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Case Report

Cervical Ectopic Pregnancy

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Abstract

Ectopic Cervical Pregnancy (CP), is rare condition with an incidence of less than 0.1% of all pregnancies. It is 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. A 30-yrs old woman presented with vaginal bleeding, admitted as inevitable miscarriage for conservative vs surgical treatment. Diagnosis of cervical ectopic was made on clinical examination, confirmed by Ultrasound on 2nd day of admission, and managed very well surgically. Follow up was uneventful with satisfactory results.

Keywords: Cervical ectopic pregnancy; Interventional radiology; Hysterectomy; Fertility

Introduction

Cervical pregnancy, a rare type of ectopic pregnancy, but potentially related to life-threatening and high morbidity rate. It is defined as an implantation of a fertilized ovum in the cervical canal (accounts for less than 1% of all ectopic pregnancies) [1].

The following ultrasound criteria may be used for the diagnosis of cervical ectopic pregnancy [1].

An empty uterus and barrel-shaped cervix.

Gestational sac presents below the level of the internal cervical os.

Absence of the 'sliding sign' and blood flow around the gestational sac using colour Doppler.

Case Presentation

A 30-year-old woman was admitted to hospital as threatened miscarriage at 7 weeks of gestation. Patient had no ultrasound for localization of pregnancy earlier as was low risk for ectopic. She didn't pass any tissue and had mild vaginal bleeding and lower abdominal pain. Pain was controlled by 1st line analgesics and not radiating. Before this recent pregnancy, the woman's menstrual cycle had been regular every 30 days with normal blood loss of 4-5 days' duration. She had had two previous normal vaginal deliveries, and last SVD was 12 years earlier. She had no history of miscarriage, dilatation and curettage, infertility or any contraception before consultation. No previous history of pelvic or abdominal surgery and no history of STDs or PID. She had cervical surgery as LETTZ 10years ago for cervical CIN3 and since then cervical smears were 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. Trans vaginal ultrasound scan identified an empty uterine cavity, and a large echogenic area in cervical canal which was thought to be cervical pregnancy/products of conception failed to pass through cervical canal due to stenosis. BHCG was 41507.

Next day patient was complaining of pain in lower abdomen and vagina which was worsening and needed strong analgesia but not helping her. 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 in management plan and bilateral internal iliac balloons inserted before starting procedure so that in case of heavy bleeding balloons will be inflated to control bleeding.

Under general anaesthesia cervix explored and it was not stenosed so easily dilated upto 10mm and products of conception were evacuated with suction from cervical canal. Total blood loss was 150mls and large vascular area at 10'o clock position size reduced from 4cm to 2cm and mild bleeding was noticed from cervix. Folleys catheter inserted in cervix and filled with 30mls of fluid for temponade. It stayed in, for 24 hours.

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The patient was in satisfactory condition with no complaints after 24 hours and post op HCG was 12193.

Patient discharged to home with plan to follow HCG weekly till it comes to non-pregnancy range [2]. Products sent for histopathology.

Outcome

Patient was last seen in clinic early pregnancy clinic after 3 weeks of surgery when she had blood levels of HCG as 2(non pregnant range) and was well clinically.

Discussion

Although cervical pregnancy is very rare, but still increased number of cases being reported, because of risk factors like high cesarean section rate (specially 2nd stage sections) and increased use of assisted reproductive technique for infertility[4](as now infertility treatment centers are working in very high numbers as compared to past and specially in area where this case was reported, loads of private IVF centers are well established). The success of conservative treatment depends on the timely and prompt diagnosis by early ultrasound, which can reduce the chances of severe life-threatening hemorrhage leading to hysterectomy or blood transfusion and prolonged hospital stay.

At same time, I would like to highlight importance of public awareness about complications of early pregnancy (with the help of patient information leaflets and signposting to other informative resources) and valuable addition of dedicated early pregnancy units in most of heath care set ups [3].

Another point, I want to mention is, in this particular case, on speculum examination it was looking like, gestational sac is sitting in cervical canal and if some junior doctor would examine and try to remove products, could lead to excessive haemorrhage and serious outcome. So, i advise to take second opinion whenever cervix looks remarkably hyperaemic along with some POCs in cervical canal.

While working in KSA, where PID & STDs rate was not very high, I still noticed ectopic pregnancy cases were common and, in my opinion, it needs to be audited for improvement of health care [4]. Dedicated early pregnancy clinics should be encouraged along with EPAC ultrasound trained sonographers/doctors. PUL cases should be under follow-up of EPAC unless proved otherwise, and on weekends their follow ups including blood tests (Serum beta-HCG & progesterone levels) and emergency ultrasound services should be handed over to on-call gynaecology team.

Low threshold to review patients with risk factors for ectopic pregnancy and to be seen in detail within 24 hours of their 1st contact with medical team (if they are clinically stable).

24/7 help line should be provided to pregnant women where they could contact experienced medical staff to discuss their issues and ask for help [5].

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