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Case Series

Unmasking the hidden dangers in caesarean scar pregnancy: a case series

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ABSTRACT

Caesarean scar pregnancy (CSP) is a rare form of ectopic pregnancy with increasing incidence due to rising caesarean section rates. This case series aims to describe the clinical presentation, diagnostic approach, management, and outcomes of patients with caesarean scar pregnancies managed at our institution. This retrospective case series included eight patients diagnosed with caesarean scar pregnancy at Sri Ramachandra Institute of Higher Education and Research over a two-year period (January 2023–January 2025). Diagnosis was based on established ultrasonographic criteria. Clinical presentation, management strategies, and outcomes were analyzed. All patients had a history of prior caesarean deliveries. The majority presented with vaginal bleeding in early pregnancy, while one patient was diagnosed incidentally. Transvaginal ultrasound confirmed caesarean scar implantation in all cases. Management included systemic and intrasac methotrexate administration, ultrasound-guided suction evacuation, and uterine artery embolization in selected cases. Serial β-hCG monitoring guided treatment response. Fertility-preserving conservative management was successful in all patients without major complications. Early diagnosis and individualized conservative management can result in favourable outcomes in caesarean scar pregnancy. Increased awareness, early imaging, and careful monitoring are critical to prevent life-threatening complications and preserve reproductive potential. Further studies are needed to establish standardized treatment guidelines.

Keywords: Caesarean scar, Ectopic pregnancy, Suction evacuation, β-HCG

INTRODUCTION

Caesarean scar pregnancy (CSP) is a rare but serious form of ectopic pregnancy, where the gestational sac implants at the site of a previous caesarean section scar. Although ectopic pregnancies comprise 1–2% of all pregnancies, CSP accounts for approximately 1 in 2000 pregnancies.[1] The rising global caesarean delivery rates have contributed to increasing reports of CSP, posing significant diagnostic and therapeutic challenges.[2,3] Implantation occurs when the blastocyst embeds into a myometrial defect formed by incomplete healing of prior caesarean incisions or other uterine procedures like myomectomy and curettage.[3,4] Poor scar healing due to factors such as infection, ischemia, or suture technique can lead to a fibrotic niche, deficient decidualization, and abnormal trophoblastic invasion.[4,5]

The clinical presentation of CSP varies widely. While some patients present with painless vaginal bleeding or abdominal pain, others remain asymptomatic, leading to delayed diagnosis and increased risk of catastrophic complications such as uterine rupture or severe haemorrhage.[6,7] Approximately 25% may be asymptomatic initially.[7] Early transvaginal ultrasonography remains the cornerstone of diagnosis, often allowing detection between 5 and 9 weeks of gestation.[8] Key sonographic features include an empty uterine cavity, gestational sac located anteriorly in the lower uterine segment, thin or absent myometrium

between the sac and bladder, and characteristic vascular patterns on Doppler imaging.[9]

CSP is broadly classified into two types based on its sonographic appearance: type I (endogenic), where the sac grows towards the uterine cavity, and type II (exogenic), where it invades the myometrium and extends towards the serosal surface.[3] Type II carries a higher risk of early uterine rupture and hemorrhage, often requiring prompt intervention, while type I may occasionally continue as an ongoing pregnancy but carries risks of placenta accreta spectrum later.[3] Management strategies for CSP remain varied due to its rarity and heterogeneous presentation. Options include systemic or local methotrexate administration, ultrasound-guided suction evacuation, uterine artery embolization, hysteroscopic resection, laparoscopic removal, or hysterectomy in severe cases.[10,11] Choice of treatment depends on gestational age, sac size, fetal viability, hemodynamic status, and future fertility desires.[12] Early diagnosis permits conservative, fertility-preserving interventions, while delayed recognition often leads to more invasive procedures with significant morbidity.[12]

The growing incidence of CSP underscores the need for heightened awareness, early detection, and individualized management strategies. Given its rarity and potential for life-threatening outcomes, every reported case contributes valuable insight into its pathophysiology, diagnosis, and optimal management approaches.[13] We present a case series of cesarean scar pregnancies managed at our institution to further enrich the existing literature and emphasize the importance of timely recognition and tailored interventions to optimize maternal outcomes.

