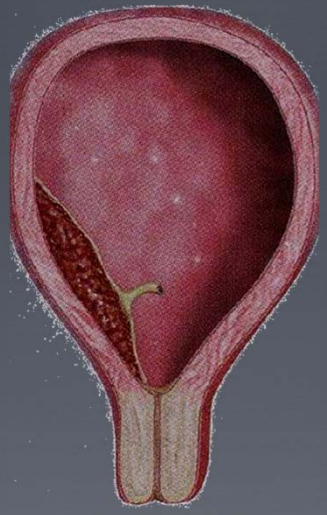
CONTRAZIONE

ANNESSI FETALI: PLACENTA

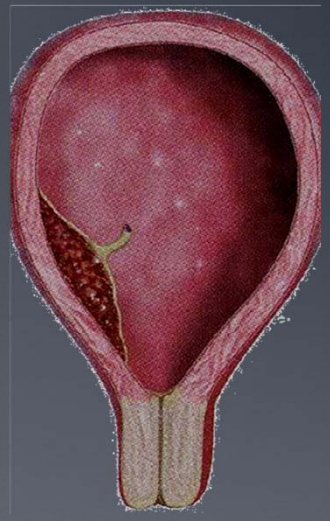


3- PLACENTA PREVIA

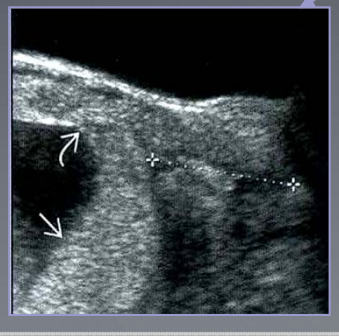
CENTRALE

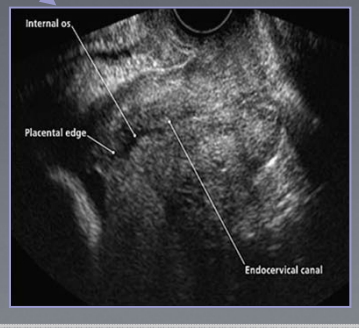


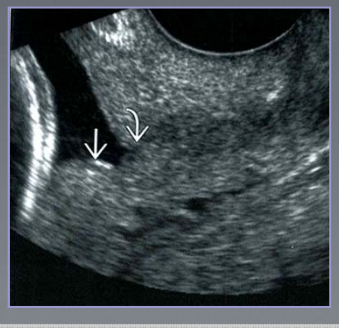
MARGINALE

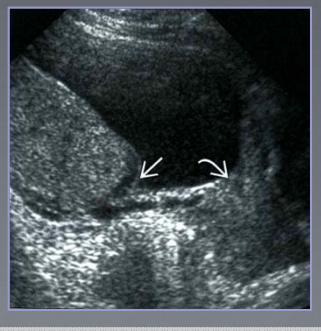


"BASSA"









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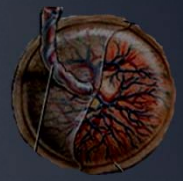
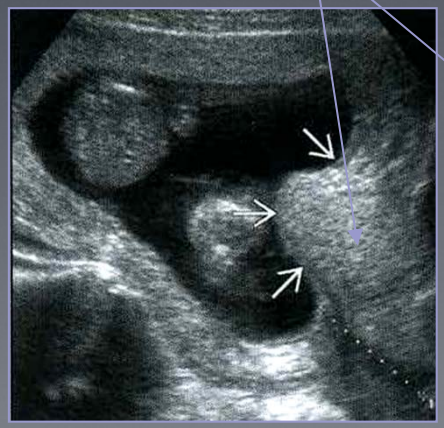


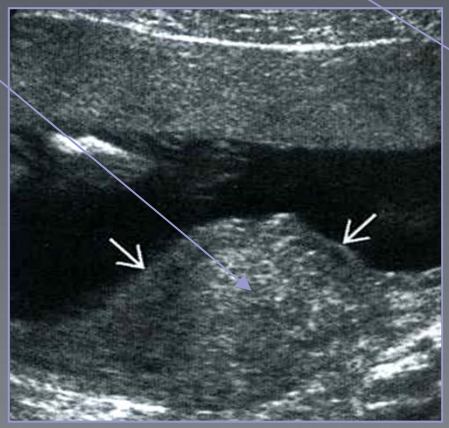
3- PLACENTA PREVIA

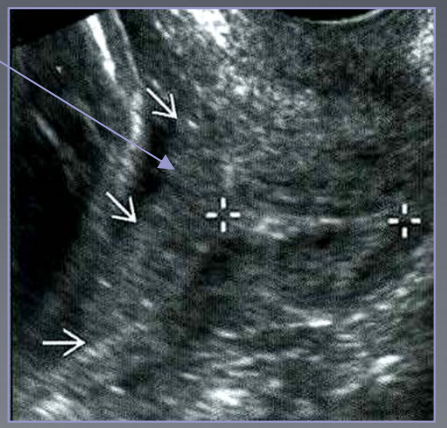
- Base di impianto placentare sopra o vicino all'OUI
- Diagnosi certa: eco TV!!

- ***Centrale***: copre completamente l'OUI
- ***Marginale***: bordo < 25 mm dall'OUI
- ***Parziale***: copre parzialmente l'OUI
- ***"Bassa":*** > 25 mm dall'OUI

- 5% sono associate a placenta accreta
- DD con contrazioni miometriali focali e distacco di placenta







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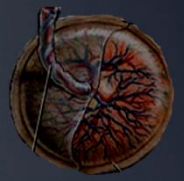
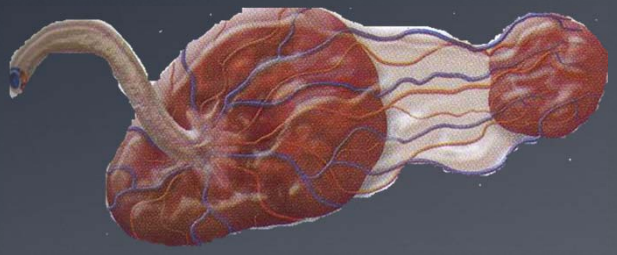
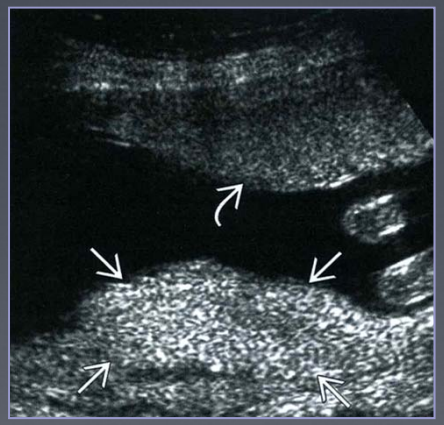
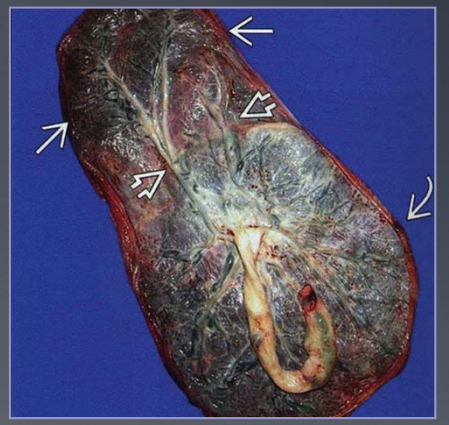


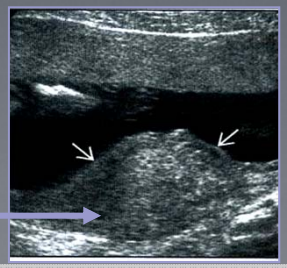
4- LOBO SUCCENTURIATO







- Uno o più lobi placentari accessori (dimensioni minori della placenta)
- Inserzione del cordone: nel lobo placentare principale
- Due masse placentari separate ma connesse da vasi sanguigni
- Principale causa di VASA PREVIA!!
- Possono raggiungere l'OUI fino a ricoprirlo (eco TV)
- Controllare tutto l'utero prima di definire posizione placentare!!
- DD: contrazioni uterine



