

A Case of Complex CS Scar Ectopic

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Objective: This case highlights the crucial importance of imaging in the diagnosis and management of Caesarean scar ectopic, MDT discussion ,the role of CT,MRI in measuring the endometrial thickness , and whether there is myometrial/serosal invasion as to aid in the management plan

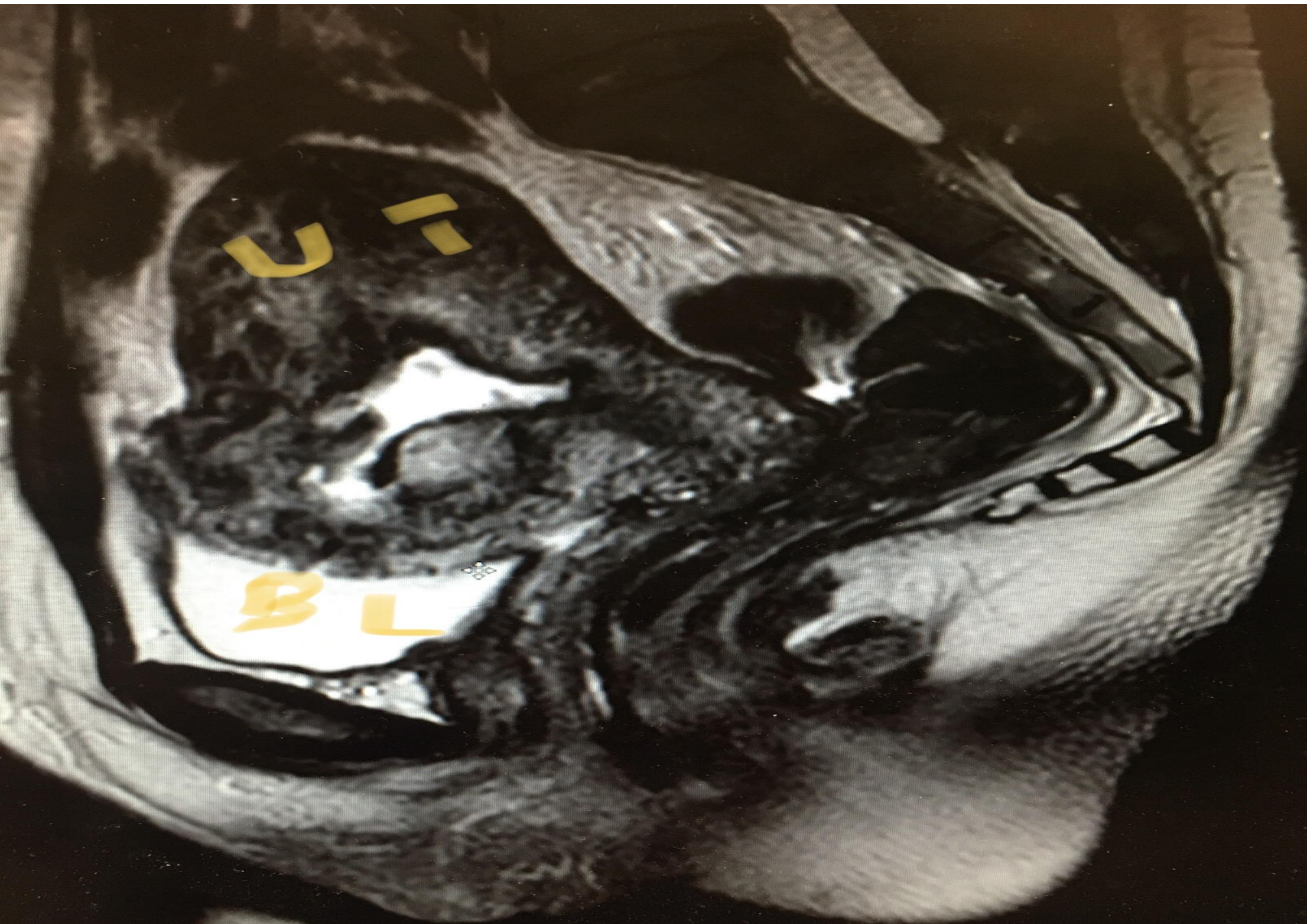
Brief description of the case: P1,28 yrs ,Previous CS in Romania,12w pregnant 29/12/22 coming with PV bleeding and lower abdo pain,bhcg 2354, Us shows uterus contains heterogenous mass within endometrial cavity, solid and cystic components seen, Solid component is likely possible fetal pole but is abnormal in appearance = 35x21mm, no fetal heartbeat seen. Adjacent to this is a solid area which is infiltrating the endometrial cavity, demonstrates multiple cystic spaces = 49x13mm ?partial molar pregnancy,no vascularity seen,?complex RPOC,BHCG ON 31\12 2080,offered EVAC,Romanian language line used as pt doesn't speak or understand English,EVAC done on 3\1\23 ,active bleeding during the procedure,us guidance ?CS scar ectopic,iv synto and txa given,rusch ballon inflated with 45 mls in utero,bleeding settled ,EBL 100 MLS,iv atx,BHCG on 4\1 1200,us on 4\1 ?cs scar ectopic,MRI 5\1/23 HIGHLY SUSPICIOUS OF MOLAR CS scar ectopic,loss of interface between anterior uterus&bladder,MDT with MRI gynaecology radiologist& Gyn oncologist at Sheffield GTN centre who agreed with the suggestion of CS scar pregnancy unlikely to be molar and these changes are related to the effect of balloon pressure, more than 50% of myometrium at CS scar involved by pregnancy tissue that might reach to bladder serosa,can wait for histopathological results of the tissues removed,plan was for methotrexate as per protocol,given on 6\1,bhcg on D 4 693 10/1,D7 465 13/ On 16\1 patient admitted with septic shock,tachycardia,hypotension,fever,CT scan was done showed 7.3x6x6.2cm gas and fluid containing collection within the endometrial cavity,admitted to ITU for 24hrs,on iv atx,bhcg on 16\1 235,then 100 on 18\1,pt improving,decision for conservative management not for laparotomy.On 23\1 BHCG 54 and discharged home,histology no molar pregnancy just RPOC.On 27\1 BHCG 53,US :anterior myometrium around the level of cs scar is bulky heterogenous hypervascular producing a mass 80x29x46 mm,plan was for weekly bhcg and repeat scan in 14 d.On 30/1 pt admitted via A&E with sepsis ,significant pv bleeding,decision was for stabilization and midline laparotomy,findings: Bulky uterus 12 weeks size,Caesarean scar ectopic occupying the entire scar is vascular and offensive +++,The caesarean scar ectopic was invading the myometrium and the serosa(confirmed by histology(percreta)),There was a loss of cleavage plane between the bladder and the lower segment with no recognizable U-V fold .Both tubes and ovaries normal.Very vascular and friable tissues.TAH+bilateral salpingectomy with ovarian conservation performed,bladder injury repaired by urology with bilateral ureteric stents,EBL 2 L,ITU admission,IV tx,4 units of PRBCS,stepdown care to the ward after 48hrs,pt recovering well

