

CASE REPORT

A RARE CASE REPORT OF A GESTATIONAL SAC SEEN OVER A PREVIOUS LSCS SCAR - CAESAREAN SCAR ECTOPIC

¹Dr Hemant Deshpande, ²Dr Madhukar Shinde, ³Dr Rajendra Shitole,
⁴Dr Nikita Samantara

¹Professor & HOD, Department of Obstetrics & Gynaecology, Dr. DY Patil Medical College, India

²Associate Professor, IVF, High Risk Obstetrics and Endoscopy Consultant, Department of Obstetrics & Gynaecology, Dr. DY Patil, Medical College, India

³Assistant Professor, IVF and Endoscopy Consultant & Robotic Surgeon, Department of Obstetrics & Gynaecology, Dr. DY Patil, Medical College, India

⁴Third year Resident, Department of Obstetrics & Gynaecology, Dr. DY Patil Medical College, India

Correspondence:

Dr Nikita Samantara

Third year Resident, Department of Obstetrics & Gynaecology, Dr. DY Patil Medical College, India

Email : drnikitasamantaraobgydp@gmail.com

ABSTRACT

Introduction: This term describes implantation within the myometrium of a prior cesarean delivery scar. Its incidence approximates 1 in 2000 normal pregnancies and has increased along with the cesarean delivery rate. It is rarest of all ectopic pregnancies. It is a life threatening condition, causes excessive haemorrhage and risk of uterine rupture.

Case Summary: A 35 year old female, presented to OBG Department with complaints of Per Vaginal spotting since 3 days (with less than half pad soaked) and lower abdominal pain since 3 days, UPT was positive. Her obstetric score was Gravida 4 Para 2 Living 2 Abortion 1 with 6 weeks of amenorrhea. On eliciting her obstetric history, her married life was 10 years. She had history of one spontaneous abortion at 2 months of gestation for which a dilatation & evacuation was done. She had 2 previous Caesarian sections indicated because of low lying placenta and previous caesarean respectively. On Per abdomen examination, previous LSCS scar was seen and on palpation abdomen was soft and non tender with no scar tenderness. On per speculum examination minimal bleed was seen on the cervical os. On per Vaginal examination - uterus was normal in size, retroverted and bilateral fornices were free and non tender. An urgent USG OBS was advised, which showed- A gestational sac in the lower uterine segment along the anterior wall, with thinning of anterior myometrial wall. Adjacent to the sac, an heterogenous echogenicity was seen - likely previous LSCS scar. Hysteroscope port with camera was put into the cervix, a gestational sac with clots adjacent to it was seen over the anterior uterine wall over the lower segment of uterus. Curetting was done and products were removed. Patient was discharged within 8 hours and was asked to follow up after 1 week with an USG abdomen pelvis which was normal, and showed no RPOC or any other significant abnormality.

Conclusion: With increasing rates of Caesarean section, this complication of scar ectopic can be anticipated more frequently now. Prompt diagnosis and early treatment

can prevent untoward complications. In this particular case report, gestational sac of caesarean scar ectopic pregnancy was removed safely by laparoscopy and hysteroscopy. Abbreviations: CSP (caesarean scar pregnancy)

INTRODUCTION

Caesarean ectopic describes implantation within the myometrium of a prior cesarean delivery scar. Its incidence approximates 1 in 2000 normal pregnancies and has increased along with the cesarean delivery rate (Ash, 2007; Rotas, 2006). The pathogenesis of cesarean scar pregnancy (CSP) has been likened to that for placenta accreta and carries similar risk for serious hemorrhage (Timor-Tritsch, 2014a,b). It is unknown if the incidence increases with multiple cesarean deliveries or if it is affected by either one- or two-layer uterine incision closure during cesarean.(1)

Women with CSP usually present early, and pain and bleeding are common. Still, up to 40 percent of women are asymptomatic, and the diagnosis is made during routine sonographic examination (Rotas, 2006).