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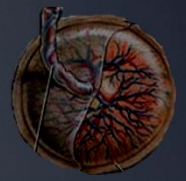
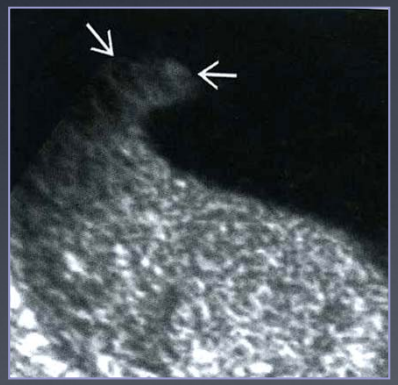
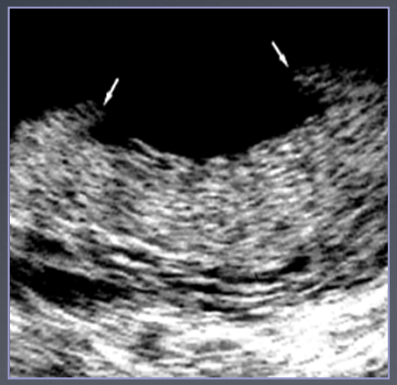
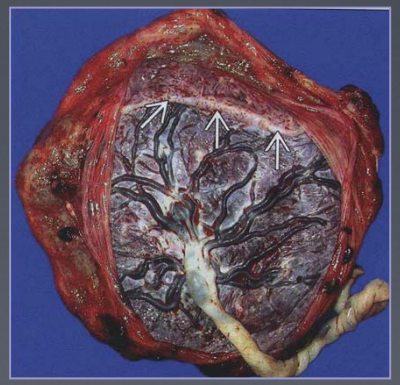
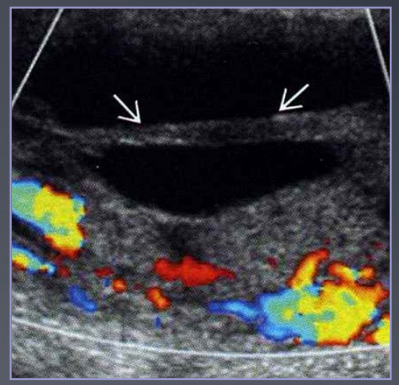


5- PLACENTA CIRCUMVALLATA





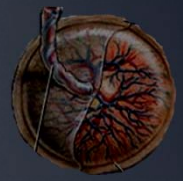




- Margini placentari sollevati completamente o parzialmente (“a mensola”)
- Rima iperecogena periferica
- Solo parziale: asintomatica

  se > 2/3 della placenta: sintomatica (Abruptio placentae, PPROM, IUGR, PPT)
- Diagnosi ecografica difficile

ANNESSI FETALI: PLACENTA



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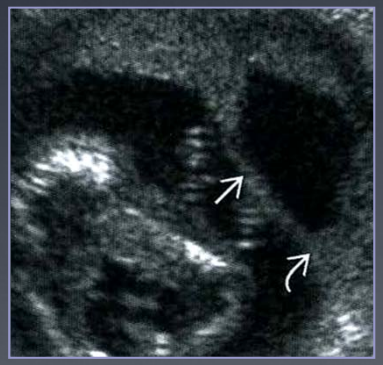
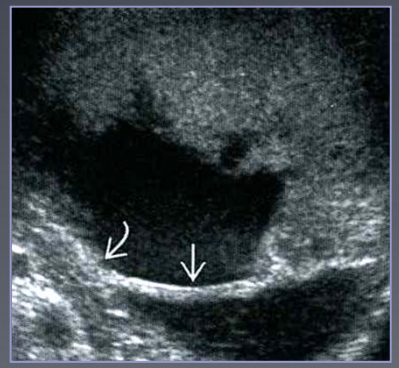
DIAGNOSI DIFFERENZIALE



SINECHIA



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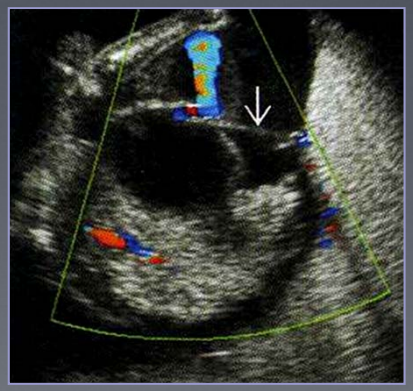
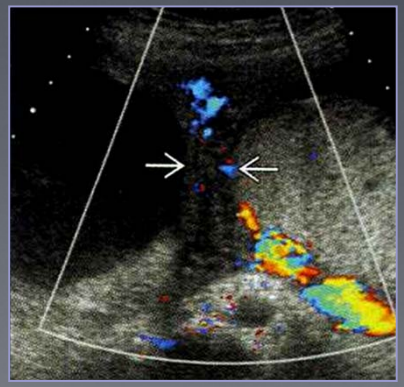
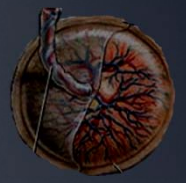


BANDA
AMNIOTICA



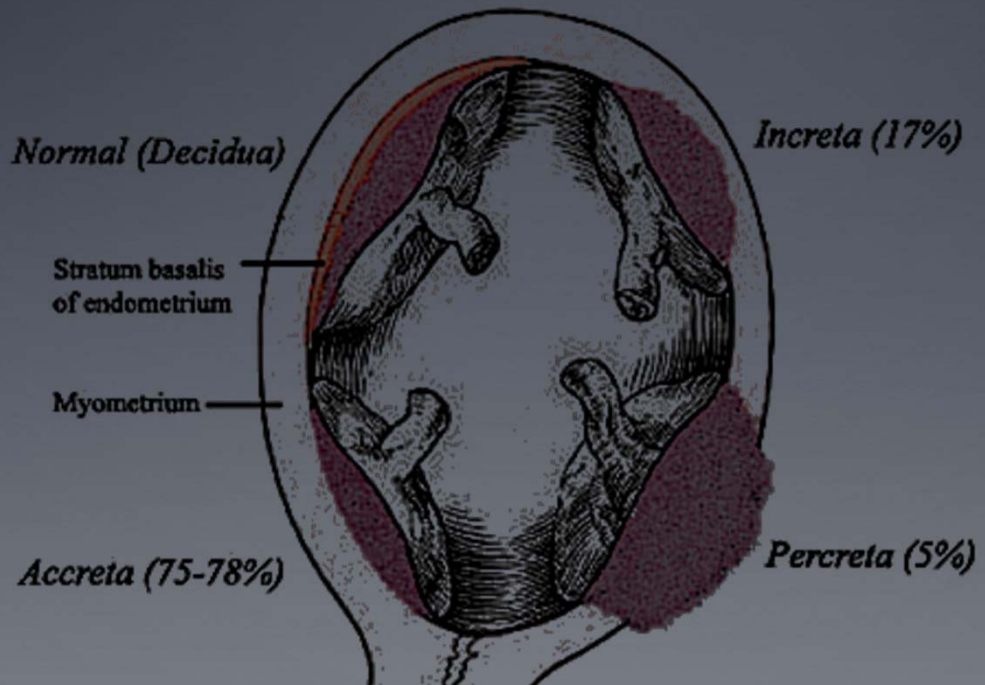
SETTO
UTERINO

IESSI FETALI: PLACENTA

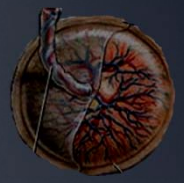


PLACENTA ACCRETA

omala penetrazione plcentare oltre lo spessore endometriale



ESSI FETALI: PLACENTA



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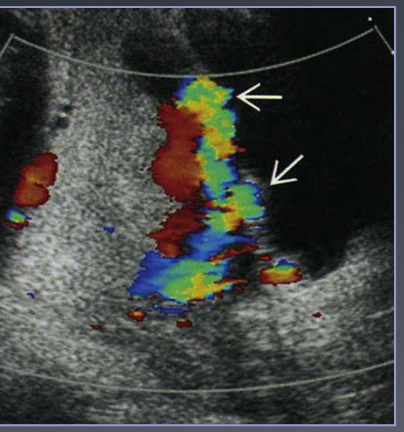
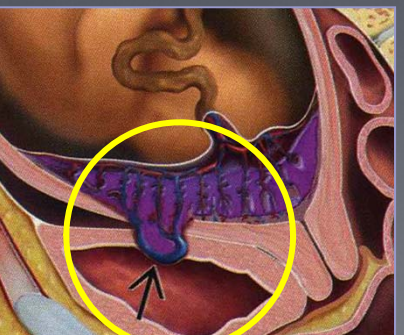
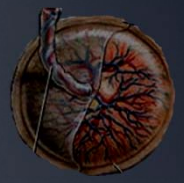




