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Catastrophe averted: caesarean scar pregnancy masquerading as intrauterine pregnancy.

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ABSRACT:
Introduction: scar pregnancy is a rare and unique form of pregnancy with implantation of the embryo within the myometrium and fibrous tissue of previous scar of the uterus(1)
First case was reported in 1978, and since then the rate of CSP has been on a rise.
Case Report
A multiparous women with previous one caesarean section, misdiagnosed as missed abortion at first was referred with continuous bleeding per-vaginum. The case was reviewed and a possibility of caesarean scar pregnancy was considered. An MRI was done to confirm the same and laparotomy was done followed by evacuation of products through lower segment transverse incision.
Discussion
The rising incidence of this potentially devastating condition should serve as a warning bell to rein in the caesarean section rate.
It is interesting to note, that the suspicion of cesarean scar pregnancy first arose when the patient did not respond to medical line of management of missed abortion. Given the 80% success rate with medical management of miscarriage reported in literature3, failure of this line of management should trigger a case review by a consultant obstetrician
Admittedly our decision for a laparotomy is 'out of sync' in this era of minimally invasive surgery, however this decision was made after an honest assessment by the surgical team at our local center. This points to a need to individualize management of every patient taking into account available resources to achieve an optimal outcome. Perhaps even in this age of innovation, the age old adage 'primum non nocere' serves as a relevant watchword.
Conclusion
Increased awareness about this condition, good clinical acumen, multidiscipinary team effort and an individualized treatment plan are essential to achieve a good clinical outcome.

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I. Introduction:

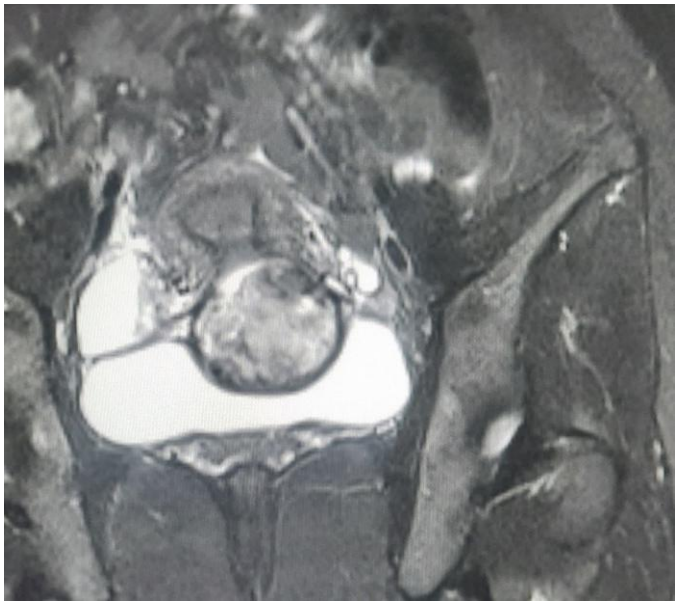
caesarean scar pregnancy is a rare complication of caesarean delivery. It occurs due to implantation of the blastocyst in a microscopic or macroscopic tract on the caesarean/hysterectomy scar(2). Once a rare entity, CSP rate has been increasing parallel with caesarean section rates. Terminology differs in various literature, some names are retained and some are obsolete. Terms such as caesarean ectopic pregnancy, caesarean scar ectopic,isthmocele, a caesarean delivery scar pregnancy have been used(2). Early detection and timely interventions can prevent catastrophes like uncontrolled bleeding, need for hysterectomy.

