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PECULIARITIES OF HYSTEROSALPINGOGRAPHY USAGE

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Soares and coworkers showed that hysterosalpingography (HSG)a sensitivity of 58% and a positive-predictive value of 28,6% for polypoid lesions, and a sensitivity of 0% for endometrial hyperplasia. The same study showed HSG to have a sensitivity of 44,4% for uterine malformations, and a sensitivity of 75% for the detection of intrauterine adhession.This contraindication can be avoided by performing the examination before the ovulation phase, between the 7th to 10th day of the menstrual cycle. Because of the scattering risk, the examination should be avoided when there is active intrapelvic inflammation. The procedure is performed in the first half of the menstrual cycle following cessation of bleeding. The endometrium is thin during this proliferative phase, which facilitates better image interpretation and shouldalso ensure that there is no pregnancy.

Antibiotics might be required 1 day before and fora few days after the examination if previous inflammations are present in the patient's clinical history. Antibiotics are required after the examination when the maneuvers are fairly sanguineous or if the fallopian tubes present a certain degree of dilation. The suggested antibiotic regimen is metronidazole 1 grectally at the time of the procedure, plus doxycycline 100 mg twice daily for 7 days. The cervix is localized and cleansed with iodine solution. Afterward, the uterine cervix is straightened by one (at the 12 o'clock position) or two (at the 9 and 3 o'clock positions) surgical forceps exercising a degree of pulling. Next, the outside uterine cervix ostium is catheterized. The catheterization can be performed in two ways. In the past, oil-soluble contrast media were mainly used. Today, we use all available iodinated hydrosoluble contrast media.Results Examination of different patient population has resulted in widely disparate estimates, with a reported prevalence that ranges from 0,16 to 10%. As a result of selection bias, a prevalence of 8 to 10% has been reported in women being evaluated with HSG because of recurrent pregnancy loss. The overall data suggest that the prevalence both in women with normal fertility and infertility is approximately 1%, and the prevalence repeated pregnancy loss is approximately 3%.While the majority of women with mullerian duct anomalies have little problem conceiving, they have higher associated rates of spontaneous abortion, premature delivery, and abnormal fetal position and dystocia at delivery. Most studies report an approximate frequency of 25% for reproductive problems, compared with 10% in the general population.

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VITAMIN D DEFICIENCY DURING PREGNANCY

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Why should anyone be concerned about vitamin D deficiency during pregnancy? The answer is simple: the function of vitamin D is now known to extend well beyond skeletal integrity.

The next question is, how much vitamin D is required to correct this deficiency and achieve circulating 25(OH)D concentrations of >80 nmol/L? It is certain that, in the absence of meaningful sun exposure, the current adequate intake of 200 IU vitamin D/d is far less than enough. Such an intake will do nothing to maintain nutritional vitamin D status, let alone increase it. To increase nutritional vitamin D to meaningful concentrations, dietary intakes of ≥2000 IU/d may be required

Indeed, we believe that these studies are essential. As mentioned earlier, we believe that they are important because vitamin D deficiency during pregnancy not only is linked to maternal skeletal preservation and fetal skeletal formation but also is vital to the fetal "imprinting" that may affect chronic disease susceptibility later in life as well as soon after birth. One need only review a recent report to appreciate the effect of maternal nutritional vitamin D status on childhood bone mineral accrual. The same may well be true for the risks of developing autoimmune diseases, such as multiple sclerosis (which has recently been linked to seasonality of birth) and rheumatoid arthritis, or of conditions such as malignancy.

For study we collected on 20 black women and 20 white women. Samples of maternal blood were collected prior to 22 weeks pregnancy and again just before delivery. Samples of newborn umbilical cord blood also were tested for 25 hydroxyvitamin D, an indicator of vitamin D status. Finding such a proliferation of vitamin D insufficiency in spite of prenatal multivitamin use is troubling, she noted, suggesting that higher dosages, differing vitamin formulations or a moderate increase in sunlight exposure might be necessary to boost vitamin D stores to healthier levels.

In both groups, vitamin D concentrations were highest in summer and lowest in winter and spring. But differences were smaller between seasons for African-American mothers and babies, whose vitamin D deficiency remained more constant. It must be said that study included only children born at term that is between 37 and 42 weeks. In addition, it was also found that women who had in the first trimester, that is during the first 14 weeks, low levels of vitamin D had children with a lower weight for gestational age. These babies are called "small for gestational age.

In our study, more than 80 percent of African-American women and nearly half of white women tested at delivery had levels of vitamin D that were too low, even though more than 90 percent of them used prenatal vitamins during pregnancy. The numbers also were striking for their newborns - 92.4 percent of African-American babies and 66.1 percent of white infants were found to have insufficient vitamin D at birth. Vitamin D is found naturally in fatty fish but few other foods.