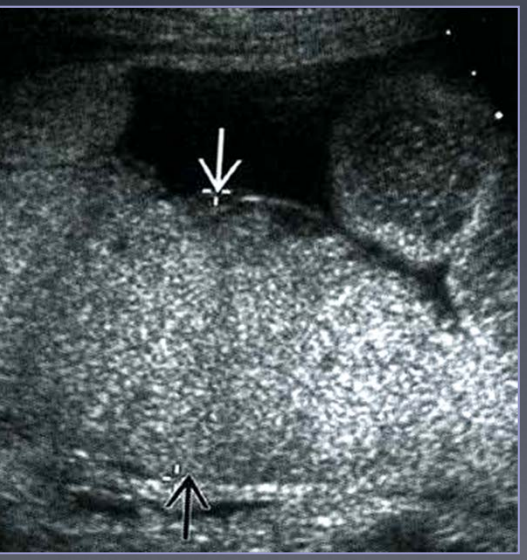
- Assenza della zona ipoecogena sottoplacentare
- Lacune vascolari irregolari
- Spesso con placenta previa
- Grossi vasi si estendono attraverso il miometrio fino alla vescica
- RMN e ECO hanno poco valore predittivo (> se percreta)
- Accreta → percreta
- In 10% pz con >4 TC e non previa
- In 67% pz con previa e > 4 TC

IESSI FETALI: PLACENTA



PLACENTOMEGALIA

SPESSORE PLACENTARE > 4 cm



SPESSORE ↑ IN GRAVIDANZA:

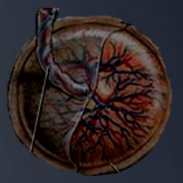
- 10mm a 10 sg
- 20mm a 20 sg
- 30mm a 30 sg

iagnosi “aspecifica”

orfologia normale ma spessore >

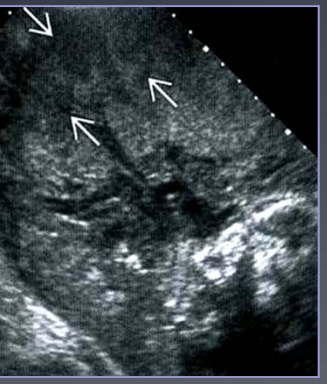
scludere miometrio nella misurazione!

ESSI FETALI: PLACENTA

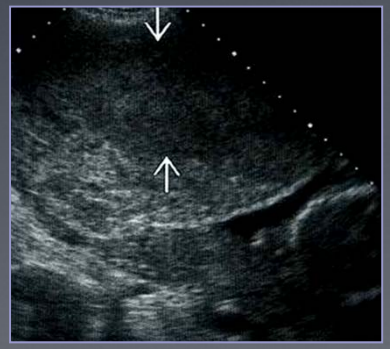


PLACENTOMEGALIA

GNOSI DIFFERENZIALE



ABRUPTIO



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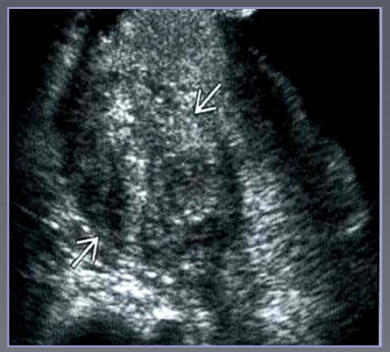
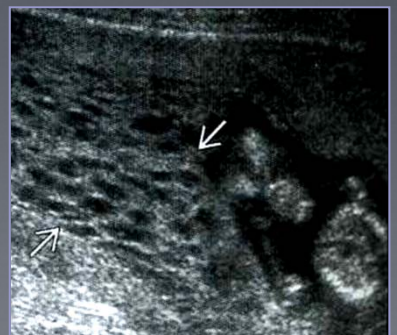
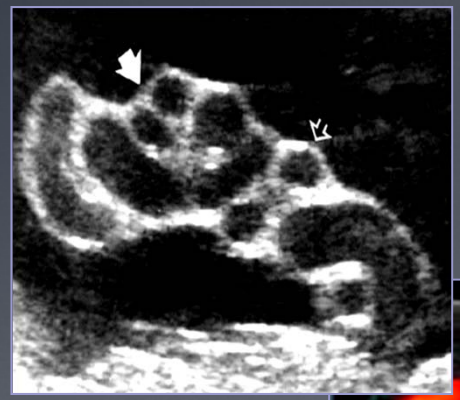
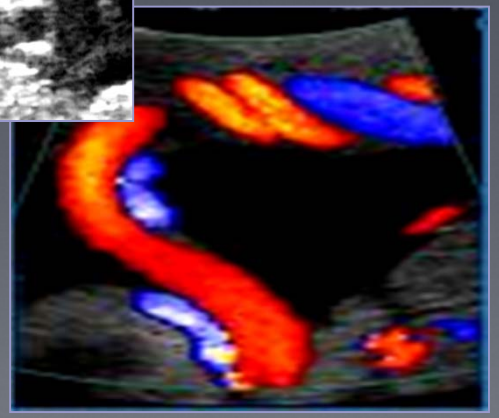


MIOMA



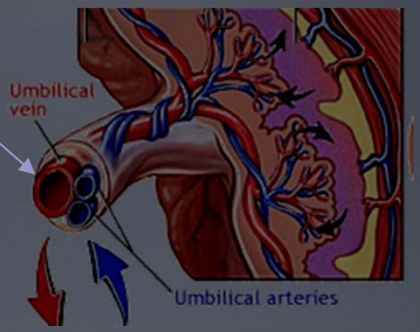
ESSI FETALI: CORDONE OMBELICALE

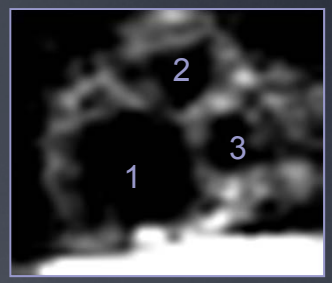




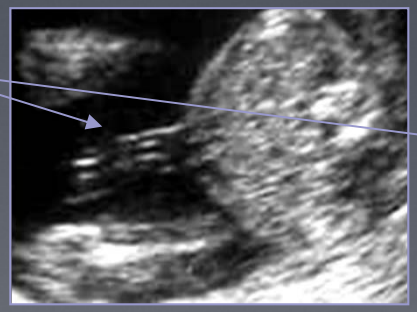
ESSI FETALI: CORDONE OMBELICALE

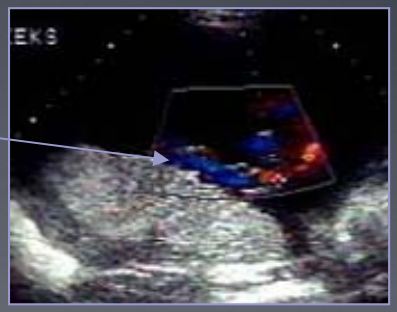
e normale: 3 vasi circondati da gelatina di Wharton
erie ombelicali (dal feto alla placenta)
a ombelicale (dalla placenta al feto)



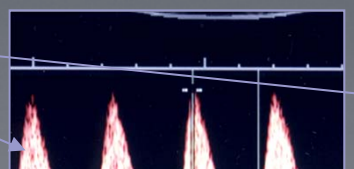


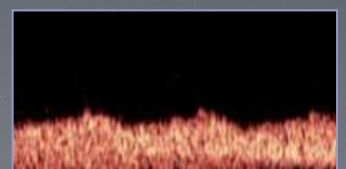
ne funicolare placentare
ne funicolare parete addominale fetale





