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Consecutive Failed Treatment Approaches in a Cesarean Scar Ectopic Pregnancy-placental Accretism Sprectrum

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Abstract

A cesarean scar pregnancy is a rare entity for which there is no consensus on the preferred mode of treatment. We present a case of a 20s woman who presented with profuse vaginal bleeding in the context of a cesarean section pregnancy. Multiple therapeutic approaches have been tried (uterine curettage, mifepristone, uterine artery embolization) without success. Hysterectomy was decided with support from Urology due to suspicion of bladder invasion. The anatomatological examination confirmed placental incretism at the site of a previous cesarean scar. This case demonstrates that, although treatment must be individualized, the potential risk of major complications must be considered.

Introduction

A cesarean scar pregnancy is an entity with an increasing trend in incidence given the increase in the rate of cesarean sections. There is no consensus regarding the most appropriate therapeutic approach, which is why it must be individualized considering the patient's characteristics and the technical skills and experience of the medical team.

With this clinical case, we intend to recall the complexity of the therapeutic approach in some of these situations, with multiple failures of conservative approaches and the need for hysterectomy. It should be noted that this case validates the hypothesis that cesarean scar pregnancy and abnormal placentation may be manifestations of the same disease process: Placental accretism spectrum.

Case description

A woman in her 20s, gravida 4 (2 previous cesarian sections and a voluntary first trimester pregnancy interruption) without any previous health problem was admitted at our emergency department with heavy vaginal bleeding in her 7th week of pregnancy.

On transvaginal ultrasound, a gestational sac with a viable 7-week embryo, at a low implantation on the anterior uterine wall, imbedded in the hysterotomy scar was recorded, residual myometrial thickness was 3mm. Upper uterine cavity was empty.

To control vaginal bleeding, she underwent emergent ultrasound abdominal guided suction curettage with subsequent placement of intrauterine balloon with acute control of hemorrhage.

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After progressive deflating the balloon, vaginal bleeding persisted. Ultrasound revaluation showed hematometra and diffuse increased vascularity in the anterior uterine wall. Although myometrial layer measurement was not possible, bulging into the bladder was not noted.

In attempt to preserve the uterus, mifepristone and systemic methotrexate were administered, with persistent vaginal bleeding requiring multiple transfusions of red cells.

Magnetic Resonance Imaging (MRI) showed a continuity defect with 17mm on the anterior-inferior wall with a heterogeneous mass with 86x69x95mm that extended from the endometrial surface, infiltrating and virtually replacing the entire myometrial thickness of the anterior wall. Mass effect on adjacent structures (upper third of the vagina) was also documented. Furthermore, disruption of the myometrial-serous interface, with the posterolateral bladder wall presenting markedly heterogeneous was recorded, leading to placenta percreta suspicion (Figure 1).

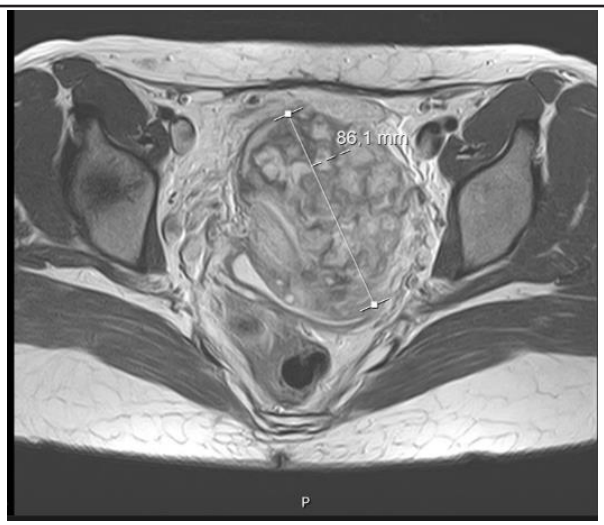

Figure 1: MRI T2 weighted showing a heterogeneous mass extending to the entire uterine wall.

Given the patient preference to conserve the uterus, an embolization of the uterine arteries was proposed that occurred without intercurrences. In post-procedure, difficult to manage pain and worsening of bleeding complaints, with heavy vaginal bleeding associated with periods of hemodynamic instability, lead to a shared decision of hysterectomy.

