# Mismatch nightmare!

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**ABSTRACT**

**Introduction:** Mismatched transfusion of blood. in women in the reproductive age group poses a risk of intravascular hemolysis to the woman and hemolytic disease of fetus and newborn (HDFN) in subsequent pregnancies. We present 2 cases of mismatched transfusion for learning purposes for all. **Case Description:** Two RhD-negative patients with ruptured ectopic pregnancy were unstable, and required transfusion of Rh-D-positive blood for emergency resuscitation, as immediate procurement of rhesus-negative blood was impossible. Both patients received anti-D immunoglobulin and were monitored closely for hemolysis. Both recovered well post-surgery without any signs of severe intravascular hemolysis or multiorgan failure. Short-course steroids, erythropoietin stimulating agent, and parenteral iron were prescribed for the second patient post-surgery. Monthly out-patient reviews with monitoring of full blood count, liver function, and antibody titres were arranged for 6 months. There was no delayed hemolysis for both patients at 3 months post-event. **Discussion:** Mismatched transfusion should be a "never event". However, with the shortage of rhesus-negative blood, we will face situations whereby mismatched transfusion would be required as a lifesaving measure. It is important to have a protocol for the management of inadvertent mismatch transfusion and immediate and long-term follow-up involving multidisciplinary teams. The dose and timing of anti-D immunoglobulin are crucial in ensuring adequate removal of D-positive red cells while monitoring for complications of intravascular hemolysis. The couple must also be made aware of the risk of Hemolytic Disease of the fetus and newborn (HDFN) in subsequent pregnancies with the possibility of requiring in-utero transfusion and iatrogenic premature delivery. All future pregnancies are deemed high risk and require Maternal Fetal Medicine follow-up.



# Bilateral tubal ectopic pregnancies: A rare phenomena

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**ABSTRACT**

**Introduction:** Ectopic pregnancy is common in the general population. Conversely, bilateral tubal ectopic pregnancy (BTP) is the rarest form of extra-uterine pregnancy. The occurrence has increased with most cases being associated with assisted reproduction techniques (ART), pelvic inflammatory disease and a history of previous ectopic pregnancy or tubal surgeries. In this report, we discuss a patient with spontaneous BTP diagnosed intra-operatively. **Case Description:** A 30-year-old lady, Gravida 2 Para 1 with previous caesarean section with unknown gestation period, presented to the Emergency Department with abdominal pain associated with per vaginal bleeding. She was pale, hypotensive, and tachycardic. A full clinical examination and abdominal ultrasound were performed. Hence, a diagnosis of ruptured ectopic pregnancy in hypovolaemic shock was made. She was resuscitated and had an emergency laparotomy. Intra-operatively there were two liters of hemoperitoneum with ruptured left tubal pregnancy, and right tubal pregnancy which was adhered to the omentum. Other pelvic structures were normal. Left salpingectomy and right salpingotomy were performed. The patient made a complete recovery post-operatively and histology examination confirmed BTP. During follow-up, a serial beta-hCG measurement was performed until complete resolution. A tubal patency test done 6 months later showed a patent right fallopian tube. **Discussion:** Diagnosis of BTP is challenging as the presentations are similar in unilateral involvement. Serum beta-hCG level and ultrasonography have a limited role in making the diagnosis pre-operatively. Therefore, a careful inspection of the adnexa at the time of surgery should be the standard of care in any ectopic case.