



Cervical Ectopic Pregnancy Case Presentation

Dr. Raana Bibi (raananiazi@hotmail.com)
Milton Keynes University Hospital, NHS England

Objective: Ectopic cervical pregnancy (CP), a rare condition associated with potentially high morbidity and mortality. In this case report of cervical pregnancy, the challenges in the diagnosis and management are discussed along with follow-up protocol and final outcome.

Case report: A 30-year-old woman admitted to hospital as threatened miscarriage at 7 weeks of gestation with mild vaginal bleeding and abdominal pain. No previous history of abdominopelvic surgery or STDs or PID. She had cervical surgery as LLETZ 10 years ago for cervical CIN3, and since then, cervical smears have been normal. Vaginal speculum examination found mild bleeding, but a bulky, soft cervix with sac-like green-blue vascular area at 10 o'clock position on anterior cervical lip. Anterior vaginal fornix was normal looking and rest of cervix was looking normal too but external os was hardly seen as this sac was extending medially and covering that part. Transvaginal ultrasound scan identified an empty uterine cavity, and a large echogenic area in the cervical canal, which was thought to be cervical pregnancy/products of conception that failed to pass through the cervical canal due to stenosis. BHCG was 41507. The next day patient was complaining of pain in lower abdomen and vagina which was worsening. She also passed gush of blood with this pain but no products. Repeated speculum and ultrasound had same findings. Decision made to take to theatre and explore. High risk consent taken after discussion with patient possibility of hysterectomy. Intervention radiology involved and bilateral internal iliac balloons inserted before starting the procedure so that in case of heavy bleeding balloons would be inflated to control bleeding. Under GA cervix easily dilated up to 10mm and the products of conception were evacuated with suction from cervical canal. Total blood loss was 150mls and large vascular area at 10 o'clock position reduced in size. Mild bleeding was noticed from the cervix. Foley's catheter inserted in the cervix and filled with 30mls of fluid for tamponade. It stayed in for 24 hours. The patient was in satisfactory condition after 24 hours, and post-op HCG was 12193. Patient discharged to home with plan to follow HCG weekly till it comes to the non-pregnancy range. Products sent for histology. Patient was last seen in the early pregnancy clinic after 3 weeks of surgery with blood levels of HCG as 2 (non-pregnant range) and was well clinically.

Discussion: Diagnosis was basically on clinical examination, confirmed by Ultrasound and managed very well surgically.

Conclusions: Timely diagnosis helped to reduce morbidity.