

Case Report

Acute Hemorrhage Related to a Residual Cervical Pregnancy: Management with Curettage, Tamponade, and Cerclage

Nigel Pereira, MD*, Irene Grias, DO, Sarah E. Foster, BS, and Carl R. Della Badia, DO

From the Department of Obstetrics and Gynecology (Drs. Pereira, Grias, and Della Badia and Ms. Foster), and Division of Minimally Invasive Gynecologic Surgery (Drs. Grias and Della Badia), Drexel University College of Medicine, Philadelphia, Pennsylvania.

ABSTRACT Cervical ectopic pregnancy is uncommon, with no universally accepted protocol for conservative management of acute hemorrhage due to residual cervical ectopic pregnancy. Herein is presented the case of a 33-year-old woman with profuse vaginal bleeding 3 months after receiving treatment including intraamniotic potassium chloride injection, systemic methotrexate, and uterine artery embolization because of a cervical ectopic pregnancy. A residual cervical pregnancy was suspected. Hemorrhage was controlled using curettage, tamponade with a Bakri balloon, and cerclage. The balloon and cerclage were removed on postoperative day 2, with no recurrence of symptoms. Our experience suggests that a combination of curettage, balloon tamponade, and cerclage may be considered in the management of cervical ectopic pregnancies with acute hemorrhage, in particular in patients desiring future childbearing. *Journal of Minimally Invasive Gynecology* (2013) 20, 907–911 © 2013 AAGL. All rights reserved.

Keywords: Balloon tamponade; Cerclage; Cervical pregnancy; Curettage; Hemorrhage

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Cervical ectopic pregnancy (CEP) is uncommon, representing <1% of all ectopic gestations [1–3]. Historically, the diagnosis of CEP was delayed, invariably leading to life-threatening hemorrhage necessitating hysterectomy [4,5]. The advent of sensitive quantitative β -human chorionic gonadotropin (β -hCG) assays and first-trimester ultrasonography has enabled early diagnosis of CEP and has also provided opportunities for the use of nonsurgical treatment methods [4,5]. We searched MEDLINE using PubMed for all English-language articles published from 1990 to 2012, using search terms “cervical pregnancy,” “conservative management,” “curettage,” “balloon tamponade,” and “cerclage.” Our search revealed 120 publications

describing conservative management strategies for CEP. Of these publications, at least 20 have described the use of curettage, balloon tamponade, and cerclage as single agents or in combination for management of early CEP. Our search, however, did not show the use of this combination in managing acute hemorrhage related to a residual CEP. Herein we report a case that highlights the management of life-threatening hemorrhage related to a previously treated CEP, using a combination of curettage, balloon tamponade, and cerclage in a patient desiring future childbearing.

Case Report

A 33-year-old woman, gravida 2 para 0 abortus 1, came to the emergency department with profuse and painless vaginal bleeding. Three months previously at another institution, a spontaneous cervical pregnancy had been diagnosed at 7 weeks of gestation on the basis of crown-rump length. She received treatment including ultrasonographically directed intraamniotic potassium chloride (KCl) injection, systemic methotrexate (MTX), and uterine artery embolization (UAE) and was subsequently followed up with serial serum β -hCG measurements. At 1 week before presentation, we

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Corresponding author: Nigel Pereira, MD, Drexel University College of Medicine, Department of Obstetrics and Gynecology, 245 N 15th St., MS 495, 16th Floor, New College Building, Philadelphia, PA 19102.
E-mail: Nigel.Pereira@drexelmed.edu

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received a single hCG measurement from the providers at the other institution, which was a serum β -hCG concentration of 22 mIU/mL. Other than a previous surgical termination of pregnancy, the patient's gynecologic, medical, and surgical history was unremarkable.

On initial evaluation in the emergency department, the patient appeared pale, with tachycardia, and normal blood pressure. Profuse vaginal bleeding was noted at speculum examination. A residual CEP was suspected, and we proceeded immediately to the operating room. The patient's hemoglobin concentration was 12.9 g/dL, and serum β -hCG concentration was only 9 mIU/mL.

Intraoperative vaginal examination revealed clots in the vaginal vault, with brisk bleeding from the 11-o'clock position on the anterior lip of the cervix. A 2 × 2-cm, pink to tan, firm, polyplike hemorrhagic sac was noted. The cervix felt enlarged and globular, with the external os dilated to 2 cm. The sac was evacuated using suction curettage, and the tissue obtained was sent for histopathologic evaluation. After suction curettage of the uterine cavity, bleeding continued from the CEP site. Balloon tamponade of the cervix was performed using a Bakri balloon (Cook Medical Inc., Bloomington, IN). The balloon was placed in the uterine cavity and inflated to 45 mL. The tamponade effect was further re-

inforced with a single McDonald cervical cerclage using a 0 polydioxanone suture (Fig. 1). The cerclage was tied immediately below the inflated balloon, after which excellent hemostasis was noted. The hemoglobin concentration had decreased to 10.1 g/dL intraoperatively, and 2 U packed red blood cells was transfused immediately because of extensive intraoperative bleeding.

