

Maternal euglycemia in gestational diabetes mellitus and intrauterine fetal death: A case report

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ABSTRACT

Introduction: Prevalence of diabetes in pregnancy world-wide is 1% to 28% and it is 27% in Malaysia. Since 1909, evidence showed that diabetes in pregnancy had high perinatal mortality. **Case Description:** A 35-year-old Gravida 2 Parity1 booked antenatal care at 9 weeks of pregnancy. Previous pregnancy was delivered by caesarean section indicated with unstable lie. Her booking antenatal investigations were normal as well as protein and sugar were absent in her urine protein. Her BMI was 21.2 Kg/m². Ultrasound scan at 15-week pregnancy showed fetal biometry measurements consistent with gestational age. At 25 weeks of pregnancy, she was diagnosed with gestational diabetes mellitus as modified oral glucose tolerance test result showed 5.4 mmol/L and 8.5 mmol/L at fasting and 2 hours post prandial respectively. Her 7 points blood sugar monitoring results were satisfactory. At 28 weeks of pregnancy, fetal movement was lost, and intrauterine fetal death was confirmed by ultrasound scan. She was referred to Sarawak General Hospital for further management. **Discussion:** Maintenance of normal blood sugar level is accepted as a key modifiable factor to reduce adverse perinatal outcomes. Evidence showed that the intrauterine fetal death in diabetes in pregnancy is associated with antenatal risks high body mass index, weight gain during pregnancy and advanced maternal age. But this pregnant lady didn't have those factors except her age. Causes of intrauterine fetal death in diabetes in pregnancy was still unclear and even in antenatal euglycemia, it would be possible.

45,X/46,X,idic(Y)(q11.2) in a phenotypically normal male with infertility: A case report

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ABSTRACT

Introduction: Testicular biopsy is done for men with azoospermia to determine whether the cause is due to blockage or primary testicular failure. Primary testicular failure affects 1% of the population and 10.7% of these men have chromosomal abnormalities. **Case Description:** We report a case of a 34-yr-old phenotypically normal male with primary infertility with chromosomal abnormalities of 45,X/46,X,idic(Y)(q11.2). At 31 years old, he was referred to our hospital's fertility unit for azoospermia. He has below average height for a Malaysian man (155 cm) but with normal body weight (59 kg). Genital examination showed no abnormalities. Testicular size on the right was 8 mls and on the left was 10 mls. The results of his blood investigation are as follows: FSH 23.0 mIU/ml, LH 10.0 mIU/ml, testosterone 4.87 ng/ml. Biopsy from his testicular tissue showed that only Sertoli cells were present but no germ cells. Chromosomal analysis of his blood revealed 2 cell lines, that is, 46,X,idic(Y)(q11.2) and monosomy X. SRY gene was detected present via PCR analysis. **Discussion:** This case provides new insights regarding genetic causes for non-obstructive azoospermia (NOA) and emphasized the importance for chromosomal analysis for these group of patients. There are reported cases of successful sperm retrieval by microdissection-testicular sperm extraction (MD-TESE) in men with presumed Sertoli Cells Only Syndrome (SCOS), but on men with presumed SCOS with 45,X/46,X,idic(Y)(q11.2). The question remains: Should we proceed with MD-TESE in these group of patients so that they can have hope to have their own biological children?