CASE REPORT

Cervical Ectopic Pregnancy: Case Reports and Management Modalities

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Abstract

Cervical pregnancy is a rare variety of ectopic pregnancy. The diagnosis of cervical pregnancy can be missed by an unsuspecting mind inspite of the routine use of first trimester ultrasonography. We present two cases of cervical pregnancy managed at our hospital alongwith a brief review of literature highlighting the various treatment modalities.

Keywords: Ectopic pregnancy, cervical pregnancy, foley's catheter tamponade.

INTRODUCTION

Cervical ectopic pregnancy is the implantation of a pregnancy in the endocervical canal. Diagnosis and treatment of cervical ectopic pregnancy has changed dramatically in the last two decades. Now cervical ectopic pregnancy is commonly diagnosed on a first-trimester ultrasound examination. Although the advent of sonography has made the diagnosis more accurate, it is still a problem in developing countries. Moreover, the condition should be kept in mind and suspected in event of an abnormal sonography report. This is a lesson learnt from the following case reports presented by us.

CASE REPORT 1

A 37 years old para 3 presented with amenorrhea of 2 months with history of excessive bleeding per vaginum 12 days back. There was history of attempt of D&E 12 days back at a private nursing home. This led to profuse bleeding per vaginum. Tight vaginal packing was done following which bleeding had stopped.

On examination her vitals were stable but marked pallor was present. On per speculum examination, there was a growth on anterior cervical lip 3×4 cm as seen in Figure 1. Cervix was very vascular and congested, vagina was healthy. On per-vaginum examination, uterus was retroverted, multiparous size, mobile and fornices were free.

Her urine pregnancy test was positive. Sonography report revealed a sac-like area in endometrial cavity with no fetal poles with sizeable chorioamniotic separation with thick endocervical canal suggestive of missed abortion.

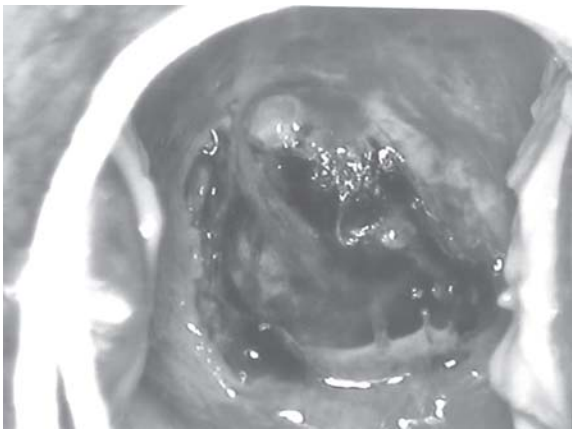

Fig. 1: Per speculum visualization of 3 × 4 cm growth on anterior cervical lip

Pap smear showed inflammatory infiltrate amidst few superficial and intermediate squamous cells, clusters of endocervical cells against a hemorrhagic background. Cervical biopsy was not attempted in view of risk of another bleeding episode. She was diagnosed as cervical pregnancy on the basis of clinical examination. Her differential diagnosis was missed abortion with carcinoma cervix.

Total abdominal hysterectomy was done and specimen sent for HPE (Fig. 2).

On HPE cervix showed chronic cervicitis with chorionic villi, endometrium from isthmus showed chorionic villi and decidual implantation. Endometrium from body and fundus showed hypersecretory endometrium and arias stella reaction of pregnancy with partial decidualization of stroma.

Fig. 2: Posthysterectomy specimen showing cervical pregnancy

CASE REPORT 2

A 27 years old presented with bleeding P/V since 1 day following amenorrhea of 15 weeks. Her previous menstrual cycles were regular. Her marred life was 5 years and there was history of primary infertility. Patient was referred from District Hospital as a case of missed abortion for D and C.

Sonography done outside revealed a single ill-defined gestational sac in the uterine cavity. No fetal poles were seen and patient diagnosed as missed abortion (blighted ovum). There was no comment on the cervix or adnexa in the sonography report. Patient was taken for suction evacuation. As soon as the dilator was put in the cervical canal, patient started bleeding profusely. Uterine cavity was empty but bleeding continued and patient went into shock.

Simultaneous resuscitation was done. Blood was transfused as per requirement. It was found that cervix was extremely soft and broad and bleeding was from within the cervical canal below the internal os. Gentle cervical curettage was done and then a Foley's catheter no. 16 was placed and the bulb inflated in the cervical canal with 30 ml saline for tamponade. Bleeding stopped. Foley's catheter was removed after 24 hours after deflation. Patient was discharged on 3rd day in satisfactory condition.

DISCUSSION

The incidence of cervical pregnancies is calculated to be less than 1% of ectopic pregnancies.[1] An actual increase in the incidence of cervical ectopic pregnancy may be attributed to an increased prevalence of women with a history of uterine curettage and the use of interventional treatment in women with infertility.

Often patients with cervical pregnancy are misdiagnosed as complications of intrauterine pregnancy by the admitting doctor and the correct diagnosis is only made after further reviews. Sivalingam et al reported 3 cases of cervical pregnancies with variable clinical presentation and managed by different modalities of treatment.[2]

Jacob et al reported an ectopic cervical pregnancy which presented in such an atypical fashion (as a missed abortion) that diagnosis was only made at surgical evacuation during which the sudden severe hemorrhage could only be controlled by emergency hysterectomy.[3] Inspite of various advances, surgical interventions like total abdominal hysterectomy may be required to arrest life-threatening hemorrhage, especially in women who do not desire future fertility.[4]

Palazzetti reported a 27 years old Para 1 who presented with cervical pregnancy. Inspite of intracervical tamponade, bleeding did not stop and abdominal hysterectomy was done.

Our first case was also wrongly diagnosed as missed abortion and D&E was tried but it led to profuse bleeding. The finding of thick endocervical canal was ignored and cervical pregnancy not suspected. Since she was Para 3, total hysterectomy was done.

Hysterectomy can be avoided with the use of Foley's catheter for adequate tamponade and thereby controlling the hemorrhage, as seen in our second case. Similar cases have been reported in the past.[5,6]

Other management options of cervical ectopic pregnancy are reduction of blood supply, intra-amniotic feticide and systemic chemotherapy.[7]

Methods of reduction in blood supply to the cervical pregnancy include cervical cerclage, vaginal ligation of the cervical arteries, uterine artery ligation, internal iliac artery ligation and angiographic embolization of cervical, uterine or internal iliac arteries. Angiographic embolization has been used primarily as 'rescue' therapy when profuse bleeding follows other conservative measures such as chemotherapy.[8]

Cervical ectopic pregnancy has been treated successfully with systemic methotrexate.[7] Reports since 1990 have suggested a success rate of more than 80% in well-selected cases.[9]

There is a need to confirm viable intrauterine pregnancy by pelvic ultrasound. In case of abnormal intrauterine findings, abnormally sited pregnancies should be specially searched for and this includes both adnexae as well as cervix. Nowadays, successful treatment with cytotoxic drugs and other conservative measures is possible in the management of cervical pregnancy. But at the same time, in the presence of profuse hemorrhage, early resort to radical treatment may produce good maternal outcome.

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