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Conservative management of 14 weeks cervical ectopic pregnancy: Case report[☆]

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Abstract Cervical ectopic pregnancy is implantation of an embryo into the cervical mucosa below the level of the internal os. Cervical pregnancy is an infrequent form of ectopic gestation both in naturally conceived pregnancies and even after assisted reproductive technology (ART). It accounts for less than 1% of all ectopic pregnancies. The Transvaginal ultrasonographic diagnosis rests upon empty uterus, trophoblastic invasion of the cervix below the internal os and enlarged barrel shaped cervix containing a gestational sac present below the level of internal os. Early detection is desirable in order to plan the management early and to avoid serious and often life threatening complications. Management options vary and depend on the gestational age at diagnosis, general condition of the patient and woman's desire to maintain fertility. Medical treatment with methotrexate is the therapy of choice in early gestation with hemodynamically stable patient. Surgical intervention is indicated in late gestation, unstable cases or failed medical treatment.

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1. Case report

A 34 years old gravida three para 1, presented for the first time to our department at 14 week gestation with single living

[☆] **Synopsis:** We presented a conservative approach to a case of cervical ectopic pregnancy at 14 weeks gestation in which hysterectomy was avoided.

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cervical ectopic pregnancy. The patient was admitted and the diagnosis was confirmed. Following counseling and a written informed consent obtained for hysterectomy the patient was scheduled for surgery. Laparotomy was done and a loop was applied on the anterior division of the internal iliac arteries on both sides. The peritoneum of the lower uterine segment was dissected to expose the cervix and to free the urinary bladder. Both uterine arteries were ligated. A c-shaped incision was done on the upper part of the cervix, the fetus was gently and easily extracted and the cervix was digitalized to manually remove the placenta. The cervical canal was explored and an intra-cervical balloon tamponade was applied. The anterior division of the left internal iliac artery was ligated and the loop on the right internal iliac artery was removed because the bleeding was controlled. The patient received 2 units of packed RBCs. The postoperative period passed smooth and the

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catheter was deflated gradually after 2 days. The patient was followed up by β -HCG estimation after discharge until it becomes negative.

2. Introduction

Cervical ectopic pregnancy is implantation of an embryo into the cervical mucosa below the level of the internal os. It is extremely rare in both naturally conceived pregnancies (1–3) and in assisted reproduction (4). It accounts for less than 1% of all ectopic pregnancies and 1 in 1000–95,000 pregnancies (5). The first report of a cervical ectopic pregnancy diagnosed by ultrasound was in 1978 (6). It is a serious and often life threatening complication.

The exact etiology of cervical pregnancy is unknown. One theory suggests that there is rapid transport of the fertilized ovum to the cervical location before it is capable for implantation. There are many predisposing factors, which include previous cervical and endometrial damage due to uterine curettage, anatomic anomalies (myomas, Asherman's syndrome), intrauterine device (IUD) use, assisted reproduction, diethylstilbestrol exposure and previous cesarean section (7,8).

Historically, the diagnosis of cervical pregnancy was made primarily after hysterectomy for uncontrolled bleeding. However, more recently, the use of Trans-vaginal ultrasound has facilitated an earlier diagnosis. The endovaginal ultrasonographic diagnosis rests upon empty uterus, trophoblastic invasion of the cervix below the internal os, enlarged barrel shaped cervix containing a gestational sac present below the level of internal os and absence of the sliding sign. Color Doppler allows the placenta's location, the extent of trophoblastic invasion, and the flow of blood to be documented. A classic sign on ultrasound is a hyperechogenic trophoblastic ring surrounding the implantation site. Without ultrasonographic evidence of trophoblastic invasion of the cervix, no diagnosis can be confirmed. Cervical pregnancy can be confused with product of conception in transit through the cervical canal during a miscarriage. Doppler study and "the sliding sign" can help to distinguish between these conditions.

Significant progress has been made in the management of cervical ectopic pregnancies (9). Management options vary and depend on the time of diagnosis and the clinical presentation (10). In the first trimester if the patient is hemodynamically stable several conservative measures could be used. The use of Methotrexate intra-amniotically under ultrasound guidance or systemic single or multiple doses is the therapy of choice (11). Intra amniotic methotrexate may be performed alone or with feticide using potassium chloride. Most reports of successful conservative therapy however involve the use of methotrexate in combination with cervical evacuation and use of a hemostatic technique. In the past, curettage with packing of the cervix for almost inevitable bleeding was commonly done. Foley's catheter placed gently past the external os and inflated for tamponade has also been used with some success (12). The risk of hemorrhage may also be reduced by cervical cerclage, intra-cervical vasopressin injection, vaginal ligation of the cervical arteries, uterine artery ligation, internal iliac artery ligation, and angiographic embolization of the cervical, uterine, or internal iliac arteries (13).

Most published cases of cervical pregnancy beyond 12 weeks have ultimately resulted in hysterectomy in order to prevent maternal morbidity or mortality from hemorrhage (13).

3. The case

A 34 years old gravida three Para 1 with one previous cesarean section and a miscarriage at 13 weeks which was terminated medically, Presented for the first time to our department at 14 week gestation with ultrasonic and MRI reports. The patient was hemodynamically stable, her vital signs were stable, and the abdomen was soft and not tender, with a hemoglobin of 11 g/dL. She had a dating scan at 11 week gestation (Fig. 1), which reported bulky empty uterus, a large gestation sac located in the uterine cervix surrounded by regular doubling decidual reaction and containing a single living fetus, Crown Rump length was 4.2 cm corresponding to gestational age of 11 weeks and 2 days with absence of sliding sign (the intra-cervical sac fails to slide along the cervical canal when the vaginal transducer was used to apply gentle pressure to the cervix). A non contrast MRI of the pelvis using multipulse sequences in different planes (Fig. 2) revealed cervical gestational sac with fetal pole inside associated with empty uterine cavity with thickened endometrial plate. Her menses had been regular, with the last being approximately 13–14 weeks prior to presentation. To confirm the diagnosis a pelvic ultrasound scan (both trans-abdominal and trans-vaginal) was arranged which reported bulky empty uterus with no focal masses or lesions, the endometrium was thickened and hyperechoic but no pseudosac was identified. Both ovaries were normal and there was no free fluid, enlarged barrel shaped cervix in which a gestational sac was present below the level of the internal os with a fetal pole and evident cardiac pulsation. The patient was counseled, the potential risks and alternative methods of treatment were explained to her, and written informed consent was obtained. The patient was scheduled for surgery and the pre-operative investigations were within normal values.



Figure 1 Transvaginal sonography showing cervical ectopic pregnancy.

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