A diagnostic dilemma of 18 week cervical ectopic pregnancy: A case report

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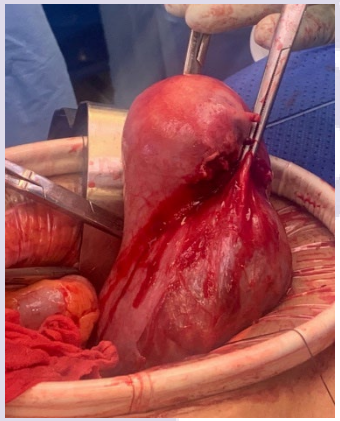
Cervical ectopic pregnancy (CEP) is characterised by the implantation of trophoblastic tissue along the lining of the endocervical canal [1]. It accounts for less than 1 % of ectopic pregnancies and is associated with a significant risk of maternal morbidity and mortality due to brisk and often difficult to control haemorrhage [2-3]. CEP is difficult to diagnose at a late gestation as the highly distorted vascular signal on colour ultrasound is also pathognomonic of placenta accreta spectrum (PAS).

Case Presentation

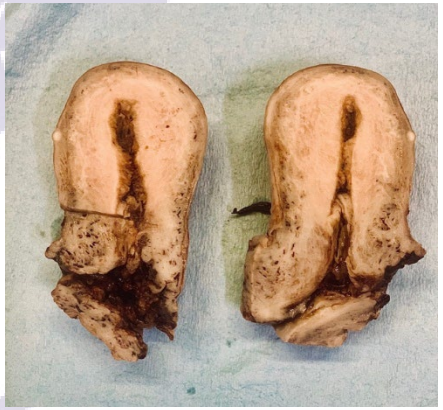
A 27-year-old woman, G6P2, presented to the labour ward of a rural hospital at 18 weeks gestation with premature rupture of membranes. The index pregnancy was complicated by an absence of any antenatal care, as well as a history of cigarette smoke and cannabis use. An ultrasound scan demonstrated a live pregnancy with the foetal head within the cervical canal. A termination of pregnancy was arranged with misoprostol 200 mg orally followed by an oxytocin induction. However, a repeat ultrasound scan, after 12 hours of oxytocin infusion, which failed to terminate the pregnancy, demonstrated a still alive foetus as well as increased vascularity concerning for PAS. The patient underwent an emergency abdominal hysterectomy, with an intraoperative diagnosis of a cervical ectopic pregnancy. The postoperative course was unremarkable, and the patient was discharged home on day 3 post-operatively.

Discussion

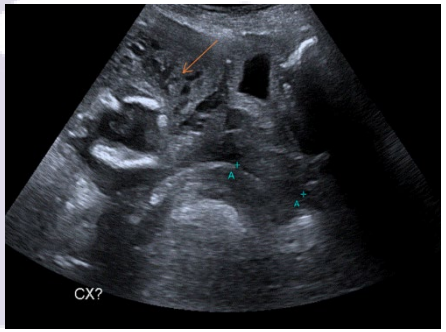
CEP is rare complication of pregnancy associated with significant risk of maternal morbidity and mortality. These risks are made worse by the potential for an incorrect diagnosis, which has a significant impact on management decisions, made even more challenging in rural or resource limited settings. Appropriate antenatal care and early booking in would have identified a CEP at an early gestation and allowed for minimally invasive management and potential conservation of fertility. However, when this is not possible, meticulous pre-operative planning by a gynaecologist with experience in advanced pelvic surgery, can minimise the associated morbidity and mortality.



A normally sized, non-gravid uterus on top of a ballooned cervix indicative of a cervical ectopic pregnancy



Histopathology specimen showing cervical implantation site and anterior cervicotomy



Ultrasound evidence of finger-like placental projections (arrow) invading beyond decidua basalis, suspicious of placenta accreta spectrum

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