CASE SUMMARY

A 35 year old female, presented to OBG Department with complains of Per Vaginal spotting since 3 days (with less than half pad soaked) and lower abdominal pain since 3 days. Her last menstrual cycle was 1.5 months ago, so a Urine Pregnancy Test was done which came positive. Her obstetric score was Gravida 4 Para 2 Living 2 Abortion 1 with 6 weeks of amenorrhea. On eliciting her obstetric history, her married life was 10 years. She had history of one spontaneous abortion at 2 months of gestation for which a dilatation & evacuation was done. She had 2 previous Caesarian sections indicated because of low lying placenta and previous caesarean respectively. Both babies are alive and healthy and both sections were uneventful. She gave no other significant past medical, surgical or drug history. On examination, general condition was fair. Vitals stable, P = 88bpm and BP = 124/78mmHg. No evidence of pallor. CVS and RS were auscultated and found to be within normal limits. On Per abdomen examination, previous LSCS scar was seen and on palpation her abdomen was soft and non tender with no scar tenderness seen. On per speculum examination minimal bleed was seen on the cervical os. On per Vaginal examination - uterus was normal in size, retroverted and bilateral fornices were free and non tender.

An urgent USG OBS was advised, which showed - A gestational sac in the lower uterine segment along the anterior wall, with thinning of anterior myometrial wall. Adjacent to the sac, an heterogenous echogenicity was seen - likely previous LSCS scar. Within the sac, foetal pole and yolk sac was seen with severe bradycardia. A heterogenous hyperechoic collection seen adjacent to the sac suggestive of haemorrhage. Findings were in favour of scar ectopic pregnancy.

The patients haemogram, serology were sent and values were traced, Hb - 9.8g/dL, WBC - 9000, platelet count was 2.5 lakhs/uL and serology was non reactive. Patient was counselled and planned for Laparoscopy and Hysteroscopy. On table, laparoscopically pouch of Douglas was visualised and contained minimal fluid. The bilateral ovaries and fallopian tubes were normal. Uterine fundus was normal, lower segment of the uterus was not fully seen due to her previous 2 caesareans bladder was slightly pulled up and adhered to anterior uterine wall obscuring the previous LSCS scars.

Hysteroscope port with camera was put into the cervix, a gestational sac with clots adjacent to it was seen over the anterior uterine wall over the lower segment of uterus. Curetting was done and products were removed. It was checked again hysteroscopically. Haemostasis was achieved, patient withstood procedure well and was shifted to recovery for observation. Patient was discharged within 8 hours and was asked to follow up after 1 week with an USG

abomen pelvis which was normal, and showed no RPOC or any other significant abnormality.

Figure 1: Pouch of Doughlas seen containing minimal free fluid, rest structures appear normal.

