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A RARE CASE REPORT OF HETEROTOPIC CAESAREAN SCAR ECTOPIC WITH NON-VIABLE INTRAUTERINE PREGNANCY.

Obstetrics & Gynaecology

Dr. Jamuna Kanakaraya	HOD Department of Obstetrics and Gynecology
Dr. Avni Bhardwaj	Junior Resident Obstetrics and Gynecology
Dr. Priyanshi Pipada	Junior Resident Obstetrics and Gynecology
Dr. Ruthala Laxmi Sai Prasanna	Junior Resident Obstetrics and Gynecology

KEYWORDS

INTRODUCTION

Heterotopic pregnancy are rare type of pregnancy having intrauterine and extrauterine gestations simultaneously. An ectopic gestation implanted in myometrium of previous caesarean scar is called scar ectopic. Such heterotopic pregnancy with ectopic at previous scar is being presented.

Aims and Objective

No ideal management approach is available and thus making management difficult and non-uniform. These cases are clearly challenging to clinicians and distressing for patients. Therefore, multidisciplinary input, particularly from experts in ultrasound and advanced gynaecological surgery, is very important for effective and safe management of these complex cases.

MATERIALS AND METHODS

We report a case of 34 year female with previous one caesarean section, presenting with spotting pervaginally. On USG an intrauterine Gestational sac was seen. She was managed medically at nearby hospital. Still symptomatic and underwent MRI showed thinning of myomectomy at lower uterine segment with cystic structure in endometrium. Management was surgical as there was an isthmocele, and its repair was required to prevent recurrence of scar ectopic pregnancy.

Thus scar ectopic presents as a diagnostic dilemma. Early diagnosis and prompt evaluation is required to avoid maternal near miss-situation.

Case Report: Patient is 34 year old female, married since -6 years, G3P1L1A1 (Previous lower segment caesarean section in view of non-progress of labour, 2 years back, came to outpatient department at BAMH with chief complain of spotting per vagina on and off since 21st February, 2024 till she came to BAMH on 05/03/24, with right iliac fossa pain since 8 days.

History of presenting illness - Patient was amenorrhic since 1.5 months, last menstrual period was 16 january,2024 .She had complaint of spotting per vagina since 21 February, 2024 associated with right iliac fossa pain ,she visited private hospital on 25 February, 2024. Urine pregnancy test was positive on 25 Feb 24 and sonography done, USG was suggestive of bulky uterus with homogeneous myometrial echo pattern, both ovaries appeared normal. A cystic area measuring 1.3x1.0cm seen in region of lower segment caesarean section scar with echogenic area measuring 0.6cm within ?scar ectopic ,?focal collection at LSCS scar site

Patient was admitted at private hospital and beta HCG done on 26 February, 2024 was 2000 IU , Injection Methotrexate and T. Misoprostol 600mcg per vaginal given at private hospital on 26 Feb 24 along with antibiotics and kept under observation. Patient again developed right iliac fossa pain on 28 February .USG repeated on 28 February, 24 suggestive of bulky and gravid uterus with gestational sac of ~5+2weeks. Yolk sac faintly seen ~1-4×1.3×0.9cm single small anechoic fluid pocket is noted in lower anterior uterine wall at LSCS scar site. Mixed echogenic blood clot in the body of endometrium. Borderline prominent visualized appendix with minimal fluid and mild probe tenderness in right iliac fossa on described ~subacute appendicitis

Patient was referred to higher centre, so she came to BAMH on 05/03/24, with complaint of bleeding per vagina on and off and mild pain in right iliac fossa .Patient was examined and vitally stable. On per abdomen examination - Mild tenderness in right iliac fossa and at p'fannestiel scar site. On per speculum examination: Cervix and vagina healthy, bleeding seen. On per vaginal examination-Uterus normal size, bilateral fornices free, non-tender

She was admitted and based on examination findings and previous sonography report advised emergency USG Pelvis at BAMH, suggestive of intrauterine foetal gestational sac with MSD ~5 weeks, yolk sac seen. A projection seen from the cervical canal? Isthmocele? Scar ectopic & subacute appendicitis

