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A RARE CASE OF CERVICAL ECTOPIC PREGNANCY AND ITS MANAGEMENT.

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ABSTRACT Cervical ectopic pregnancy (CEP) is an uncommon and serious condition, accounting for fewer than 1% of all pregnancies and less than 0.1% of all ectopic pregnancies. Early diagnosis and treatment is critical to avoid serious complications such as severe hemorrhage and the need for hysterectomy. Given the rarity of the condition, even today, the most effective method of its management is under investigation. Transvaginal ultrasound and USG guided interventions have helped in development of conservative treatment options leading to decreased mortality and morbidity of patients. Here we report a case of a 43 year old elderly primigravida with IVF conception with USG suggestive of cervical ectopic pregnancy and its management.

KEYWORDS : Cervical ectopic, Ultrasound guided, Methotrexate, Uterine artery embolisation, Ectopic pregnancy

CASE REPORT

INTRODUCTION

Cervical ectopic pregnancy occurs when a fertilized egg implants abnormally in the cervical canal, beneath the internal os of the cervix. It may cause vaginal bleeding, a common but non-specific symptom, and is often diagnosed through obstetric ultrasonography, which reveals the gestational sac in the cervix and an empty uterine cavity.

In the past, cervical ectopic pregnancies were typically diagnosed during surgery due to heavy bleeding during uterine curettage, with hysterectomy as the standard treatment. However, with advancements in transvaginal ultrasound and serum hCG assays, early detection has become possible. As a result, the approach to management has shifted, focusing on conservative treatment to preserve fertility for hemodynamically stable patients in the first trimester, rather than resorting to invasive procedures like hysterectomy.

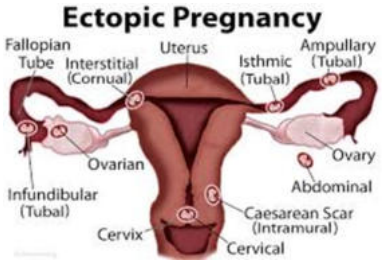

Figure No1- Locations Of Various Ectopic Pregnancies

Case-

A 43 year old female, Primigravida, IVF conception, 6.1 weeks of gestation, referred to our hospital in view of bleeding per vaginum which was sudden in onset and was not associated with pain in abdomen.The patient was a known case of chronic hypertension and had history of two dilatation and curettage done 18 and 6 months ago respectively.

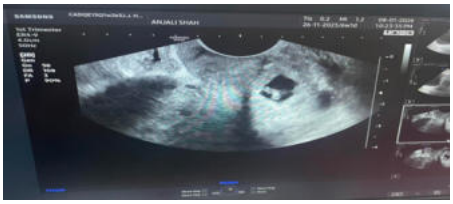

Figure No2- Ultrasound showing cervical ectopic pregnancy.

On admission, her haemoglobin was 12.2g/dl and her BHCG was 6661. All other investigations were within normal limits. Ultrasonography was suggestive of a single live gestation sac of 6 weeks in the cervix suggestive of cervical ectopic pregnancy.

MRI pelvis showed a 2.4x2.4cm heterogenous structure in the cervix, most likely fetal pole, limited to the cervix with normal size and shape of the uterus, ovaries and fallopian tubes.

Injection methotrexate 50mg/m2 of body surface area was given intramuscularly (single dose regimen) after which USG guided bilateral uterine artery embolisation was done which helped control the bleeding. USG guided Inj methotrexate was given in the live gestational sac following which serial levels of BHCG were monitored.

Day 4 BHCG- 1849
Day 7 BHCG- 581

Repeat ultrasound on day7 was done suggestive of ill defined hypo echoic lesion 2.2x2.5cm with minimal fluid within with no evidence of fetal pole or internal vascularity suggestive of clot. Ultrasound on day28 showed a reduction in size of clot to 0.9x1.4cm. Follow up ultrasound was suggestive of no gestational sac or fatal pole.

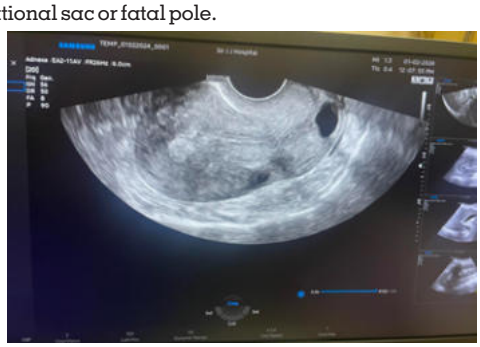

Figure No3- Post procedure ultrasound

DISCUSSION

Cervical pregnancy, a rare condition, is on the rise, likely due to increased use of assisted reproductive technologies (ART) and better detection with transvaginal ultrasound. Factors that may hinder implantation in the endometrium and increase the risk of cervical pregnancy include in vitro fertilization (IVF), pelvic inflammatory disease, post-surgical trauma (e.g., cesarean sections or uterine curettage), history of abortions, intrauterine devices, and uterine structural issues.

In cases of first-trimester cervical pregnancy with a stable patient and minimal bleeding, medical treatment is preferred, typically using methotrexate, mifepristone, or misoprostol. Methotrexate is most effective, but its success decreases with high serum hCG levels, larger crown-rump length, or the presence of a fetal heartbeat. In such cases, combining systemic methotrexate with intra-amniotic injections can improve outcomes. If a heartbeat is detected, intra-amniotic potassium chloride is used for embryocide or feticide.

If medical treatment fails or is not suitable, fertility-preserving surgical methods like curettage, aspiration, or hysteroscopy can be considered.(1)However, these procedures carry a high risk of significant bleeding due to the lack of smooth muscle tissue in the cervix.(2)To manage hemorrhage, measures like Foley balloon tamponade, arterial ligation, and uterine artery embolization are recommended. Uterine artery embolization has been shown to be highly effective in obstetric and gynecological emergencies with minimal complications.(3)

CONCLUSION

While cervical ectopic pregnancy remains rare, it is crucial to maintain awareness of the condition. Early and accurate diagnosis is key for successful treatment, reducing the need for interventions that could result in severe bleeding and the potential loss of fertility. Early detection also improves the chances of preserving future fertility in affected patients.

Declaration

Conflict of Interest

None

Disclosure

None

Informed Consent

Informed consent taken from patient.

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