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AN OBSTETRICIAN'S DAYMARE : CERVICAL PREGNANCY WITH PLACENTA PERCRETA : A CASE REPORT

Obstetric & Gynaecology

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ABSTRACT

Objective: Cervical pregnancy along with Placenta Accreta Spectrum (PAS) disorders is an extremely rare and deadly entity which is not only challenging in diagnosis but in management also. Here, a case of cervical pregnancy complicated with placenta percreta and bladder invasion at 14 weeks of gestation is presented .

Case Report: A 35-year-old woman, Gravida 3, para 2, living 1 with previous 1 cesarean was diagnosed with cervical pregnancy at an estimated gestational age of 13^{+4} weeks. Patient presented with vaginal bleeding which couldn't be managed conservatively , and Peripartum hysterectomy was performed eventually. Decision for Surgery was taken in view of acute episode of massive vaginal bleeding not controlled by curettage . Intraoperatively cervical ectopic pregnancy with placenta percreta involving the bladder was found. Peripartum Hysterectomy along with DJ stenting and bladder repair was performed. Post operative period had been uneventful.

Conclusion: Cervical ectopic pregnancy with placenta percreta with bladder invasion can result in maternal mortality and morbidity. Timely decision making can help with successful treatment and management of bleeding. We thus present our experience of the management of this rare condition.

KEYWORDS

Cervical pregnancy , Haemorrhage, Placenta percreta, Peripartum hysterectomy

INTRODUCTION

Cervical pregnancy is a type of ectopic pregnancy where there is implantation of the pregnancy outside the body of uterus within the endocervicalcanal. These are rare, accounting for less than 1% of ectopic pregnancies, and the incidence varies from one in 2,500 to 18,000 pregnancies.[1,2]

Placenta accreta in cervical pregnancy is extremely rare with incidence of around 1 in 93,000 pregnancies[3].Placenta percreta with cervical pregnancy is a life threatening condition for both mother and fetus[4].

The contributing factors for cervical pregnancy are curettage, history of cesarean delivery, Asherman's syndrome, *In-vitro* fertilization, and history of cervical or uterine surgery.[5]

Incidence of adherent placenta is on a growing trend with increasing number of cesarean section as a risk factor.[6]

Conservative management of cervical ectopic pregnancy has also been described in the literature with the main aim of fertility preservation. Various conservative techniques include systemic or local ultrasound guided intraamniotic methotrexate injection, local potassium chloride injection, dilatation andcurettage, and amputation of the cervix or partial trachelectomy.[9]

In acute presentation of vaginal bleeding ,uterine artery embolisation or emergency exploratory laparotomy may need to be done with consent for peripartum hysterectomy.

Bladder involvement or percreta with cervical pregnancy is a rare and uncommon condition with very few cases being reported in International Journals. Here, we report a rare case of 35 year old female with a cervical ectopic pregnancy with placenta percreta and bladder invasion presenting with massive vaginal bleeding.

Case report

Mrs. X, 35 year old Gravida 3, para 2 live with previous 1 LSCS 11 year back and 1 full term still birth delivered vaginally 1 year back was admitted with history of on and off spotting per vaginum at 4 months of amenorrhea. Patient had ultrasound done at 9 weeks and 2 days which was suggestive of pregnancy in lower uterine segment .After admission patient had repeat ultrasound which was suggestive of cervical pregnancy of 13 weeks gestation with thinned out lower segment scar. Patient was planned for MRI pelvis for confirmation. On routine investigation her haemoglobin was 11gm/dL with stable vitals.Before she could be evaluated further,patient had sudden bout of bleeding episode in next morning for which she was taken for emergency operation. On examination cervical os was open and there was massive gush of vaginal bleed. Dilatation and curettage was tried but bleeding did not stop. Tight cervical packing was done and decision for emergency laparotomy was taken with consent for peripartum hysterectomy. General anesthesia was given. Intraoperatively placenta was seen popping out of previous scar and invading the bladder surface. Bilateral internal iliac artery ligation was done before proceeding for hysterectomy. With the assistance of surgeon, decision for partial cystectomy was taken as the placenta was invading bladder mucosa . Post hysterectomy bladder repair and bilateral DJ stenting was done. Patient received 3 units of blood transfusion and 4 units of plasma intraoperatively and 2 packed RBCs postoperatively.

Patient was shifted to Intensive Care Unit Post operatively. Postoperatively patient was mobilised on day 2 and remained unenventful. Patient was discharged with Foley's in situ for 3 weeks with bladder relaxant.

