alert, conscious and seated on a wheel chair. The power on the right leg was 2/5. Babinski was up going. Patient was not transferred to the examination couch as it was difficult for her to move.

DISCUSSION

Not really knowing what to do, a quick consultation was made to the other specialties but unfortunately no conclusive results were made. Patient was then referred to the neuromedical consultant who agreed to see the patient in his clinic on the very same day, even though his clinic was fully booked. Examination in the neuromedical clinic revealed a sensory level much higher than the spinal insertion site. A MRI was ordered.

CONCLUSION

In what appeared to be a surprise diagnosis, the patient was subsequently referred to the neurosurgical department in HKL for surgery.

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DON'T MISS IT!!!

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INTRODUCTION

Heterotopic pregnancy, the coexistance of intraueterine and extrauterine gestation, is very rare in natural conception and reported to be 1:30000 pregnancies. We report a case presented with haemoperitoneum from ruptured tubal pregnancy with no life of intrauterine gestation. This give a challenges to the managing team especially in detecting the sources of bleeding especially if they miss the extrauterine pregnancy.

CASE REPORT

A 33 years old lady 6 weeks of amenorrhea presented with clinical features of shock. Urine pregnancy test was positive. Transabdominal ultrasound revealed free fluid in the abdomen. Left extrauterine sac seen with fetal heart present. Intrauterine sac was seen without fetal heart.

Provisional diagnosis of a heterotopic pregnancy with ruptured left ectopic gestation was suggested. The patient underwent emergency exploratory laparotomy salphingectomy.There was ruptured left sided tubal pregnancy with haemoperitoneum.

DISCUSSION AND CONCLUSION

A heterotopic pregnancy is difficult to diagnose clinically because the clinical symptoms is lacking. It can be life threatening condition and can be easily missed. Usually sign of extrauterine pregnancy predominates. Sign and symptoms may include abdominal pain, adnexal mass, peritoneal irritation, enlarged uterus and vaginal bleeding. Vaginal bleeding may be retrograde from the ectopic pregnancy due to intact endometrium of the intrauterine pregnancy. Challenges in the emergency setting lie in the identifying of ectopic pregnancy with the presence of the large heamoperitoneum. Haemodynamic instability in ruptured ectopic pregnancy need to be addressed appropriately by the managing team and intervention is life saving. This requires high index of suspicion from the emergency personnel to identify this condition.