

Cervical Ectopic Pregnancy presenting as Cervical Fibroid

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ABSTRACT

Cervical pregnancy is a rare but serious type of ectopic pregnancy in which the implantation site is within the cervical mucosa that lines the endocervical canal. This is a rare cervical ectopic pregnancy wrongly diagnosed as a cervical fibroid by clinicoradiological examination. The actual diagnosis was revealed by histopathological examination.

KEY WORDS: Cervical ectopic, cervical fibroid, histopathology, hysterectomy

INTRODUCTION

Cervical pregnancy is a rare but serious type of ectopic pregnancy in which the implantation site is within the cervical mucosa that lines the endocervical canal, with reported incidences ranging from 1:1,000 to 1:95,000 which represents nearly 0.15% of all ectopic pregnancies.^[1] Due to rarity of this condition retrospective analysis of the cases cannot be done to find out the risk factors. Usually it presents with uncontrolled hemorrhage per vaginum during the first trimester of pregnancy.^[2] Clinically it is often mistaken for inevitable or missed abortion.^[3] Improved sonographic techniques have allowed for earlier diagnosis and successful attempts at conservative treatment.^[4,5]

The presentation was similar in our case too, but it was unique in the sense that it was managed with the provisional diagnosis of a degenerated cervical fibroid, clinical and radiological picture being altered by prior dilatation and curettage (D and C).

CASE REPORT

A 28-year-old female with parity three (previous normal vaginal deliveries) last child birth 3 years back presented in casualty with excessive vaginal bleeding. She had

history of heavy flow during her menstrual period 1 month back (without any history of overdue) with passage of clots 1 month back for which hemostatic D and C was done at a private nursing home without any attempt to rule out pregnancy. Previous cycles were normal in flow amount and duration. There was history of massive hemorrhage during the procedure which according to her was controlled by vaginal packing. The pack was removed 24 h later and she was discharged. At home, she continued on and off vaginal bleeding for next 1 month which compelled her to present at our institution. The patient had no abdominal pain. The patient was pale and diaphoretic but alert and cooperative on presentation. She had cold clammy extremities with pulse rate of 118 per min, respiratory rate of 28 per min, and blood pressure of 90/60 mmHg. Rest systemic examination was normal. On speculum examination, vagina was full of clots. On removing clots, the cervix was firm and barrel-shaped with active bleeding through os. External os admitted one finger, cervical canal was smooth, internal os was closed, and uterus was bulky. Bilateral adnexa were normal. Her urine pregnancy test was negative. Serum beta-Human Chorionic Gonadotrophin (b-HCG) was less than 5 mIU/L. Her ultrasonography (USG) showed an enlarged cervix of 3 × 4 cm with hypoechoic shadow with suggestive of a cervical fibromyoma. Her initial hemoglobin was 4.7 g%. Provisional diagnosis of a degenerated cervical fibromyoma was made.

The patient received initial volume resuscitation and promptly taken to the operation theater (OT), a Foley's

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catheter was inserted in the cervical canal, and the bulb inflated for temporary tamponade in attempt to stop the ongoing vaginal hemorrhage; but the patient continued to have significant vaginal hemorrhage with hypotension and subsequently taken for emergency hysterectomy. Peroperatively, uterus was found to be bulky with ballooned up cervix. Bilateral adnexa were normal.

The patient received 6 units of whole blood during the intra- and postoperative period. Her postoperative period was uneventful; patient did well and was discharged on 16th postoperative day in satisfactory condition.

Gross examination of hysterectomy specimen showed 3 × 4 cm of degenerated, necrotic area within the cervix on cut-section [Figure 1]. Histological examination showed degenerated chorionic villi, necrosis, inflammatory cells, and clumps of bacteria within the cervix indicating a cervical ectopic pregnancy [Figures 2 and 3]. Endometrium did not show evidence of chorionic villi.

DISCUSSION

Cervical pregnancy is a rare form of ectopic pregnancy, which usually presents with excessive first trimester vaginal bleeding. Clinical diagnosis though difficult, yet a softened and disproportionately enlarged cervix in appropriate clinical setting should arouse suspicion.

