International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Akhator AE et al. Int J Reprod Contracept Obstet Gynecol. 2026 Oct;15(10):4134-4136
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20263457

Case report

Cervical ectopic pregnancy: a rare case report and review of literature

Aimiehinor Edward Akhator[1,2]*, Osamudia Okhionkpamwonyi[1,2], Innocent Okoacha[1,2], Robinson Onyekachukwu Ogwu[3]

[1]Department of Obstetrics and Gynaecology, Delta State University Teaching Hospital, Oghara, Delta State, Nigeria
[2]Department of Obstetrics and Gynaecology, Delta State University, Abraka, Delta State, Nigeria
3Department of Obstetrics and Gyneacology, Federal Medical Centre, Asaba, Delta State, Nigeria

Received: 13 January 2026
Accepted: 11 September 2026

***Correspondence:**
Dr. Aimiehinor Edward Akhator,
E-mail: akhatoramiehinor@gmail.com

ABSTRACT

Cervical pregnancy is a gyneacological emergency which is rear and life threaten, the ectopic pregnancy implant in the endocervical canal and the trophoblast can penetrate through the cervical wall and into the uterine blood supply resulting in catastrophic haemorrhage. The incidence of cervical ectopic is less than 1%. Historically, the treatment had been hysterectomy because of the considerable risk of life-threatening haemorrhage, but in the recent past various conservative management modalities have been applied to preserve fertility. We report a case of cervical ectopic pregnancy in a young Nigerian woman who was managed conservatively. She was a 34 years old Gravida 4, Para2^{+1} lady with living child and one previous caesarean section. She presented to our facility with painless vaginal bleeding of 6 hours duration following amenorrhoea of 8 weeks and 3 days. She had a serum positive pregnancy before presentation and Transvaginal scan done revealed gestational sac at the cervical region. She subsequently had evacuation of retained product and balloon catheter insertion at the cervix. She did well post operatively.

Keywords: Cervical ectopic, Amenorrhoea, Bleeding per vaginum, Foleys catheter, TVS

INTRODUCTION

Ectopic pregnancy is a life threaten gyneacological emergency that is associated with severe maternal morbidity and mortality as a result prompt diagnosis and management is paramount in preventing its complication.[1] It's a condition where by the pregnancy is located outside of the normal endometrial lining.[2] The most common site of ectopic pregnancy is at the fallopian tube, it account for 90% of ectopic pregnancy, other sites of implantation include the ovaries, abdomen, caesarean section scar and cervix.[2] Cervical ectopic pregnancy is rear and they account for less than <1% of all cases of ectopic pregnancy.[3] The cause is idiopathic but some studies has reported that previous dilatation and curettage, previous caesarean section, use of intrauterine contraceptive devices, use of assisted reproductive technology, cervical surgery, endometritis and Asherman's syndrome has been implicated.[4] The report presents a case of 34years old multiparous lady that was diagnosed and managed for rare cervical ectopic pregnancy.

CASE REPORT

Mrs K.C was a 34years old Gravida 4, $P2^{+1}$ lady with one previous caesarean section. She presented with absence of menses of 8weeks and 3 days duration and vaginal bleeding of 6 hours duration. Bleeding per vaginum said to have started 6 hours prior to presentation, it first presented as spotting noticed after passing urine, later became heavy and was curtailed with use of sanitary pad that was soaked. There was no associated history of dizziness or fainting spell.

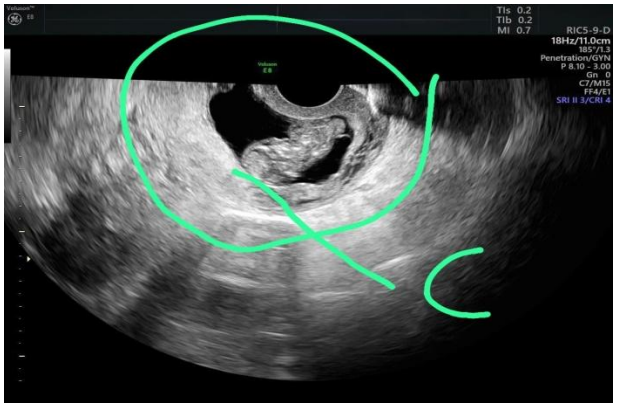

Figure 1: This image shows ectopic pregnancy with closed internal Os Point C.

