INTRODUCTION

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. The Endometrial cavity and fallopian tube is separated from the gestational sac. The CSP is a dangerous disease, as the trophoblastic invasion in the myometrium may lead to uterine rupture and profuse bleeding as the pregnancy advances. Pregnancy within a caesarean fibrous tissue scar was first reported by Lansen and Solomon in 1978. It may constitute a life threatening condition because of its high risk for massive vaginal bleeding and uterine rupture. In the last decade, it has been encountered more frequently worldwide. The increased number of cases may reflect the greatly increased incidence of caesarean deliveries and the adoption of Transvaginal ultrasound or Colour Doppler imaging in recent years. Cesarean scar pregnancy is diagnosed on patients having amenorrhea and a history of prior caesarean section. Diagnosis is based on sonographic and Doppler flow findings: (a) an empty uterus and cervical canal; (b) The gestational sac is located in the anterior part of the isthmus of the uterus with a diminished myometrial layer between the bladder and sac; (c) A discontinuity in the anterior wall of the uterus. Most patients diagnosed with caesarean scar pregnancy are managed using one of the following Primary treatments: Dilatation and curettage (DEC), systemic Methotrexate as well as locally and Uterine Artery Embolisation (UAE) and conservative surgical treatment. Excision of the gestational sac followed by repair of the caesarean scar defect using either Laparotomy or Laparoscopy, has emerged a conservative therapy, however the operation still carries a significant risk of uncontrolled hemorrhage, resulting in Hysterectomy and loss of reproductive function in some patients.

CASE HISTORY

Mrs. X a young lady of 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 Ultrasound of pelvic organ giving the differential diagnosis of Molar pregnancy, mass in the cervix and incomplete abortion. She was admitted in...
hospital for evacuation and curettage. During the procedure she develops severe pervaginal bleeding leading to Hypovolumic shock. Venesection was done So decision was taken for emergency Hysterectomy. After transfusion of 5 units of blood she underwent Total Abdominal hysterectomy. On laparotomy, small amount of blood was found in the peritoneal cavity. There was a longitudinal rupture on the lower part of body of the uterus and moderate amount of clotted blood was present in the uterine cavity. Urinary bladder was intact. Vaginal vault sutured. Postoperative period was uneventful. On 8th postoperative day patient was discharged.

**DISCUSSION**

Caesarean scar pregnancy (CSP) is a rare form of Ectopic pregnancy, and is estimated to constitute approximately 1% of ectopic gestations. The diagnosis is important as CSP is associated with life threatening complications such as uterine rupture, massive hemorrhage and the need for Hysterectomy with subsequent loss of fertility. Although the exact mechanism of CSP is not known, it is believed that a highly possible predisposing factor for CSP is a micro tubular tract between the caesarean section scar and the endometrial canal. This tract is developed from the trauma of uterine surgery. Thus conservative medical treatment, curettage and Hysteroscopy that leave the uterine defect unrepaired may potentially cause the recurrence of CSP. Therefore Transvaginal surgery for caesarean scar pregnancy appears to be effective, safe and minimally invasive surgical treatment to remove ectopic pregnancy tissue and repair the underlying defect. Ultrasonography is useful for diagnosing CSP. Because outcomes and treatment may differ, CSP must be distinguished from other types of abnormally implanted pregnancies. CSP is different from intrauterine pregnancy with placenta increta or percreta in that it is more aggressive, occurs in the first trimester and involves the complete embedding of the gestational sac in the myometrium. Valley et al reported a case confirmed 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—a 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 as 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.

**CONCLUSION**

Caesarean scar pregnancy is one of the causes of maternal morbidity. Clinical presentation of CSP may mimic other disorders and result in diagnostic delay and mismanagement. Accurate diagnosis can be made by Sonographic and Doppler flow findings. Early diagnosis and use of multiple modalities can reduce morbidity in cases of ectopic pregnancy at unusual location. Surgical treatment or combined systemic and intragestational methotrexate were both successful in the management of Caesarean scar pregnancy. Because subsequent pregnancies may be complicated by uterine rupture, the uterine scar should be evaluated before as well as during these pregnancies.

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