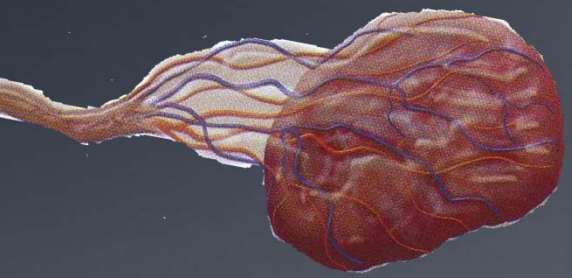
arteria ombelicale: bassa resistenza
vena ombelicale: flusso continuo

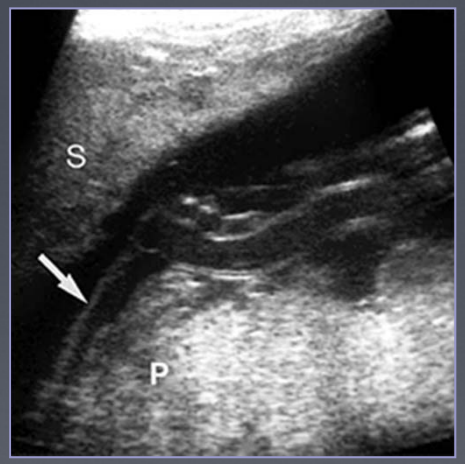


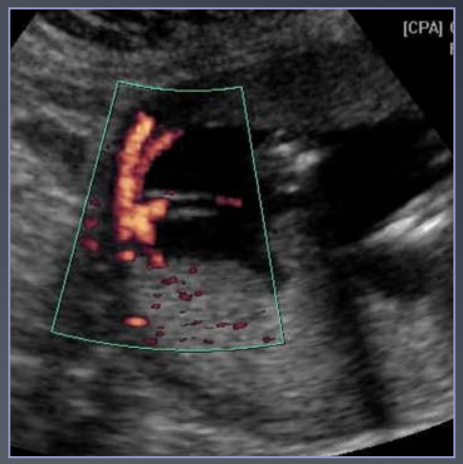


IESSI FETALI: CORDONE OMBELICALE

SERZIONE VELAMENTOSA







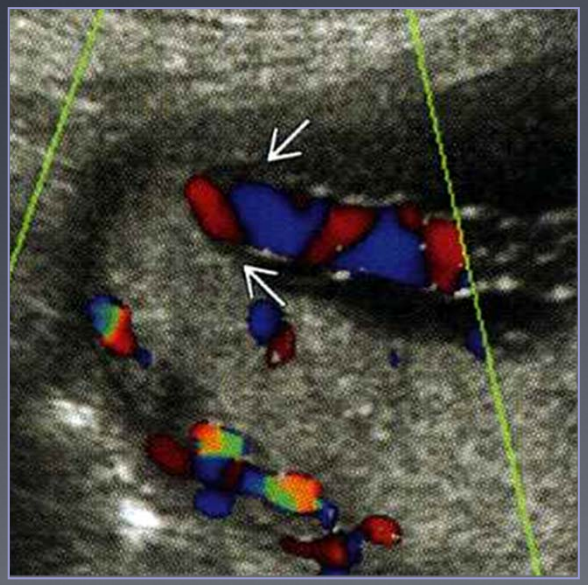
one funicolare sottomembranosa

- Usare Color Doppler: funicolo adiacente alla placenta
- Vasi possono apparire dilatati
- Vasi separati dal margine placentare
- Vasi sono estremamente fragili!!
- Possono essere VASI PREVI

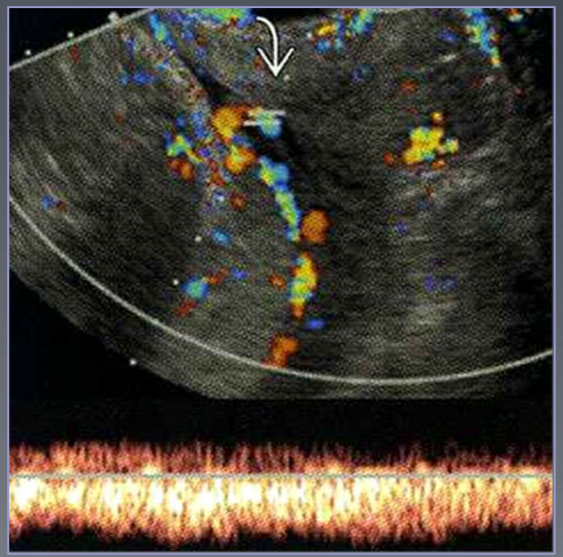
IESSI FETALI: CORDONE OMBELICALE

SERZIONE VELAMENTOSA

NOSI DIFFERENZIALE



INSERZIONE MARGINALE



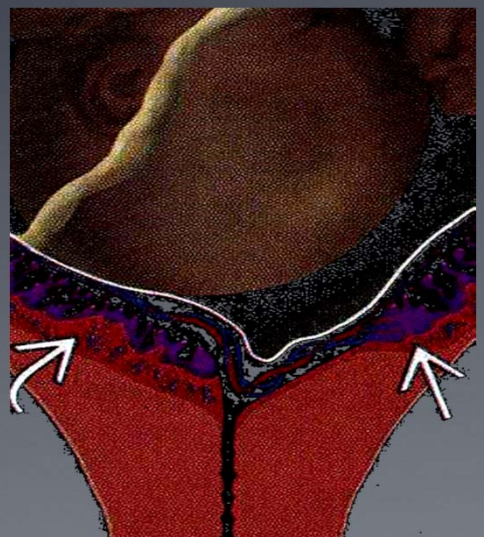
IESSI FETALI: CORDONE OMBELICALE

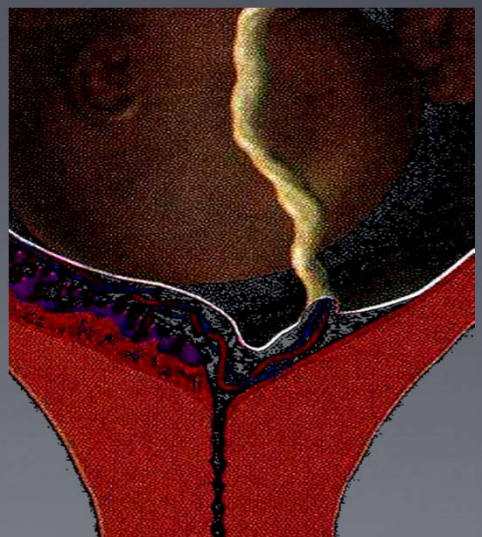
ASA PREVIA

Vasi fetali sottomembranosi a ridosso dell' OUI

>> Associati a PLACENTA SUCCENTURIATA

INSERZIONE VELAMENTOSA del funicolo





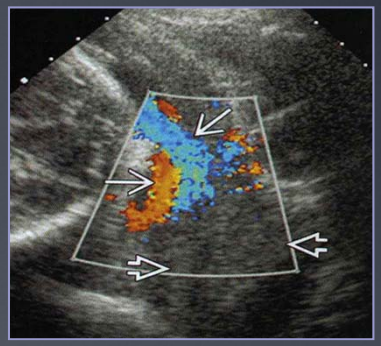
IESSI FETALI: CORDONE OMBELICALE

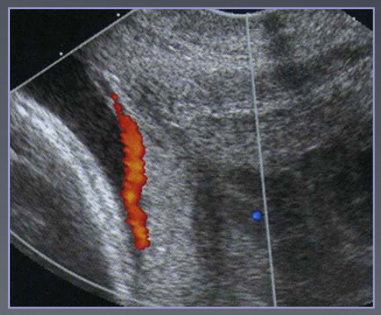
ASA PREVIA

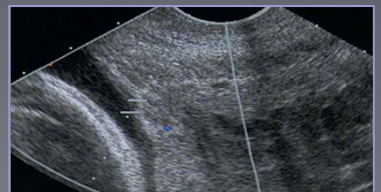
NOSI ECOGRAFICA:

Eseguire ecografia TV con Doppler flussimetria → Doppler fetale !!

dentificare lobi accessori o inserzione velamentosa





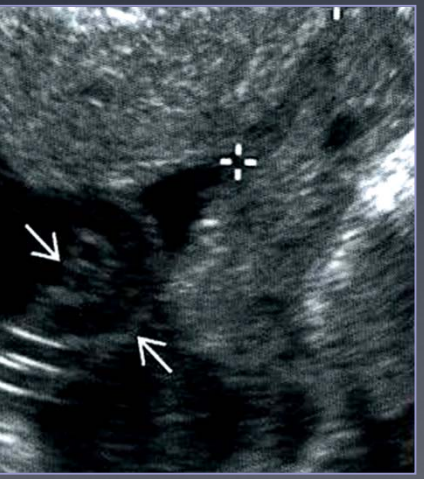


- 60-80% mortalità
- TAGLIO CESAREO!!

