

A Rare Presentation of Cervical Pregnancy

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ABSTRACT

Cervical pregnancy is a pregnancy where implantation occurs in the cervix of uterus rather than occurring in the uterine cavity. It is a rare life-threatening condition so early diagnosis and treatment can save life. Here, we are reporting a case of cervical pregnancy which presented to us with amenorrhea and bleeding per vaginum after misoprostol intake.

Keywords: Ectopic pregnancy, Cervical pregnancy, Misoprostol.

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INTRODUCTION

Cervical pregnancy is extremely rare. It is a rare form of ectopic pregnancy where implantation occurs in cervix rather than in uterine cavity it is a serious condition which can land up in profuse hemorrhage and can threaten the life of a pregnant lady. It accounts for less than 1% of ectopic pregnancies.^{1,2} Usually such pregnancies does not continue for longer duration but if implantation occurs in cervico-isthmic region it can continue for longer duration and even can reach upto term.³ The incidence is around one 1 in 9000 deliveries.^{4,5} Although the cause is unknown but it is common in pregnancies achieved after assisted reproductive technique and after instrumentation in uterine cavity.⁶

CASE REPORT

A 28-year-old female came on 1st March 2011 to JNMCH, AMU, Aligarh, with complaints of amenorrhea since 3 months and bleeding per vaginum following misoprostol intake 400 microgram orally. Her last menstrual period was 22nd November 2010, by dates she was 14 weeks, by ultrasound 10 weeks 2 days. She was G 6 P 3+2 L 3 with one spontaneous abortion 5 years back, at 2 months of gestation,

four and half years male delivered at full term at hospital, Three and half years female delivered at full term at hospital, 1 medical abortion 2 years back at 2 months of gestation which was followed by dilatation and curettage and one 7 months male delivered full term at hospital. There was history of endometrial tuberculosis diagnosed 6 years back for which she took antitubercular treatment for 9 months and conceived thereafter. On examination patient was of average built and nutrition, her vitals were stable. Per abdomen uterus was not palpable, on P/S bleeding per vaginum was present and on P/V examination uterine size was 10 weeks size. Her hemoglobin was 10 gm%, her blood group was O +, ultrasound dated 26/2/2011 reported an intrauterine gestational sac lying in the lower uterine segment with viable fetus with the following parameters: CRL—10 weeks, placenta—anterior grade 1, FHR—165BPM, MLP—2 cm and cardiac activity present. Manual vaccum aspiration done on 1st March 2011, fetus expelled out and placenta was adherent to the cervical canal and there was profuse bleeding per vaginum, intra uterine Foleys was inserted and syntocinon drip was started but the bleeding per vaginum continued and was profuse; patient went into shock, her shock was managed, blood was arranged and laparotomy was done which revealed cervical pregnancy (Fig. 1). Hysterectomy was done (Fig. 2).

DISCUSSION

True cervical pregnancies usually aborts in first trimester but if implantation occurs higher, pregnancy can be prolonged as



Fig. 1: Peroperative uterus and cervix

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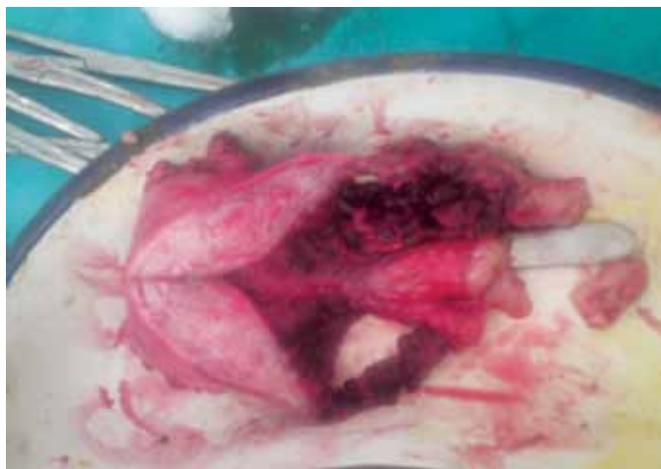


Fig. 2: Uterus with cervix after hysterectomy

in our case. The pregnancy had advanced to 14 weeks and it lead to profuse hemorrhage when evacuation was tried. Early pregnancies usually abort themselves or can be managed by suction-evacuation, ligating the cervical branches of uterine arteries, cauterization of arteries or balloon tamponade.^{3,7} Uterine arteries embolization may be tried for controlling the bleeding,⁸ but if the pregnancy get advanced it may lead to hysterectomy like in our case.

CONCLUSION

Ectopic pregnancy can never be prevented completely but incidence, morbidity and mortality can be prevented

by effective diagnosis and timely intervention. Cervical pregnancy is a rare condition and difficult to diagnose, early diagnosis made by noninvasive means can help in conservative management and surgery can be avoided.

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