Case Report

Case Report of Cervical Ectopic Pregnancy
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Abstract

Cervical pregnancy is an extremely rare condition with potential grave consequences if not diagnosed and treated early enough. We present a case and ultrasound images of an early cervical ectopic pregnancy with a history of one previous caesarean section who was successfully treated with suction curettage with cervical suture and tamponade.

Introduction

Cervical ectopic pregnancies (CPs) account for less than 1% of all ectopic pregnancies, with an estimated incidence of one in 2500 to one in 18,000[1,2]. In the past, CP was associated with significant hemorrhage and was treated presumptively with hysterectomy. Improved ultrasound resolution and earlier detection of these pregnancies has led to the development of more conservative treatments that attempt to limit morbidity and preserve fertility. There are reports of association with chromosomal abnormalities as well as a prior history of procedures that damage the endometrial lining such as caesarean section, intrauterine device, and in vitro fertilization [3].

Case Report

A 32 year old woman, gravida 2 para 1, presented to our department at 6+ weeks gestation on 30/12/2015 with painless vaginal bleeding for one hour after sexual intercourse. Her medical history was unremarkable, with previous history of lower segment caesarean section 1 year ago, and history of Intrauterine device removal by her GP about 2 months ago. No previous history of pelvic inflammatory disease. Vital signs were stable, and the abdomen was soft and not tender.

On transvaginal scan, uterine cavity appeared empty at fundal part with endometrial thickness of 8mm. A small intrauterine gestational sac measuring 0.47x 0.65cm was seen in lower part of uterus close to the cervical canal with no fetal pole. There was no evidence of free fluid in pouch of douglas. Vaginal speculum examination showed small amount of clots in vagina and cervical os was closed. Patient had normal rise of B-HCG in next 48 hours. Suspicion of cervical ectopic pregnancy/caesarean scar pregnancy was in view.

After 48 hours, on 01/01/2016 the patient had profuse vaginal bleeding associated with minimal pain. Serum B-hCG was 8690 IU/l. Transvaginal scan showed single gestational sac, below the level of internal Os measuring 1.2 x 0.85 cm, with yolk sac. No fetal pole or fetal heart was observed. The upper part of the gestational sac was 2.8cm from the external cervical os (Figure 1). The internal cervical Os was closed endometrial cavity was normal (Figure 2).

An urgent suction curettage, with cervical suturing and cervical balloon tamponade was explained to patient. Possibility of hysterectomy discussed and a written consent taken from the patient. Patient underwent suction curettage with cervical suturing followed by cervical balloon tamponade same day. Minimal PV loss was observed in post op period. The balloon tamponade was removed 24 hours later. The patient made a good recovery and was discharged in good health on 3rd post op day. Serum B-hCG dropped to 1.4 iu/l in 24 days (Table 1).

Afterwards, the patient conceived again in March 2016 and delivered a healthy baby boy in December 2016.

Discussion

Although cervical pregnancy is a rare form of ectopic pregnancy it is a life-threatening disease due to its late diagnosis in symptomatic women. Its etiology is still unknown but many risk factors have been suggested: previous surgical termination of pregnancy, endometrial ablation, Asherman syndrome, previous caesarian section or other cervical or uterine surgery and assisted reproductive techniques [4,5,6,7,8]. In our case, a previous caesarian scar, IUCD removal were the known risk factor. With regard to clinical presentation, the most frequent symptom of cervical ectopic pregnancy is a painless vaginal bleeding, which was also the presenting symptom of our patient [3].

The ultrasound diagnosis of a cervical pregnancy requires visualization of an intracervical ectopic gestational sac or trophoblastic mass below a closed internal os. Recognizing its sonographic appearance is the first step for a correct management, because it may be mistaken for an intrauterine pregnancy, an incomplete abortion.
or even an endocervical cyst [4,9]. Transvaginal ultrasound seems to be the most appropriate imaging method.

Treatment choices may be divided into five categories: cervical balloon tamponade, reduction of blood supply, excision of trophoblastic tissue, intra-amniotic feticide, and systemic chemotherapy [10]. In most reported cases of cervical pregnancy, treatments from more than one category are used [10]. Our patient presented with active bleeding and surgical intervention was strongly favored by both physicians and the patient.

Table 1: B-hCG level at and after suction curretage

<table>
<thead>
<tr>
<th>Date</th>
<th>01/01/16</th>
<th>07/01/16</th>
<th>14/01/16</th>
<th>25/01/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-hCG level</td>
<td>8690</td>
<td>342.5</td>
<td>29.2 iu/L</td>
<td>1.4 iu/L</td>
</tr>
</tbody>
</table>

![Ultrasound findings of Cervical Pregnancy showing a gestational sac (1.2 x 0.85 cm) with a Yolk sac but no fetal pole. The entire gestational sac is below the level of the internal os as marked by the bladder neck.](image1)

![Ultrasound scan findings of closed internal cervical Os and an empty uterine cavity.](image2)

Figure 1: Ultrasound findings of Cervical Pregnancy showing a gestational sac (1.2 x 0.85 cm) with a Yolk sac but no fetal pole. The entire gestational sac is below the level of the internal os as marked by the bladder neck.

Figure 2: Ultrasound scan findings of closed internal cervical Os and an empty uterine cavity.

Treatment with methotrexate chemotherapy of patients with either viable or nonviable cervical pregnancies at <12 weeks' gestation carries a high success rate for preservation of the uterus [11]. Although we considered antimetabolite medications such as methotrexate, studies have shown unsatisfactory results if serum B-hCG is more than 10000 iu/L [12], which was very close to the level in our case.
References


