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Case Report

A rare case report on cervical pregnancy

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ABSTRACT

Cervical pregnancy is a rare type of ectopic pregnancy and it represents <1% of all ectopic pregnancies. Tubal ectopic, Interstital, caesarean scar pregnancy, cornual, ovarian, Intramural are other types of ectopic pregnancy. Timely diagnosis and Treatment are key to management any type of ectopic pregnancy. Cervical ectopic pregnancy is the implantation of blastocyst in the intracervical canal. Cervical pregnancy are high risk cases as they may present with an unexpected life-threatening hemorrhage secondary to the erosion of cervical blood vessels, which may require hysterectomy to save the patient. Here is case of 22yr old primi patient with 6 weeks and 2 days of cervical ectopic pregnancy planned for dilatation and evacuation followed by medical management span; Improved ultrasound resolution and earlier detection of these pregnancies have led to the development of more conservative treatments that attempt to limit morbidity and preserve fertility.

Keywords: Cervical ectopic pregnancy, Methotrexate, Dilatation and evacuation, Balloon tamponade

INTRODUCTION

Cervical pregnancy is a rare type of ectopic pregnancy and it represents <1% of all ectopic pregnancies.[1] Early diagnosis and medical management with systemic or local administration of methotrexate is the treatment of choice.[1] Cervical ectopic pregnancy is the implantation of blastocyst in the intracervical canal. Cervical pregnancy are high risk cases as they may present with an unexpected life-threatening hemorrhage secondary to the erosion of cervical blood vessels, which may require hysterectomy to save the patient. Early diagnosis and nonsurgical management with local and systemic methotrexate help in decreasing maternal mortality and morbidity.

CASE REPORT

22-year-old primigravida admitted in civil hospital with complaints of mild bleeding per vaginum of 3-day duration following 6 weeks amenorrhea. She was vitally stable. Clinical examination revealed ballooning of cervix with partially open external OS. Blood investigation reports were within the normal limits. Serum beta hCG level was 5550 mIU/ml at that point of time. Transvaginal ultrasound scan revealed empty uterine cavity with closed internal os and a G sac of 14mm corresponding to 6 weeks 2 days was seen in cervical region. Provisional diagnosis of cervical pregnancy was made. Patient shifted to ward with analgesics and antibiotics. In ward, the patient suddenly started bleeding. After counseling, informed consent was taken for dilation and evacuation and for SOS exploratory laparotomy and hysterectomy if required. Under local anesthesia, gentle cervical curettage was done followed by insertion of a no. 14 Foleys' catheter with 30 ml saline inflated in the cervical canal to control bleeding by tamponade effect. T. misoprostol 400 microgram kept in PR. Hemostasis was achieved. Foleys' catheter was removed after 24 h. Postoperative period was uneventful. Single dose of 50 mg methotrexate was given intramuscularly on Postoperative Day 2. Histopathology report confirmed presence of chorionic villi and decidual

tissue with cervical stroma and glands. Patient was discharged on the 4thday and advised for weekly follow-up with serum Beta hCG report. Beta hCG level was 168 mIU/ml after 1 week and 15 mIU/ml 2 week after the procedure. The patient resumed her normal periods after 2 months.

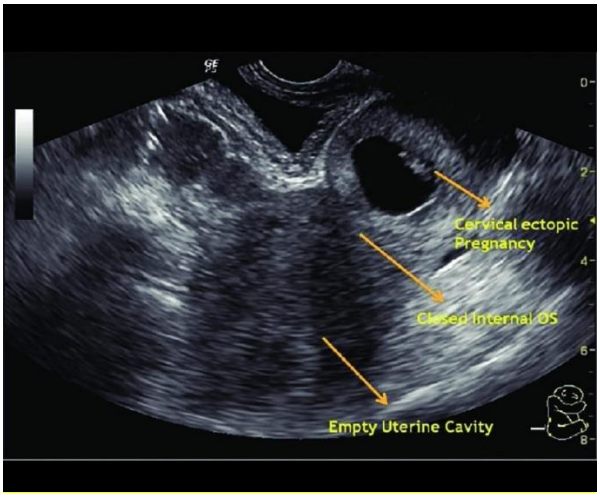

Figure 1: Ultrasound figure of cervical pregnancy.

DISCUSSION

Common risk factors for Cervical ectopic pregnancy are prior Dilatation and curettage and prior Caesarean section and in vitro fertilization.[1] The most common symptom is vaginal bleeding following a period of amenorrhea which is often painless and at times massive bleeding can occur which may even require hysterectomy to save the patient as observed in our first case. Paalman and McElin in 1959 proposed five more clinically practical criteria which includes: Uterine bleeding without cramping pain following a period of amenorrhea, A soft, enlarged cervix equal to or larger than the fundus, Products of conception entirely confined within and firmly attached to the endocervix, A closed internal cervical OS and a partially opened external cervical OS. Most of the criteria were seen fulfilled in our cases.[2] Differential diagnosis include an aborting intrauterine pregnancy residing in cervix which can be differentiated by detecting 'Sliding sign' on transvaginal ultrasound When gentle pressure was applied on the cevix with the probe, the gestational sac of an abortus slides against the endocervical canal unlike an implanted cervical pregnancy.[3] Furthermore, peritro-phoblastic blood flow can be demonstrated on color Doppler ultrasonography in case of cervical pregnancy. Introduction of methotrexate with or without intra-amniotic potassium chloride represents a major advance in terminating cervical ectopic pregnancy especially when fetal heart is present. Among the various routes for methotrexate administration, intramuscular route is usually preferred. The patient should be hemodynamically stable. Her LFT, RFT Should be normal and must comply with posttreatment monitoring.[4,5] In recent times, in vitro fertilization and other assisted reproductive technique have been reported to be associated with increased risk of cervical pregnancy and the etiology is attributed to the rapid transport of fertilized ovum in to the endocervical canal because of an unreceptive endometrium.

CONCLUSION

Although cervical pregnancy are rare, increased number of cases being reported because of risk factors like high cesarean section rate and increased use of assisted reproductive technique for management of infertility. The success of conservative treatment depends on the timely and prompt diagnosis by early ultrasound, which can reduce the chances of severe life-threatening hemorrhage necessitating hysterectomy or blood transfusion.

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