



A case of caesarean scar ectopic pregnancy with invasion into urinary bladder

Hume LC, Campbell DJ

St James University Hospital, Leeds Teaching Hospitals Trust, Leeds, United Kingdom

Objective

Caesarean scar ectopic pregnancies are an increasingly common major complication of pregnancy. They are associated with a high risk of morbidity and mortality. Early and accurate diagnosis is essential to guide best patient counselling, treatment and monitoring options. Our aim is to present a case of a scar ectopic pregnancy that was detected late, and subsequently managed with total abdominal hysterectomy & partial cystectomy with bladder repair.

Methods

This is a case report.

Results

A 39 year old para 2, with a previous cesarean section, presented with fresh, heavy vaginal bleeding and lower abdominal pain at weeks of gestation according to her LMP. She underwent a private ultrasound scan, and was diagnosed as having had a 'missed miscarriage'. She subsequently attended for surgical management under general anaesthesia, but this was complicated by intractable uterine bleeding, managed by transfusion of packed red cells & FFP, uterine balloon tamponade insertion and by bilateral uterine artery embolisation. Few informations about the procedure (DC) was obtained. The patient was noted to have marked haematuria post-operatively, but initial imaging suggested no evidence of any defect to the urinary bladder wall. CT imaging was suboptimal due to patient's allergy to IV contrast (which was first diagnosed at time of uterine artery embolisation). The patient subsequently underwent a cystoscopy, as her haemoglobin continued to fall. This demonstrated what appeared to be an amniotic sac containing products of conception arising from the posterior wall of of the bladder, extending into the trigone. Good distension of the urinary bladder was achieved, and no bladder perforation was visible at that time. A large pelvic mass was palpable on bimanual palpation. After further discussion with the patient, decision to proceed with total abdominal hysterectomy and partial cystectomy was made. A laparotomy was performed, the pregnancy was found to be invading the posterior wall of the bladder, with a large haematoma posterior to the mass. The bladder was mobilised to open the Space of Retzius, and both ureteric orifices were stented. A Hegar dilator was placed in the cervical canal and a Foley catheter placed into the urinary bladder to enable identification of both the cervix and the bladder. The affected area of the posterior bladder wall was excised, and a TAH and a bilateral salpingectomy were then performed, allowing the specimen to be removed 'en bloc'. Subsequent histopathology reports confirmed a completely-excised caesarean scar ectopic pregnancy with invasion into the urinary bladder. The patient's serum hCG levels returned to normal within 2 weeks of the surgery, renal function tests were normal and her wounds have now healed well. Follow-up cystogram at 2/52 post-operatively showed no leak, and the ureteric stents were removed a fortnight after this.

Conclusion

Caesarean scar ectopic pregnancies are a potentially life-threatening condition that may require urgent intervention. Though surgical options for treatment may often need to be employed, there are conservative therapies that may, when used appropriately and early-enough after accurate diagnosis, limit associated morbidities. This was a rare case of a caesarean scar ectopic pregnancy invading into the urinary bladder, which was not detected until complications arose from what was anticipated to be a routine surgical management of missed miscarriage. It highlights the importance of early pregnancy scans being carried out by skilled & experienced operators, especially with such complications becoming ever more frequent, as well as the need to counsel patients about this rare but significant complication of pregnancy when discussing mode of delivery options.