

**CERVICAL ECTOPIC PREGNANCY**

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ABSTRACT Less than 0.1% of pregnancies result in ectopic cervical pregnancy (CP), a rare disease. It is linked to possibly elevated rates of morbidity and mortality. The difficulties in diagnosis and treatment are addressed in this case report on cervical pregnancy, along with the course of follow-up and ultimate result. After presenting with vaginal bleeding, a 30-year-old lady was diagnosed with an impending miscarriage and treated conservatively rather than surgically. Cervical ectopic pregnancy was diagnosed during the clinical examination, confirmed by ultrasound on the second day of hospitalization, and successfully treated surgically. The follow-up went smoothly and had good outcomes.

KEY WORDS: Cervical ectopic pregnancy, Interventional radiology, Hysterectomy, Fertility

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INTRODUCTION

Cervical pregnancy is a rare kind of ectopic pregnancy, however it has a high morbidity rate and may be fatal. A fertilized ovum implanted in the cervical canal is what is meant to be understood by this term (less than 1% of ectopic pregnancies have this condition). The diagnosis of cervical ectopic pregnancy may be made using the ultrasonography criteria listed below¹.

1. A cervix that is barrel-shaped and an empty uterus. ². The gestational sac is situated beneath the internal cervical os. ³. The absence of the "slide sign" and color Doppler blood flow measurements surrounding the gestational sac.

CASE PRESENTATION

At seven weeks of gestation, a 30-year-old lady was taken to the hospital due to a threatened miscarriage. Patient was at low risk of ectopic pregnancy, hence no ultrasound was performed to localize the pregnancy sooner. She experienced little vaginal bleeding, lower abdomen pain, and no tissue pass. First-line analgesics were used to control the pain, which did not radiate. The woman's menstrual cycle was regular, occurring every 30 days, and her blood loss was typical, lasting 4-5 days, prior to this most recent pregnancy. She had two prior vaginal deliveries that went well, and her last

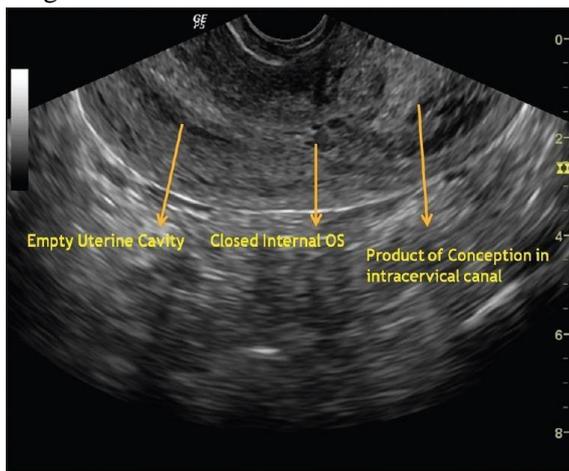
SVD occurred 12 years prior. Prior to consultation, she had no history of miscarriage, dilatation and curettage, infertility, or use of any form of contraception. No prior history of STDs or PID, nor any history of pelvic or abdominal surgery. Her cervical smears have been normal ever since she underwent LETTZ surgery for cervical CIN3 ten years ago. A vaginal speculum examination revealed a soft, thick cervix with a sac-like green-blue vascular region at the 10 of the clock position on the anterior cervical lip, along with some light hemorrhage. The external OS was rarely visible since the sac was spreading medially and obscuring the area, but the anterior vaginal fornix and the rest of the cervix appeared normal. A transvaginal ultrasound examination revealed an empty uterus and a sizable echogenic region in the cervical canal, which was initially believed to be a cervical pregnancy or the products of conception that were unable to move through the canal because of stenosis. BHCG stood at 41507..

The woman complained of increased pain the following day in her lower abdomen and vagina, requiring strong analgesic medication that was not working for her. Along with this pain, she also passed a flood of blood, but nothing useful.

The results of multiple speculum and ultrasounds were the same. The choice was made to explore and go to the theater. High-risk consent obtained following patient discussion of hysterectomy options. Bilateral internal iliac balloons are placed prior to the procedure and intervention radiology is involved in the management plan. This allows the balloons to be inflated to reduce bleeding in the event of excessive bleeding. The cervix was examined while under general anesthesia, and it was easily dilated up to 10 mm. The results of conception were suctioned out of the cervical canal. A total of 150 milliliters of blood were lost, and a sizable vascular region at 10 of the clock in size shrank from 4 to 2 cm. Mild cervical hemorrhage was also observed. A 30 cc fluid-filled Foleys catheter is placed in the cervix to facilitate tamponade. It was there for a full day. After 24 hours, the patient was in acceptable condition, had no complaints, and had a post-operative HCG of 12193. Patient sent home with instructions to check HCG every week until it reaches the non-pregnancy range². Products sent for histopathology.

OUTCOME

The patient was in good clinical standing when she was last examined in the early pregnancy clinic three weeks following surgery, when her blood levels of HCG were in the non-pregnant range at 2.



DISCUSSION

Although cervical pregnancy is extremely rare, there are still more cases being reported due to risk factors such as the high rate of cesarean sections (especially second stage sections) and the rising use of assisted reproductive techniques

for infertility⁴ (since there are a lot more private IVF centers in the area where this case was reported than there used to be). Early ultrasound diagnosis is crucial for the efficacy of conservative treatment as it can minimize the risk of serious hemorrhage that could require a hysterectomy or blood transfusion, as well as a longer hospital stay³. In addition, I would like to emphasize the value of early pregnancy units being added to the majority of health care facilities and the necessity of raising public knowledge of the risks associated with early pregnancy (with the aid of patient information booklets and referrals to other educational resources). I would also like to bring out the fact that, in this specific instance, a speculum examination revealed that the gestational sac was positioned in the cervical canal. If a junior physician attempted to remove the sac, there could have been severe consequences and significant bleeding. Therefore, once the cervix is noticeably hyperaemic and there are some POCs in the cervical canal, I advise getting a second opinion. Even though the PID and STD rates were not particularly high in KSA where I worked, I saw that ectopic pregnancy instances were frequent. In my opinion, this should be investigated in order to enhance healthcare⁴. EPAC ultrasound-trained sonographers and physicians should be promoted alongside dedicated early pregnancy clinics. Unless otherwise demonstrated, PUL patients should be monitored by an EPAC, and on weekends, the on-call gynecology team should be tasked with overseeing their follow-up care, which includes blood testing (for progesterone and serum beta-HCG levels) and emergency ultrasonography services.

Low barrier for reviewing patients who have ectopic pregnancy risk factors and for seeing them in-depth 24 hours after their initial visit with the medical team (if they are stable clinically). Pregnant women should have access to a 24/7 help line where they can speak with knowledgeable medical professionals about their concerns and request assistance⁵.

Case study is from Maternity and Children hospital Dammam KSA. Informed consent has

been obtained from the patient to publish the case.

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