Case Report

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Caesarean Scar Pregnancy: A Dreaded Complication of LSCS

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Abstract

Caesarean scar pregnancy is a rarest type of ectopic pregnancy, characterized by vaginal bleeding associated with abdominal pain, usually manifested during the warly first trimester of pregnanacy. It can be diagnosed by serial beta-HCG levels monitoring coupled with ultrasonography. The treatment modalities can be Inj. Methotrexate, D&C associated with laproscopy/ laprotomy or uterine artery embolization. Rupture of ectopic pregnancy may lead to massive haemorrhage, shock & DIC.

Keywords: Caesarean scar pregnancy (CSP); Methotrexate; DIC.

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Introduction

Ectopic pregnancy can be defined as the implantation and maturation of the fetus outside the endometrial cavity characterized by– pain abdomen, amenorrhea and bleeding P/V, associated with nausea, breast fullness, dizziness, weakness. It is one of the most common causes of first trimester bleeding, leading to massive heamorrhage, infertility & high mortalilty rate.

Serial Beta-HCG levels in correlation with ultrasonography and colour-flow Doppler are diagnostic of ectopic pregnancy.

Caesarean scar pregnancy (CSP) is the ectopic fetal implantation at the site of previous caesarean scar. It's a rarest kind of ectopic pregnancy with an incidence rate of about <1%, with a case reporting of 1:1800 to 1:2200.

In the current times and with the advancement in the technology, LSCS has become the choice of women to ease the discomforts of labour pains. With the increasing incidence of LSCS, better understanding of the disease and advancement in radiological investigations, there has been a substantial increase in the disease. Women are mostly counselled only about the cosmetics of the scar, complications like scar dehiscence, precautions to be taken in near future, but what happens in long run, is what most of us unaware of.

It is generally diagnosed at a gestational age between 5 weeks – 12 weeks with a time interval

of 6 months – 12 years between the diagnosis of cesarean scar pregnancy and previous cesarean section.

Accurate diagnosis of CSP can be made by following USG criteria-

- empty uterine cavity and cervical canal
- close proximity of the gestational sac and the placenta to the anterior uterine surface within the scar or niche of the previous cesarean delivery
- color flow signals between the posterior bladder wall and the gestation within the placenta
- abundant blood flow around the gestational sac.

The risk factors for ectopic pregnancy attribute to tubal damage due to Pelvic Inflammatory Disease (PID), H/O previous ectopic pregnancies, smoking, use of Intra-uterine Devices (IUD), use of fertility drugs or assisted reproductive technology, multiple sexual partners, increased maternal age (>35 yrs), previous surgeries and conception after tubal ligation. Late or misdiagnosis may lead to ruptured ectopic, massive heamorrhage, shock, Disseminated Intravascular Coagulation (DIC) & death.

Case Report

31-year-old female patient, G3P2L2 with 6 weeks +3 days gestation with previous caesarean section 1year back, presented to ER with complain of heavy bleeding P/V since 2 days. There was no H/o pain abdomen, vomiting, burning micturation, fever, discharge P/V, recent trauma.

P1- NVD with a healthy, live female child 7 years old with a birth weight of approximately 3.5 kgs.

P2- LSCS with a healthy, live female child 1 year old with a birth weight of approximately 3 kgs.

No previous H/O of abortions/use of oral contraceptives/medical or surgical MTP.

No H/O any medical illness during the previous pregnancies.

On Examination in ED she was conscious, oriented with stable vitals (Pulse-78/min, BP-110/80 mmHg RBS-98 mg/dl).

Ample History

Allergies-None

Medications-None

Past Medical History-Previous 2 cesarean section

Last Meal- 1 hour back

LMP-10 days back from the date of ED arrival

ECG- Sinus Rhythm

Care Plan

- Keep the patient Nill P/O (NPO)
- Inj Methotrexate 60 mg IV stat
- Inj Perinorm 10 mg IV stat
- Inj Rantac 50 mg IV stat
- Inj Supracef 1.5 G IV stat
- IV Fluids 100 ml 25% Dextrose NS STAT
- IV Fluids RL @100 ml/Hr
- USG Whole abdomen
- Immediate Gynaecologist opinion was obtained
- Room admission was planned
- Routine Investigations were sent- CBC, KFT, Thyroid profile, Coagulation Profile, Blood Grouping & cross matching, HBsAg.
- Patient was shifted to the room & reports were chased.

