Objective
Velamentous cord insertion (VCI) is an umbilical cord attachment to the membranes surrounding the placenta instead of the central mass. Because of the lack of protection from Wharton’s jelly, these vessels are prone to compression and rupture, especially when they are located near the cervical ostium (vasa previa), which sometimes coincides. The estimated incidence of VCI was 0.4%-11% in singleton pregnancies, with higher incidence in twin pregnancies (1.6%-40%). VCI was associated with adverse perinatal outcomes, most notably pre-term birth and emergency caesarean section in singleton pregnancies, and perinatal mortality in twins; however, the prenatal diagnosis is based upon the presence of characteristic sonographic findings (membranous umbilical vessels) at the placental cord insertion, this becomes more difficult with advancing gestation.

Methods
A 32 year old woman, gravid 2, para 1, with a 24 weeks low-risk gestation came to our clinic to have a routine transabdominal ultrasonography with a suspicion of velamentous cord insertion (VCI). The fetal growth was normal, the cord seemed to end some centimeters from the placenta, at which point the umbilical vessels separate from each other and cross between the amnio and chorion before connecting to the subchorionic vessels of the placenta, located on the anterior wall. Color doppler imaging enhances identification of the vessels. The suspicion of VCI was done at 12 weeks gestation scan when the site of placental cord insertion seemed localized at the edge of the placental disk. I warned for adverse perinatal outcome (fetal growth restriction, need for caesarean delivery, intrapartum and postpartum bleeding) and I advised pregnancy monitoring more closely.

Results
Fetal growth was normal and compatible with 12th weeks scan. She has done more two scans before delivery: one at 24th weeks and the last one at 32 weeks. The suspicion of VCI was strong in the two scans, especially with the use of color doppler. The pregnant woman was admitted to the hospital with this clinical information when she went into labour at 39th weeks gestation. A vaginal delivery it happened. A female infant was delivered, weighing 3100 gr, with Apgar scores of 8 and 9 at 1st and 5th min. There was no record of neonatal or obstetric complications. After giving birth to the baby, the mother was instructed by the clinical team to expel the placenta, which according to her was like having another birth. A small placenta with VCI were observed.

Conclusion
Through our management of pregnant woman, it is believed that a safe delivery can be provided with accurate identification of high-risk pregnancies with abnormalities of the placenta and umbilical cord. Although VCI was suspected before delivery, many of its sequelae are readily identifiable only during the intrapartum period, the potential for preventive obstetric intervention appears to be limited. A definitive diagnosis is made by local examination of the placenta, cord, and membranes after delivery. There are no data from large or controlled studies on which to base management recommendations. Despite the favorable outcome of this case, it allows to highlight the importance of antenatal diagnosis of VCI in early gestation and possible improves obstetric management.