A rare case of lower segment scar pregnancy

Jaydeep Bhatu¹*, Nikhil A. Anand², Ankita B. Chaudhari¹

INTRODUCTION

Bleeding per vaginum in the first trimester is a common obstetric entity. Caesarean scar ectopic is one of the rarest of all ectopic pregnancies. It is defined as when a blastocyst implants on a previous caesarean scar. The incidence of caesarean scar ectopic has increased due to increase in number of caesarean deliveries. The gestational sac was located in an anterior position toward the anterior lower uterine segment at the level of prior caesarean scar with little visible myometrium noted anterior to the gestational sac in the lower uterine segment and tissue was sent for histopathological examination and diagnosis of caesarean scar ectopic pregnancy was confirmed. Reports found that it is a life-threatening condition, causes excessive hemorrhage and risk of uterine rupture. The diagnosis of this type of ectopic pregnancy is very difficult and false negative diagnosis can lead to major complications.

CASE REPORT

A 31-year-old woman (G4P3003) presented from an outside facility to Sola Civil Hospital with vaginal bleeding and discharge. The patient did not have abdominal pain or any discomfort. The gestational sac was located in an anterior position toward the anterior lower uterine segment at the level of prior caesarean scar with little visible myometrium noted anterior to the gestational sac in the lower uterine segment and tissue was sent for histopathological examination and diagnosis of caesarean scar ectopic pregnancy was confirmed. Reports found that it is a life-threatening condition, causes excessive hemorrhage and risk of uterine rupture. The diagnosis of this type of ectopic pregnancy is very difficult and false negative diagnosis can lead to major complications.

Figure 1: USG finding of scar ectopic.
Transvaginal ultrasound at the treating hospital demonstrated a gestational sac located at the level of the internal cervical os. A fetal pole was noted with the presence of fetal cardiac motion.

The gestational sac was located in an anterior position toward the anterior lower uterine segment at the level of prior cesarean scar with little visible myometrium noted anterior to the gestational sac in the lower uterine segment.

Laparotomy was planned and explained to the patient about the situation.

**Outcomes**

Figure 2 shows Intraoperative findings which suggestive of soft and vascular mass seen at the site of previous scar. Incision was given over bulge and products of conception were gently removed. It was communicating with uterine cavity, edges of scar tissue were excised and freshened, gentle uterine curettage was done. Tissue was sent for histopathological examination and diagnosis of Caesarean scar ectopic pregnancy was confirmed. Patient was discharged on post op day 3 and regular follow was advised.

**DISCUSSION**

A caesarean scar (ectopic) pregnancy occurs when a pregnancy implants on a caesarean scar. It is rarest of all ectopic pregnancies. Incidence estimated in overall caesarean delivery is 1/1800-1/2500. It is life threatening condition, causes excessive hemorrhage and risk of uterine rupture. The diagnosis of this type of ectopic pregnancy is very difficult and false negative diagnosis can lead to major complications. Endo vaginal ultrasonography was the diagnostic method in most cases, with a sensitivity of 84.6% (95% confidence interval 0.763-0.905). Expectant management of 6 patients resulted in uterine rupture that required hysterectomy in 3 patients. Dilation and curettage were associated with severe maternal morbidity. Simultaneous administration of systemic and intra gestational methotrexate to 5 women, all with β-hCG exceeding 10,000 milli-International units/mL required no further treatment.

**CONCLUSION**

The most common clinical presentation of caesarean ectopic pregnancy is painless vaginal bleeding without any specific clinical signs. For its diagnosis transvaginal ultrasonography and color flow Doppler are very helpful. MRI has important role when sonography is equivocal or inconclusive before therapy or intervention.

**ACKNOWLEDGMENTS**

Authors would like to thank Dr. Heena Ganatra, who operated the patient, Dr. Ajesh Desai for giving guidance and Dr. Jaya Varu for scripting and language correction.

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

**REFERENCES**