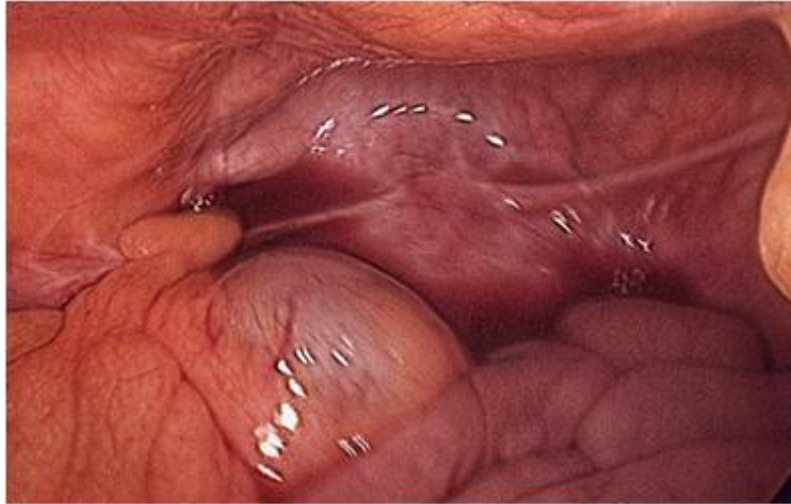
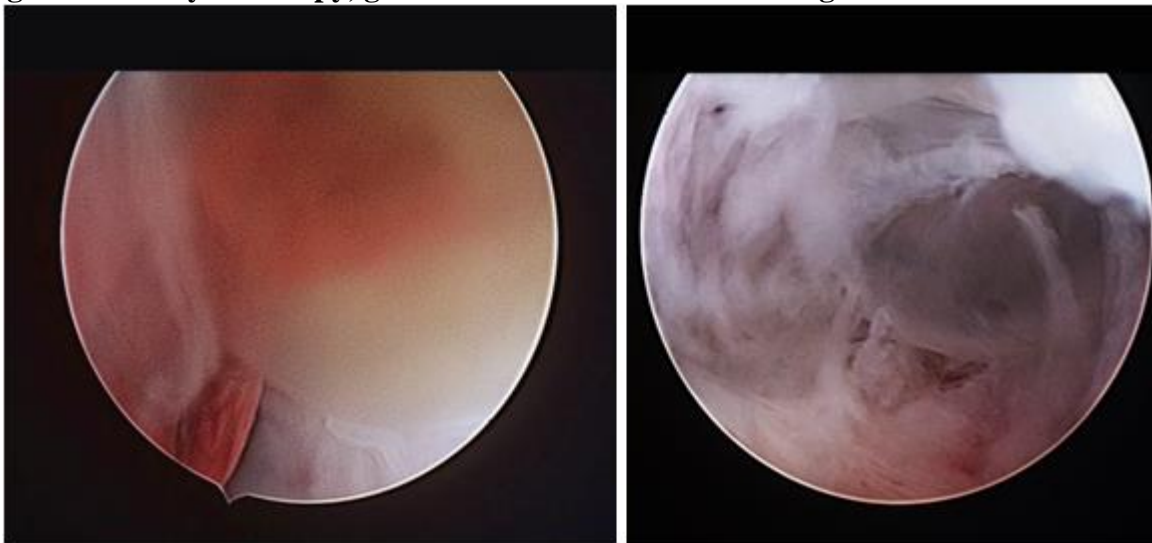


Figure 2: On Hysteroscopy, gestational sac seen over thinned out myometrium.

Figure 3: On Hysteroscopy, gestational sac seen after curetting blood clots.



DISCUSSION

It can be called by various names as “Caesarean scar pregnancy’, Caesarean ectopic pregnancy or simply Caesarean scar ectopic [3]. The diagnosis of this type of ectopic pregnancy is very difficult and false negative diagnosis can lead to major complications. The pregnancies with previous caesarean section have increased the risk of placenta previa, placental abruption, placenta accreta, percreta as well as ectopic pregnancies in future. 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. [3]. As per another theory in absence of previous uterine surgery, Caesarean ectopic pregnancy can occur due to trauma done in assisted

reproduction techniques [4]. The most common clinical presentation of Caesarean ectopic pregnancy is painless vaginal bleeding without any specific clinical signs.

According to Godin (1997), four sonographic criteria should be satisfied for the diagnosis: Transvaginal sonogram of a uterus with a cesarean scar pregnancy (CSP) in a sagittal plane. An empty uterine cavity is identified by a bright hyperechoic endometrial stripe. An empty cervical canal is similarly identified. Last, an intrauterine mass is seen in the anterior part of the uterine isthmus. Myometrium between the bladder and gestational sac is absent or thinned (1 to 3 mm). (1)

There are two recognized types of hysterotomy scar ectopic pregnancies. Type 1 develops in the myometrium and grows toward the uterine cavity, whereas type 2 progresses exophytically toward the uterine serosa [4]. Type 2 pregnancies have an ominous prognosis because they may result in spontaneous uterine rupture, hemorrhage, and maternal death. (5)

Various case reports of patients with Caesarean scar ectopic pregnancy even in the absence of bleeding, supports our management as the surgical option [4]. This includes elective laparotomy and excision of the gestational mass. The benefit of Surgery is less recurrence because of the resection of the old scar, with a new uterine closure. Other is a shorter follow-up period [6,9]. In another study with Caesarean scar pregnancy cases, surgical excision of scar is considered as a key management and helpful to prevent recurrence [7].

CONCLUSION

With increasing rates of Caesarean section, this complication of scar ectopic can be anticipated more frequently now. Prompt diagnosis and early treatment can prevent untoward complications. In this particular case report, surgical removal of gestational sac of caesarean scar ectopic pregnancy was removed safely by laparoscopy and hysteroscopy.

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