

Catastrophe Averted: Caesarean Scar Pregnancy Masquerading as Intrauterine Gestation

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Objective: Caesarean Scar Pregnancy is an underdiagnosed and underreported condition associated with significant maternal morbidity, further complicated by challenges in securing a timely diagnosis and uncertainty regarding optimal treatment once identified. Here we present such a case masquerading as a missed abortion. A failure of medical management of the same raised the suspicion of scar pregnancy which was subsequently managed by a laparotomy.

Case Report: A multiparous patient with previous one LSCS presented to her GP with amenorrhea of two months. A transvaginal ultrasonogram suggested a missed abortion and the patient opted for medical line of management. However, the patient continued to bleed heavily for a month thereafter and a repeat TVS by a consultant radiologist showed a gestational sac – yolk sac complex embedded in the previous LSCS scar with a suspicious thinning of the anterior myometrium in the region of implantation of the gestational sac. An MRI revealed thinning of myometrium in the region of the scar with loss of fat planes with the base of the bladder. HCG titres returned insignificant.

At laparotomy, the bladder was found to be densely adherent in the entire region of the previous LSCS and had to be dissected off the uterus with fine bipolar forceps (finer than the currently available laparoscopic hand instruments). The products were evacuated after transversely incising the bulging lower pole of the uterus. The postoperative period was uneventful.

Discussion : The rising incidence of this potentially devastating condition should serve as a warning bell to rein in the rising caesarean section rates. Given the 80% success rate with medical management of miscarriage, a failure of this line of management should trigger a case review by a consultant obstetrician. Admittedly our decision for a laparotomy is ‘out of sync’ in this era of minimally invasive surgery, it was taken after an honest assessment by the surgical team of its surgical skill set. Perhaps even in this age of innovation, the age-old adage ‘*primum non nocere*’ serves as a relevant watchword.

Conclusion : Increased awareness about this condition, good clinical acumen, multidisciplinary team effort and an individualized treatment plan are essential to achieve a good clinical outcome.

