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"I thought it was a miscarriage!"

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ABSTRACT

Introduction: Cervical ectopic pregnancy (CEP) is very rare with an incidence of <1% of all ectopic pregnancies. When misdiagnosed, it results in intractable haemorrhage and even mortality. Most often, CEP is misdiagnosed as miscarriage. **Case Description:** We discuss 2 cases of misdiagnosed CEP which fortunately conservative management resulted in favourable outcomes. We managed two multiparous patients with previous history of caesarean section who presented with persistent painless per-vaginal bleeding from early pregnancy with a diagnosis of miscarriage. Speculum examination revealed opened cervical os. An attempt for evacuation resulted in torrential haemorrhage and hypovolemic shock. However, after Foley's balloon tamponade and vaginal packing, the bleeding stopped. Both the patients received methotrexate 50 mg/m2. One of the patients subsequently required a second dose of MTX and re-bled. Her transvaginal doppler showed reduced in size and vascularization of the cervical mass. She was subjected to suction and curettage. It was successful. Both patients were followed up till βhCG levels normalized and discharged well. **Discussion:** CEP can be managed conservatively with MTX. Some patients may require additional dose of MTX, and timely attempt of evacuation may be done once vascularization has reduced. Future fertility and uterine conservation are factors for consideration especially in the reproductive age group. Conservative management for CEP is a valid option in patients whose bleeding is controlled. Compliance to follow up and monitoring is vital. The decision for hysterectomy should be reserved only for patients with intractable haemorrhage.

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Fetal anaemia following preterm en caul delivery with velamentous cord insertion

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ABSTRACT

Introduction: En caul delivery is defined as delivery of fetus in the sac with fully intact membrane. It was recommended in preterm in estimated fetal weight < 1,500 gram during Caesarean section to reduce risk of fetal injury caused by 'hug-me-tight' uterine contraction and surgeon hands. However, in some cases en caul can be dangerous due to fetal hemorrhage. **Objectives:** This case series describes our experience in IIUM performing en caul delivery in preterm birth and its immediate sequalae with regards to fetal anemia and birth trauma. **Methods:** Case series. **Results:** Two were born with intact membrane and one in partial en caul. One reported to have severe anemia and another two without neonatal anemia. None of the babies had birth trauma. **Conclusions:** En caul delivery can be beneficial in properly selected cases and application of good surgical technique resulting in less birth injury and good fetal outcome. From our experience to make this delivery technique safe and beneficial for extreme preterm fetus, we strongly suggest that the cord insertion need to be identified prior caesarean section, in case of central cord insertion it is safe to deliver en caul. However, if velamentous or abnormally localized cord insertion was identified, immediate clamping of the cord can reduce the complication of fetal hemorrhage and anemia.