Although thorough search of literature did not show any such case where diagnosis of cervical ectopic was difficult. In our case this was owing to the D and C which changed the clinical and radiological findings. There has been a report where a difficult case of first trimester bleeding was managed by hysterectomy, and the diagnosis was clarified by pathological examination.^[6] There has been case report of cervical ectopic presenting with profuse vaginal hemorrhage managed conservatively^[3] and by hysterectomy in nonresponding cases.^[7]

In our patient, the history lacked any preceding amenorrhea, moreover the urine pregnancy test and serum b-hCG was negative. Apart from profuse vaginal hemorrhage during D and C and a barrel-shaped cervix there was no other sign or symptom to suggest possibility of cervical ectopic pregnancy. The cervix was firm in consistency; moreover the urine pregnancy test was negative due to the D and C which disrupted the pregnancy 1 month back. USG is the most important diagnostic tool in cervical pregnancy. But in our case USG picture could not demonstrate a gestational sac in cervix but a cervical fibroid. Again this was due to D and C which altered the findings. The surgeon performing her D and C missed the diagnosis by missing pregnancy test and

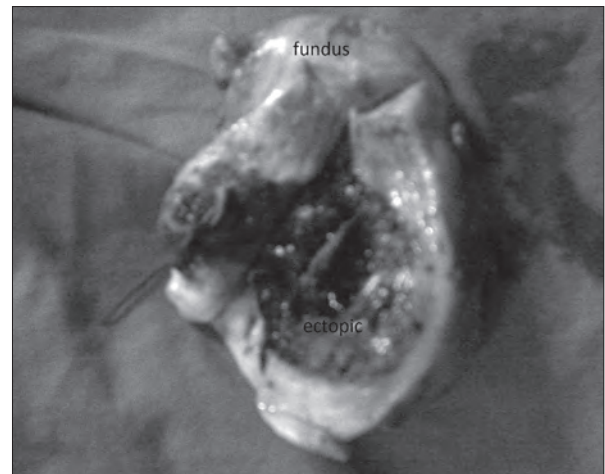


Figure 1: Specimen of uterus with barrel-shaped cervix opened anteriorly with cervical mass having histological evidence of ectopic pregnancy

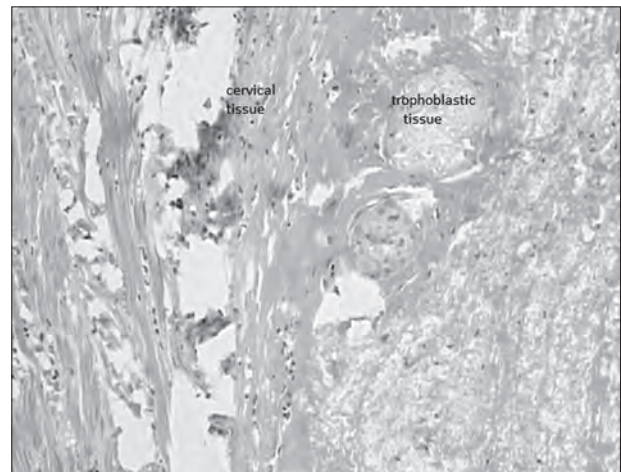


Figure 2: 10× magnified view of section from mass in cervix showing evidence of trophoblastic tissue hence cervical ectopic pregnancy

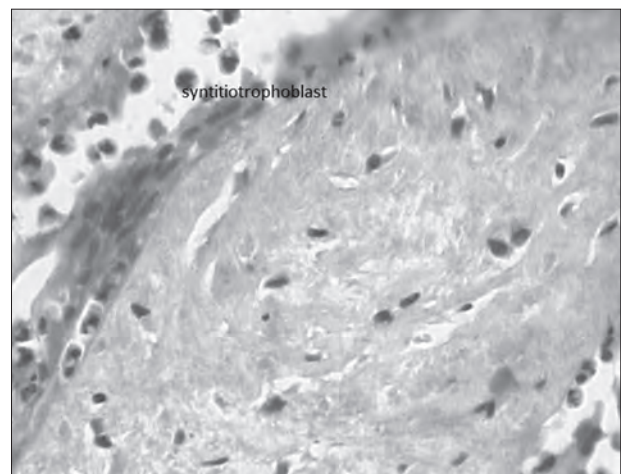


Figure 3: 40× magnified view showing syntitiotrophoblast from section obtained from cervical mass

USG. Final diagnosis was only made after histopathology report. A correct clinical approach when the patient was

primarily seen would have helped in clinching the diagnosis and hence a proper management.

The modality of management depends on the clinical presentation. Conservative treatment like methotrexate administration or local excision and curettage can be given to hemodynamically stable patients. Surgical techniques are generally applied only when chemotherapy fails or in emergency conditions of life-threatening acute hemorrhage.

CONCLUSION

The authors suggest that in patients with heavy vaginal bleeding without preceding amenorrhea along with clinical examination, a simple urine pregnancy test can help; and prior to taking such patient for D and C a simple USG can demonstrate the ongoing pregnancy and help to make a correct diagnosis and thus proper management. The newer medical and surgical procedures allow preservation of fertility.

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