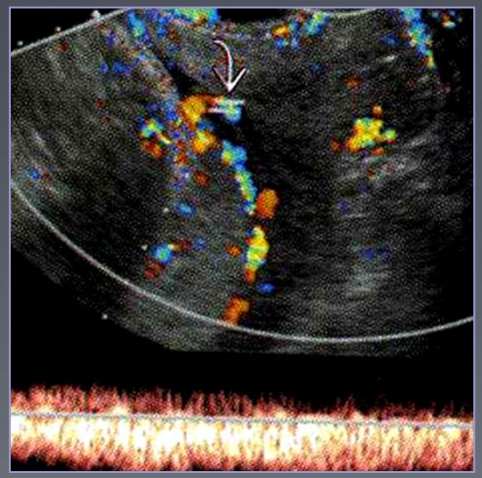
IESSI FETALI: CORDONE OMBELICALE

ASA PREVIA

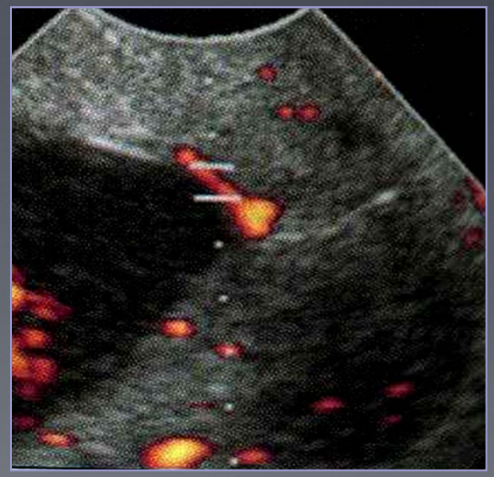
IOSI DIFFERENZIALE



Presentazione del
ORDONE OMBELICALE

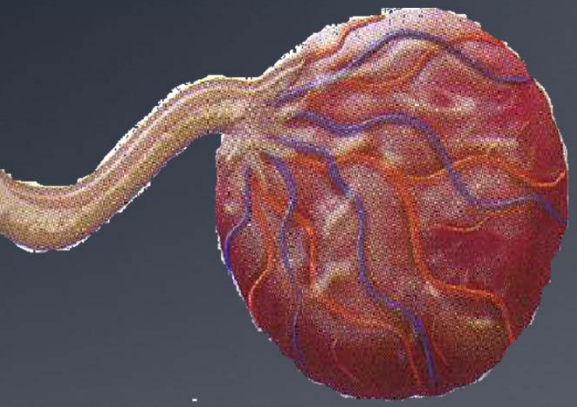


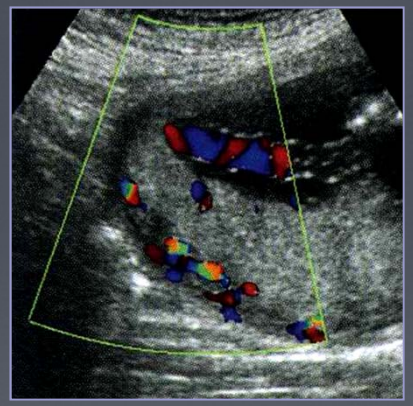
VASI DI
PLACENTA PREVIA

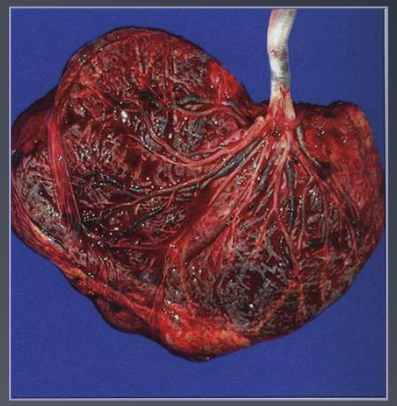


ESSI FETALI: CORDONE OMBELICALE

SERZIONE MARGINALE







nserzione del cordone ombelicale a 2 cm dal margine placentare: inserzione marginale/eccentrica del cordone (Placenta a racchetta)

Cercare sempre l'inserzione del funicolo sulla superficie placentare!!

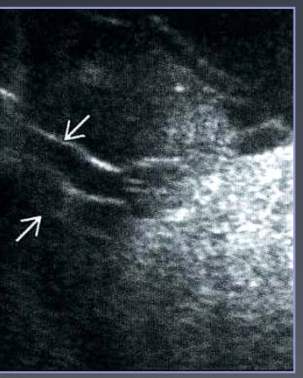
Usare Doppler per identificare uscita dei vasi nel cordone

Raramente evolve in velamentosa

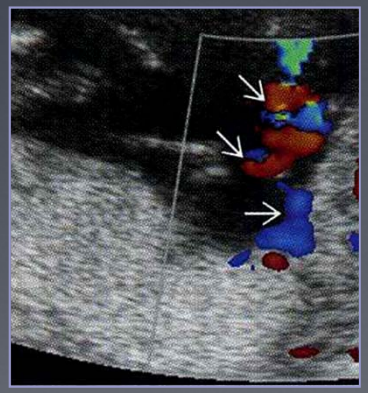
IESSI FETALI: CORDONE OMBELICALE

SERZIONE MARGINALE

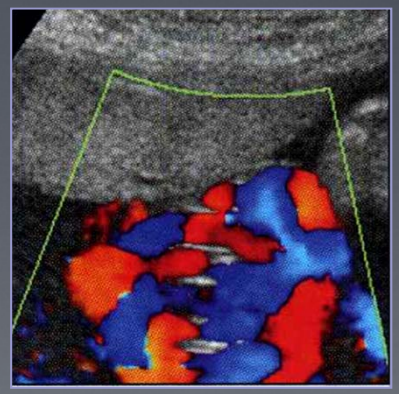
SI DIFFERENZIALE



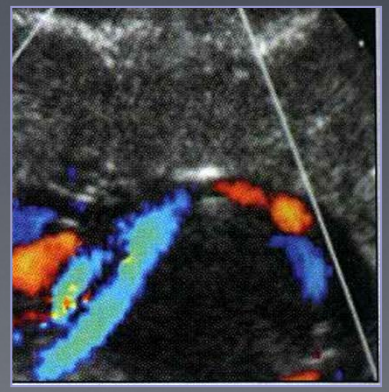
NSERZIONE
ELAMENTOSA



INSERZIONE
VELAMENTOSA



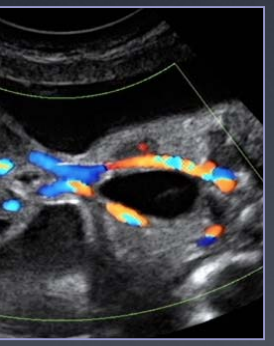
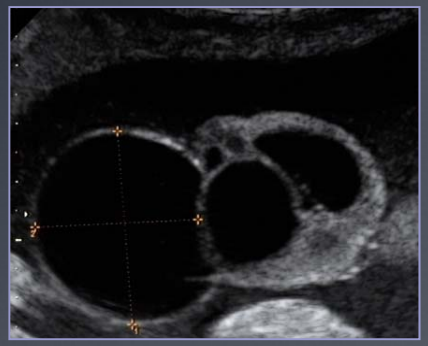
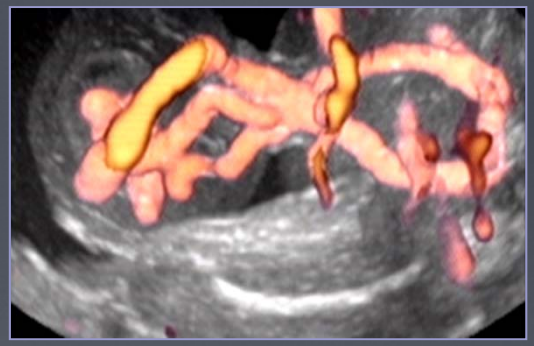
CORDONE
ADIACENTE