Surgery underwent with the support of Urology with cystoscopy evaluation and double-J stent placing. During the surgery, a vascularized hard consistent mass deforming the uterine isthmus with approximately 8 cm was objectified, with adhesions to the bladder and left pelvic wall. A total hysterectomy with bilateral salpingectomy was carried out without complications (Figure 2 and 3).

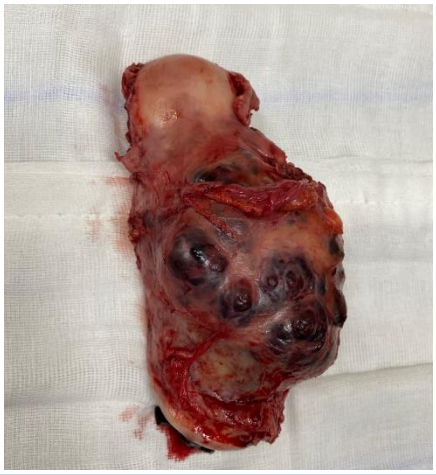

Figure 2: Hysterectomy specimen showing an 8cm mass in the isthmic region compatible with pregnancy in a cesarean section scar.

Anatomopathological examination confirmed placental increatism at the site of a previous cesarean scar. Post-operative period was uneventful.

Discussion

A cesarean scar pregnancy is a rare entity for which there is no consensus on the preferred mode of treatment. Treatment should be tailored to the individual patient [1] and availability of the treatment choice and/or technical skills [2]. Minimally invasive treatment modalities and desire of fertility preservation should also be considered. However, this is a severe maternal complication with high risk of significant maternal illness and death [3]. Our case illustrates a pregnancy in a cesarean scar with an unfavorable evolution despite multiple therapeutic approaches. Moreover, although desire for fertility preservation was important, persisting symptoms, lead to the hysterectomy decision. In this sense, the importance of a timely approach with targeted diagnosis and treatment is reinforced.

The presence of myometrial invasion supports the concept in which cesarean scar pregnancy and abnormal placentation may be manifestation of the same disease process: Placental accretism spectrum.

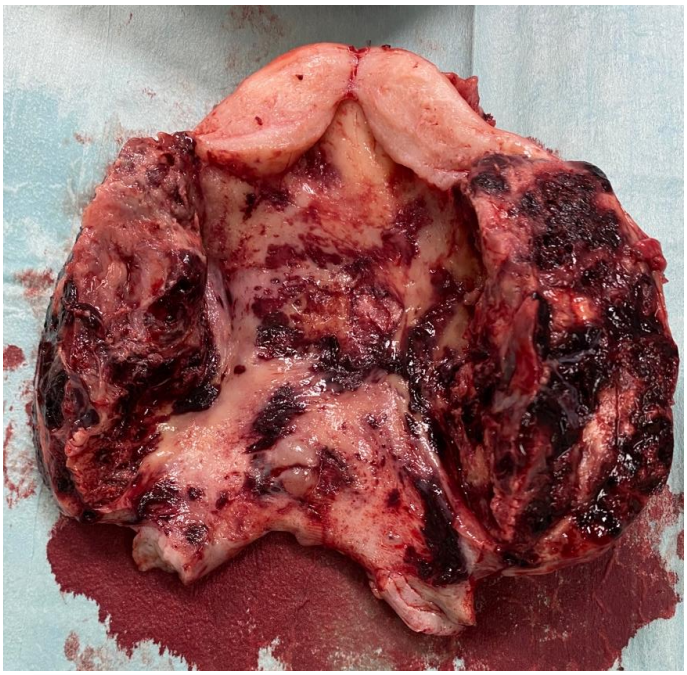

Figure 3: Cross-sectional hysterectomy specimen showing involvement of the trophoblastic mass throughout the depth of the myometrium.

Patient's perspective

Throughout the process, my perspective changed as the situation evolved. Initially, despite being scared by the loss of blood, I wanted to preserve the uterus, as I was still very young. However, given the worsening, my priorities changed and all the fear I felt only improved when they removed my uterus. Recov-

ery was not easy, physically and emotionally, but I have now accepted the situation and am happy to have survived without any sequelae.

The entire text was translated by the authors.

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