CASE SERIES

Study setting and period

This case series was conducted at Sri Ramachandra Institute of Higher Education and Research over a period of two years, from 2023 to 2025.

Case selection

All patients diagnosed with CSP during the study period were included in this series. No exclusion criteria were applied, as all confirmed cases were analyzed.

Diagnostic criteria

The diagnosis of CSP was established based on transvaginal ultrasonographic findings. The following criteria were used: an empty uterine cavity with clearly visualized endometrium, absence of products of conception within the cervical canal, presence of a gestational sac implanted in the anterior lower uterine segment at the presumed site of the previous caesarean section scar, a thin or absent myometrial layer between the gestational sac and the bladder, with the majority of cases demonstrating a myometrial thickness less than 5 millimeters, a prominent vascular pattern at the level of the scar on Doppler imaging, and visualization of an embryonic or fetal pole, yolk sac, or both, with or without detectable fetal cardiac activity.

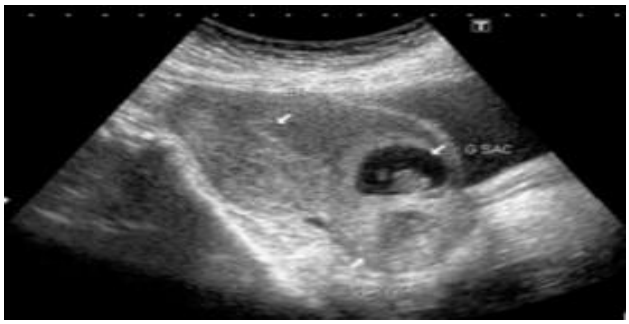

Figure 1: Criteria for diagnosis of scar ectopic pregnancy.

Treatment protocol

After confirmation of diagnosis, all patients underwent detailed counselling regarding the potential risks, including the possibility of severe hemorrhage and the need for emergency hysterectomy. As all patients expressed a desire for fertility preservation, conservative management was employed. Treatment modalities included systemic or local methotrexate injection, dilatation and curettage (D&C), or wedge resection of the ectopic pregnancy depending on clinical presentation, gestational age, sac size, and response to initial therapy.

Follow-up and monitoring

Serum β-hCG levels were monitored during hospitalization. After discharge, serial β- hCG testing was performed on a weekly basis until levels declined to below 5 miu/ml, indicating resolution of the pregnancy.

Case presentation

The clinical and diagnostic details of the patients included in this case series are summarized in Tables 1 and 2.

Case 1

A 28-year-old woman, gravida 3 para 2 living 2, with a history of two previous caesarean sections, presented at 7 weeks and 4 days of gestation with complaints of spotting per vaginum. She was hemodynamically stable with normal vital signs. Abdominal examination revealed a healthy suprapubic transverse scar without tenderness. On speculum examination, bleeding was noted through a closed os, with no cervical motion tenderness on bimanual examination. Laboratory investigations showed hemoglobin 10.4 g/dl, total leukocyte count 12,620 cells/cumm, and platelet count 2.6 lakhs/cumm. Blood group was O positive. Transvaginal ultrasonography demonstrated a 5×4 cm gestational sac with irregular

margins implanted at the cervicoisthmic junction with peripheral ring-like vascularity, consistent with endogenic type caesarean scar ectopic pregnancy. Ultrasound-guided suction evacuation was performed. Serial β-hCG monitoring showed a declining trend from 94,650 IU to 18,323 IU on postoperative day 2 and 3,718 IU on day 4.

