Cervical Pregnancy

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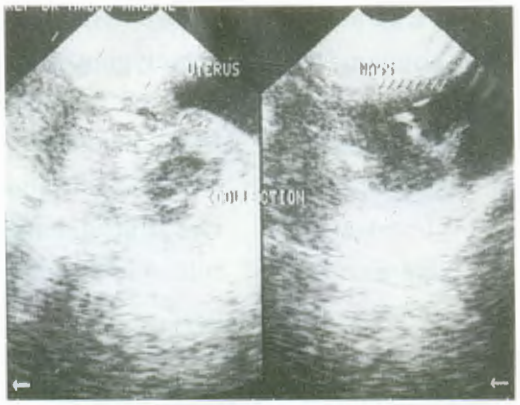
This is a rare variant of ectopic pregnancy with incidence of 1:16000. The cervix is a dangerous site for placental implantation because trophoblast can invade through the cervical substance into the uterine blood supply. Cervical gestation is frequently confused with neoplastic process and profuse bleeding may occur if an attempt for biopsy from the suspected tumor is undertaken.



Patient, R 35 yr. F, G2P1 with previous Caesarean section was admitted with h/o 4 months and 6 days amenorrhoea and bleeding p/v which was sudden and profuse after expelling the fetus at home. However, there was no h/o expulsion of placenta. She gave h/o intermittent bleeding p/v without lower abdominal cramps all through pregnancy. Her Hb at admission was 4.5gm and B.P. 90 mm of Hg. P/A exam. revealed a suprapubic mass of 20 wks size of a gravid uterus. On p/v exam, external os admitted one finger. Cervix was ballooned out to a size of fetal head, all full with probably placenta. However, the ultrasound did not comment upon the cervical pregnancy with residual placenta. (see photograph)

Evacuation, under anaesthesia, was attempted with prior preparation for laparotomy, although the consent for hysterectomy was not granted. No sooner did dilator No. 7 was inserted in the cervix, than the profuse bleeding started and immediate laparotomy was performed. Uterus was badly adherent to the anterior abdominal wall and urinary bladder, due to the previous Caesarean section. The uterus was of normal shape and size with shallow uterovesical pouch and intact scarline. A low vertical incision was given in the anterior uterine wall but the uterine cavity was empty. Placental tissue was taken out from the cervical canal completely but the bleeding persisted despite removal of adherent products, oxytocics and compression of cervix with fist in the pouch of Douglas. Patient went into hypotension secondary to heavy blood loss. Patient's condition did not permit total abdominal hysterectomy because of dense adhesions at and below the level of isthmus. So tight cervical packing was done and tail end was taken out from the cervix in the vagina. This controlled bleeding effectively p/v and post operative care stabilised the patient within the first 24 hrs. The packing was removed after 48 hrs. No alarming hemorrhage occurred in the 1st postoperative week and patient was discharged 2 wk. later with sub-involuted cervix. The patient was followed up for next 6wks for complete involution of uterus and cervix to normal size. Except for prolonged lochial flow and delayed involution patient had uneventful puerperium.

Total abdominal hysterectomy following torrential haemorrhage from transcervical intervention is absolutely indicated but at times technical inability to do so in case with previous surgery, limits its role. So technique of internal iliac vessel ligation should be known to gynaecologist. This case has been reported due to its rare clinical presentation and altered line of management due to technical difficulties and social restraints on females with incomplete family.