

Caesarean Scar Pregnancy



Medical Science

KEYWORDS :

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ABSTRACT

We present a case where a diagnosis of missed abortion on USG (in a case of caesarean scar pregnancy) led to torrential haemorrhage during MVA (Manual Vacuum Aspiration) and the uterus had to be sacrificed to save the mother.

Introduction

A caesarean scar ectopic pregnancy occurs when a pregnancy implants on a previous caesarean scar. The exact cause and mechanism are not well understood but it is thought that caesarean scar pregnancy occurs when a blastocyst implants on fibrous scar tissue with a wedge shaped myometrial defect in the previous caesarean scar. Though uncommon this condition is potentially devastating. Early recognition by TVS can prevent maternal mortality and morbidity and improves outcome by preserving future fertility.

Case Report

A 31-year-old G₃P₁A₁ presented to the OPD at 4:00 pm with the C/O Amenorrhoea 3 ½ mths followed by a brownish discharge for 3d. Her urine pregnancy test was +ve 1 mth back.

Her previous cycles had been regular and she was not sure of her LMP. She had had a LSCS 4 yrs back for CPD and a medical abortion 1yr back.

In this pregnancy after the pregnancy test was +ve she had no ANC. There was a mild blood stained discharge 3 days back for which she was advised USG pelvis by the local doctor. Her USG report done the previous day gave the final impression – Retained Products of Conception (3x3.5cm) with blood clots in the uterine cavity. O/E BP 110/70mm of Hg Pulse 78/min, other examination Normal, P/A previous scar healthy. Ps- Cx healthy, brownish discharge+, Pv – Ut 10 wks size soft mobile, non tender, both Fx free. She was admitted to the hospital and was planned for an evacuation next morning. Hb- 10.4gm%, Bl grp –O+ve and other reports were normal.

In the minor OT under sedation with Evacuation was started with No.5 cannula and MR Syringe. 10 ml of clear liquor came out. On inserting the cannula again the syringe was filled with blood immediately. When this happened 3 times an IV line was started. Inj Prostodin given IM, and the suction machine was used for a continuous suction suspecting a molar pregnancy. Bleeding continued, Bimanual massage of uterus tried, Inj Syntocinon 10 units in 5% Dextrose was given, Tab Misoprostol(600) given per rectal. The bleeding seemed to be from the upper part of the cx so a Foley's catheter was inserted through the cx and bulb was inflated with 40ml distilled water, bleeding pv reduced, but after 15 mins Pulse 120/min, thready, BP- 70/50 and bedside USG showed uterine cavity enlarged and full of blood. As her vitals were going down she was shifted to OT for Laparotomy with 2 units of blood.

On laparotomy there was a 3 x 2cm bluish black swelling at the isthmus, and the bladder was adherent to the lower part of the swelling which had a thin wall through which blood clots could be seen. (Figure – 1) As the bladder was being pushed down the wall of the gestation sac ruptured and the margins could not be sutured as they were friable. With the patient's condition deteriorating a sub total hysterectomy was done with her husband's consent. Abdomen was closed after maintaining haemostasis. A total of 5 units of fresh blood was transfused. She had an uneventful recovery. Her stitches were removed on 7th POD and she was discharged with Hb at 9 gm%.

The histopathology report showed uterine scar tissue with areas of trophoblastic tissue, hyalinised chorionic villi surrounded by areas of haemorrhage. Myometrium showed stromal oedema with trophoblastic cells.

Discussion

Once considered extremely rare implantation of a pregnancy within the scar of previous caesarean is becoming more common. Clinicians must have heightened awareness of this serious and potentially fatal pregnancy complication (1) A computer Medline bibliography search yielded 26 cases reported from 1966 – Mar 2003 ; It was found that if early diagnosis is made treatment options are capable of preserving the uterus and subsequent fertility. However a delay in diagnosis can lead to uterine rupture or hysterectomy. (2) In 18 cases of caesarean scar pregnancy Jurkovic et al used expectant management with local injection of Methotrexate and suction curettage followed by Foleys balloon tamponade. Success with Methotrexate was five of seven patients (71%) with the two failures requiring emergency surgery. Expectant management was successful in only one of these cases so not recommended. (3) Godin et al have put forward the sonologic diagnostic criteria for pregnancy in caesarean scars : no evidence of pregnancy in uterine cavity or within cervical canal, presence of gestation sac growing and developing in the anterior uterine wall and defect in the myometrium between the gestation sac and bladder wall Use of TVS in all post CS pregnancy in early weeks to rule out scar pregnancy is a good option for early diagnosis. (4)

Conclusion

At present there is no protocol for caesarean scar pregnancy. D & E followed by balloon tamponade, Hysteroscopic removal and Laparoscopic management have all been tried with varied results in different hands but early TVS diagnosis has definitely improved the outcome. Local injection with Methotrexate is also being tried.



Figure 1 Showing Gestation sac bulging out of the LSCS scar

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