

## ABSTRACT

Caesarean scar ectopic is one of the rarest of all ectopic pregnancies. It is defined as when a blastocyst implants on a previous Caesarean scar. The incidence of Caesarean scar ectopic has increased due to increase in number of Caesarean deliveries. Early diagnosis of this can be done by using sonography. It is very important because a delay can lead to increased maternal morbidity and mortality. Early diagnosis leads to prompt management and improves the outcome by allowing preservation of future fertility. Magnetic Resonance Imaging (MRI) has important role when sonography is equivocal or inconclusive before therapy or intervention. We are reporting a rare case of G3P2I2 with previous two Caesarean deliveries, diagnosed as Caesarean scar ectopic pregnancy with the help of sonography and MRI. Patient underwent laparotomy and on histopathological examination Caesarean scar pregnancy was confirmed.

## CASE REPORT INTRODUCTION

25-year-old female complaint of

- two month amenorrhea with bleeding per vaginum on and off since 10-12 days.
- history of dilation and curettage in present pregnancy in view of incomplete abortion.
- histopathological report showed hyperplastic endometrium and decidual reaction and no villi were seen.
- obstetric history- G3P2I2 with previous two Caesarean deliveries.
- General physical examination was normal. On per speculum, cervix was normal, no discharge or bleeding per vaginum was seen.
- On bimanual examination, cervix pointed upward, uterus was bulky, retroverted and bilateral fornices were free with no tenderness
- B-HCG level was 7118 IU/L, and after 48 hours B-HCG value was 8108 IU/L,
- Trans vaginal ultrasound [Table/ Fig-1].

## CASE OPERATION PROCEDURE

planned for laparotomy.

### Intraoperative findings:

soft and vascular mass seen at the site of previous scar [Table/Fig-2]. Incision was given over bulge and products of conception were gently removed. It was communicating with uterine cavity

, edges of scar tissue were excised and freshened, gentle uterine curettage was done.

Tissue was sent for histopathological examination and diagnosis of Caesarean scar ectopic pregnancy was confirmed.

Patient was followed up with serum Beta human Chorionic Gonadotropin ( $\beta$ -hCG) level, till B-HCG came to non-pregnant level.

**Keywords:** Accreta, Caesarean section, Percreta



[Table/Fig-1]: Ultrasound image-Caesarean scar pregnancy.



[Table/Fig-2]: Intraoperative-Caesarean scar pregnancy.

## DISCUSSION

A Caesarean scar (ectopic) pregnancy occurs when a pregnancy implants on a Caesarean scar. It is rarest of all ectopic pregnancies [1].

Incidence estimated in overall caesarean delivery is 1/1800-1/2500 [2].

It is life threatening condition, causes excessive haemorrhage and risk of uterine rupture. It can be called by various names as "Caesarean scar pregnancy", Caesarean ectopic pregnancy or simply Caesarean scar ectopic [3].

The pregnancies with previous caesarean section have increased the risk of placenta praevia, placental abruption, placenta accreta, percreta as well as ectopic pregnancies in future. There are various theories which explain the etiology and mechanism of Caesarean ectopic pregnancy, the most accepted one is blastocyst invade into the myometrium through a microscopic dehiscence tract, which may be due to previous uterine surgery like Caesarean section, manual removal of placenta etc. [3].

As per another theory in absence of previous uterine surgery, Caesarean ectopic pregnancy can occur due to trauma done in assisted reproduction techniques [4].

The most common clinical presentation of Caesarean ectopic pregnancy is painless vaginal bleeding without any specific clinical signs. For its diagnosis endovaginal ultrasonography and color flow Doppler are very helpful [5,6].

MRI has important role when sonography is equivocal or inconclusive before therapy or intervention. There should be differentiation of Caesarean scar pregnancy from cervical pregnancy. To differentiate from a cervical pregnancy, in trans vaginal sonography no myometrium between the gestational sac and bladder must be seen, because the gestational sac grows into the anterior portion of the isthmus [7].

To determine

whether a Cesarean Scar Pregnancy (CSP) has occurred, USG in the sagittal position can be used to indicate a clear uterine cavity and an empty cervical canal [8].

Various case reports of patients with Caesarean scar ectopic pregnancy even in the absence of bleeding, supports our management as the surgical option [4]. This includes elective laparotomy and excision of the gestational mass. The benefit of

surgery is less recurrence because of the resection of the old scar, with a new uterine closure. Other is a shorter follow-up period [6,9]. In another study with Caesarean scar pregnancy cases, surgical excision of scar is considered as a key management and helpful to prevent recurrence [7].

The availability of Uterine Artery Embolization (UAE) in cases of Caesarean ectopic pregnancies treated has contributed to successful management without any haemorrhage [10].

## CONCLUSION

Caesarean scar ectopic pregnancies can have very fatal and poor outcomes, including uterine rupture, massive haemorrhage and maternal death. Thus, it is important that early and accurate diagnosis of Caesarean scar pregnancy is obtained in order to avoid complications and preserve fertility.