The hemoglobin concentration equilibrated to 6.3 g/dL on postoperative day 2, and an additional 2 U packed red blood cells was transfused. The total output from the Bakri balloon was 20 mL. As a precaution, on postoperative day 2, the patient was returned to the operating room, and the balloon and cervical cerclage were removed. The CEP site appeared completely hemostatic (Fig. 2). On postoperative day 3, the hemoglobin concentration was 8.3 g/dL, and the serum β -hCG concentration was <5 mIU/mL. Detailed histopathologic analysis showed chorionic villi, hypersecretory endometrium, and decidua. The patient was discharged on postoperative day 3 and made an uneventful recovery. Currently, the patient is pregnant with spontaneous dizygotic twins.

Discussion

CEPs continue to be an uncommon clinical entity, with an estimated prevalence of 1 in 2500 to 1 in 18 000 pregnancies [3]. CEPs are thought to arise when the blastocyst implants and grows within the endocervical mucosa after passage through the uterine cavity [3]. Although the precise etiology of CEPs remains unknown, several risk factors have been implicated including previous instrumentation of the endometrial canal, intrauterine device use, in vitro fertilization, diethylstilbestrol exposure, previous cesarean delivery, previous uterine curettage, and anatomic aberrations of the uterine cavity such as leiomyomas or synechiae [3,4].

Most patients with CEPs have painless vaginal bleeding; however, occasionally this may be accompanied by

Fig. 1

Intraoperative view of the cervix shows the presumed CEP site (white arrow), cerclage knot (black arrow), and distal channel of the Bakri balloon emerging from the external os. The cerclage tail (with multiple knots) is also seen.

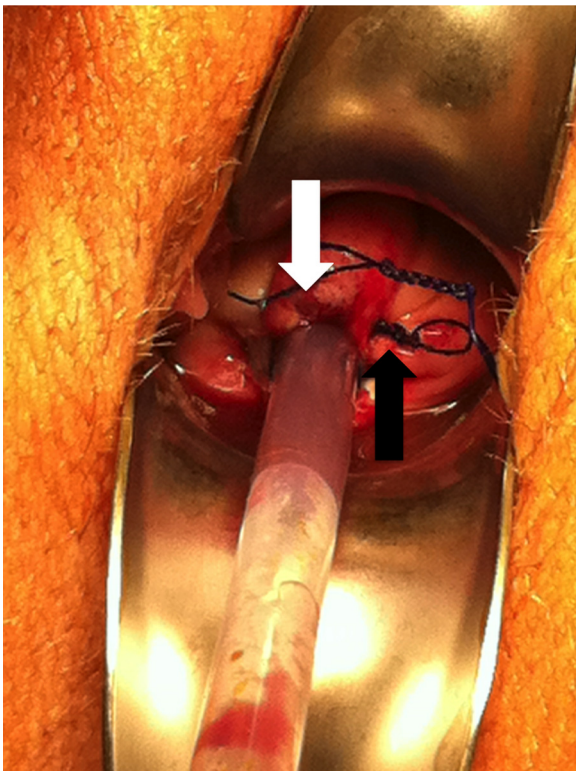
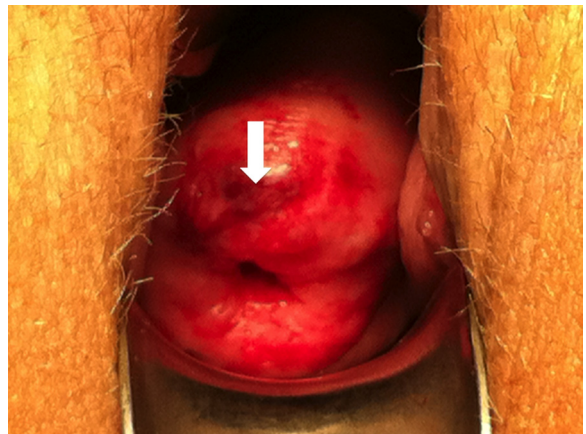


Fig. 2

Intraoperative view of the cervix shows the hemostatic CEP site (arrow) after removal of the Bakri balloon and cervical cerclage.



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