

CASE REPORT

A RARE CASE OF CERVICAL ECTOPIC PREGNANCY

Rajalekshmi M¹, Vijay Narayanan S², Chitra Jayakrishnan³

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ABSTRACT: A 30 years old nulligravida woman presented with bleeding PV for 5 days and lower abdominal pain for 3 days. Her urine pregnancy test was positive. Speculum and per vaginal examination revealed open cervix with fleshy mass protruding through the cervix. Ultrasound showed normal, empty uterine cavity with mixed echogenic contents in the cervix. Emergency dilatation and evacuation was done. Histopathological examination revealed products of conception. All these factors confirmed it to be cervical ectopic pregnancy. In this case report we discuss the diagnosis and management of a rare case of cervical ectopic pregnancy encountered in our hospital.

KEYWORDS: Cervical pregnancy, ectopic pregnancy, dilatation and curettage.

INTRODUCTION: Cervical pregnancy is a type of ectopic pregnancy where the implantation of the fertilized ovum occurs in the endocervical canal. Pregnancy develops in the cervical wall due to erosion of endocervix by the trophoblast. It is highly fatal if there is delay in diagnosis and treatment.

CASE REPORT: A 30 years old nulligravida woman married for 7 years, with history of irregular periods for 5 years, presented with complaints of continuous bleeding PV for 5 days and lower abdominal pain for 3 days. Her last menstrual period was on 3rd April 2015. She gives history of having taken treatment in another hospital for irregular periods and was started on oral contraceptive pills for one cycle. Following this, she got her periods. She is a known hypothyroid patient on treatment with T. Eltroxin 50 mcg OD.

On examination she was pale, her pulse rate was 92/min, BP was 100/60mmHg. Per abdomen was soft, no distension, tenderness was present in the lower abdomen. Speculum examination revealed open cervix with fleshy mass protruding through the cervix. In Per vaginal examination cervix was open and bulky; soft mass was felt through os. Uterus was normal size and bilateral fornices appeared free. Mild bleeding PV was seen. Her hemoglobin was 9g/dl. Other investigations were within normal limits. Urine pregnancy test was positive. Ultrasound showed normal upper abdominal study; normal uterine size and there was no evidence of intra-uterine gestational sac. Ovaries were of normal size. Mixed echogenic content was seen in the cervix. Since she had continuous bleeding, she was planned for emergency on-table examination with dilatation and curettage.

Examination was carried out on the operating table under general anaesthesia. The same speculum and per vaginal examinations were confirmed. Her external os was open and the cervix was bulky (Figure1). The protruding fleshy mass was removed using ovum forceps. Following this she had severe bleeding for which Inj. Oxytocin 20 unit's i.v infusion was started. When Hegar's dilator was introduced the internal os was found to be closed.

Post operatively she was managed with i.v antibiotics. Her post-operative period was uneventful and she was discharged after 5 days. Histopathological examination revealed that the

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removed contents to be products of conception. Clinical examination, ultra sound and histopathological examination confirmed the diagnosis of cervical ectopic pregnancy in our patient.

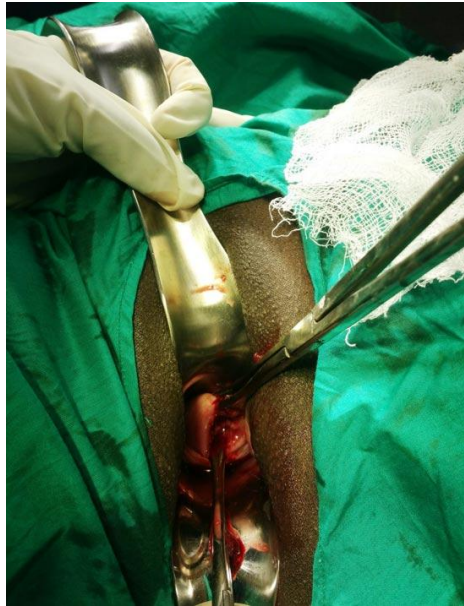


Fig 1. Bulky Cervix

DISCUSSION: One of the rarest forms of ectopic pregnancy is cervical pregnancy with incidence rate of less than 1%.^[1] Usually it gets aborted within first trimester. It may be life threatening if the pregnancy prolongs beyond first trimester. Damage to endometrium due to repeated curettage, intra-uterine contraceptive devices, artificial reproductive techniques,^[2] previous caesarean section scars have been found to be the predisposing factors for cervical pregnancy.

Paalman and McElin proposed clinical criteria for the diagnosis of cervical pregnancy in which the patient will present with history of amenorrhoea followed by painless, profuse vaginal bleeding. Clinical examination shows enlarged, dilated cervix larger than the fundus (Hour glass uterus), closed internal os and partially open external os with products of conception entirely inside and attached to the endocervix. Diagnosis can be confirmed by ultrasound as well as MRI.^[3,4]

Ultrasound will show empty uterus, enlarged cervix, gestational sac within the cervical canal. Rubin criteria can also be used for the diagnosis of cervical pregnancy. The criteria includes cervical gland being opposite to the attachment of trophoblast/placenta, attachment of trophoblast being below the entry of uterine vessels into the uterus or anterior peritoneal reflection and absence of foetal elements from the corpus uteri.^[5]

Differential diagnosis of cervical pregnancy includes incomplete abortion, pregnancy in caesarean or hysterotomy scar. Treatment of cervical pregnancy depends on clinical presentation. Haemodynamically stable patients with absent foetal cardiac activity and gestational sac less than 4cm can be treated with medical management using Inj. Methotrexate, single or multi dose. Uterine artery embolization is done in patients where methotrexate therapy fails or where it cannot be used.^[6] Cervical cerclage, local haemostatic sutures, intracervical balloon tamponade, vaginal packing and curettage followed by prostaglandin instillation are some of the interventions done to arrest

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haemorrhage.^[7,8] In haemodynamically unstable patients and in patients with failed medical treatment, surgical intervention such as transvaginal ligation of cervical branches of uterine arteries, bilateral uterine and internal iliac artery ligation. Hysterectomy is considered as the last resort.

In our case only dilatation and evacuation of the products was done as the patient was haemodynamically stable. Considering the fact that the patient was nulligravida, she was lucky that there was no uncontrollable bleeding which could have resulted in hysterectomy.

CONCLUSION: Earlier diagnosis and management in cases of ectopic pregnancies help in conservation of uterus and reproductive function without the need for hysterectomy.

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AUTHORS:

1. Rajalekshmi M.
2. Vijay Narayanan S.
3. Chitra Jayakrishnan

PARTICULARS OF CONTRIBUTORS:

1. Assistant Professor, Department of Obstetrics and Gynaecology, Saveetha Medical College, Chennai.
2. Associate Professor, Department of Anaesthesiology and Critical Care, Saveetha Medical College, Chennai.

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3. Consultant, Gynaecologist, Appasamy Hospital, Chennai.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Vijay Narayanan S,
Plot No. 10, No. 6,
Mullai Street, Fathima Nagar,
Valasaravakkam, Chennai-600087.
E-mail: drvijay2000@gmail.com

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