CORDONE

IESSI FETALI: CORDONE OMBELICALE

CISTI DEL CORDONE OMBELICALE


associate al cordone ombelicale

- Parassiali (60%)
- Assiali (40%) – dislocano i vasi ombelicali

- Inserzione parete addominale fetale (28%)
- Inserzione placentare (33%)
- Lungo il cordone (39%)

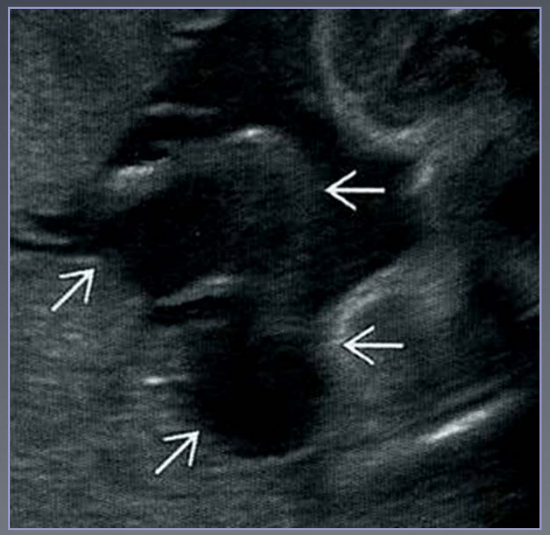
- Cisti semplici anecogene a parete sottile
- Diametro e forma variabili
- Spesso transitorie (prognosi eccellente)

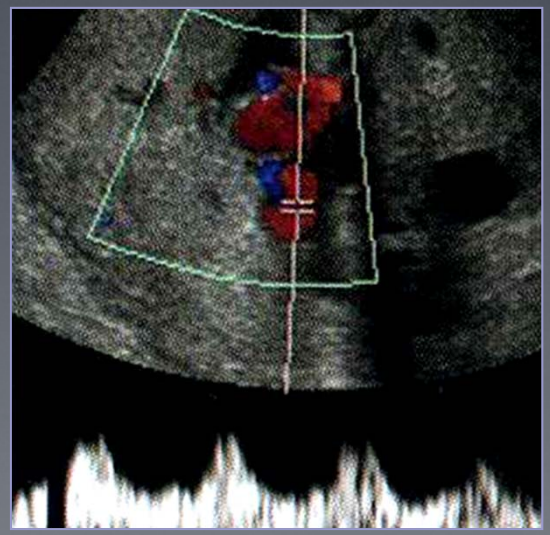
IESSI FETALI: CORDONE OMBELICALE

CISTI DEL CORDONE OMBELICALE

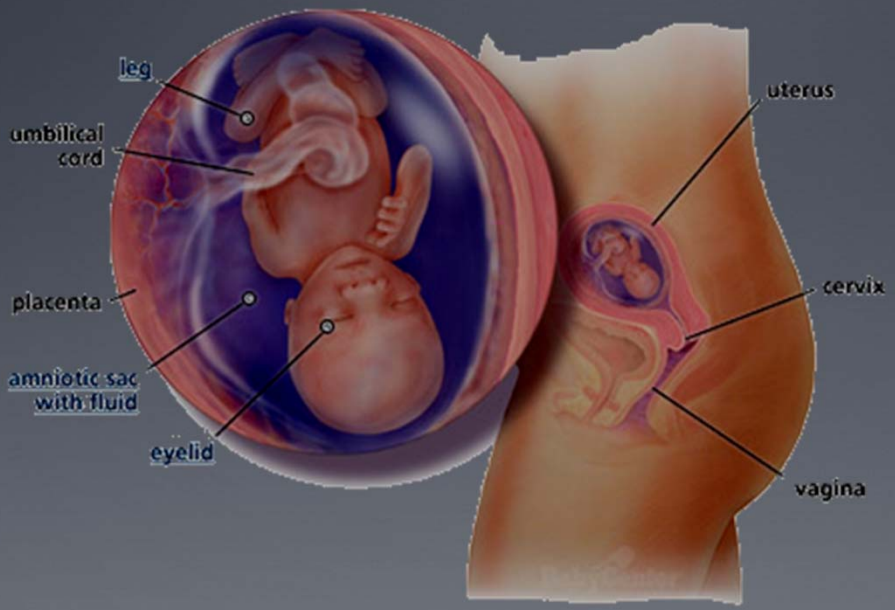
SI DIFFERENZIALE

eurisma dell'arteria ombelicale
si soprannumerari
natoma del cordone ombelicale





ESSI FETALI: LIQUIDO AMNIOTICO



ESSI FETALI: LIQUIDO AMNIOTICO

LUTAZIONE DELLA QUANTITA'

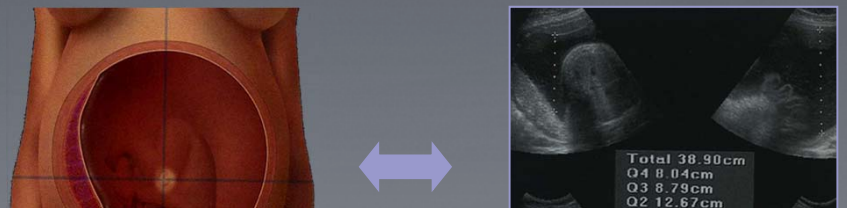
GETTIVA → "… è sufficiente una valutazione soggettiva (quantità normale, ai limiti inferiori della norma, oligoamnios ecc.)…"

(SIEOG 2006)

NTITATIVA

- TASCA MASSIMA
  - Tasca massima: 2-8 cm: normale
  - Tasca massima < 2 cm: oligoidramnios
  - Tasca massima > 8 cm: polidramnios
- AFI
  - Somma delle 4 tasche massime dei 4 quadranti
    - <4: anidramnios
    - <5: oligoidramnios
    - 6-18: normale
    - >18: polidramnios

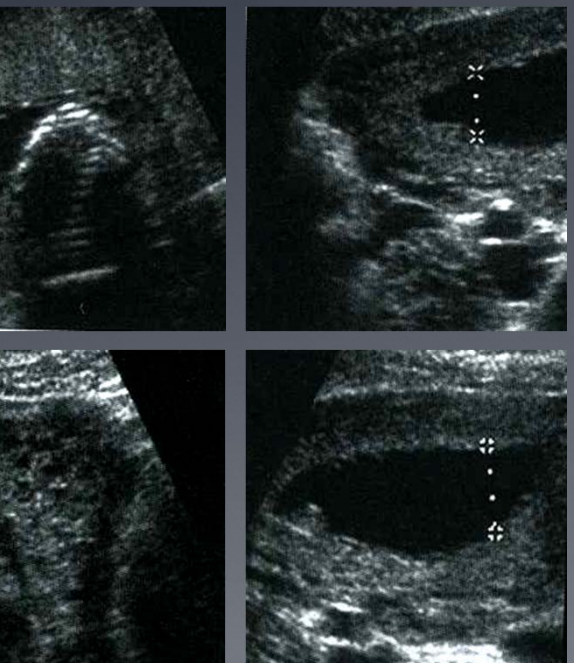
1 cm AFI = 30 mL



ESSI FETALI: LIQUIDO AMNIOTICO

IGOIDRAMNIOS

zione del liquido amniotico — AFI < 5 cm — Tasca massima < 2 cm



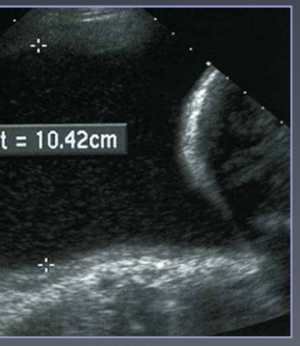
- Idiopatico: raro
- Gravidanza oltre il termine
- Escludere PPROM
- Visualizzare vescica (anomalie GU)
- Controllare crescita fetale (IUGR)
- Considerare patologia materna (ipertensione, preclampsia, malattie autoimmuni…)
- Frequente follow up AFI (bisettimanale)

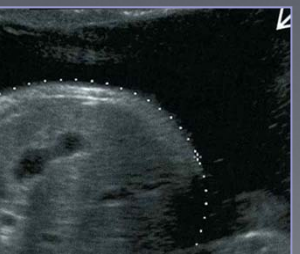
Tasca massima verticale, priva di:

