PP-09

Amniotic fluid embolism: A successful outcome

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ABSTRACT

Introduction: Amniotic fluid embolism (AFE), characterized by sudden cardiorespiratory collapse and disseminated intravascular coagulation, is a rare obstetric emergency with a high maternal mortality rate. An estimated 2-6/100,000 pregnancies are affected by amniotic fluid embolism and comprise of 10% of maternal deaths. **Case Description:** A 37-year-old, G7P6 at 37 weeks of gestation, was admitted for expectant management of asymptomatic major placenta praevia since 34 weeks. She was diagnosed with asymptomatic sinus arrhythmia with resolved bradycardia in 2020. Her last echocardiogram in September 2020 was reported as normal. She also had chronic hypertension not on treatment, and a history of macrosomia with an uneventful vaginal delivery. The patient developed contractions and vaginal bleeding prior to her planned operation hence emergency caesarean section was performed. During the delivery, patient developed: 1) cardiac arrest requiring intubation and cardioversion, and 2) primary postpartum haemorrhage secondary to disseminated intravascular insemination requiring massive blood transfusion. Hysterectomy and bilateral internal iliac artery ligation were then performed. The baby weighed 3.7 kg and was admitted to the Neonatal Ward for transient tachypnoea of the newborn with a good Apgar score. Post-operatively, she was nursed in the Intensive Care Unit, and extubated the day after. On day 3, she developed intra-abdominal bleeding from the bladder base and retroperitoneal areas, requiring re-laparotomy and haemostatic sutures. **Discussion:** Studies vary depending on how the data is collected, but the mortality rate is as high as 60%. Prompt management and treatment of patients with AFE will improve survival. Survivors may have long-term physical or psychological side effects.

PP-10

A case series of successful aspirin desensitization in acetylsalicylic acid-sensitive pregnant women

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ABSTRACT

Introduction: Low-dose acetylsalicylic acid (ASA) is an essential drug used in pregnancy to prevent pre-eclampsia and to treat anti-phospholipid syndrome (APS). However, some pregnant women who are indicated for low-dose ASA cannot benefit from it because of ASA hypersensitivity. We described three cases of successful ASA desensitization in pregnancy for which they were able to continue daily ASA throughout their pregnancy. **Case Description:** The first case was a 44-year-old, G4P3 at 15 weeks gestation with underlying systemic lupus erythematosus (SLE) and hypersensitivity to ASA and non-steroidal anti-inflammatory drugs (NSAIDs) who required low-dose ASA to prevent pre-eclampsia. The second case was a 24-year-old primigravida at 12 weeks gestation with SLE, chronic hypertension, and positivity of triple antiphospholipid antibodies. She was allergic to ASA but required it to prevent pre-eclampsia and thrombosis. The third case was a 35-year-old G4P0+3 at 6 weeks gestation with primary obstetric APS and ASA-sensitive. In her third pregnancy, she was treated with therapeutic low-molecular weight heparin without ASA, but the pregnancy ended up a pregnancy loss at 19 weeks gestation. All three patients underwent successful ASA desensitization for which they received incremental doses of ASA up to 150 mg over 3.5 hours and were monitored for signs and symptoms of allergic reactions. **Discussion:** ASA desensitisation procedure, which involves gradually increasing exposure to ASA, eliminates immunological reactions. It is the most viable option for ASA-sensitive pregnant women who have obstetric complications preventable by daily ASA prophylaxis.