DISCUSSION

Cervical pregnancy results from implantation of the gestational sac within the cervical canal. There are two types of cervical pregnancy: true cervical pregnancy and cervico-isthmic pregnancy. Cervico-isthmic pregnancy is a rare and potentially life-threatening form of ectopic gestation in which the blastocyst implants in the uterine cervico-isthmus between the histological and anatomical internal os, followed by subsequent extension to the lower uterine segment. True cervical pregnancy is that in which gestational sac is confined to cervix.[10,11] Cervical pregnancy can be identified based on speculum examination, palpation and transvaginal ultrasound. Transvaginal sonographic findings may include: (1) an hourglass uterine shape and ballooned cervical canal; (2) gestational tissue at the level of the cervix; (3) absent intrauterine gestational tissue; and (4) a portion of the endocervical canal seen interposed between the gestation and the endometrial canal.

Cervical pregnancy presents as painless vaginal bleeding in most of the cases.One third of cases lead to massive hemorrhage. Cervical pregnancy can be diagnosed after pregnancy termination as was observed by Grigoras and Kang. [4,12] Management of cervical

pregnancy can be medical or surgical. Expectant management can be done in stable patient to preserve fertility. Termination of pregnancy due to absence of myometrial tissue in the cervix can result in massive bleeding and high rates of maternal mortality.

In placenta percreta abnormal placental adherence to the myometrium stems in part from partial or total absence of the decidua basalis and imperfect development of the fibrinoid or Nitabuch layer. Most common site for this is previous scar on uterus from previous cesarean section or any uterine surgery. In this case previous cesarean section was the potential risk factor. It can be diagnosed during labor or during pregnancy. During pregnancy it can be diagnosed with transvaginal ultrasound and MRI. MRI is the best modality to diagnose invasive placenta. Management of placenta percreta can be conservative with expectant management or uterine conservation surgery like Uterine artery embolization or triple P procedure.[13] Other cases are managed with peripartum hysterectomy.

Weichert presented expectant management in a case of cervical pregnancy with placenta accrete,patient was kept admitted from 20 weeks gestation and underwent c-section at 33weeks after steroid coverage under tocolytic.[14] In present case due to sudden deterioration of patient condition,dilatation and curettage was tried but bleeding did not stop. Tight cervical packing was done and decision for emergency laparotomy was taken with consent for peripartum hysterectomy. Intraoperatively invasion of placental tissue in bladder and active bleeding from placenta percreta site led to decision of hysterectomy.

Atypical cases like cervical pregnancy with placenta percreta requires timely presence of multi disciplinary team of anesthesiologist, a gynecologist and a urosurgeon. Unplanned and emergency surgery can be very dangerous and might increase the rates of mortality and morbidity. Due to acute presentation of active vaginal bleeding conservative procedures could not be tried in the present case. With timed availability of multi disciplinary team mortality was averted with peripartum hysterectomy and bladder reconstruction and patient was rescued.

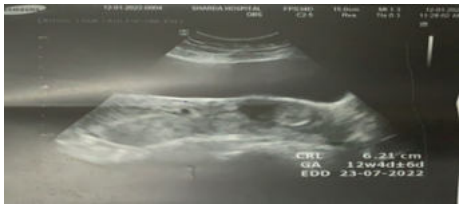

Figure 1 : Ultrasound depicting Single live pregnancy in upper cervical region at 12^{+4} weeks of gestation

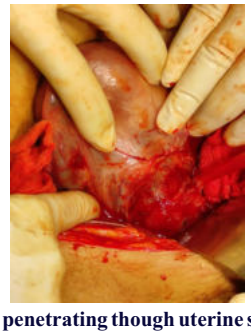

Figure 2 : Placenta penetrating though uterine serosa into bladder.

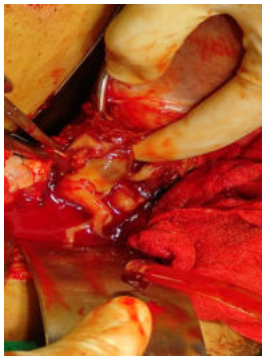

Figure 3: Intra operative picture of fetus seen in the cervical region.

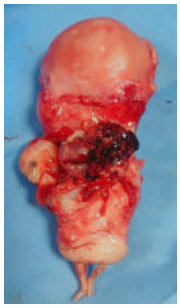

Figure 4. Total Hysterectomy specimen of uterus along with fetus and placenta engaged in the length of the cervix

CONCLUSION

Cervical ectopic pregnancy amounts to only less than 1% of total ectopic pregnancies. Association of this condition with placenta percreta and bladder invasion is very rare and poses a great challenge to the treating gynaecologist. Conservative management has been described but in present case due to massive hemorrhage and deteriorating general condition of the patient an emergency laparotomy with peripartum hysterectomy had to be undertaken. Association with placenta percreta complicated the condition needing timely surgical management.

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