

Case Report

A CASE OF SCAR ECTOPIC PREGNANCY IN A TERTIARY CARE INSTITUTION

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ABSTRACT

Cesarean scar ectopic pregnancy has a high rate of morbidity with nonspecific signs and symptoms making identification difficult. As cesarean delivery numbers rise, a subsequent increase in scar ectopic pregnancies can be anticipated. The ability to accurately diagnose and treat this morbid condition is vital to the practice of any Obstetrician & Gynaecologist.

KEY WORDS: Scar ectopic, abnormal implantation, uterine rupture, previous

INTRODUCTION

Caesarean scar ectopic pregnancy (CSP) is defined as a condition where the implantation occurs on muscle or fibrous tissue of previous caesarean scar. The incidence of CSP continues to rise with increasing caesarean section rates¹. Incidence is 1 in 800 to 1 in 2500 of all ectopic pregnancies. It comprises of 6.1% of all ectopic pregnancy with a recurrence rate of approximately 5%. Mortality rate is about 1 in 500 cases.² Thus, there is an increased need of clinical suspicion for early diagnosis for prevention of catastrophic events.

CASE

A 24 years old housewife, resident of Kankinara, West Bengal, third gravida, with previous two LSCS, having a non-consanguineous marriage, belonging to Middle socio-economic class, attended ER on 31st August, 2022 with the chief complaint of bleeding per vagina for three days. She gave history of three months of amenorrhea. Bleeding was moderate in amount. It was not associated with pain in abdomen. There was no history of abortifacient intake.

Patient attended menarche at 14 years of age. She used to have regular menstrual cycle where bleeding lasting for 4-5 days every 28 days with mildly painful and moderate flow.

Her last menstrual period (LMP) was on 22nd May, 2022 and expected date of delivery was on 26th February, 2023. Her estimated gestational age by LMP was 14 weeks 2 days and by USG 13 weeks 2 days. She gave history of infrequent use of condom as contraception. Patient was married for 6 years. She was third gravida with two living issues delivered at term by LSCS with indication of Foetal Distress and Previous LSCS with Scar tenderness respectively. Last child birth was 2 years back.

She did not give history of Bilateral Tubal Ligation or any other surgery performed previously. There was no history of blood transfusion or drug allergies.

There was no significant medical history of diabetes mellitus, hypertension, bronchial asthma, thyroid disorders, tuberculosis, heart conditions in patient or in her Family.

GENERAL EXAMINATION

Patient was examined after obtaining proper informed consent. She was conscious, alert, cooperative, moderately built and well nourished. She had mild pallor but no icterus/ edema/ clubbing / cyanosis. She was afebrile with oral temperature 97F, Pulse rate 87 bpm, regular, normal volume, no radio-radial or radio-femoral delay. Blood pressure 110/70 mmHg in supine position.

SYSTEMIC EXAMINATION:

No abnormalities detected in Respiratory, Cardiovascular or central nervous system.

OBSTETRICAL EXAMINATION:

Abdomen was soft, non-tender.

On per vaginal examination, uterus was found to be of 12 weeks size approximately, anteverted, bilateral fornices were free, no cervical motion tenderness noted, cervical Os admitted tip of finger, mild bleeding was found to be present.

Patient came with USG Report dated 23rd August, 2022 suggestive of **missed abortion** and another USG dated 27th August, 2022 having **bulky uterus with huge amount of echogenic material seen in Endometrial cavity suggestive of incomplete abortion.**

In ER urine pregnancy test was done which was found to be positive. Patient was given Tb. misoprostol (200 mcg) Sublingual and per vaginal stat. Her USG (lower Abdomen and pelvis) was repeated in the institute on 01st September, 2022 in view of retained product of conception. USG Suggested **heterogeneous echogenic material in endometrial cavity 4.8*2.7cm. Uterus found to be bulky. Right and Left ovary normal, adnexa pouch of Douglas free.** She was planned for *Dilatation and Evacuation* in OT on very next day with 1 unit blood reserved. Serial dilatation had to be done and product of conception was removed. Post D&E, patient’s vitals were stable. Before discharge, after evacuation, USG was repeated and report showed presence of Heterogeneous

mass even after evacuation suggestive of incomplete procedure.

Keeping in mind the history of previous two LSCS, the Radiologist of the institution was consulted and in the presence of Obstetrician, USG was repeated which denoted presence of **5*4 cm heterogeneous mass, at the scar line, invading bladder anteriorly, having vascular supply thus taking colour on Doppler study.**

This radiologically confirmed the diagnosis of **SCAR ECTOPIC PREGNANCY** and immediately **EXPLORATORY LAPAROTOMY** was planned on that day itself. Two-unit Blood was arranged and two-unit blood was kept in reserve. High Risk party counselling was done. Patient was prepared for OT.

