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A Rare Case Report of Caesarean Scar Ectopic Pregnancy

Dr. Shakuntla Sonkaria[1], Dr. Oby Nagar[2], Dr. Neha Choudhary[3*]

[1]Senior Resident, Department of Obstetrics and Gynaecology, SMS Medical College, Jaipur, Rajasthan, India
[2]Senior Professor and Unit Head, Department of Obstetrics and Gynaecology, SMS Medical College, Jaipur, Rajasthan, India
[3]Assistant Professor, Department of Obstetrics and Gynaecology, SMS Medical College, Jaipur, Rajasthan, India

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***Corresponding author:** Dr. Neha Choudhary
Assistant Professor, Department of Obstetrics and Gynaecology, SMS Medical College, Jaipur, Rajasthan, India

Abstract | **Case Report**

Caesarean scar pregnancy is rarest pregnancy, increasing incidence due to increasing in number of caesarean deliveries. It is defined as blastocyst implants on a previous caesarean scar Herman A. Early diagnosis can be done by using ultrasound with empty uterus and cervix, mass in the anterior wall of uterus in scar area. Early diagnosis leads to prompt management and improves the outcome by allowing preservation of future fertility and decreases maternal morbidity and mortality, this is possible with ultrasound imaging. When ultrasound is inconclusive or equivocal then MRI has important role in diagnosis before therapy or intervention. Here we are presenting a case of G11P2+(1)L2A7 with previous two caesarean deliveries, diagnosed as caesarean scar ectopic pregnancy with the help of sonography. Patient underwent laparotomy and on histopathology report, caesarean scar pregnancy was confirmed.

Keywords: Caesarean scar pregnancy, amenorrhoea, bleeding per vagina.

Case Report

A 35 years old female presented to outpatient department of gynaecology with chief complaint of 3 months amenorrhea with bleeding per vaginum since 3 hours. In obstetric history, she was G11P2+(1)L2A7 with previous two caesarean deliveries. Her first caesarean due to MSL and second was due to previous LSCS with scar tenderness. Patient also have history of irregular periods and hypothyroidism since 3 years. Patient have seven abortions, last abortion 3 years back, all not followed by dilatation & evacuation. In present pregnancy patient came previously with c/o spotting at 1 and half month amenorrhoea for which she was taken on line of management of threatened abortion though USG hinted upon a low lying pregnancy. Now she again came to OPD with above mentioned complaints. This time caesarean scar site pregnancy clearly defined with the help of clinical signs symptoms and USG findings. General physical examination was normal. On per speculum, cervix was normal, bleeding per vaginum was seen and manual examination was not done. On investigations, routine blood and urine investigations were normal. Ultrasound show single intrauterine G sac of 12 weeks with yolk sac and foetal pole with cardiac activity in the anterior parts of lower uterine segment with thinning of myometrium between the bladder wall and gestational sac likely? caesarian scar pregnancy. Cervical canal empty and adnexa normal (Fig 1) With hypoechoic collection of depth 10mm around 25% of G-sac circumference,? subchorionic haemorrhage. Patient was planned for laparotomy.

Fig-1: USG Image

Intraoperative Findings

Soft and vascular bulging mass seen at the site of previous scar (Fig 2).

Opened the abdomen with transverse incision up to deep parietal peritoneum and a soft & vascular bulging mass seen over uterine scar site. Adherent

bladder and mentum pushed down. Both side uterine arteries ligated to control and secure bleeding. Incision given at healthy uterine tissue and evacuated the foetus and placenta both and sent for histopathological examination and diagnosis of caesarean scar ectopic pregnancy was confirmed. Then ridge of healthy tissue raised with alley's forceps just above internal os and needle passed inside to upper edge of wound & held loose, 5 interrupted sutures passed and tied. Redundant scar tissue reshaped and tied to upper segment. Thus uterine incision sutured in two secure layers for better approximation and strength. Complete haemostasis achieved.