Case 2

A 30-year-old gravida 3 para 1 living 1 abortion 1 woman with one previous lower segment caesarean section presented at 6 weeks and 4 days gestation with bleeding per vaginum. She was afebrile with stable vital signs. Examination revealed brownish discharge through a closed os and no cervical motion tenderness. Laboratory evaluation showed hemoglobin 8 g/dl, total leukocyte count 6,370 cells/cumm, platelet count 4.8 lakhs/cumm, and blood group B negative. Ultrasound identified a 3×4 cm gestational sac located on the anterior myometrium of the caesarean scar with peripheral ring-like vascularity, indicating endogenic type caesarean scar ectopic pregnancy. Management involved anemia correction with two units of packed red blood cells, multidose methotrexate administration, and anti-D immunoglobulin. β-hCG levels showed a decreasing trend following treatment.

Case 3

A 33-year-old gravida 2 para 1 living 1 woman with previous caesarean delivery presented at 9 weeks gestation with complaints of spotting per vaginum. She was afebrile with stable hemodynamic parameters. Mild spotting was noted on speculum examination, and the cervix was closed without tenderness. Laboratory investigations revealed hemoglobin 9.6 g/dl, total leukocyte count 8,030 cells/cumm, platelet count 3.5 lakhs/cumm, and blood group A positive. Ultrasound demonstrated a 3×3 cm heterogeneous gestational sac within the anterior myometrium of the caesarean scar with minimal vascularity. A diagnosis of failing caesarean scar ectopic pregnancy was made. Conservative management was opted, and β-hCG dropped from 190 IU to 93 IU by day 5.

Case 4

A 30-year-old gravida 3 para 1 living 1 abortion 1 woman, previously diagnosed with scar pregnancy outside the hospital, presented at 7 weeks and 4 days of gestation without active complaints. Clinical examination was unremarkable with a healthy scar and no bleeding. Laboratory parameters included hemoglobin 10.6 g/dl, total leukocyte count 11,000 cells/cumm, platelets 3.24 lakhs/cumm, and blood group O positive. Transvaginal ultrasonography showed a 2.1×2.8 cm gestational sac implanted in the anterior myometrium with minimal vascularity, consistent with endogenic caesarean scar ectopic pregnancy. Ultrasound-guided intrasac methotrexate instillation was initially performed; however, as β-hCG levels increased, the patient underwent suction and evacuation. β-hCG levels subsequently decreased from 152,600 IU to 870 IU at 1 week and 50.26 IU at 2 weeks post-procedure.

Case 5

A 32-year-old gravida 2 para 1 living 1 woman with prior caesarean delivery presented after 35 days of amenorrhea with ultrasonographic findings of an anembryonic gestation near the caesarean scar. Clinical examination was unremarkable. Laboratory tests revealed hemoglobin 12.2 g/dl, total leukocyte count 10,120 cells/cumm, platelets 2.4 lakhs/cumm, and blood group O positive. Ultrasound revealed a 3×3 cm sac in the anterior myometrium with minimal vascularity, suggestive of an anembryonic scar pregnancy. Ultrasound-guided suction evacuation was performed; due to excessive bleeding, a Bakri balloon tamponade was placed. Histopathology revealed decidual tissue, chorionic villi, endometrial glands with Arias-Stella reaction, and no evidence of molar pregnancy. β-hCG levels showed a decreasing trend from 74,869 IU to 10,503 IU by day 5.

Case 6

A 33-year-old gravida 3 para 1 living 1 abortion 1 woman with prior caesarean delivery presented 45 days after her last menstrual period with an ultrasonographic diagnosis of scar ectopic pregnancy. She was hemodynamically stable with unremarkable examination. Laboratory findings showed hemoglobin 11.9 g/dl, total leukocyte count 9,400 cells/cumm, platelets 2.7 lakhs/cumm, and blood group A positive. Ultrasound showed a 2.1×2 cm sac in the anterior myometrium with detectable fetal heart activity. An initial transabdominal intrasac methotrexate injection was given; however, persistent fetal cardiac activity necessitated a second methotrexate dose administered per vaginam under anesthesia. Fetal cardiac activity ceased 5 minutes post-procedure, confirmed by ultrasound. β-hCG levels subsequently declined, and the patient developed methotrexate-induced myelo-suppression and hepatotoxicity, which were managed conservatively.

