



HETEROTOPIC TWIN PREGNANCY WITH CONCURRENT LIVE CERVICAL + UTERINE SCAR ECTOPICS

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CASE SUMMARY

A 37 year old female (G3P1, 1 previous lower uterine segment caesarean section) presented at 6+3 weeks gestation by menstrual dates with vaginal spotting and abdominal cramping. Quantitative Beta hCG was 35,256 mIU/ml. Transvaginal pelvic ultrasound (TVUS) identified a dichorionic diamniotic ectopic pregnancy with a live fetus in the uterine scar and cervix (Figure 1 and Figure 2). Both crown rump lengths were consistent with menstrual dates. The patient was haemodynamically stable.

MANAGEMENT

Potassium chloride (KCl) was injected transvaginally into each gestational sac under ultrasound guidance followed by needle aspiration of the sac contents. Methotrexate (MXT) was then injected into each sac at a dose of 50 mg/m². A similar dose of MXT 50mg/m² was then administered intramuscularly on days 2 and 7. Serum bHCG on the day of the procedure was 67554 mIU/ml and was monitored weekly until reaching an undetectable level 13 weeks later. Follow up TVUS also confirmed resolution of both ectopic pregnancies.



Figure 1: Cervical + Uterine Scar Ectopic.

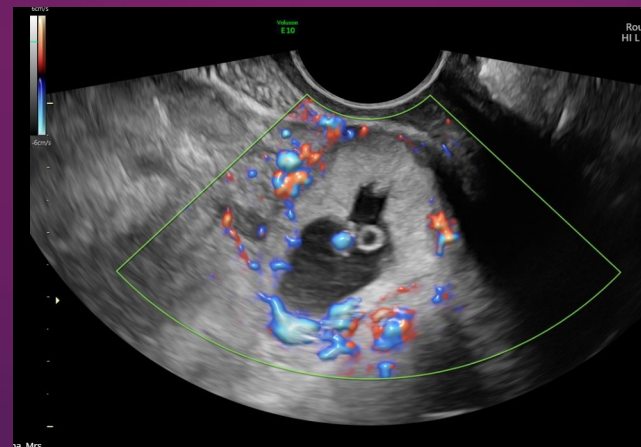


Figure 1: Uterine Scar Ectopic.

DISCUSSION

To our knowledge, a concurrent cervical and uterine scar ectopic pregnancy has not been reported previously and presents a challenging scenario. The principal risks of haemorrhage and non-resolution are considerable but current outcome data relates to each pathology in isolation. Treatment options comprise systemic MXT, local MXT and KCl injection, sac aspiration, surgical curettage and laparoscopic resection (1). Local expertise can influence selection and in-patient management may be required. Treatment of haemorrhage includes balloon tamponade, cervical cerclage, arterial ligation or embolization & hysterectomy (2). Australian guidelines currently recommend surgical management of scar ectopics (3). Here, fertility preservation was very important so local TVUS guided MXT to each sac followed by systemic MXT was favoured. Complete resolution of both occurred over XX weeks

LEARNING POINTS

- Non-tubal ectopic pregnancy is a rare condition associated with significant morbidity and increased mortality due to haemorrhage
- Uterine scar ectopics are increasingly common likely due to higher rates of caesarean section.
- Optimal management of uterine scar or cervical ectopic pregnancies is debated but a combination of medical and surgical techniques may be needed.
- Individual factors such as desire for fertility preservation, size and gestation of the pregnancy, haemodynamic status and local expertise / resources must be considered.