Caesarean Scar Pregnancy - A Rare Case Report
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Abstract:
Objective: The aim is to publish the case report of the rarely occurring and life threatening ectopic pregnancy developing in a Caesarean section scar causing uterine rupture.

Methods and Results: This patient was diagnosed initially as a case of incomplete abortion. Other possible diagnoses were molar pregnancy, mass in the cervix. She was admitted in hospital for evacuation and curettage. During the procedure she developed severe pervaginal bleeding leading to hypovolemic shock. So decision was taken for emergency laparotomy. After opening the abdomen rupture was found in the lower uterine segment extending up to upper part of cervix. So hysterectomy was performed and histopathology confirmed the diagnosis of ectopic pregnancy that developed in a Caesarean section scar. Analysis of the women's obstetric history revealed that she had been previously operated because of breech presentation.

Conclusion: Heightened awareness of the possibility of pregnancy in caesarean scar and early diagnosis by means of transvaginal sonography along with colour doppler can improve outcome and minimize the need for emergency extended surgery.

Key words: Caesarean scar Pregnancy (CSP), Transvaginal ultrasound, Total Abdominal Hysterectomy (TAH).

Introduction:
Implantation of a pregnancy within a Caesarean fibrous tissue scar also known as intramural pregnancy is considered to be the rarest form of ectopic pregnancy and a life threatening condition¹. This is because of the very high risk for uterine rupture and all the maternal complications related to it¹,²,³. Caesarean scar pregnancy is a rare form of ectopic pregnancy where the gestation sac is surrounded by myometrium and fibrous tissue of scar from the previous caesarean section separated from endometrial cavity and endocervical canal⁴,⁵. Cesarean scar pregnancies (CSPs) are more commonly seen today, both in the East and the West, as a result of a significant increase in the proportion of Cesarean deliveries over the last three decades⁶. It is often misdiagnosed as Molar pregnancy or Inevitable Abortion and can be associated with massive hemorrhage and pervaginal bleeding leading to uterine rupture. Here a case of Caesarean scar pregnancy is reported who presented with history of amenorrhea and pervaginal bleeding. Dilatation and curettage was planned but during the operative procedure profuse bleeding started leading to hypovolaemic shock which was managed by blood transfusion and venesection. After recovering from shock emergency laparotomy was done followed by Total Abdominal Hysterectomy as a life saving procedure. Postoperative period was uneventful and the patient was discharged on ⁸th postoperative day. Early diagnosis is important as caesarean scar pregnancy is associated with life threatening complications such as uterine rupture, massive hemorrhage and the need for hysterectomy with subsequent loss of fertility.

Case History
Mrs. X a young lady, 25 year old, mother of one child with history of caesarean section presented with history of amenorrhea for about ⁸ weeks, with mild pervaginal bleeding for two months. She was diagnosed initially as a case of incomplete abortion. She underwent ultrasonography of pelvic organs giving the differential diagnosis of molar pregnancy, mass in the cervix or incomplete abortion. She was admitted in hospital for evacuation and curettage.

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During the procedure she developed severe per vaginal bleeding leading to hypovolaemic shock. She was managed by blood transfusion & venesection. So decision was taken for emergency hysterectomy. After transfusion of 5 units of blood she underwent total abdominal hysterectomy. On laparotomy, there was a longitudinal rupture on the lower part of body of the uterus including the upper part of cervix and there was moderate amount of clotted blood present in the uterine cavity. Urinary bladder was intact. Postoperative period was uneventful. On 8th postoperative day the patient was discharged. Histopathology report confirmed the diagnosis of ectopic pregnancy that developed in the previous caesarean scar area.
by MRI which also demonstrated that no normal endometrium existed between gestational sac and the bladder wall. Strict imaging criteria must be used in performing the diagnosis—an empty uterus, empty cervical canal, development of the sac in the anterior part of the isthmic portion and an absence of healthy myometrium between the bladder wall and the gestational sac. A retrospective cohort study was done in University hospital in China to determine the efficacy of Uterine Artery Embolisation (UAE) combined with local Methotrexate (MTX) for the treatment of Caesarean scar pregnancy between Jan 2003 and Dec 2008 and they concluded that UAE with local MTX is of benefit to women wishing to preserve fertility, and is suitable for use as a primary treatment of caesarean scar pregnancy. Because of difficult diagnosis and probably delayed treatment this patient developed complication resulting extended surgery with loss of fertility.

**Conclusion:**
Caesarean scar pregnancy is one of the causes of maternal morbidity. Accurate diagnosis made by ultrasonography and Doppler is obligatory for conservative medical and surgical management.

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