Részlet a következő dokumentumból:

Clinical practice guidelines for the care of girls and women with Turner syndrome: proceedings from the 2016 Cincinnati International Turner Syndrome Meeting

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*(Details of the International Turner Syndrome Consensus Group is presented in the Summary section)

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http://www.eje-online.org/content/177/3/G1.full.pdf+html

3. Fertility, assisted reproductive technologies and pregnancy

R 3.1. We recommend counseling females with TS that their probability to conceive spontaneously decrease rapidly with age, if at all present, and consideration should be given to offering fertility treatment at a young age (⊕⊕⊕⊕).

R 3.2. We suggest that young mosaic TS women with persistent ovarian function should be counseled that oocyte cryopreservation after controlled ovarian hyperstimulation is a possible fertility preservation option (⊕◯◯◯).

R 3.3. We recommend against routine oocyte retrieval for fertility preservation of young TS girls before the age of 12 years (⊕◯◯◯).

R 3.4. We recommend considering oocyte donation for fertility, only after thorough screening and appropriate counseling (⊕⊕⊕⊕).

R 3.5. We recommend that management of pregnant women with TS should be undertaken by a multidisciplinary team including maternal–fetal medicine specialists and cardiologists with expertise in managing women with TS (⊕⊕⊕◯).

R 3.6. We suggest that other options for motherhood such as adoption or using a gestational carrier should be mentioned during preconception counseling (⊕◯◯◯).

R 3.7. We suggest that all women with TS should be counseled about the increased cardiovascular risk of pregnancy (⊕◯◯◯).

R 3.8. We recommend imaging of the thoracic aorta and heart with a transthoracic echocardiography (TTE) and CT/cardiac magnetic resonance scan (CMR) within 2 years before planned pregnancy or assisted reproductive therapy (ART) in all women with TS (⊕◯◯◯).

R 3.9. We suggest that ART or spontaneous conception should be avoided in case of an ascending aortic size index (ASI) of >2.5 cm/m$_2$ or an ascending ASI 2.0–2.5 cm/m$_2$ with associated risk factors for aortic dissection (AoD), which include bicuspid aortic valve, elongation of the transverse aorta, coarctation of the aorta and hypertension (⊕◯◯◯).

R 3.10. We suggest that women with a history of AoD should be advised against pregnancy. If already pregnant these women should be followed very closely at a specialist center and deliver by cesarean section (⊕◯◯◯).

R 3.11. We suggest performing TTE in women with TS without aortic dilatation or other risk factors (hypertension, bicuspid aortic valve, coarctation, previous aortic surgery) at least once during pregnancy, at approximately 20 weeks of gestation (⊕◯◯◯).

R 3.12. We suggest that women with TS with an ascending ASI >2.0 cm/m$_2$ or any risk factor (hypertension, bicuspid aortic valve, coarctation, previous AoD or surgery) should be monitored frequently, including TTE at 4- to 8-week intervals during pregnancy and during the first 6 months postpartum (⊕◯◯◯).

R 3.13. We suggest that CMR imaging (without gadolinium) should be performed during pregnancy when there is suspicion of disease of the distal ascending aorta, aortic arch or descending aorta (⊕◯◯◯).

R 3.14. We recommend that blood pressure control is strict (135/85 mmHg) in all pregnant women with TS (⊕◯◯◯).

R 3.15. We suggest that during pregnancy, prophylactic surgery is reasonable in case of a dilated aorta with rapid increase in diameter (⊕◯◯◯).

R 3.16. We suggest that in case of an acute ascending AoD before the fetus is viable, to perform emergency aortic surgery understanding that fetal viability may be at risk. If the fetus is viable, it is reasonable to perform cesarean section first, followed by aortic surgery, which should be performed under near-normothermia, pulsatile perfusion, high pump flow and avoidance of vasoconstrictors (⊕◯◯◯).

R 3.17. We suggest that exercise testing before pregnancy can be useful to reveal exercise induced hypertension, especially in women with coarctation (⊕◯◯◯).

R 3.18. We suggest that women with aortic dilatation, bicuspid aortic valve, elongation of the transverse aorta, coarctation of the aorta and/or hypertension should be advised that pregnancy would carry a high risk of AoD (⊕◯◯◯).

R 3.19. We suggest that vaginal delivery is reasonable in women with TS with an ascending ASI below 2.0 cm/m$_2$ (⊕◯◯◯).

R 3.20. We suggest that in women with TS with an ascending ASI of 2.0–2.5 cm/m$_2$, a vaginal delivery with epidural anesthesia and expedited second stage is preferred or a cesarean section may be considered. In women with TS with an ascending ASI >2.5 cm/m$_2$, a cesarean section is reasonable or a vaginal delivery with epidural anesthesia and expedited second stage may be considered (⊕◯◯◯).

R 3.21. We recommend that in women with TS with a history of AoD, a cesarean section should be performed (⊕◯◯◯).