II. Case Report:

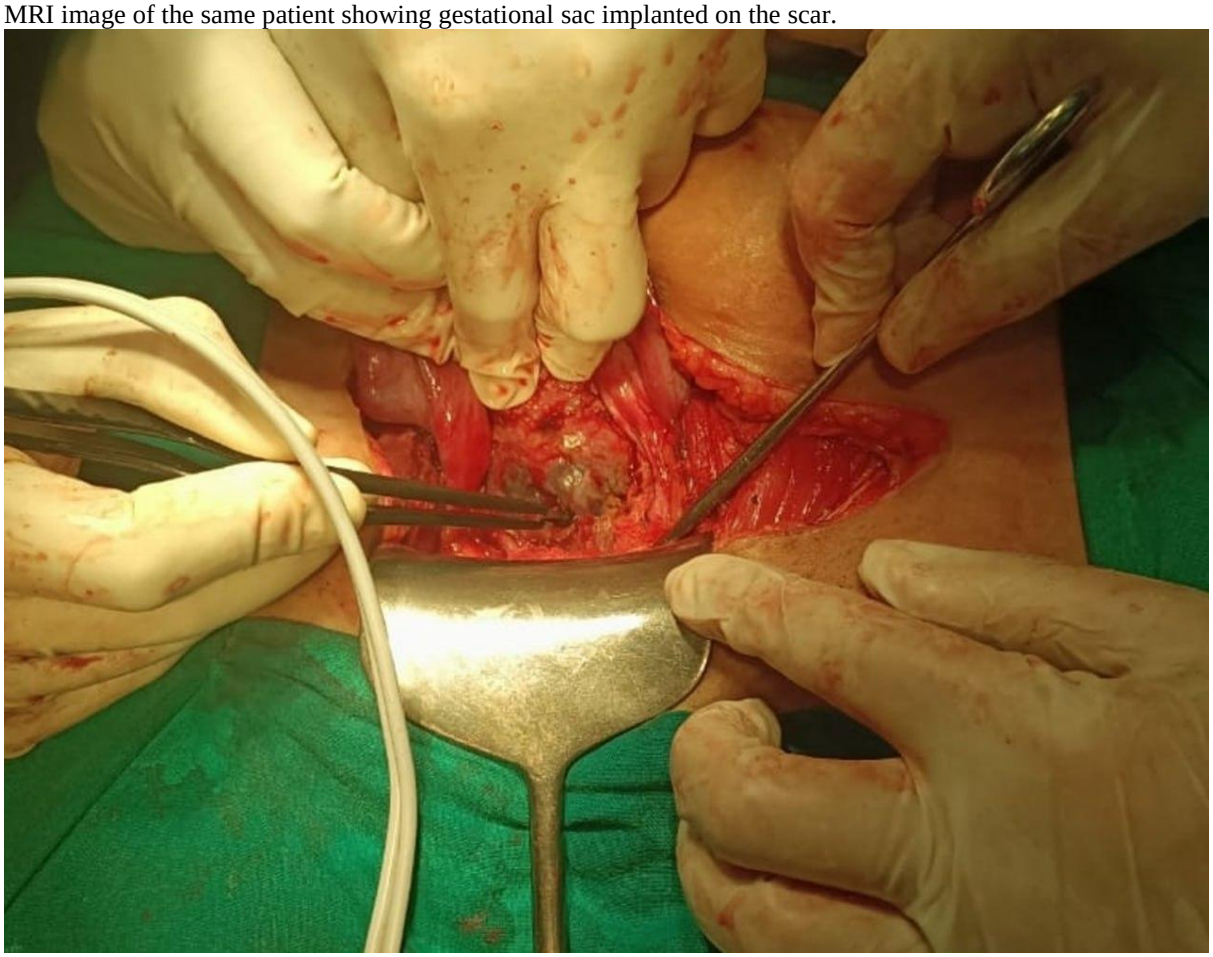
A multiparous patient with previous one LSCS presented to her GP with amenorrhea for two months. A transvaginal ultrasonogram was done which was suggestive of a missed abortion, the patient opted for medical line of management. However, the patient continued to bleed heavily for a month thereafter and was subsequently referred to the local referral center. A repeat TVS by a consultant radiologist showed a gestational sac – yolk sac complex embedded in the previous LSCS scar. A suspicious thinning of the anterior myometrium in the region of implantation of the gestational sac was noted. An immunoassay for HCG did not reveal

significant titers in the patient. The patient was offered referral to a higher care, however due to personal considerations, the patient declined.

At laparotomy, the bladder was found to be densely adherent to the region of the previous LSCS. The lower pole of the uterus was noted to be thinned out, bulging with products of conception. After adequate dissection of the bladder off the uterus, a transverse incision was made over the lower pole of the uterus, followed by evacuation of products of conception. The patient had an uneventful postoperative period.



MRI image of the same patient showing gestational sac implanted on the scar.



III. Discussion:

The true incidence of CPS is not known. Various studies estimate the incidence to be between 1/1800 to 1/2500 of pregnancies. Patients with previous caesarean section, CSP accounts for 6.1% of all ectopic pregnancies. 0.15% patients with previous sections have risk of CSP(3).Caesarean Scar Pregnancy is an underdiagnosed and underreported condition associated with significant maternal morbidity, further complicated by challenges in securing a timely diagnosis and uncertainty regarding optimal treatment once identified(4).

Pregnancy implanted in scars can rarely present after uterine procedures like myomectomy, curettage, vacuum aspiration, manual removal of placenta.(5)

CSP typically presents with bleeding per vaginum and pain is a rare symptom. It can be easily misdiagnosed as missed abortion, threatened abortion, miscarriage or a simple intra uterine pregnancy. A positive urine pregnancy test and ultrasound features help in the correct diagnosis(2).

1)An empty uterine cavity and endocervical canal

2) implantation of the embryo close to the scar with or without cardiac activity.

Other ultrasound features include:

3) increased blood flow around the gestational sac, a thin or absent myometrium between the gestational sac and the anterior uterine wall or bladder.

CSP can be associated with PAS(placenta actreta spectrum), can lead to uterine rupture, severe hemorrhage. But there are chances that the pregnancy may go upto term or near term. Hence cases where there is cardiac activity on TVS, patients should be given the option of both conservative mode of management as well as termination pf pregnancy after having explained risks associated with both.The rising incidence of this potentially devastating condition should serve as a warning bell to rein in the caesarean section rate.

It is interesting to note, that the suspicion of cesarean scar pregnancy first arose when the patient did not respond to medical line of management of missed abortion. Given the 80% success rate with medical management of miscarriage reported in literature, failure of this line of management should trigger a case review by a consultant obstetrician

Admittedly, our decision for a laparotomy is 'out of sync' in this era of minimally invasive surgery, however this decision was made after an honest assessment by the surgical team at our local center. This points to a need to individualize management of every patient taking into account available resources to achieve an optimal outcome. Perhaps even in this age of innovation, the age old adage 'primum non nocere' serves as a relevant watchword.

IV. Conclusion:

Increased awareness about this condition, good clinical acumen, multidiscipinary team effort and an individualized treatment plan are essential to achieve a good clinical outcome.

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