IESSI FETALI: LIQUIDO AMNIOTICO

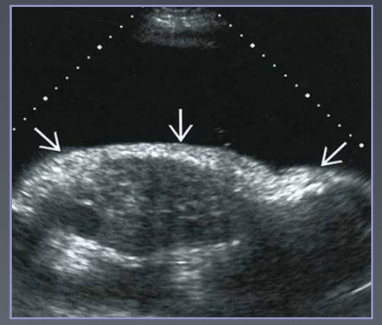
OLIDRAMNIOS

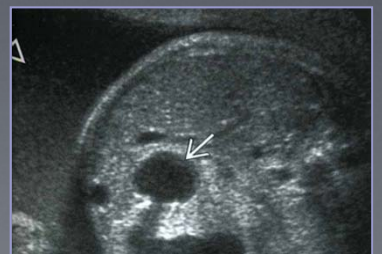
mento del liquido amniotico
- AFI > 18 cm
- Tasca massima > 8 cm





- Idiopatico (2/3) → buona prognosi
- Associato a diabete → macrosomia
- Malattie SNC, GI, cardiache, disp. scheletriche
- Idrope
- Controllare crescita fetale (macrosomia)
- Frequente follow-up AFI (bisettimanale)
- Può causare PPROM, PTD



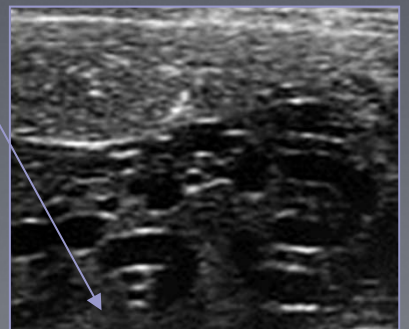


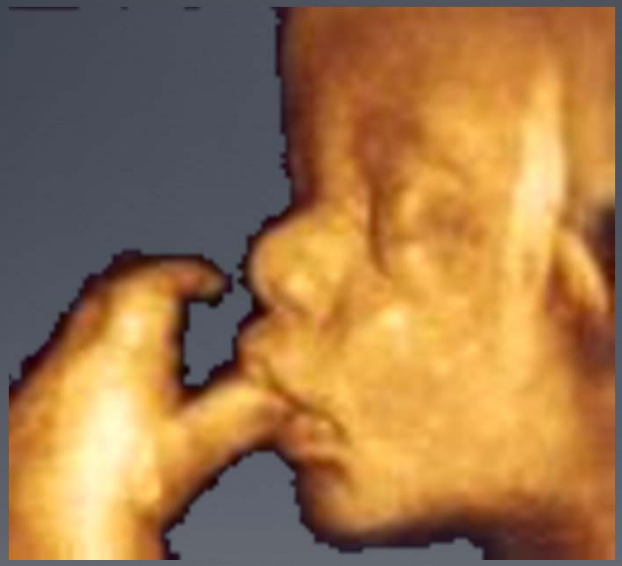
ANNESSI FETALI: LIQUIDO AMNIOTICO

Nelle gravidanze gemellari biamniotiche:

- Polidramnios: TASCA MASSIMA ≥ 8 cm;
- Oligoidramnios: TASCA MASSIMA ≤ 2 cm

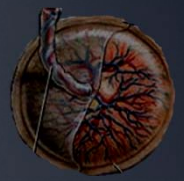
Liquido amniotico "corpuscolato" → NON ha significato clinico



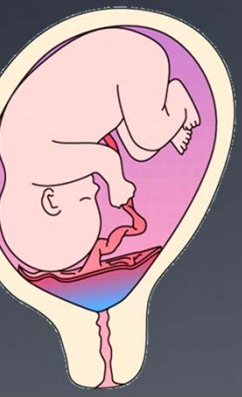


grazie

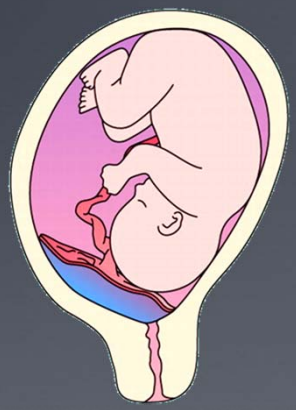
...IESSI FETALI: PLACENTA



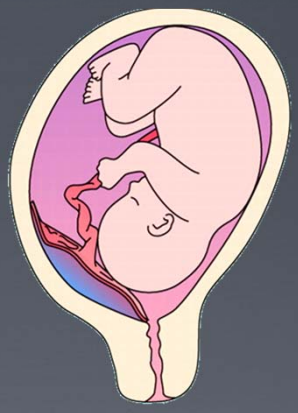
... PLACENTA PREVIA



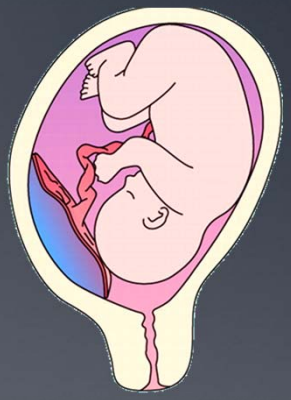
CENTRALE



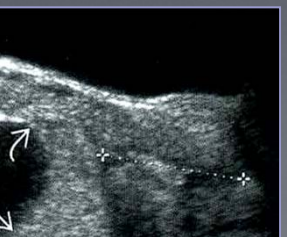
PARZIALE

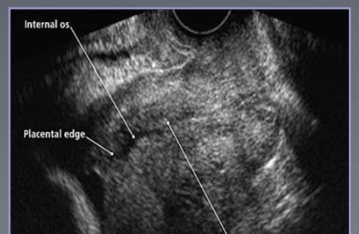


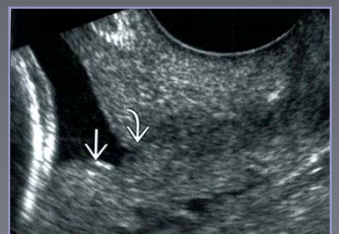
MARGINALE

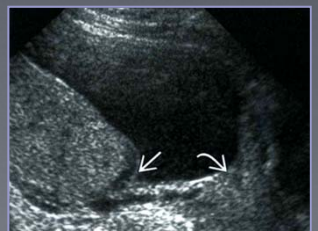


"BASSA"

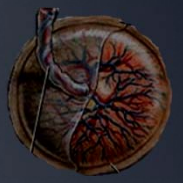




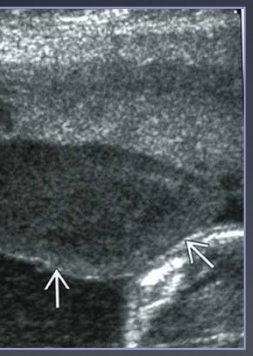
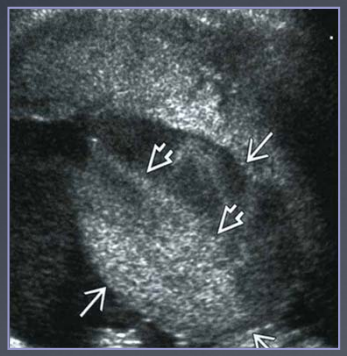
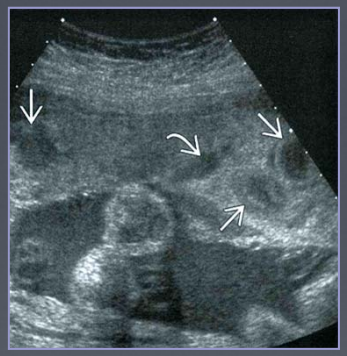
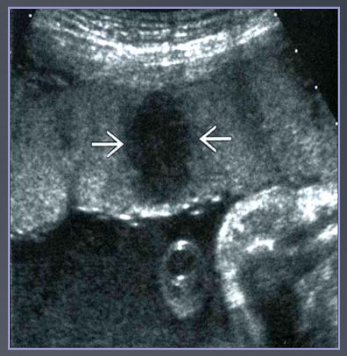