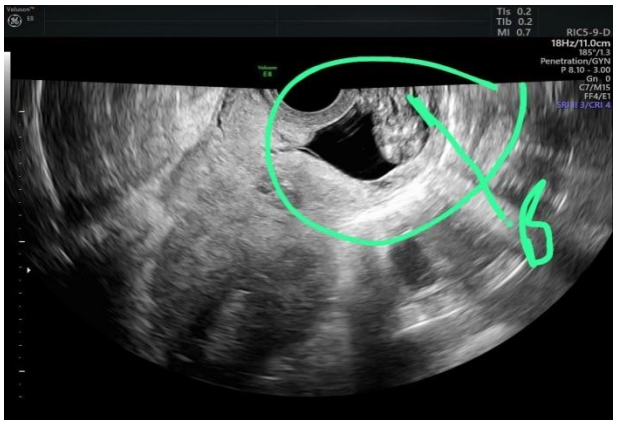

Figure 2: This image shows the cervical ectopic pregnancy with dilated external Os Point B.

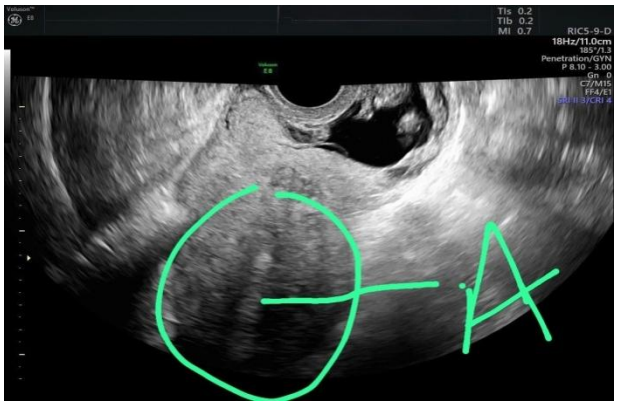

Figure 3: This image shows ectopic pregnancy with closed internal Os Point A.

There was no passage of vesicles. There was no history urinary or bowel symptoms. At the onset bleeding she presented to a nearby private facility where serum pregnancy test done was positive and ultrasound did not reveal any extra or intrauterine pregnancy but quantitative Bhcg done was >50,000 iu/ml. She was counseled to present in 2 weeks for a follow up scan. Due to the persistent bleed per vaginal she presented to our facility where she had a transvaginal scan done and a cervical ectopic pregnancy (Figure 1 and 2) and an empty uterus (Figure 3) were identified. She was immediately counseled for evacuation for which she gave an informed consent.

She had pre – operative haematocrit of 36%, blood group O rhesus D positive, total white blood cell count of 5×10^6 cells/ml, random blood sugar of 72 mg/dl, retroviral status was negative, electrolyte urea and creatinine along with liver function test were essentially normal values. Two unit of comparable whole blood were grouped and crossed matched for her. Following evacuation patient was noticed to be bleeding torrentially. A cervical balloon catheter was inserted and homeostasis was secured. She had two units of blood transfused and placed on broad spectrum antibiotics and a 24 hours dose of antifibrinolytic agent (tranexamic acid 1 g 8 hourly for 24 hours. The balloon catheter was gradually removed after 72 hours and there was no vaginal bleeding thereafter. She did well post operatively and was discharged home on 4 days post-operation, with a 2 week follow up appointment. Histopathological examination of the products of conception showed product of conception macroscopically, and on microscopic Chorionic villi invading the mucosa and muscle of the cervix.

