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Cerebral venous thrombosis in postpartum: A case series

Siti Nuriah Rafiah Ibrahim, Sarah Yi Xin Khoo, KN Kamarudin

Obstetrics & Gynaecology Department, Hospital Seri Manjung, Seri Manjung, Perak, Malaysia

ABSTRACT

Introduction: Cerebral venous thrombosis (CVT) is a rare neurological emergency that occurs more often in women during pregnancy and puerperium than in the general population. The symptoms of CVT include sudden onset headache, altered level of consciousness and seizure. **Case Description:** (Case 1) A 33-year-old, para 1, who underwent emergency caesarean section for placenta abruptio at 32 weeks and was treated for hypertension post-delivery. She had a prolonged hospital stay due to a wound infection. On day 9 postpartum, she complained of a severe headache which was not resolved with analgesia. Subsequently, she developed a generalised tonic clonic seizure with post-ictal drowsiness. Magnesium sulphate infusion for eclampsia was administered. CT brain was performed in view of the altered level of consciousness. The CT reported a superior sagittal sinus thrombosis complicated by a worsening venous haemorrhagic infarct. (Case 2) A 35-year-old, Para 6 underwent elective caesarean section for a transverse lie. Her BMI was 44.9 kg/m^2. On day 2 post-operation, she had a sudden onset of left-sided weakness and developed recurrent seizures. She was treated for eclampsia and started on magnesium sulphate. No evidence of intracranial haemorrhage was found on CT Brain. Later on, due to her worsening neurological deficit, a repeat CT brain with a CT venogram was performed, which showed superior sagittal sinus and left sinus thrombosis. **Discussion:** Different clinical manifestation of CVT makes it difficult to be diagnosed early. It usually mimics other postpartum clinical diagnoses such as eclampsia. Early diagnosis of CVT is crucial so that appropriate management can be made.

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Ovarian ectopic: A diagnostic dilemma

Suriani Idris, Zaidatul Husna binti Mohamad Noor, Jamiyah Hassan

Department of Obstetrics and Gynaecology, Faculty of Medicine UiTM, Selangor, Malaysia

ABSTRACT

Introduction: Ovarian ectopic pregnancy is one of the most uncommon types of ectopic pregnancy. Primary ovarian pregnancy occurs between 1/7,000 and 1/40,000 times in live births and accounts for between 0.5 and 3% of all ectopic pregnancies. The main risk factors include the intrauterine contraceptive device (IUCD), salpingitis, infertility, and assisted reproductive methods. **Case Description:** A 31-year-old, Para 0+2 (with a past history of right salpingectomy for tubal ectopic in 2011) presented with worsening acute lower abdominal pain of 3 days duration. Her last menstrual period was 6 weeks ago and was regular. Initial diagnosis of ectopic was made as tenderness was elicited on abdomen examination with scan showing an empty uterus with free fluids. Emergency diagnostic laparoscopy showed negative findings. Serial B-HCG showed a persistent rise after surgery, from 28,836.6 to 38,633.8 U/L. The transvaginal scan showed an echogenic sac with fetal cardiac activity in the right ovary. The patient underwent a second diagnostic laparoscopy. Intraoperative findings were an enlarged right ovary with a product of conception, which was expulsed upon manipulation. Right oophorectomy was subsequently performed. Histopathology report confirmed fragments of ovarian tissue with deciduoid stroma and attached chorionic villi which is consistent with ectopic (ovarian) pregnancy. **Discussion:** The incidence of ovarian pregnancy is on the rise. While ultrasonography can identify ovarian ectopic in unruptured cases, it is not easy to differentiate ovarian from tubal ectopic in a ruptured state. Most patients present in a ruptured state, making medical management options largely impossible. Surgical management remains the main treatment option.