IESSI FETALI: PLACENTA

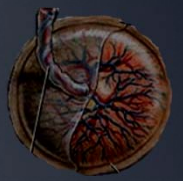


LACUNE PLACENTARI

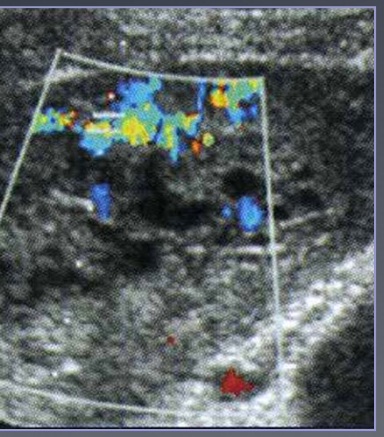
ree ipoecogene placentari NON patologiche
resente flusso sanguigno turbolento (materno) → trombi intervillosi → deposito di fibrina
ngole o multiple
ubcorioniche, intraplacentari o sulla superficie fetale
mensioni variabili
olor Doppler presente (flusso turbolento o lento) o assente se trombizzato

IESSI FETALI: PLACENTA

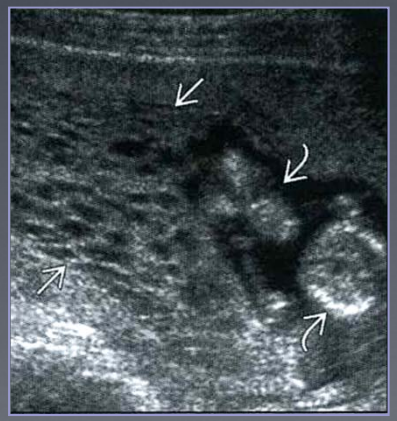


LACUNE PLACENTARI

GNOSI DIFFERENZIALE



MOLA



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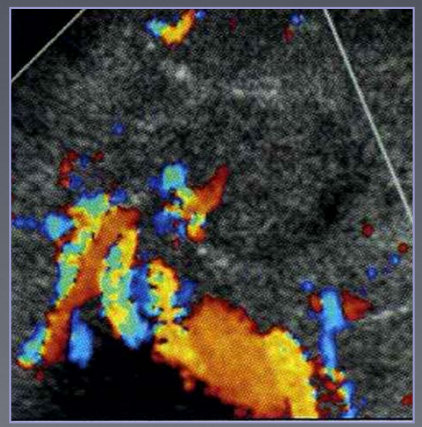
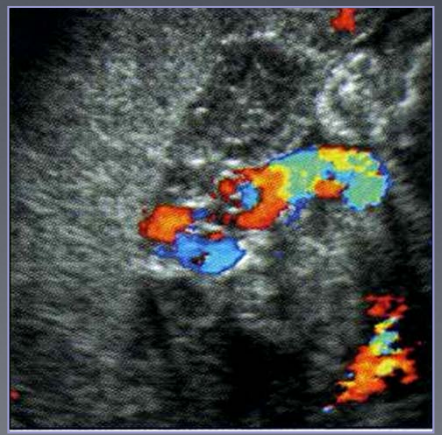


CORIONANGIOMA



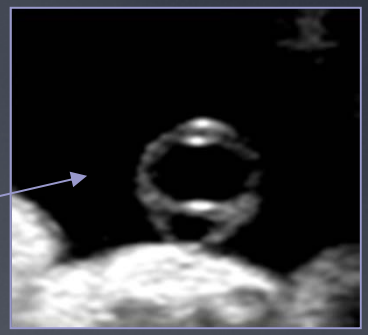
ESSI FETALI: CORDONE OMBELICALE

TERIA OMBELICALE SINGOLA

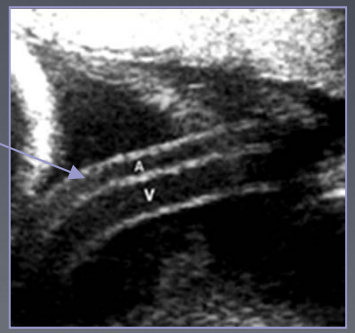
a dell'arteria ombelicale sinistra (70%) o destra (30%)

SI ECOGRAFICA:

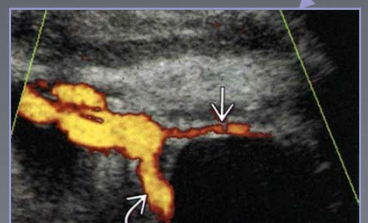
zione trasversale cordone : 2 soli vasi (arteria >>)

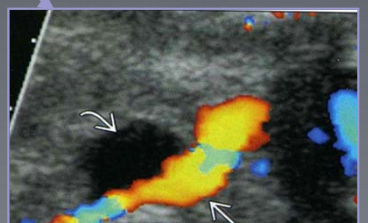


zione longitudinale cordone: 2 vasi longitudinali



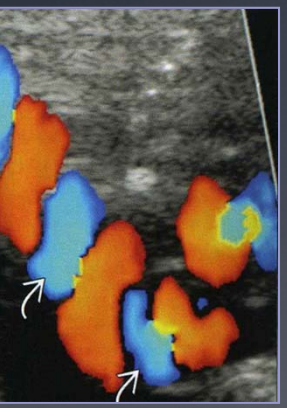
zione trasversale vescica: 1 sola a. ombelicale al Color Doppler



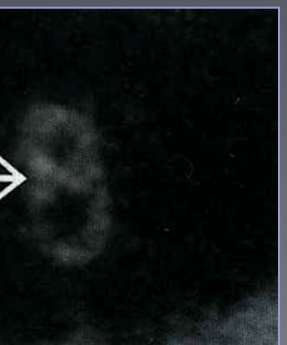


IESSI FETALI: CORDONE OMBELICALE

TERIA OMBELICALE SINGOLA



- 15% sviluppano IUGR (Eseguire follow up ecografico!!)
- Associato a T13 e T18
- NON associato a T21
- Cercare altre anomalie morfologiche (cardiache, renali)



DIAGNOSI DIFFERENZALE

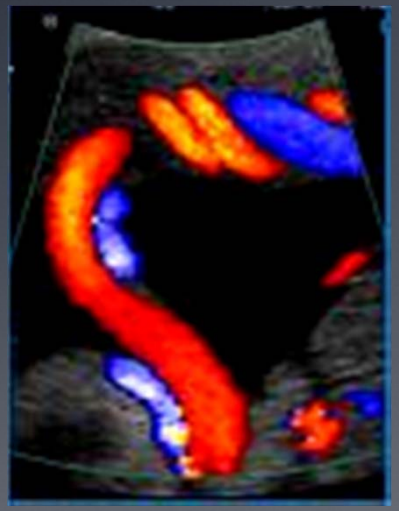
1- Eccessiva gelatina di Wharton

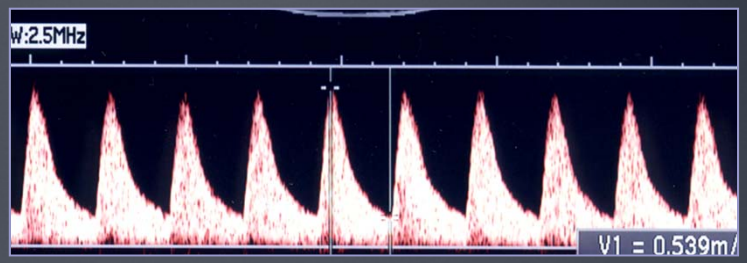
2- Trombosi dei vasi ombelicali

3- Arterie ombelicali fuse

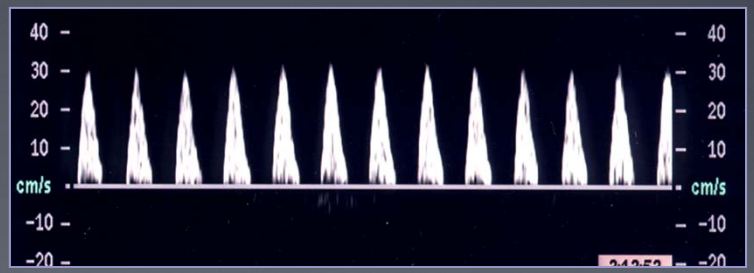
ESSI FETALI: CORDONE OMBELICALE

ER FLUSSIMETRIA





FLUSSO NORMALE



ASSENZA FLUSSO IN DIASTOLE