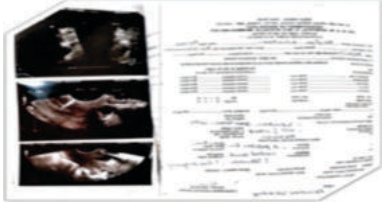

Fig 1: Ultrasonography Report Of Caesarean Scar Ectopic

In such diagnostic dilemma MRI pelvis also advised –which was suggestive of thinning of the anterior myometrial wall at the level of lower segment with residual myometrium measuring approximately 2mm with isthmocoele formation measuring ~0.6x1.2cm ,% of surrounding myometrium is 17%. Thickened endometrium showing a well-defined T2 hyper intense fluid containing cystic structure measuring ~1.3x1cm but no content seen within it, another suspicious T2 hyper intense fluid containing cystic structure measuring ~0.8x0.6cm seen at the previous LSCS scar site with hypo intense content within.

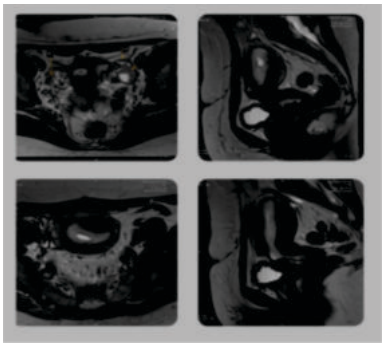

Fig 2: MRI Images Of Patient.

Patient was managed surgically considering her isthmocele and non-viable intrauterine gestation. Surgery performed was exploratory laparotomy with evacuation of intrauterine gestation sac with excision of scar ectopic pregnancy with isthmocele repair. Intraoperative Findings-

1) Omentum densely adherent to bowel and bladder, uterus.
2) Ventrofixed uterus, uterus mobilised
3) Bladder adherent to uterus.
4) Upper limit of bladder traced, Uterovesicle pouch opened above that.
5) Elliptical incision made over previous caesarean scar, gestational sac seen popping out at left margin of caesarean scar.

Evacuation of intrauterine gestational sac done. All samples were sent for histopathological examination .Histopathology report is s/o

1. Intrauterine contents: Decidua with hyper secretory endometrium.
2. Scar ectopic sac: Consistent with ectopic gestation

Fig 3: Popping Out Sac From Left Margin Of Caesarean Scar

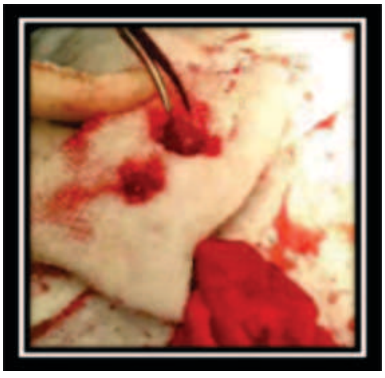

Fig 4: Scar Excised

Fig 5: Histopathology Report

DISCUSSION

This is an interesting case as the patient came after taking abortifacients and methotrexate prescribed by private practitioner based on very early pregnancy localization scan, where only intrauterine pregnancy was seen. Patient presented to us with nonviable intrauterine pregnancy with scar ectopic pregnancy.

Diagnosis of the case was difficult as ultrasound was also inconclusive regarding isthmocele and caesarean scar gestation. So definitive diagnosis was concluded with MRI which was suggestive of thinned myometrium and cystic lesion in endometrium at site of previous caesarean scar.

Management poses a significant dilemma because no national or international guidelines are available as of now regarding heterotopic caesarean scar ectopic pregnancy. Since the case presented with isthmocele, scar ectopic pregnancy was also managed surgically.

CONCLUSION

Heterotopic caesarean scar ectopic pregnancy is a rare case. One should be very diligent in diagnosis. Multidisciplinary approach is required in managing it and management options depend on viability of intrauterine pregnancy, patients will to continue intrauterine pregnancy and medical comorbidities of patient. Primary open surgical treatment is considered in this patient as patient did not respond to medical and/or other surgical treatments and presented too late and in diagnostic dilemma .Some obstetricians recommend as best treatment option due to complete removal of scar pregnancy with repair of scar and quick return of serum βhCG level to normal in 1–2 weeks. Excision and repair of old scar result in removal of micro tubular tracts and thus reduce the risk of recurrence.

Thus diagnosis and management of heterotopic caesarean scar ectopic pregnancy is dicey. Vigilant diagnosis with high suspicion is required. Management should be prompt and apt as per individual needs of the patient.

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