Differential Diagnosis of First Trimester Bleeding

- Abortion
- Ectopic pregnancy
- Hydatiform mole
- Sunchorionic hemorhhage
- Vanishing twins

Investigations

- CBC: Haemoglobin-12.6, Platelet Count-3,36,000, TLC-12,100
- KFT: Urea-28, Creatinine-0.7
- TFT: FT3-3.52, FT4-0.66, TSH-1.472
- Coagulation Profile- PT-11.0, INR-0.97, APTT-29.5
- HBsAg- Negative
- Blood group- B Positive
- USG W/A- Early live intra-uterine scar ectopic pregnancy of approximately 6 weeks + 2 days. FHR-114/min. Small subchorionic collection of 9 cc. Corpus luteum seen on right side. Right ovarian cyst measuring 3.4 cm.

Course in the Hospital

After thorough history & examination, patient was given Inj Methotrexate in view of ectopic scar pregnancy. Pre-anesthetic clearance was obtained after admission. Patient was planned for USG Guided suction & evacuation of caesarean scar ectopic G-sac followed by Hysteroscopy & Dilatation & curettage under General anaesthesia.

Postsurgery period was uneventful. Patient was hemodynamically stable. NO active bleeding for noted in post-surgery period. Patient was managed on IV antibiotics & IV Fluids. Patient was encouraged to pass urine. Patient was discharged with advice to follow up with Gynaecologist on OPD basis after 1 week with a repeat USG W/A.

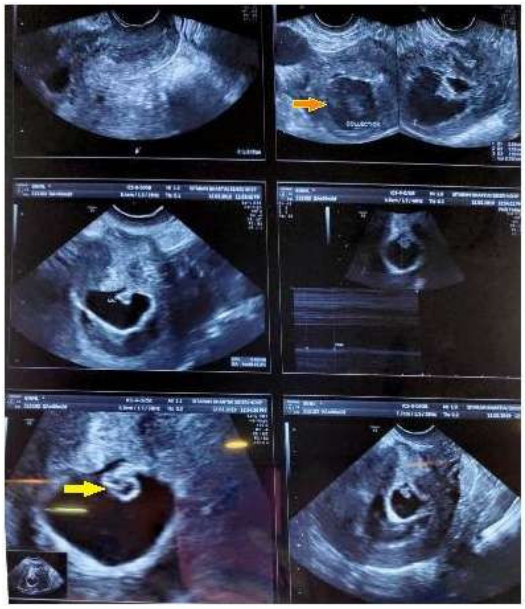

Fig. 1: Ultrasonography showing Ectopic pregnancy (yellow arrow) with subchorionic collection (brown arrow).

Discussion

This above case report shows the scar Ectopic pregnancy is rare but a vivid complication of previous LSCS with a high mortality and morbidity if left misdiagnosed/under-diagnosed. In the era of advancing technologies, better understanding of the use of contraceptives, early and multiple termination of pregnancies predispose the young females with a complication like CSP at the prime of their reproductive age-group.

The risk increases with the increasing age and so does the mortality. With the result of UPT being positive, more so it delays the diagnosis until it is detected on the first encounter with USG pregnancy.

Therefore, we as a medical fraternity, should save LSCS as a measure for judicial causes like Large for date babies, fetal distress, complicating PIH, placental abnormalities, trauma, poor decent, ethical issues and so on & so forth.

Conclusion

Lastly, a brief history with adequate clinical examination & timely investigations should be immediately carried out & prompt medical management should be started, escalating to surgical modalities to achieve better outcomes.

From the emergency medicine perspective, in such cases we should keep our mind open to variety of differential diagnosis.

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