CASE REPORT

A Cervical Ectopic Masquerading as a Molar Pregnancy

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Summary

We report a case of cervical pregnancy complicated by life threatening hemorrhage. An initial diagnosis of molar pregnancy was made preoperatively. During uterine evacuation she developed profuse hemorrhage which required an emergency hysterectomy for uncontrolled bleeding. Histopathological examination confirmed a cervical pregnancy. The clinical and pathological criteria for the diagnosis and the etiology of cervical pregnancy are discussed.

Key Words: Ectopic pregnancy, Cervical pregnancy, Diagnosis

Introduction

Cervical pregnancy is the rarest type of ectopic pregnancy, comprising less than 1% of all cases[1]. Preoperative diagnosis is often difficult. A diagnosis is usually made when hemorrhage occurs during the attempted removal of the products of conception. Majority of cases undergo emergency hysterectomy for massive bleeding.

Case Report

A 35-year old Chinese lady, gravida 5 para 2 was admitted to the hospital with profuse per vaginal bleeding. She had 2 previous life births. Both were delivered by cesarean section. The other 2 pregnancies ended with incomplete abortions requiring evacuation.

Four weeks prior to admission, she presented at a private clinic with a history of per vaginal bleeding of 8 days duration. She was unsure of her dates. She had an evacuation done for a diagnosis of incomplete abortion. This however was not confirmed by any histopathological examination.

On examination, the patient was stable. Her general physical examination was within normal limits. Abdominal palpation revealed an eighteen-week size uterus and vaginal examination showed blood clots. The cervical os was partially open.

The ultrasound showed an enlarged uterus with a honeycomb appearance. A diagnosis of molar pregnancy with a differential diagnosis of a degenerated uterine fibroid was made. She was prepared for evacuation of the uterus under general anaesthesia.

During evacuation, she developed profuse hemorrhage after the os was dilated. She became hypotensive and an emergency total abdominal hysterectomy was performed for uncontrolled bleeding. Intraoperatively, a large mass resembling a fibroid was seen at the lower segment.

The estimated blood loss was 5 liters. She was transfused with whole blood, fresh frozen plasma, cryoprecipitate and crystalloids. Measurements of human Chorionic Gonadotrophin progressively declined from 2,342mIU/ml preoperatively, to 35mIU/ml 5 days later. She was discharged on the 10th postoperative day.

Pathological findings

The specimen received was a total hysterectomy specimen comprising of the corpus uteri, the cervix and the right fallopian tube, measuring 14 x 9 x 6cm. in dimension. The cervix was deformed and dilated, measuring 9cm. in diameter. The endocervical canal was obliterated with a hemorrhagic fragile mass eroding part of the cervical wall. The uterine cavity appeared normal.

Microscopic examination showed presence of necrotic and hemorrhagic chorionic villi, decidual tissue and endocervical glands (Figure 1). The endometrium showed decidual alteration. No placental tissue or molar tissue were present in the uterine cavity. The myometrium showed adenomyosis. A histopathological diagnosis of cervical ectopic pregnancy was made.

Fig. 1: Hemorrhagic placental tissue with chorionic villi (C) adjacent to endocervical glands (E). (H&E x 100)

Discussion

Cervical pregnancy is a rare obstetric phenomenon, potentially dangerous to the pregnant woman. The incidence varies from 1 in 17,000[2] to 1 in 95,000[3] pregnancies. Seventy percent of cervical pregnancies underwent hysterectomy[2]. Pregnancies of more than ten weeks' gestation tend to bleed profusely and hysterectomy is almost inevitable. Because of this important risk, diagnosis at an early stage is pertinent for possible conservative therapy[2].

Diagnosis is based on a wide range of clinical, ultrasound and pathological criteria. The most widely accepted clinical criteria are those of Paalman and McElin[3] which stated that there must be profuse but painless vaginal bleeding in a woman with amenorrhoea, a softened and disproportionately enlarged cervix equal to or longer than the corporeal portion of the uterus, the presence of conception in the cervix, a closed internal os and a partially opened external os.

Transvaginal ultrasound is the method of choice for establishing diagnosis early in the first trimester[2]. With advances in high resolution ultrasonography, early diagnosis allows conservative management and prevention of potentially lethal hemorrhage with maintenance of fertility. Ultrasound diagnosis is however difficult after twenty weeks gestation when the corpus can be mistaken to be a mass or is not demonstrable.

Histopathological criteria[1] for diagnosis requires the presence of chorionic villi within endocervical stroma. The attachment of placenta to the cervix must be intimate with the whole portion of placenta situated below the peritoneal reflection of the anterior and posterior surface of the uterus. Fetal elements must not be present in the corpus uteri. The histopathological examination of the uterus in this case was consistent with a cervical pregnancy with an adherent placenta.

This patient had multiple risk factors for cervical pregnancy. She had two uterine evacuations for incomplete abortion, two previous cesarean sections as

well as adenomyosis. Other factors which have been proposed to play a role in the etiology of cervical pregnancy include structural anomalies of uterine corpus and cervix, leiomyoma, intrauterine contraceptive device, chronic endometritis, high parity and in vitro fertilization pregnancies[2,1].

This patient was unsure of her dates. Clinical examination together with ultrasonography failed to make the correct preoperative diagnosis. Although rare, cervical pregnancy should be considered in a patient with such multiple risk factors presenting with abnormal bleeding.

References

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