



A RARE CASE OF SCAR ECTOPIC MISDIAGNOSED AS HEMATOMETRA WITH ENDOMETRIAL POLYP

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ABSTRACT

Caesarean scar ectopic pregnancies, rare form of extra uterine pregnancies. Many women may present without any of the characteristic clinical features. It is important to timely intervene in a case of women with missed period, keeping the possibility of extra uterine gestation in mind. Here, a 34 year P2L2 (previous 2LSCS)with 2MOA and irregular menses with c/o acute pain abdomen was evaluated. UPT: negative, B-hCG :0.91mIU/ml, USG s/o endometrial polyp with hematometra. With consent patient taken up for diagnostic hysteroscopy with hysteroscopic polypectomy. Intraoperative findings s/o scar ectopic gestation. Products removed with MVA syringe and sent for HPR. Post operatively patient kept in ICU facility for 24hrs. The preoperative diagnosis was endometrial polyp with hematometra and the postoperative diagnosis of 34 year G3P2L2 with 2MOA with previous 2 LSCS with scar ectopic gestation confirmed by histopathology was made. Hence any women in the reproductive age group with missed period, especially previous LSCS cases should be evaluated in line of gestation timely intervention is necessary.

KEYWORDS :

INTRODUCTION

- Caesarean scar ectopic pregnancies are a rare (1:1800 to 2216) form of extra uterine pregnancies.
- The incidence is increasing due to the rise in caesarean deliveries.
- Caesarean scar ectopic pregnancies pose a great risk for maternal haemorrhage and ultimately maternal mortality, just like other ectopic pregnancies.
- While the presentation of ectopic pregnancy can be variable, its most common sign is early pregnancy vaginal bleeding with pain abdomen.
- Despite the known risk factors, however, many women may present without any of these characteristics.

Objective:

- To timely intervene in a case of women with missed period, keeping the possibility of extra uterine gestation in mind.

Method

A 34-year-old woman (P2L2) presented with two months of amenorrhea and acute abdominal pain. The patient did not have history of PV discharge or vomiting. The patient had a history of 2 caesarean deliveries in the past due to breech presentation in her first pregnancy and 1 subsequent scheduled caesarean delivery after normal pregnancy. Her most recent pregnancy was 3 years prior to presentation. She had irregular menses at intervals of 40-50 days. She had no other significant medical history and no history of sexually transmitted infections.

At presentation, her vitals were within normal limits and stable. Physical exam was only notable for moderate clear-white discharge in the vaginal vault without blood and a closed cervix on speculum evaluation. Urine Pregnancy Test was negative. The patient's haemoglobin and haematocrit were within normal limits, as was her white blood cell count. Basic metabolic panel, wet prep, KOH, and STIs were negative. Quantitative Beta-hCG was 0.91mIU/ml at presentation.

USG Findings: Uterus anteverted bulky, measures 1.9 x 5.1 x 6.9cms (Volume-222 cc). Endometrium appears thickened and hyperechoic, measures 16.4 mm. Mixed echogenic collection

predominantly hypoechoic seen in endometrial cavity, measures 7.3 x1.8 x 2.8 cms (vol.20.2cc) most likely suggest hematometra. E/o well-defined, hyperechoic lesion of size 8x5 mm seen in endometrial cavity suggestive of endometrial polyp.

After discussing ultrasonography findings with patient and relatives, written, informed, valid consent was taken and patient was taken up for diagnostic hysteroscopy with hysteroscopic polypectomy.

Intraop: There was no evidence of hematometra. Right ostium was not visualised. Left ostium was occluded with clots. Along the anterior wall of uterus at the site of previous caesarean scar, transparent sac like structure was noted. Considering two months of amenorrhea with sac like structure, on table diagnosis of scar ectopic was made. Relatives were informed about the same and consent was taken. With preparation of diagnostic hysteroscopy sos exploratory laparotomy, sac was removed under observation by gentle curettage. No active bleeding confirmed and patient was kept under observation in ICU for 24hrs postoperatively. Products removed were sent for histopathology.

Gross appearance: multiple grey brown to light brown soft tissue bits and pieces together measuring 9 x 5 x 0.5 cm. Cut surface was grey brown to light brown, soft to spongy and cystic.

HPR of endometrial curetting: Biopsy showed hyalinised chorionic villi with variably preserved decidua and fibrinohemorrhagic material. No evidence of gestational trophoblastic disease. Features were consistent with products of conception.

RESULTS

- Preoperative diagnosis: endometrial polyp with hematometra.
- Postoperative diagnosis: 34 year G3P2L2 with two months of amenorrhea with previous two LSCS with scar ectopic gestation confirmed by histopathology.

CONCLUSION

Any women in the reproductive age group with missed period, especially previous LSCS cases, should be evaluated in line of gestation and timely intervention is necessary. Scar ectopic, can lead to hematometra which can be misdiagnosed as endometrial polyp on ultrasonography. Hence, timely intervention with a carefully performed diagnostic hysteroscopy can be useful.