CT angiogram in triple phase showed high probability of AV malformation with a high risk of sudden massive hemorrhage. Treatment options of uterine artery embolisation (UAE), surgical excision, hysterectomy and methotrexate discussed within multidisciplinary team meeting (MDT) and patient, who had methotrexate injection and UAE. Post-embolisation the bleeding significantly reduced and BHCG fell significantly to 142IU with 60% reduction in the vascularity of the vessels on scan. Patient is still under follow-up with BHCG levels.

Scar ectopic pregnancy is increasing due to higher Caesarean section rates. The incidence in the UK is 1.5 per 10,000 and occur due to implantation of the embryo into the myometrium and fibrous tissue caused by uterine surgery. The UK Early Pregnancy Surveillance Service found that surgery is more successful compared to medical (methotrexate) or conservative options with lower complication rates. The diagnosis and management is complex and as in our case management options must be discussed in MDT and extensively with the patient.

VP59.34
Edematous fallopian tube from ovarian torsion can be mistaken for acute appendicitis
R.B. Singson1,2

1 Obstetrics and Gynecology, St Luke’s Medical Centre Global City, Muntinlupa, Metromanila, Philippines; 2 Obstetrics and Gynecology, Makati Medical Centre, Makati, Philippines

A 27-year-old, G1P1, 12 weeks’ pregnant was admitted to the emergency room for severe right-sided pain radiating to the flank since 4 hours PTA. She had no fever, no diarrhoea but had 6 episodes of vomiting. Her ultrasound 2 months prior to admission, at 8 weeks +4 days of pregnancy, revealed an 8.1 x 8.5 x 8.9cm right ovarian unilocular, anechoic cyst. She had been asymptomatic until the day of admission to the ER. Repeat ultrasound showed no change in the size of the ovarian cyst at 8.1 x 6.4 x 6.9cm anechoic, with a smooth inner wall, presumably benign. The appendix was not visualised. The patient had an acute abdomen with a pain score of 10/10 which reduced to 7/10 after paracetamol. Her white blood cell count was 14,000. To rule out appendicitis, MRI was done revealing an intrauterine pregnancy w a 7.4 x 8.5 x 5.6cm right unilocular adnexal mass. A retroilial appendix was noted to be dilated, with fat stranding, signed out as acute appendicitis. Upon entry via laparoscopic surgery, a normal appendix was visualised. The edematous right fallopian tube, was what was apparently mistaken as the appendix on MRI. It was cystic since the enlarged ovary twisted upon itself 3 times. The ovary was triply untwisted, thus restoring the colour and circulation. The clear serum fluid was evacuated and an oophorocystectomy was performed. No tocolytics were used intra-op nor post-op and the patient went home 35 hours later. An acute appendicitis is more common than ovarian torsion and must be considered in a pregnant with an acute abdomen in pregnancy. Ovarian torsion should be untwisted for organ viability and oophorocystectomy should be considered to preserve the ovary in a young patient. The paper discusses the diagnostic accuracy of the MRI versus transvaginal ultrasound in ovarian torsion with a review of literature as well as the differential diagnosis.

VP59.35
Pregnancy in the uterovesical pouch
M. Sharma

Gynecology, Barking Havering Redbridge University Teaching Hospitals, London, United Kingdom

A 34-year-old P3 + 3, previous 3 LSCS followed by three terminations of pregnancy, attended Marie Stopes for TOP at seven weeks period of gestation. Pregnancy could not be visualised, therefore she was referred to Queen’s Hospital for a second opinion. She was scanned in EPAU and diagnosed to have viable intrauterine pregnancy. She had a medical termination of pregnancy with misoprostol and mifepristone. She had significant bleeding following the medication. Four weeks after the procedure, the patient attended the gynecology emergency unit with bleeding, pain lower abdomen and persistent positive urine pregnancy test. A transvaginal scan showed ectopic pregnancy with non-viable fetus measuring 22mm. She had a laparotomy (COVID-19 protocol); both tubes were normal; the pregnancy sac was seen in the UV fold, the sac thickened and adherent over the bladder; there was a 0.5cm dehiscence in the previous LSCS scar area. Diagnosis of scar pregnancy expelled outside the scar was made, pregnancy tissue was removed and the dehiscence was closed with no1 vicryl.

Diagnosis of scar pregnancy depends on a high degree of suspicion in all cases of previous LSCS. The location of the pregnancy sac, in relation to the scar, should be reported in all cases. Management depends on the type of scar pregnancy. Medical termination of pregnancy with mifeprisone and misoprostol has not been seen to successful as it is not effective in expelling the pregnancy from the niche of the scar.

VP59.36
Place of vasopressin in demarcation of interstitial ectopic pregnancy during laparoscopic resection: scientific review of a case series
N.C. Samarawickrama

Ministry of Health, Castle Street Hospital for Women, Colombo, Sri Lanka

The diagnosis and management of interstitial ectopic pregnancy is challenging. Resistance of decidual vessels to vasopressin when compared to rest of the uterine vasculature taken into consideration in laparoscopic excision of interstitial ectopic pregnancies to demarcate the margins and to minimise blood loss. A case series of nine patients diagnosed with interstitial ectopic, undergoing laparoscopic surgery, were injected with diluted vasopressin to the myometrium prior to make the surgical resection. The myometrial tissue turned pale in contrast to pink and vascular interstitial ectopic revealing a clear margin between the two tissues. Significantly reduced blood loss noted as oppose to procedure done without vasopressin.

In conclusion, injection of vasopressin to the myometrium prior to resection of an interstitial ectopic provides well-demarcated zones to aid in complete resection while minimising the blood loss.

Supporting information can be found in the online version of this abstract

VP59.37
Ectopic pregnancy masquerading as an ovarian cyst
A. Parr1, C. Johansson1, S. Reid1,2

1 Obstetrics and Gynaecology, Liverpool Hospital, SWLHD, Sydney, NSW, Australia; 2 Western Sydney University, Sydney, NSW, Australia

A 32-year-old woman attended the Emergency Department with a week of constant left iliac fossa (LIF) pain and vaginal spotting for a month. She had a background of glioblastoma multiforme which was resected and treated with radiotherapy and ongoing chemotherapy. Outpatient imaging prior to presentation showed a 5.2cm complex left ovarian cyst and a bilobed cystic focus in the right ovary. Blood tests and tumour markers were unremarkable except for serum hCG of 31. Pelvic ultrasound in clinic showed a normal right ovary and well circumscribed unilocular cyst in the left ovary.