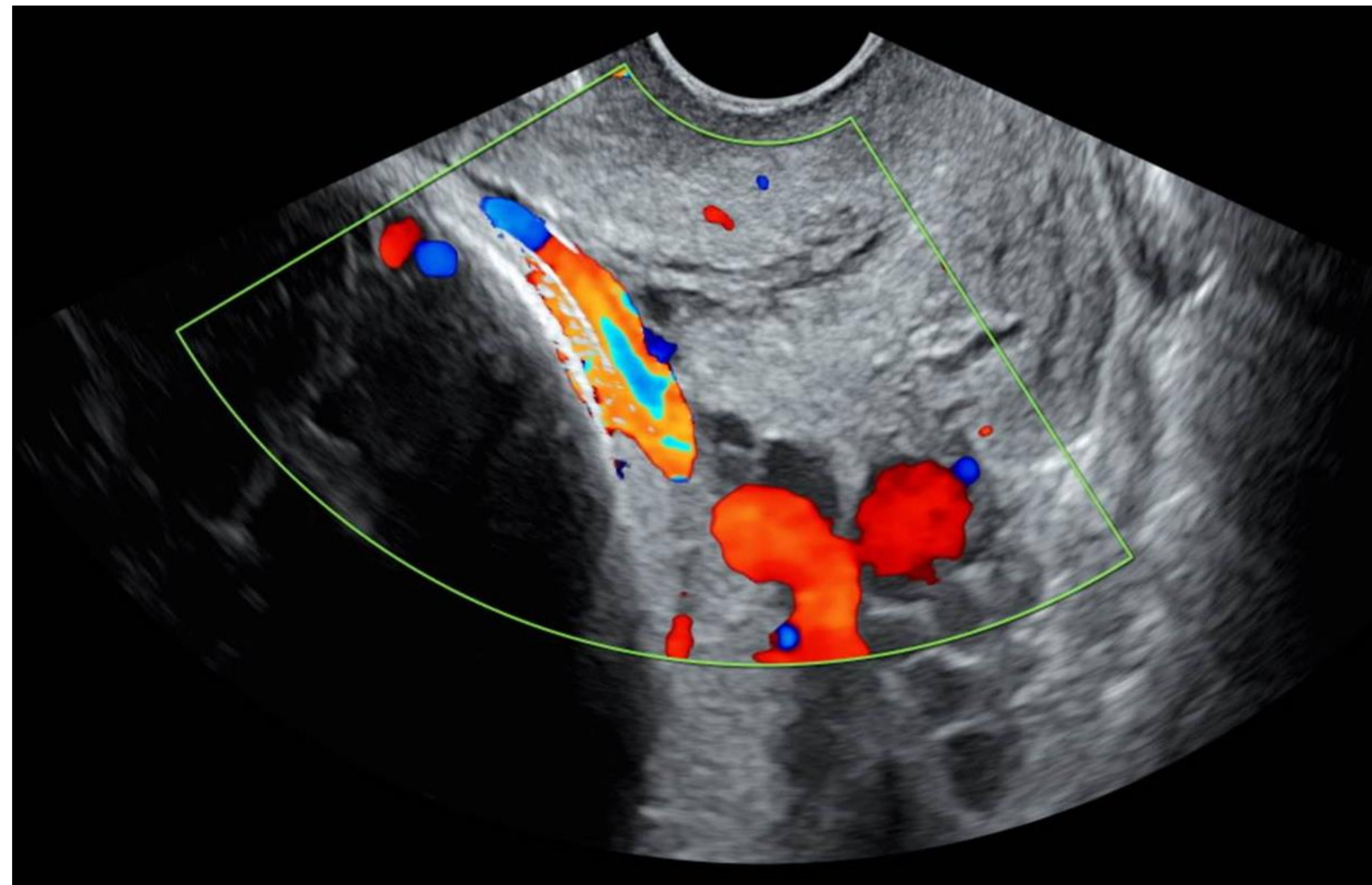


Type 2 vasa praevia in a patient with previous surgical pregnancy termination

Shingai Makotore, Oguljemal Redjepova, Jack Lowe-Zinola, Manuela Heim

Case report

We present a 24 year old, gravida 2 para 0, with a body mass index of 29, and no significant past medical history. Her only surgical history was of a surgical termination of pregnancy performed 10 years previously at 9 weeks gestation. She was identified as having a posterior low lying placenta with an anterior succenturiate lobe, with free fetal vessels seen running over the internal cervical os (image below). She was delivered by caesarean section at 36 weeks gestation after the administration of antenatal corticosteroids to promote fetal lung maturity, and both mother and baby were well following delivery. Type 2 vasa praevia with bilobate placenta was confirmed at delivery (image right).



Discussion

Vasa praevia is a rare condition in which unprotected fetal vessels run freely in the placental membranes. The incidence is thought to be between 1 in 1200 to 1 in 5000 pregnancies, and with a reported fetal mortality rate of at least 60% in the case of fetal haemorrhage with rupture of membranes. The Royal College of Obstetricians and Gynaecologists support delivery by planned caesarean section between 34 and 36 weeks gestation following administration of antenatal corticosteroids in diagnosed cases of vasa praevia.¹ Vasa praevia is associated with placenta praevia, and research has demonstrated an increased risk of placenta praevia following endometrial curettage.² There is, however, a paucity of evidence as to a specific link between surgical curettage, including termination of pregnancy and management of miscarriage, and an increased risk of vasa praevia.

Conclusion

Given the high risk of vasa praevia in patients with low lying bilobate placenta, and the potentially devastating consequences of undiagnosed vasa praevia, we suggest that screening for the condition between 32 and 34 weeks gestation is necessitated in all such patients. Furthermore, as vasa praevia is not always visible on trans-abdominal ultrasound, we recommend this screening should be carried out using trans-vaginal ultrasonography, even where the placenta is no longer low lying.

