



CESAREAN SCAR ECTOPIC PREGNANCY- AN ENIGMA

Obstetrics & Gynaecology

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ABSTRACT

Cesarean section scar ectopic is a rarest form of abdominal ectopic pregnancy. It has a relation with increasing numbers of cesarean delivery and has an incidence of about 0.09% of all pregnancies nowadays. In this case a 27 years old woman had presented with amenorrhea, pain in lower abdomen and per vaginal bloody discharge. Her serum beta-HCG level was elevated. She was haemodynamically stable. No abnormalities were detected per abdominally, only bloody discharge was present on per speculum examination. Radiological findings of G-sac like structure embedded in previous lower segment caesarean scar of uterus suggested of caesarean scar ectopic. Color Doppler had shown blood flow in scar deficient area. In this case medical management with systemic methotrexate failed. Eventually surgical resection of the G-Sac with scar tissue was done by laparotomy followed by repair of the wound. Thus early diagnosis and management prevented further complications like uterine rupture, hysterectomy and even maternal death

KEYWORDS

cesarean delivery, scar pregnancy, diagnosis, radiology, treatment

INTRODUCTION

Cesarean section scar ectopic is the implantation of embryo in the myometrium and fibrous tissue of previous scar in the uterus. It is a potentially dangerous consequence of previous cesarean section.

It is the rarest form of abdominal ectopic, the incidence being 1/1800-1/2215 of all pregnancies. Nowadays there is an increased incidence of scar ectopic from 0.05% to 0.09% of all pregnancies. There are two types of scar ectopic namely endogenous and exogenous. The risk factors of scar ectopic includes increased gravida, previously induced abortion(s), less time interval between two subsequent pregnancies, increasing numbers of cesarean deliveries.

This study highlights the importance of proper diagnosis of scar ectopic by clinical method and radiological procedures. Treatment depends on symptoms and hemodynamic condition of the patient.

CASE STUDY

A 27 years old primi para female presented in the emergency with complaints of abdominal pain and mild per vaginal bleeding. She had an history of amenorrhea for one and a half months with positive urinary pregnancy test. She had undergone an emergency cesarean section delivery two years back.

On general examination she was found to be haemodynamically stable. On Per abdominal examination there was no tenderness on palpation. There were no signs of rebound tenderness and rigidity. On Per speculum examination mild bloody discharge was found.

Her Hemoglobin and serum beta-HCG levels were 9.2gm/dl and 5617mIU/ml respectively.

Ultrasonography revealed a gestational sac like structure implanted completely outside of the uterine cavity into the thinned out anterior myometrium at the level of previous lower segment cesarean scar. Color doppler revealed placental circulation within deficient scar area. MRI suggested gestational sac in relation to lower uterine segment abutting endometrial lining at the site of scar and Trophoblastic invasion into myometrium. It was diagnosed to be a case of scar ectopic.

The patient was properly counseled about the risks of scar ectopic pregnancy and the advantages and disadvantages of medical and surgical methods of management.

Medical management was done by administering 50mcg systemic Methotrexate which had failed as the beta-HCG levels between day four and day seven were almost equal. Thereafter the decision of laparotomy was taken. Eventually surgical resection of scar with gestational sac at ballooned out lower segment was done with repair

of wound followed by uneventful recovery. Hysterectomy was not needed.



Fig 1: Transabdominal ultrasonography reveals G-Sac like structure completely outside the endometrium embedded into the previous scar (black arrow)



Fig 2: Gestational sac (black arrow) through scar tissue at lower segment of uterus seen during laparotomy

DISCUSSION

Location of the gestational sac is mandatory before advising medical termination of pregnancy in previous cesarean section pregnancy.

The success rate of medical management is low.

Medical management is to be done only where round the clock surgical facility is available.

Advanced radioimaging confirms placental circulation within scar and trophoblastic invasion into myometrium

In each and every case, the treatment should be individualised according to the situation.

CONCLUSION

Early diagnosis and management prevents chances of catastrophic events like abnormally invasive placenta, uterine rupture, peripartum hysterectomy and thus reduces maternal mortality

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