Case 7

A 32-year-old gravida 2 para 1 living 1 woman presented at 6 weeks gestation with bleeding per vaginum. She had a history of prior cesarean delivery. Examination revealed active bleeding through a closed cervical os without tenderness. Laboratory evaluation showed hemoglobin 9 g/dl, total leukocyte counts 11,620 cells/cumm, platelets 2.6 lakhs/cumm, and blood group B positive. Ultrasound identified a 2.5×2 cm endogenic caesarean scar ectopic pregnancy with peripheral ring-like vascularity. Management involved multiple doses of methotrexate followed by ultrasound-guided suction and evacuation combined with uterine artery embolization. Serial β-hCG monitoring showed a consistent decreasing trend.

Table 1: Baseline demographic, obstetric history, clinical presentation, and physical examination findings of patients with cesarean scar pregnancy (n=8).

Case no.	Age (years)	Obstetrics score	Gestational age	Prev mode of delivery	Clinical presentation	Vitals at time of presentation					Per abdomen			Per speculum	Per vaginum				
						A-febrile	BP (mm Hg)	PR (/min)	SpO_2 (%)	RR (/min)		Suprapubic transverse scar	Tenderness		Uterus	Os	Cervical motion tenderness	Bilateral fornices	Bleeding through OS
1	28	G3p2l2	7 weeks+4	Prev 2 LSCS	Complaints of spotting per vaginum	+	110/70	86	100	18	Soft	Seen healthy	No	Bleeding through OS noted	Bulky	Closed	No	Free	+
2	30	G3p1l1a1	6 weeks+4 days	Prev 1 LSCS	Complaints of bleeding per vaginum	+	100/60	72	100	20	Soft	Seen healthy	No	Brownish discharge noted	Bulky	Closed	No	Free	+
3	33	G2p1l1	9 weeks	Prev 1 LSCS	Complaints of spotting per vaginum	+	110/70	80	100	18	Soft	Seen healthy	No	Mild spotting+	Bulky	Closed	No	Free	+
4	30	G3p1l1a1	7 weeks+4 days	Prev LSCS	No complaints, diagnosed outside to have scar pregnancy	+	110/70	80	100	18	Soft	Seen healthy	No	No bleeding noted	Bulky	Closed	No	Free	+
5	32	G2p1l1	35 days of amenorrhea	Prev 1 LSCS	No complaints, scan showed anembryonic gestation near LSCS scar	+	110/70	80	100	18	Soft	Seen healthy	No	No spotting noted noted	Bulky	Closed	No	Free	+
6	33	G3p1l1a1	45 days	Previous LSCS	Scan showed scar ectopic pregnancy	+	110/70	80	100	18	Soft	Seen healthy	No	No spotting noted	Bulky	Closed	No	Free	+
7	32	G2p1l1	6 weeks	Prev 1 LSCS	Bleeding per vaginum	+	110/70	80	100	18	Soft	Seen healthy	No	Bleeding noted	Bulky	Closed	No	Free	+
8	37	G3p2l2	6 weeks+3 days	Prev 2 LSCS	Nil complaints	+	110/70	80	100	18	Soft	Seen healthy	No	No spotting noted	Bulky	Closed	No	Free	+

Table 2: Diagnostic findings, treatment modalities, and follow-up outcomes of patients with caesarean scar pregnancy (n=8).

