Background Pre-eclampsia is associated with maternal and neonatal morbidity and mortality. Delivery is often expedited to minimise maternal complications at the risk of prematurity-related complications in the baby. The important outcomes to be evaluated in the management of pregnant women with pre-eclampsia between 34 to 37 weeks gestation is unclear.

Objective To identify the clinically important components of maternal and neonatal composite outcomes in the management of women with mild to moderate pre-eclampsia between 34 to 37 weeks by a Delphi survey of experts.

Methods A two-generational Delphi method was used to prioritise the maternal and neonatal outcomes that are considered to be important in the timing of delivery in women with mild to moderate pre-eclampsia.

Results The maternal outcomes questionnaire was sent to 20 participants and the neonatal outcomes questionnaire to 24 participants. 18/20 participants (90%) responded in the first round for maternal outcomes and 18/24 participants (75%) for neonatal outcomes. In the second round 16/17 eligible participants (94%) responded for maternal outcomes and 18/18 participants (100%) for the neonatal outcomes. 21 maternal and 24 neonatal outcomes were evaluated in the first round and 17 maternal and 25 neonatal outcomes in the second round. We identified 17 and 18 components to be clinically important for development of the maternal and neonatal composite outcomes respectively. If accepted, we will be able to provide full details of the relevant outcomes.

Conclusion The composite maternal and neonatal outcomes will allow evaluation of the effect of intervention to reduce mortality and morbidity.

Results All patients with confirmed PPROM received erythromycin and steroid. Incidence of gestation <34 weeks at PPROM was 40%, of delivery at <34 weeks was 28%. Prolongation of pregnancy of 2–7 days occurred in 52%, 7–14 days in 2% and >14 days in 13%. Timing of induction of labour (IOL) varied from 34 to 36 + 6 weeks although without any adverse outcomes. There were two neonatal deaths (NND) following spontaneous labour.

Conclusion Prolongation of pregnancy of 48 hours or more occurred in a significant percentage of patients with conservative management. Prematurity played a crucial role in the two instances of NND. It is not clear that outcomes would have been different with different clinical management. This series shows that PPROM carries significant threat to perinatal outcome even with optimum obstetric care.

Abstracts
We discuss the case of two sets of twins, with extreme premature delivery of 1st twin prolonging the gestation of the 2nd twin using close surveillance and a cervical suture.

A 36 year old primip, IVF conception with a previous large loop excision of the transformation zone (LEEPZ) attended with blood stained discharge. Vaginal examination revealed bulging membranes (cervix 3 cm dilated). Shortly after she had spontaneous rupture membranes and delivered a 19 + 5 a SB infant. Viability of second twin was confirmed leading to a rescue McIndoals suture. Cyclogest pessaries and cinidamycin PV were commenced. At 21 weeks she was re-admitted feeling generally unwell with a low grade fever. Steroids were given at 24 weeks gestation. At 30/40 she went into pre term labour. The suture was removed and she progressed rapidly to full dilatation and delivered. The baby made good grade fever. Steroids were given at 24 weeks gestation. At 30/40 she went into pre term labour. The suture was removed and she progressed rapidly to full dilatation and delivered. The baby made good progress on neonatal unit.

A 31 year old primip, IVF twins, presented with bleeding and SRM at 17 weeks gestation. She proceeded to deliver Twin 1. A rescue suture was inserted. Ante natal course was uneventful and the suture was removed at 36/40. She progressed into spontaneous labour and had a LSCS due to persistence of a pathological CTG.

Maternal and fetal morbidity and mortality from abnormal placentation could be catastrophic. Early uterine rupture is challenging diagnosis, because initial signs/symptoms are nonspecific and this delay definitive treatment.

Pregnancy of unknown location (PUL) refers to cases where there are no signs of intrauterine or extraterine pregnancy on transvaginal ultrasound as well as no evidence of retained products of conception. The most recent report of the Confidential Enquiry into Maternal Deaths in the United Kingdom suggested that the term PUL should be abandoned and that “an early pregnancy ultrasound which fails to identify an intrauterine sac should stimulate active exclusion of tubal pregnancy”.

The Early Pregnancy Assessment Unit in the Coombe Women and Infants Maternity Hospital recorded 3,900 patient visits during the study period. We examined cases of women with a diagnosis of PUL who presented between September 2011 and September 2012. Data was obtained retrospectively from routine information ascertained at the time of initial consultation and from patient records.

190 women had a diagnosis of PUL at their initial presentation to the EPAU. Mean gestation at presentation was 7.0 weeks (4.0–12.0). 158 women (83.1%) were subsequently diagnosed with complete miscarriage. 18 women (9.5%) had an ongoing intrauterine pregnancy. 14 women (7.4%) were diagnosed with an ectopic pregnancy at a subsequent visit. The average number of samples taken for serum βHCG measurement was 2.3 and the average duration of follow-up of all women was 5.8 days. The incidence of PUL in women attending our unit was 4.8%.

Conservative management of pregnancy of unknown location is safe when carried out in a setting which enables patients to be monitored closely with rapid access to transvaginal ultrasound and serum βHCG quantification.