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Caesarean scar pregnancy – the dilemma in management

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ABSTRACT

Introduction: Caesarean scar pregnancy has an incidence of 1 in 1,800-2,500 pregnancies. Its increasing rate is a reflection of the rising cases of caesarean delivery and better ultrasound diagnosis. However, there is no one size fits all in management or follow-up. Various management protocols have been reported with varied outcomes. **Case Description:** Hospital Sultan Abdul Halim recorded 5 cases of caesarean scar pregnancy from November 2022 till date, with different treatment approaches and outcomes for each pregnancy. Four cases were detected during the first trimester and one during the second trimester. The latter was then managed conservatively till the third trimester as the patient insist on keeping her pregnancy. In the other four cases, either intracardiac potassium chloride (KCL) or intravenous Methotrexate was given, except for one case, whereby the initial diagnosis warranted a surgical biopsy which confirmed a caesarean scar pregnancy. The patients were then followed-up with serial serum beta human chorionic gonadotrophin (BHCG) level and the remaining 3 patients were subjected to surgical intervention subsequently. Postoperatively, BHCG monitoring was continued. The diagnosis of these patients was confirmed through histopathological examination. **Discussion:** Caesarean scar pregnancy carries a high risk of morbidity and mortality. Thus, a definite diagnosis should be established early for the best outcome in the management of the patient. Diagnosis and management of caesarean scar pregnancy needs skilled expertise and a multimodality approach to reduce complications. The difference in approach of medical and surgical or combination management must be considered, taking into view the age, parity, and fertility concerns to achieve the best outcome for the patients.

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"Scar pregnancy – big dilemma" Hospital Sultan Abdul Halim experience

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ABSTRACT

Introduction: The incidence of caesarean scar pregnancy is rising due to the increasing rate of caesarean deliveries and better ultrasound diagnosis. However, there are various management protocols with variable outcomes reported. The treatment approach will depend on age, parity, and fertility concern to achieve the best outcomes for the patients. **Case Description:** A 31-year-old, G5P2+2 at 9 weeks with a history of caesarean section for fetal growth restriction and maternal obesity. She was asymptomatic and referred for confirmation of pregnancy and viability. Scan findings revealed a gestational sac implanted close to the scar with thinning of the myometrium and the presence of placenta lacuna with increased Doppler uptake. There was a viable Viable singleton fetus corresponding to 8 weeks gestation. She was diagnosed to have a scar pregnancy requiring termination of pregnancy with intracardiac potassium chloride (KCL). She received a one week course of intravenous Methotrexate (MTX). Serial beta-human chorionic gonadotropin (B-HCG) monitoring showed significant reduction initially, however plateauing after week 4. She underwent uterine evacuation under laparoscopic guidance. Bilateral ascending and descending uterine arteries were ligated prior to uterine evacuation. She required blood transfusion intra-operatively. She was discharged well on day 2 post-procedure. **Discussion:** Caesarean scar pregnancy carries a high risk of morbidity and mortality. Thus, a definite diagnosis should be established early and managed at a tertiary centre for the best patient outcome. Upholding a patient's wish for uterine preservation is challenging for the surgeon who is dealing with complicated surgery.