

1. 34 yrs G5P3 (Cs × 2, SVD × 1, 1 miscarriage) admitted with pain and fainting at 25/40, deteriorated so needed Laparotomy, at surgery, large haemoperitoneum; left sided (5 × 8 cm) uterine rupture, male baby delivered by classical Caesarean died immediately, unable to stop bleeding so subtotal hysterectomy performed, had blood transfusion and admitted to ITU. Histology placenta percreta...
2. 27 yrs G3P1 (Cs × 1, ×1 STOP) known bicornuate uterus, anterior low lying placenta, admitted with massive APH at 29/40 needing emergency classical Caesarean, at surgery there was left sided (10 × 8 cm defect) uterine rupture, found haemoperitoneum, female fetus good condition died later. Uterus re-constructed; bleeding managed with Rusch balloon, medicines, blood transfusion. HDU care. Histology placenta Increta.
3. 39 yrs G6P3 (×3 Cs, miscarriage, 1 Top) known posterior placenta praevia, cerclage insitu, admitted with APH and fetal distress at 33/40, emergency Caesarean, uterine rupture and placenta accreta. Baby boy good condition PPH; failed conservative management; needed subtotal hysterectomy, blood transfusion and ITU Admission. Histology Placenta accrete.

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.

**PP.92** **MANAGEMENT OF THE SECOND TWIN AFTER EXTREME PREMATURE DELIVERY OF THE FIRST**

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*SJ Bonner, F Soydemir. Royal Preston Hospital, NHS foundation trust, Preston, Lancashire, North west, UK*

We discuss the case of two sets of twins, with extreme premature delivery of 1<sup>st</sup> twin prolonging the gestation of the 2<sup>nd</sup> 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 (LLETZ) attended with blood stained discharge. Vaginal examination revealed bulging membranes (cervix 3 cm dilated). Shortly after she had spontaneous ruptured membranes and delivered a 19 + 5 a SB infant. Viability of second twin was confirmed leading to a rescue Mcdonnalds suture. Cyclogest pessaries and clinidamycin 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 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.

Although evidence limited the cases have highlight that in some circumstances insertion of a rescue cervical suture is beneficial to prolong the gestation and viability of the second twin. Both of these sets of twins had oligohydramnios after suture insertion which then normalised throughout the rest of the antenatal course.

**PP.93** **PREGNANCY OF UNKNOWN LOCATION OUTCOMES IN AN EPAU SETTING**

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*DA Crosby, A Mullally, N Farah, M Anglim, S Gul, C Fitzpatrick. Coombe Women and Infants University Hospital, Dublin, Ireland*

Pregnancy of unknown location (PUL) refers to cases where there are no signs of intrauterine or extrauterine 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.

**PP.94** **DELAYED INTERVAL DELIVERY IN MULTIPLE PREGNANCY: A CASE REPORT**

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*J O'Neill, A Ahmed, D Hayes-Ryan, E O'Donnell. Waterford Regional Hospital, Waterford, Ireland*

We present a very unusual case of a set of twins delivering 87 days apart and with a birth weight difference of 1990 g with survival of both.

A 33 year old woman with 2 previous full term vaginal deliveries presented to the EPAU of our department at 6 weeks gestation with light PV bleeding. Ultrasound confirmed DCDA twin pregnancy. Follow-up ultrasound 10 days later confirmed an ongoing pregnancy. She had formal booking appointment at 12 weeks and an uncomplicated pregnancy with regular review until 23 + 5 gestation when she presented with brown PV watery loss. PPROM of Twin 1 was confirmed. She was afebrile with normal BP and HR. HVS was taken, oral erythromycin commenced and bethamethasone administered. She was retained for inpatient monitoring and counselled about the associated risks of preterm delivery.

24 hours following admission she began contracting and had a quick spontaneous breech vaginal delivery of twin 1, a female, at 24 + 0 weeks weighing 550 g. Twin 2 was Cephalic with normal liquor volume on ultrasound. A trial of conservative management was agreed. She was retained in hospital for 4 hourly temperature, HR and BP checks as well as weekly HVS, CRP and FBC monitoring and ultrasound surveillance.

Her inpatient management period was uneventful and she was induced at 36 + 3 gestation with 1 mg of Prostaglandin PV and went on a few hours later to have a spontaneous vaginal delivery of Twin 2, a female, weighing 2.54 Kg as well as the retained placenta of Twin 1.