Case no.	Beta hCG (IU)				Transvaginal scan				Diagnosis	Management	Follow-up
	Day 1	Day 3	Day 5	Day 7	Gestational sac	FH	Location	Colour Doppler			
1	94650	-	-	- -	5×4 cm irregular margins	Present	Cervicoisthmic junction, empty uterine cavity	Peripheral ring like vascularity	CSP-endogenic type	Ultrasound-guided suction evacuation	Decreasing trend of beta hCG, POD 2-18323, POD 4-3718
2	4303	-	-	- -	3×4 cm	Absent	Anterior myometrium on cesarean scar	Peripheral ring like vascularity	CSP-endogenic type	Anemia correction with 2 units packed red blood cells, multidose methotrexate	Beta hCG was in decreasing trend, anti D given
3	190		93		Heteroge-neous content 3×3 cm	Absent	Anterior myometrium on cesarean scar	Minimal vascularity	CSP-failing pregnancy	Expectant management	Decreasing trends
4	15260 0mtx given	125000	-	-	2.1×2.8 in anterior myomet-rium	Absent	Anterior myometrium on cesarean scar	Minimal vascularity	CSP-endogenic type	USG-guided intrasac instillation of methotrexate ↓ Follow-up: beta-hCG showed increasing trend ↓ Patient opted for suction and evacuation	Suction and evacuation performed ↓ POD 2: β-hCG=30,515 (decreasing trend) ↓ 1 week later: β-hCG=870 ↓ 2 weeks later: β-hCG=50.26
5	74869	-	-	- -	3×3 cm sac in anterior myometr-ium	Absent	Anterior myometrium at region of scar	Minimal vascularity	CSP-anembryo-nic	Ultrasound-guided suction and evacuation ↓ Increased bleeding observed ↓ Bakri balloon tamponade placed	Suction and evacuation performed ↓ POD 2: β-hCG=30,515 (decreasing trend) ↓ POD 3: β-hCG=10,503 Bakri balloon removed – no undue bleeding ↓ β-hCG continued to decrease ↓ 1 week later: β-hCG=870 ↓ 2 weeks later: β-hCG=50.26

Continued.

Case no.	Beta hCG (IU)				Transvaginal scan				Diagnosis	Management	Follow-up
	Day 1	Day 3	Day 5	Day 7	Gestational sac	FH	Location	Colour Doppler			
6	96028	-	-	-	2.1×2 cm	Present	Anterior myometrium at region of scar	Minimal vascularity	CSP-endogenic type	Transabdominal intrasac instillation of Methotrexate ↓ Repeat β-hCG after 48 hrs: 69640 Repeat scan: Fetal heart activity (FH) present ↓ Second dose of Methotrexate given per vaginam under anesthesia ↓ FH absent 5 minutes after procedure (confirmed by USG)	Day 7: β-hCG=47,136 ↓ 1 week later: β-hCG=84 ↓ Serial monitoring showed decreasing trend
7	38753	45012 (3)	58567 (5)	49038 (7)	2.5×2 cm	Present	Anterior myometrium at region of scar	Peripheral ring like vascularity noted	CSP-endogenic type	Multiple doses of methotrexate given ↓ Beta-hCG showed increasing trend ↓ USG-guided suction and evacuation ↓ Increased bleeding noted ↓ Uterine artery embolization	Beta HCG was on decreasing trend
8	4263	-	-	-	1.2×0.9×0.5 cm	Absent	Anterior myometrium previous LSCS	Not noted	CSP-endogenic type	Single dose methotrexate	Beta HCG was on decreasing trend

Case 8

A 37-year-old gravida 3 para 2 living 2 women with two previous caesarean sections presented at 6 weeks and 3 days gestation with abdominal pain. Clinical examination was unremarkable except for suprapubic tenderness. Laboratory investigations revealed hemoglobin 10.4 g/dl, total leukocyte count 12,620 cells/cumm, platelets 2.6 lakhs/cumm, and blood group O positive. Ultrasound showed a 1.2×0.9×0.5 cm endogenic scar ectopic pregnancy located within the anterior myometrium at the site of the previous caesarean scar. A single dose of systemic methotrexate was administered. Serial β-hCG monitoring demonstrated a steady decline in hormone levels.

