

Partial Hemolysis, Elevated Liver Enzyme and Low Platelets (HELLP) syndrome – dilemma in delivery

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ABSTRACT

Introduction: HELLP syndrome is a known complication of pre-eclampsia, with an incidence of around 0.5-0.9% of all pregnancies. It mostly occurs during the 3rd trimester, in the multiparous and advanced maternal age group. **Case Description:** A 38-year-old lady, G5P4 at 28 weeks of gestation, with the following risk factors: 1) gestational hypertension on treatment, 2) one previous caesarean section followed by three Vaginal Birth After Caesarean Sections (VBAC0 and 3) maternal obesity. She presented with symptoms of acute gastritis and possible gestational thrombocytopenia. Her symptoms persisted despite regular antacids and analgesia. Serial blood investigations showed a down-going trend of the platelet count and a marginal rise of liver enzymes, with no evidence of haemolysis on the peripheral smear. A working diagnosis of partial HELLP syndrome was made following a multidisciplinary discussion. She received dexamethasone for fetal lung maturation and was closely monitored in the high-dependency unit. Unfortunately, her condition worsened, and she developed a complete HELLP syndrome. Thus, she was delivered by emergency caesarean section. Post-delivery, her blood parameters slowly returned to normal. She was discharged home well on day seven postpartum. **Discussion:** HELLP syndrome is associated with haemolysis, elevated liver enzymes and thrombocytopenia. Diagnosis of the complete form of HELLP syndrome requires all three major components. In contrast, partial HELLP syndrome consists of only 1 or 2 elements of the triad and develops fewer complications than those with the complete form. The definitive management is delivery, but timing and delivery mode are paramount for balancing the pro and cons of prematurity and patient safety.

Uterine arteriovenous malformation during pregnancy

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ABSTRACT

Introduction: Arteriovenous malformation (AVM) is an abnormal connection between an artery and a vein that bypasses the capillary system. It is usually asymptomatic but can cause massive bleeding or severe pain. Uterine AVM is classified as a congenital or acquired lesion. **Case Description:** A 24-year-old primigravida at 35 weeks of gestation presented with per vaginal bleeding for a day associated with contraction pain. A diagnosis of major placenta praevia was made and we performed an emergency caesarean section for fetal distress. Intra-operatively, there was a presence of major placenta praevia posterior and uterine AVM, with multiple and severely tortuous engorged vessels involving the intrauterine cavity and right posterolateral aspect of the uterus. Multiple haemostatic sutures were applied at the placental bed and bilateral internal iliac artery ligation was performed. Bakri Balloon was inserted intrauterine cavity to create a tamponade, and we applied Taff compression over the posterior aspect of the uterus. She had a massive Post-partum Haemorrhage (PPH) with an estimated blood loss of 3 litres, requiring multiple blood transfusions. She was closely monitored in the High Dependency Unit (HDU) post-operatively, and Bakri Balloon was removed on the following day. She was discharged home on day seven post-delivery. **Discussion:** Uterine AVM is an extremely rare and potentially life-threatening condition, which can cause massive bleeding and lead to maternal death. Treatment options include hysterectomy and endovascular embolization. Massive transfusion, Bakri Balloon tamponade, and internal iliac artery ligation are part of the measures to control bleeding. Hemodynamic stabilization of the patient is the main consideration.