



Expectant Management in Cesarean Scar Pregnancy

Natasha Gupta*

Department of Obstetrics and Gynecology, Ross University School of Medicine, USA

*Corresponding author: *Natasha Gupta, Assistant Professor, Department of Obstetrics and Gynecology, Ross University School of Medicine, IL, USA, Tel: (248) 464-0451, E-mail: docnatasha3@gmail.com*

The incidence of pregnancy implantation at unusual sites like cesarean scar, cervix or ovaries is on rise due to the increase in incidence of cesarean sections, dilatation and curettages and pelvic inflammatory diseases. Diagnosis of these rare types of ectopic pregnancies is extremely challenging. Cesarean scar ectopic pregnancy as well as cervical pregnancy can be easily confused with each other or with an inevitable abortion.

Diagnosis of cesarean scar pregnancy requires a high degree of suspicion, especially in a patient with prior cesarean-section and a gestational sac identified near the lower uterine segment. Cesarean scar pregnancy when suspected on transvaginal scan should be further evaluated with MRI to confirm the diagnosis. The characteristic sonographic features suggestive of cesarean scar ectopic pregnancy include: absence of a gestational sac in the upper portion of the uterine cavity, a closed and empty cervical canal, presence of a sac in the anterior part of the lower uterine segment, and thinning or absence of myometrium between the bladder wall and the gestational sac. Patients presenting with features of spontaneous abortion in early pregnancy, may be misdiagnosed as incomplete abortion enroute to expulsion and undergo curettage leading to life-threatening hemorrhage, requiring hysterectomy.

Various medical and surgical options for treatment include Intra-gestational Methotrexate (MTX) injection [1], Intramuscular Methotrexate injection, Uterine Artery Embolization (UAE) and curettage. However, no single treatment approach has been found ideal and usually a combination of two different modalities is required to completely resolve this condition [2]. Laparoscopic or hysteroscopic resection of the pregnancy after a UAE or Intra-gestational MTX injection has also been suggested [3]. Increasing incidence of this condition necessitates the heightened suspicion, when confronted with suggestive sonography findings in a patient with previous uterine surgery. Curettage alone should be undertaken with extreme caution as it may lead to hemorrhage and loss of fertility.

Akladios et al. published a very rare case of cesarean scar ectopic pregnancy in volume 1, issue 2 of *Obstetrics and Gynecology Cases- Reviews* [4]. They reported an extraordinary outcome with a successful, full term birth in a patient with prior two cesarean sections and an undiagnosed cesarean scar pregnancy, albeit requiring a subtotal hysterectomy. This report conceives the option of conservative management as a possible management strategy in selected patients. However, as the Akladios and co-authors rightly emphasize in their

article, such management should be very cautiously undertaken [4]. Patients compliant to rigorous antepartum follow-ups and good understanding of the perils associated with this condition may be selected for expectant management. Also, patients completing their childbearing should be preferred for such an alternative, as the risk of hysterectomy remains high.

With the rampant increase in such ectopic pregnancies, it is vital for the modern obstetricians to be aware of the various treatment modalities at their disposal. Furthermore, the current practice of early termination of pregnancy in cesarean scar pregnancies needs to be reevaluated, based on patient's desire for future fertility, comorbidities and willingness to continue the current pregnancy.

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