DISCUSSION

The current case series adds to the growing body of literature on CSP, a rare but increasingly recognized form of ectopic pregnancy due to rising caesarean delivery rates worldwide. In our series, all eight patients had a history of previous caesarean sections, consistent with the pathophysiology described by Rotas et al, who highlighted that poor healing of the uterine incision scar leads to a niche or defect where trophoblastic invasion can occur abnormally.[4] The worldwide rise in caesarean delivery rates has resulted in increased incidence of CSP, as previously demonstrated in a global review by Betrán et al who reported an alarming rise in caesarean rates across multiple countries.[14]

Similar to earlier studies, the majority of our patients presented in the first trimester, with bleeding per vaginum being the most common symptom. Fylstra emphasized that vaginal bleeding, with or without abdominal pain, remains the hallmark clinical presentation in CSP, although a significant proportion may remain asymptomatic, which makes early diagnosis challenging.[2] In our series, one patient (case 4) was incidentally diagnosed during routine scanning, highlighting the importance of early sonographic evaluation in women with prior caesarean deliveries. This asymptomatic presentation has also been described by Jayaram et al, who emphasized that the absence of clinical symptoms does not exclude the possibility of CSP and mandates careful ultrasonographic assessment in at-risk patients.[15]

Transvaginal ultrasound remained the cornerstone of diagnosis in our study, consistent with recommendations by Timor-Tritsch et al, who defined specific sonographic criteria for accurate diagnosis, including the presence of an empty uterine cavity, gestational sac embedded at the scar site, and a thin or absent myometrial layer between the sac and bladder.[9] In our series, these diagnostic features were uniformly present. Color Doppler played a vital role in confirming peritrophoblastic vascularity, a hallmark feature described in detail by Riaz et al, which helps differentiate CSP from low-lying intrauterine pregnancies.[10]

Our series also demonstrated both types of CSP described by Rosen et al, endogenic type where the gestation grows towards the uterine cavity and exogenic type extending towards the serosa.[3] Most of our patients had endogenic type, consistent with several earlier reports where the endogenic form is reported more commonly in early gestation.[16] Notably, one patient (case 5) presented with an anembryonic gestation, further emphasizing the varied spectrum of CSP presentations.

Management in our series was tailored to individual cases, balancing the desire for fertility preservation and clinical stability. Several treatment modalities were employed, including systemic methotrexate, intrasac methotrexate instillation, suction evacuation, and uterine artery embolization. This multimodal approach reflects the current absence of standardized guidelines for CSP management, as highlighted in the systematic review by Maheux-Lacroix et al, who noted wide variability in treatment approaches depending on gestational age, sac size, and clinician experience.[17]

One unique feature in our series was the successful use of combined intrasac methotrexate followed by ultrasound-guided suction evacuation in multiple patients, which allowed fertility preservation while minimizing hemorrhagic complications. This aligns with recent findings by Stabile et al, who reviewed conservative protocols combining methotrexate with mifepristone or surgical evacuation, reporting high success rates and low morbidity.[18] Furthermore, in case 7, uterine artery embolization was employed successfully to manage persistent bleeding, similar to the report by Cao et al, who emphasized the safety and efficacy of embolization as a fertility-preserving option in CSP management.[19]

Our findings also demonstrate that serial monitoring of β-hCG remains crucial in guiding management decisions and assessing treatment response. Persistently rising or plateauing β-hCG levels necessitated escalation of therapy in a few cases, emphasizing the need for close follow-up. This observation is supported by Morente et al, who proposed treatment algorithms based on β-hCG dynamics to optimize patient outcomes.[20]

This case series contributes additional insight into the variable presentations and successful conservative management of CSP. It highlights that early diagnosis with meticulous ultrasound evaluation and individualized treatment planning can result in favourable outcomes, even in resource-limited settings. Our experience underscores the need for increased vigilance in women with prior caesarean deliveries presenting early in pregnancy.

The limitations of our series include its small sample size, single-center experience, and retrospective nature. However, given the rarity of CSP, each reported case adds meaningful information to the literature. Further prospective multicenter studies are needed to establish standardized protocols for diagnosis and management.

CONCLUSION

CSP poses significant diagnostic and management challenges. Early detection through targeted ultrasound evaluation is essential to prevent serious complications. Individualized, conservative treatment strategies can achieve favourable outcomes while preserving fertility. Greater clinical awareness, prompt diagnosis, and further research are needed to standardize management protocols and improve patient care in this rare condition.

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