References:

- The American College of Obstetricians and Gynecologists (ACOG) and the Society of Family Planning endorse this document. The American Society for Reproductive Medicine supports this document. This document replaces SMFM Consult Series #49: Cesarean scar pregnancy (May 2020)
- RCOG GREEN TOP GUIDELINE 21 (2016)
- Cesarean Scar Ectopic Pregnancy: A Diagnostic and Management Challenge

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Discussion

- Women diagnosed with caesarean section scar pregnancies should be counselled that such pregnancies are associated with severe maternal morbidity and mortality. Medical and surgical interventions with or without additional haemostatic measures should be considered in women with first trimester caesarean scar pregnancy. There is insufficient evidence to recommend any one specific intervention over another for caesarean scar pregnancy, but the current literature supports a surgical rather than medical approach as the most effective.
- As outlined in this case there was a combination of initial surgical intervention (Evacuation) where there was no definite diagnosis of CS scar ectopic, followed by medical management and follow-up, and then ended by laparotomy and hysterectomy.
- From this case it is clearly evident that imaging (US,MRI)is extremely valuable in the initial diagnosis and management of this cases, and this should be undertaken by experts in the diagnosis of this cases and who are able to pick up the diagnostic features, the presence or absence of myometrial/serosal invasion +/- bladder involvement as this will help the MDT decision and plan of management
- Conclusion: It is clearly evident that management of CS scar ectopic should be individualized depending on the clinical presentation imaging, and it is very difficult to recommend either the medical versus the surgical route of management