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CASE REPORT of CAESAREAN SCAR PREGNANCY AN ENIGMA HOW TO TREAT

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KEYWORDS :

INTRODUCTION-

Caesarean scar pregnancy (CSP)is a rare form of pregnancy, where G. sac is partially or fully implanted within previous cesarean section scar. incidence of CSP is 1:800 TO 1:2500 of all pregnancy[1]. It is estimated that at least 6.1%pregnancy in women with previous LSCS with ectopic will be CSP[2]. TO date more than 1000 CSPs have been reported, which is attributed to increasing number of LSCS, better USG diagnosis.

Case summary-

This is a case of 26-year-old female G4P1L1A2with previous LSCS 11 month back, who attended OPD for termination of pregnancy as she conceived in lactational amenorrhea. On investigation he was diagnosed to have 14 wks., with positive spectrum for placentas accreta and. USG reported empty uterine cavity, thin endometrium, G,SAC embedded in previous scar and very thinned out myometrium over sac . Doppler reported increased vascularity in bladder base . Lower uterine segment was ballooned out due to placental mass and more towards right side.

Patient was investigated and planned for surgical removal of CSP and excision of unhealthy scar. Preoperative Hb was 10 gm. Blood and blood components were arranged pre op in view of high risk of hemorrhage. Patient was explained of risk to undergo hysterectomy and excessive bleeding.

During procedure pneumatic compression applied on both lower limb, bilateral internal iliac ligation was performed. uterovesical fold opened and sac was found covered with blood clot and no myometrium indicating ruptured scar. Fetus and clots removed in toto while placenta could be removed in piece- mal as it was adherent. Excessive bleeding led to fall in BP and 3-unit BT was given to patient. Bladder was intact as confirmed with methylene blue instillation. Unhealthy scar excised and repaired in 2 layers. After surgery patient was shifted to HDU. Patient stayed in hospital for 4 days and discharged well with routine follow up advise as well as early reporting to doctor in case of missing periods again.

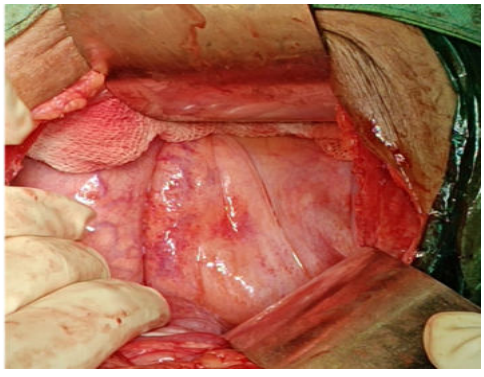

Figure 1intra operativ

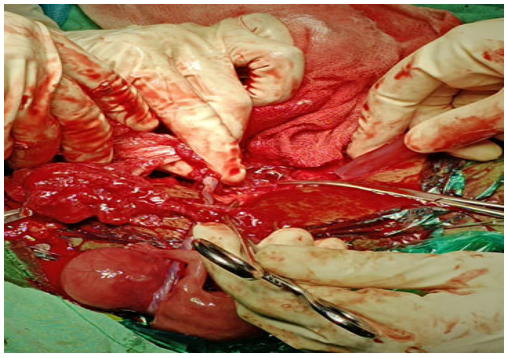

Figure 2 extraction of CSP mass

DISCUSSION-

CSP can present as typical features of ectopic pregnancy like acute pain, vaginal bleeding[3], profuse hemorrhage and may be asymptomatic.it is not uncommon to find csp during attempted surgical evacuation. When present late there may be catastrophic life-threatening bleeding. USG criterion for diagnosis of csp are as follows-

- Empty uterine and cervical cavity[6],
- Gsac and or placenta embedded in previous cesarean scar
- Thin or absent myometrium between bladder and Gsac.
- Negative sliding organ sign,
- Evidence of trophoblastic flow on color doppler examination in scar area[4].
- Sometimes ultrasound is inconclusive which may necessitate MRI for the diagnosis of CSP[5].

CSP can be of two types[7]-

- Endogenic –when sac is more towards uterine cavity and covering myometrium is more than 2 mm

Exogenic- when sac is more deeply embedded in scar and covering myometrium is thin and pregnancy grow towards bladder.

Treatment in case of CSP should be individualized with full pre - treatment evaluation. Principal of treatment is to end pregnancy as soon as possible with removal of CSP mass and retention of future pregnancy if possible. Treatment options can be medical, surgical or sequential depending on presenting symptoms and gestational age

Management Options For Csp

Medical management----------systemic methotrexate[8].
Local injection of embryocides and embolization[9,12]
- local methotrexate with sac aspiration and UAE[10,11]
Surgical management ----------

- Dilatation and evacuation.
- Hysteroscopic resection.
- Laparoscopic excision and restoring.
- Combined hysteroscopy and laparoscopic procedure.

- Laparotomy and excision /hysterectomy-

Combined medical and surgical treatment[14]

- UAE followed by dilatation and evacuation 24-48 hours
- Methotrexate followed by surgical resection after an interval

There are many factors which affect suitable treatment modality for individual patient like symptoms, fertility desire, compliance to follow up, response to initial treatment, USG findings ,B- HCG levels, myometrial thickness intervening bladder and sac, availability of facilities for interventional radiology and monitoring facilities.

When opting for medical management methotrexate is always first choice except in case of heterotopic pregnancy. Methotrexate is preferred for intra sac instillation when patient is in early gestation and hemodynamically stable. When surgical procedure has to be performed hysteroscopy is preferred mode for endogenic CSP while laparoscopy is preferred for exogenic CSP[13].

Heterotopic CSP pregnancy have been reported and treated with successful intra sac Kcl administration with continuation of intra uterine pregnancy[15].

After successful treatment, follow up should be done with β-hCG. When it has been managed with medical or S & E , scar generally heals with fibrosis leaving defect and further increasing chances of recurrence .This defect may need resuturing before attempting next pregnancy. In future pregnancy early USG by expert is recommended for early diagnosis.

CONCLUSION-

After looking at above case it can be concluded that CSP if diagnosed at early stage can be managed easily like any other ectopic pregnancy reducing morbidity and mortality significantly Once we miss early diagnosis window patient morbidity increases. Thus, we should be alert to detect CSP in case of previous LSCS.

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