DISCUSSION

Ectopic pregnancy is one of the leading causes of maternal mortality especially in Sub-Sahara region this is because it is associated with torrential bleeding that can results in severe aneamia and maternal morbidity and mortality in the face of delayed intervention.[5]

The incidence of cervical ectopic various, in developed countries it is 1 in 280 to 1 in 233 deliveries as compared to developing countries where it is 1 in 44 to 1 in 21 deliveries.[6] There are different criteria for diagnosis of cervical ectopic and the most commonly used criteria was postulated by Palman and McL in it include a closed internal cervical Os, partially opened external Os, products of conception entirely located within and firmly attached to the endo-cervical canal, uterine bleeding without cramping pain following a period of amenorrhoea and a soft enlarged cervix equal to or bigger than the fundus.[7] The patient had almost all the features. Cervical ectopic pregnancy has been classified according to site of origin these include isthmico-cervical, pure cervica, cervico-isthmic and cervico-isthmic-corporal pregnancy.[6]

The diagnosis of cervical ectopic is better made from history, pelvic examination and investigation. In the history there was amenorrhea and painless vaginal bleeding mainly, with no abdominal pain. The most important imaging modality for diagnosing cervical ectopic is trans-vaginal scan.[3] Features seen on scan include uterine enlargement, empty uterus (absence of intrauterine pregnancy), diffused amorphose intrauterine echoes and characteristic enlargement of the cervix with

products of conception as seen in Mrs K.C. Management of cervical ectopic could be medical or surgical.[6] The aim of management is to prevent hysterectomy and preserve the uterus for future fertility purposes especially in women who have not completed their family size[8]. Medical management includes administration of methotrexate which could be intravenous, intramuscular, intracervical or intrathecal route, also potassium chloride could also be used.[3] Medications was not used for Mrs K.C. Other uterine conservative measures include use of chemotherapy, foleys catheter tamponade, curettage, uterine artery embolization and local prostanglandins injection. When conservative management fails hysterectomy is the option of management in other to prevent bleeding.[8] This patient had curettage and Foleys catheter insertion done and eventual outcome was successful. Following management of this patient she was placed on long acting reversible contraceptive. This helps to prevent pregnancy and allow time for the body to recover and prepare for future pregnancy.[9]

CONCLUSION

Cervical ectopic pregnancy is a life-threatening complication that is associated with severe hemorrhage and leads to maternal morbidity and mortality. Early diagnosis and prompt management is important to curtail this complication.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Samal SK, Rathod S. Cervical ectopic pregnancy. J Nat Sci Biol Med. 2015;6(1):257–60.
2. Al Naimi A, Moore P, Brüggmann D, Krysa L, Louwen F, Bahlmann F. Ectopic pregnancy: a single-center experience over ten years. Reprod Biol Endocrinol. 2021;19(1):79.
3. Évora F, Hundarova K, Águas F, Carvalho G. Cervical ectopic pregnancy: a multidisciplinary approach. Cureus. 2021;13(10):e19113.
4. Khatib Y, Khashikar A, Wani R, Patel RD. Cervical ectopic pregnancy : A case report of missed diagnosis. Med J DY Patil Univ. 2016;8:741–3.
5. Edehwosa OH, Okoacha I, Okhionkpamwonyi O, Akhator AE, Okonta P. Ten-Year review of feto-maternal outcomes of anaemia in pregnancy at a tertiary health facility in Southern Nigeria. J Curr Biomed Res., 2025;5(4):2176-95.
6. Mouhajer M, Obed S, Okpala AM. Cervical Ectopic Pregnancy in Resource Deprived Areas : A Rare and Difficult Diagnosis. Ghana. Med J 2017;50(2):94–7.
7. Samal S, Ghose S, Pallavee P, Porkkodi P. Successful Management of Live Cervical Ectopic Pregnancy : A Case Report. J Clin Diagn Res. 2015;9(12):3–4.
8. Okhionkpamwonyi O, Okonta PI. Total Abdominal Hysterectomy at the Central Hospital, Warri: a five year review. Borno Med J., 2015;12(1):23-9.
9. Orighomisan O, Okhionkpamwonyi O, Akhator AE. Uptake of Long-acting Reversible Contraception at the Delta State University Teaching Hospital, Oghara, Nigeria. African J Health Soc Sci. 2025;2(1):53-6.

Cite this article as: Akhator AE, Okhionkpamwonyi O, Okoacha I, Ogwu RO. Cervical ectopic pregnancy: a rare case report and review of literature. Int J Reprod Contracept Obstet Gynecol 2026;15:4134-6.