Exploratory Laparotomy was done with B/L Tubal ligation and Excision of Ectopic Product of Conception Under spinal anesthesia. Abdomen was opened layer by layer after vertical skin incision and peritoneum was reached. Uterus identified. Ectopic pregnancy noted in anterior uterine wall. A **gestational sac measuring 7*7cm** noted. Dense adhesions were noted with uterus and bladder which were carefully dissected by sharp dissection. Excision of ectopic product was done and homeostasis secured. Uterus closed in layers. Product of conception was sent for histopathological examination. peritoneal washing done and abdomen closed in layers. Meanwhile one unit blood was transfused to the patient. Operation went uneventful.

Post OT reports were as follows:

CBC		
Heamoglobin	13.9	gm/dl
WBC	7,600	mm3
Neutrophils	73	%
Lymphocytes	24	%
Monocytes	02	%
Basophils	01	%
Eosinophils	00	%
Platelets	2.0	L

Liver Function Test (LFT)		
SGPT	40	IU/L
SGOT	38	IU/L
ALP	140	IU/L
Bilirubin Total	0.7	mg/dl
Direct	0.4	mg/dl
Indirect	0.3	mg/dl

Renal Function Test (RFT)		
Blood urea	13	mg/dl
Creatinine	0.3	mg/dl

Serum Electrolytes		
Na+	138	Mmol/L
K++	4.0	Mmol/L

Table 1: post operation Blood reports of the patient

Patient was stable after OT. She was discharged after a few days of observation with advice of regular follow up.

DISCUSSION

As it is a rare diagnosis, most of the evidence for management comes from case reports and small case series. Recent research supports any method that removes the pregnancy and scar to reduce morbidity and improve fertility³. Surgical treatment or combined systemic and intra gestational Methotrexate both are successful in the management of cesarean delivery scar pregnancy. In scar ectopic pregnancy, gestational sac is not uterine cavity and chorionic villi implants on scar. Hence, trophoblastic tissue is unreachable to curette. So, dilatation and curettage have a doubtful role. Seow et al in their series of 12 cases of cesarean section ectopic pregnancy concluded that TVS or TAS guided methotrexate injection emerged as treatment of choice to terminate CS ectopic pregnancy. Regression of scar ectopic mass occurred between 2 months to 1 year. However, some of the researchers reported higher failure rates with methotrexate⁴. Although expectant management has been attempted in some cases, currently available data supports termination of such a pregnancy once the correct diagnosis has been made. A cesarean scar ectopic pregnancy complicates 1 in 2226 pregnancies⁴. As

subsequent pregnancies may be complicated by uterine rupture, the uterine scar should be evaluated before as well as during these pregnancies. Cesarean scar ectopic pregnancies can have disastrous outcomes, including uterine rupture, massive hemorrhage and maternal death⁵.

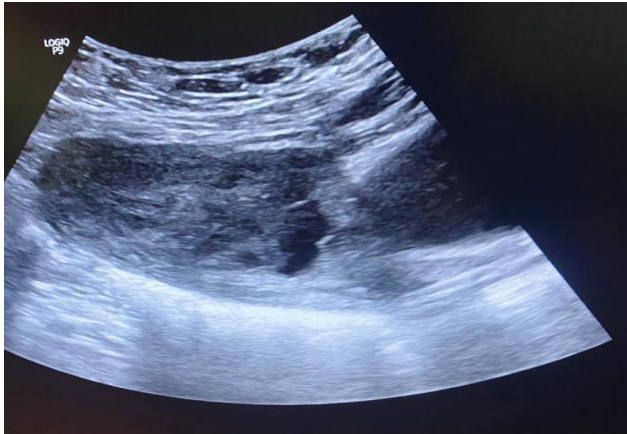
CONCLUSION

Cesarean Scar Ectopic pregnancy is rare type of ectopic pregnancy. This condition can be catastrophic if not manage on time, leading to significant morbidity and mortality. Early diagnosis by trans vaginal ultrasonography (TVS) and a high degree of clinical suspicion for probability of such scar ectopic pregnancy in previous uterine surgery patients may help in initiation and success of conservative treatment, prevention of complications and preservation of fertility.

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Figure 1: USG plate suggestive of SCAR ECTOPIC PREGNANCY invading bladder



anteriorly.

Figure 2: intraoperative finding showing Gestational sac at scar line



Figure 4: Embryo with gestational sac at scar line



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