Ruptured Scar Ectopic Pregnancy: A Near Miss Case

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ABSTRACT
Aim: Successful management of near miss case of ruptured scar ectopic pregnancy.

Background: Cesarean scar pregnancy (CSP) is an uncommon and potentially life-threatening form of ectopic pregnancy. The incidence of CSP is estimated at between 0.05 and 0.4% of all pregnancies and is expected to increase in prevalence in parallel with rising cesarean section rates. Case description: We present a case report of 30-year-old gravida 2 para 1 live 1 with previous 1 LSCS done 2 years back i/v/o fetal distress with 8.5 weeks. By date, with pain in abdomen since 2 days which aggravated since 6 hours followed by per vaginal spotting since 1 day came in emergency to our hospital. General condition of the patient on arrival was pulse 140 beats per minute, blood pressure 90/60 mm Hg, per abdominal examination was tenderness present in lower abdomen, per vaginal examination revealed uterus bulky, cervical os admits tip of finger, right fornical tenderness present, and bleeding present.

Conclusion: On emergency laparotomy, after opening the abdominal cavity, ruptured scar ectopic pregnancy was noted, withAppropriate transfusion of blood and blood products, postoperative stay was done followed by resuturing of remnant uterine wall with continuous interlocking manner with polyglactin 910. Abdomen was closed in layers. With proper counseling and possibility of torrential hemorrhage and hysterectomy along with availability of senior skilled obstetrician around.

Keywords: Maternal morbidity, Ruptured ectopic, Scar ectopic, Transvaginal sonography.

BACKGROUND
Cesarean scar pregnancy (CSP) is an uncommon and potentially life-threatening form of ectopic pregnancy.1,2 It is estimated to account for 0.15% of pregnancies after one cesarean and will likely increase in prevalence due to globally rising cesarean section rates.3,4 Abnormal implantation of a CSP probably occurs through defects in the uterine tissue caused by the trauma of a previous cesarean section. The pathophysiology of CSP is not fully understood. A possible mechanism is that trauma caused by a cesarean section creates microscopic tracts through which an implanting blastocyst abnormally invades the affected myometrium.5,6

CASE DESCRIPTION
A 30-year-old gravida 2 para 1 live 1 with previous 1 LSCS done 2 years back with 8.5 weeks by date with pain in abdomen since 2 days with per vaginal spotting since 1 day came in emergency to our hospital. General condition of the patient on arrival was pulse 140 beats per minute, blood pressure 90/60 mm Hg, per abdominal examination was tenderness present in lower abdomen, per vaginal examination revealed uterus bulky, cervical os admits tip of finger, right fornical tenderness present, and bleeding present. Cardiovascular system—S1S2+, respiratory system—air entry bilateral equal, and normal.

She already had ultrasonography report suggestive of bulky uterus with 10 × 5 × 3.8 cm and heterogeneous 4.1 × 3.6 cm echogenic area with gestational sac and fetal pole measuring 14 mm corresponding 7 weeks 5 days not showing cardiac activity noted in right adnexal area, right ovary could not be visualized separately with f/s/o ruptured right adnexal ectopic pregnancy free fluid in POD and e/o large thick complex heterogeneous collection measuring 10 × 6.6 × 5.5 cm with iliac fossa hematoma.

In investigations were as follows:
CBC—Hemoglobin: 6.2 g%, total leukocyte count: 15,800/mm3, platelet count: 348,000/mm3.

Patient was taken for emergency laparotomy after opening the abdominal cavity. Ruptured scar ectopic pregnancy was noted (Fig. 1), with 5 × 4 cm in dimension with hemoperitoneum with 300 mL of blood and 80 g of blood clots evacuated. Excision of scar with adherent ectopic tissue was done followed by resuturing of remnant uterine wall with continuous interlocking manner with polyglactin 910. Abdomen was closed in layers. With appropriate transfusion of blood and blood products, postoperative period was uneventful followed by discharged on day 4.

DISCUSSION
Combined TVS and TAS with Doppler is the current diagnostic modality for CSP with a reported sensitivity of 86.4%.7,8 Magnetic resonance imaging can be used as an adjunct imaging modality to aid in decision-making and operative planning through detailed
characterization of CSP location, depth of myometrial invasion, and presence of bladder involvement. Subdivision of CSP based on location has been suggested. Type I (endogenic) grows toward the cervicoisthmic space or uterine cavity and may result in a viable pregnancy with high risk of placental site bleeding and morbidly adherent placentae. Type II (exogenic) invade into the scar defect and progress toward the bladder and abdominal cavity and are associated with uterine rupture.

Medical approaches include administration of intragestational sac methotrexate or long-course systemic methotrexate administration. Surgical approaches may involve dilation and curettage (D&C), hysteroscopic resection, surgical excision via open, laparoscopic or transvaginal approaches, or hysterectomy.

Limitations
Due to the rarity and heterogeneity of CSP, no guidelines exist on best-practice management. A range of therapies have been described either in isolation or as part of combined management strategies.

Conclusion
This case highlights the severe risks associated with a CSP and successful management of near miss case of ruptured scar ectopic pregnancy with hemoperitoneum.

Clinical Significance
Although clinical and ultrasonography findings can mislead us, ruptured scar ectopic pregnancy should always kept in mind with proper counseling and possibility of torrential hemorrhage and hysterectomy along with availability of senior skilled obstetrician around.

Ethical Statement
Ethical principles were maintained throughout the case and consent of the patient was taken in local language.

References