ORIGINAL RESEARCH PAPER

Gynaecology

KEY WORDS: Caesarean Scar ectopic pregnancy, Previous scar, Haemorrhage, Uterine rupture, fertility.

CAESAREAN SCAR ECTOPIC PREGNANCY OUR EXPERIENCE

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INTRODUCTION :

Caesarean scar ectopic a rarest location for an ectopic pregnancy. Incidence 1 in 1800 to 2500 pregnancies. Incidence of CSEP is increasing as more caesarean sections being performed world wide. Delayed diagnosis may lead to uterine rupture, Hysterectomy and significant maternal morbidity and mortality.

CASE 1 :

30yrs G5P2L1D1A2 with 7wks period of gestation came with complaints of bleeding P/V since one week. She had D&C done twice outside in view of missed abortion. Obstetric history first pregnancy LSCS. Second pregnancy Spontaneous abortion. Third pregnancy missed abortion. Fourth pregnancy emergency LSCS in view of PPROM at 8 month period of gestation. Fifth present pregnancy. On examination general condition pallor present, vitals stable, per abdomen no tenderness, per speculam bleeding through cervical os present, PV uterus bulky. Investigations done Fig 1. On TVS scan found to be caesarean scar ectopic. Emergency laparotomy + excision of ectopic + bilateral tubectomy done (Fig 2 and Fig.3). Biopsy histological appearance consistent with products of conception.

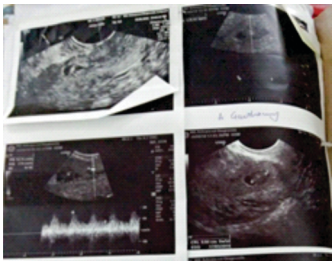

Figure 1 : Transvaginal Scan Showing Caesarean Scarectopic Pregnancy.

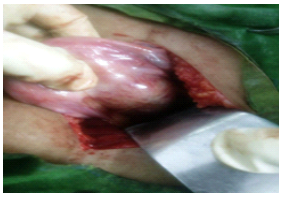

Figure 2 : Intraoperative Picture of Uterus with Caesarean scar ectopic pregnancy

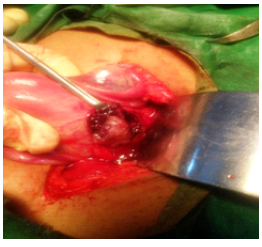

Figure 3 : Removal Of Products Of Conception During Laparotomy

Figure 4 : Products Of Conception

CASE 2 :

G3P1L1A1 with two months amenorrhoea referred from outside hospital in view of scar ectopic pregnancy. Obstetric history : First pregnancy full term LSCS. Second pregnancy 2nd month spontaneous abortion, Check curettage was done. Third present pregnancy. On examination general condition pallor present, vitals stable, per abdomen no tenderness, per speculum cervix healthy, PV uterus bulky. Investigations : hcg – 15,000 mIU/ml, Scan: TVS scan s/o scar ectopic pregnancy. Laparotomy was done (Fig.5 and Fi.6). Excision of scar ectopic done. Biopsy s/o products of conception.

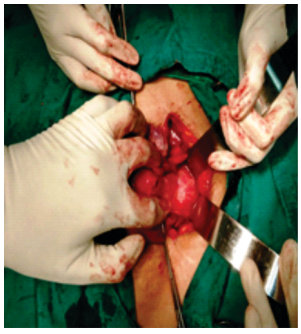

Figure 5 : Intra-operative Picture Showing Caesarean Scar Ectopic

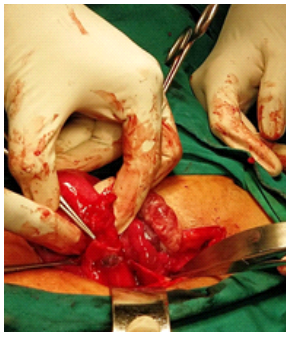

Figure 6 : Gestational sac visible through the thinned out scar

CASE 3 :

30yrs old G4P2L2A1 with 6wks of amenorrhoea referred from outside hospital in view of pain lower abdomen. She had previous 2 LSCS. 1 spontaneous abortion for which check curettage was done. On general examination pallor present, vitals stable, per abdomen no tenderness, per speculum cervix healthy, PV uterus bulky. Transvaginal scan found to be scar ectopic pregnancy. Laparotomy was done. Excision of scar ectopic done. Biopsy report S/o products of conception.

DISCUSSION

A caesarean scar ectopic pregnancy is rarest of all ectopic pregnancies [1]. The most common clinical presentation of caesarean ectopic pregnancy is painless vaginal bleeding without any specific clinical signs. There are various theories which explain the etiology and mechanism of caesarean ectopic pregnancy, the most accepted one is blastocyst invade into the myometrium through a microscopic dehiscent tract, which may be due to previous uterine surgery like caesarean section, manual removal of placenta etc.[2]. As per the another theory in absence of previous uterine surgery it may occur give to trauma done in assisted reproduction techniques [3]. Differential diagnosis : Cervical pregnancy, Spontaneous abortions in progress, Lower intrauterine pregnancies. For its diagnosis endovaginal ultrasonography and color flow doppler are very helpful [4,5]. MRI has important role when sonography is equivocal. To differentitate from a cervical pregnancy, in trans vaginal sonogarphy no myometrium between the gestational sac and bladder must be seen, because the gestational sac grows into the anterior portion of the isthmus [4]. Diagnosis : TVS scan should have following criteria : 1. Empty uterine cavity 2. Gestational sac located anteriorly at the level of internal os covering the visible or presumed site of previous scar 3. Evidence of placental circulation on doppler 4. Negative sliding organs sign. We managed surgically by laparotomy and excision of gestational mass as recurrence will be less and it will have shorter follow up period. All the 3 cases were followed up at 2 weeks by serum beta Hcg which was below 5 mIu/ml.

MANAGEMENT

- Conservative
- Operative
- D & C
- Excision of trophoblastic tissues
- Local or systemic administration of methotrexate.
- Bilateral hypogastric artery ligation associated with trophoblastic evacuation.
- Selective uterine artery embolization combined with curettage or methotrexate administration.

CONCLUSION

- Caesarean scar pregnancy is increasing due to increasing number of caesarean sections.
- Prompt diagnosis and treatment of the condition requires considerable expertise and high index of clinical suspicion to reduce associated morbidity and mortality.
- Management of caesarean scar pregnancy at the earliest will reduce complications like uterine rupture and fertility can be preserved.

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