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New Perspectives

SUCCESSFUL SURGICAL MANAGEMENT OF A LIVE CERVICAL ECTOPIC PREGNANCY IN A PRIMIGRAVIDA

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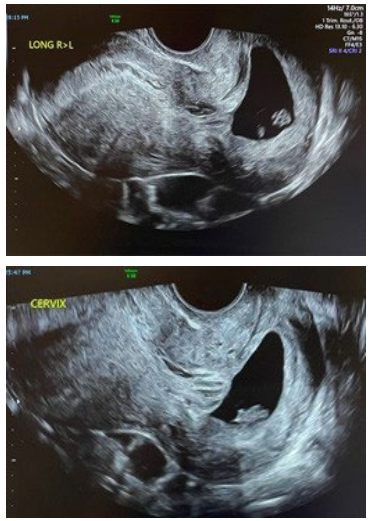
BACKGROUND

Cervical pregnancy is one of the rarest forms of ectopic pregnancy in which a pregnancy implants in the lining of the endocervical canal. A cervical ectopic accounts for <1% of ectopic pregnancies and is associated with high morbidity.i It has a reported incidence of 1in 9,000 pregnancies.ii Risk factors include previous cervical or uterine surgery, anatomical anomalies, use of intrauterine devices and IVF.

CASE

35-year-old regionally located nulliparous woman, eight weeks pregnant based on LMP, presented with 2 weeks of intermittent light vaginal spotting. Serum beta-hCG was 30,887. No history of STI's or PID. A TV ultrasound confirmed the diagnosis of cervical ectopic pregnancy, showing a live fetus with a 17mm CRL. The gestational sac was firmly implanted within the posterior wall of the cervix, measuring 35 x 29 x 21 mm. She was haemodynamically stable and had no abdominal pain. The patient underwent general anaesthetic with suction curettage under ultrasound guidance and balloon tamponade with a cooks catheter. 40mL sterile water placed in uterine balloon and 20mls placed in vaginal balloon. Intraoperatively received 1g IV tranexamic acid and 1000mcg PR misoprostol. She had a 500mL blood loss and was discharged day 2 post operatively.

IMAGING



Cervical ectopic implanted on posterior wall of cervix with decidual reaction within uterine cavity

DISCUSSION

Cervical ectopic pregnancy carries considerable risk of mortality or serious morbidity due to severe haemorrhage.iii The most common symptom is vaginal bleeding, which can be profuse and painless. Early diagnosis is critical to avoid major haemorrhage. The diagnosis can be difficult and can be misdiagnosed for miscarriage with a gestational sac passing through the cervix. Currently there are no clear standardised clinical guidelines for the management of cervical ectopic pregnancy. Stable patients have been managed conservatively with local or systemic methotrexate, with or without KCL injection. Monitoring serial beta-HCGs and awaiting pregnancy reabsorption may take several months. Bleeding or unstable patients can be managed with a variety of surgical approaches including suction curettage, uterine artery embolisation or hysterectomy. Controversy remains about clear treatment pathways.

CONCLUSION

This case discusses a spontaneous cervical ectopic pregnancy in a nulliparous woman without any identifiable risk factors for ectopic pregnancy. Severe haemorrhage from suction curettage was avoided and the patient was not exposed to the adverse effects of methotrexate treatment that she may have been exposed to with medical management. The risk of a significant bleed in a regional area after methotrexate therapy was also avoided. This case is an example of successful surgical management of a live cervical ectopic pregnancy without surgical complication.

The patient conceived spontaneously six months later. She had an ultrasound indicated cervical cerclage placed at 20 weeks gestation for an asymptomatic short cervix. The cerclage was removed at 37 weeks and she had an induction of labour at 39 weeks with a forceps delivery for fetal distress.

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