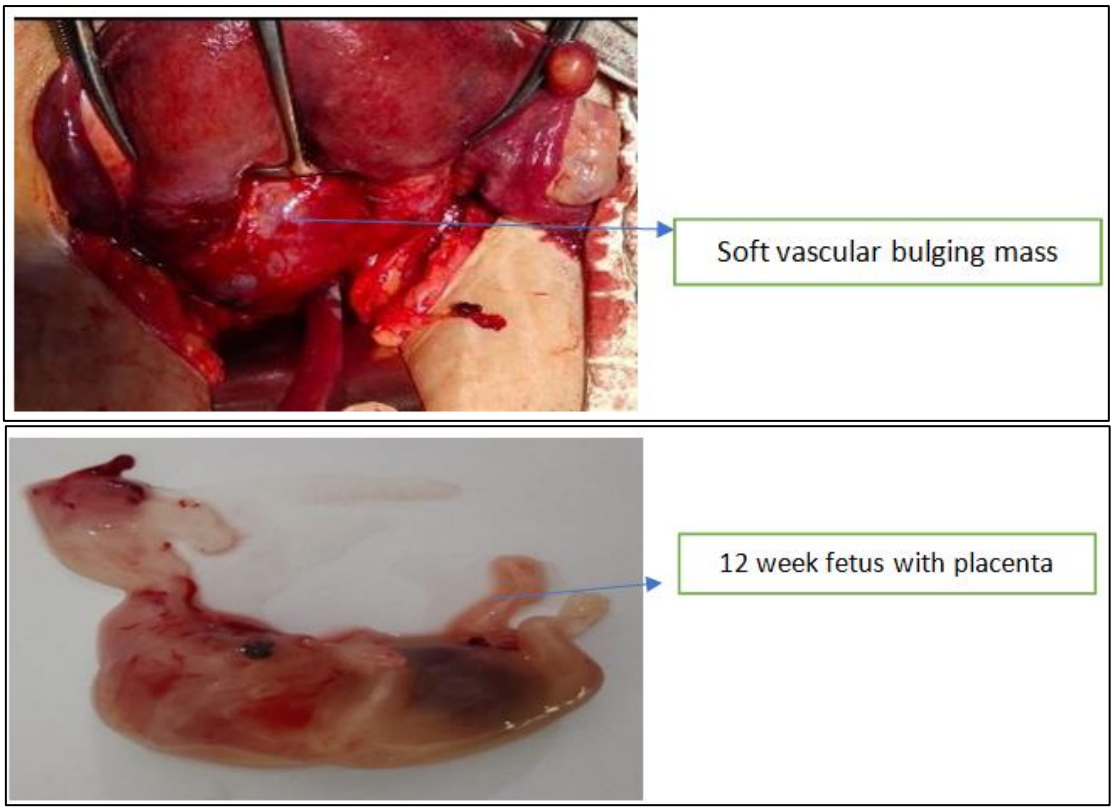

Fig-2: Intraoperative Images

DISCUSSION

Here we are reporting the case of G11P2+(1)L2A7 with previous two caesarean deliveries who presented with USG finding- caesarean scar ectopic pregnancy. It is rare that caesarean scar pregnancy presented at 12 week gestation with live fetus and surgical management was done by new technique for wound closure to give more secured and strong scar for future pregnancy.

It is a rare and uncommon form of ectopic pregnancy and the diagnosis of this type of ectopic pregnancy is very difficult and false negative reporting is very common with out of all reported cases 13% incorrectly diagnosed as low uterine or cervical pregnancy [1, 2] which leads to major complications [3]. Risk with previous scar pregnancy are morbid adherent placenta, placenta Previa, abruptio placentae, uterine rupture, haemorrhage, ectopic future pregnancy etc., all are responsible for life threatening condition [4]. Regarding to explain the etiology and mechanism of caesarean scar ectopic pregnancy various theories given, out of all most accepted one is blastocyst invade into the myometrium through a microscopic dehiscent tract, which may be due to previous caesarean section, previous hysterotomy scar, myomectomy scar, uterine evaluation, previous abnormally adherent placentation, manual removal of placenta [5], metroplasty, hysteroscopy and trauma during ART [4].

The presentation of ectopic pregnancy can be variable, it's most common clinical presentation is painless vaginal bleeding [6]. It's incidence is indeed increasing given the rise of caesarean deliveries [7]. Incidence estimated in overall caesarean delivery is (1/1800- 1/2500) [8]. It also called by various names as caesarean ectopic pregnancy, caesarean scar ectopic [5]. Although there are no specific diagnostic criteria for scar pregnancy, Imaging plays an important role in the diagnosis of ectopic pregnancy and ultrasonography features of scar ectopic pregnancy (RCOG criteria) [1] include empty uterus and cervix with normal endometrium and endo-cervical canal, gestational sac (with embryo and/or yolk sac) in the anterior part of the lower uterine segment in the region of the caesarean scar with a thin or absent myometrial layer between the bladder / anterior uterine wall and gestational sac,

evidence of prominent circulation on doppler examination [1, 6]. MRI may be used for diagnosis when USG findings are inconclusive or equivocal with other criteria in the favour of scar site pregnancy [1, 6].

The risk of recurrent scar ectopic pregnancy is low (3.2-5%) [9]. Women who intend to continue childbearing should be informed of the low risk of recurrence but the potential serious sequelae of a recurrence. Even with an intrauterine pregnancy, the women is still at risk of complications like uterine rupture, haemorrhage, morbidly adherent placenta and lastly goes into hysterectomy. Future pregnancies require meticulous specialist follow up.

Treatment modalities are dependent on the case presentation. Women have been managed expectantly, medically with methotrexate or surgically [9, 10]. Surgical excision by hysteroscopy or laparoscopy or laparotomy, vacuum aspiration can be done to remove ectopic pregnancy [11].

CONCLUSION

The caesarean scar pregnancy is very fatal condition so early and accurate diagnosis and treatment is very important for management of caesarean scar pregnancy.

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