CASE REPORT

Medical Management of Cervical Ectopic Pregnancy

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ABSTRACT
A 27-year-old woman, primigravida, presented with a history of 8 weeks of amenorrhea and painless vaginal bleeding. Pelvic examination revealed ballooned-up cervix smeared with blood. The urine pregnancy test was positive. Ultrasonography showed a gestational sac of approximately 0.6 cm implanted in the anterior wall of cervix but the uterus was empty. The patient was diagnosed as a case of cervical ectopic pregnancy based on clinical and sonographic findings. As this was her first pregnancy, it was decided to follow a conservative approach. She was treated with methotrexate (MTX) six doses on alternate days with folinic acid, administered intramuscularly. The patient made a remarkable recovery. She stopped bleeding after 1 week of MTX therapy, the gestational sac was not seen after 30 days, and the beta human chorionic gonadotropin (hCG) level decreased continuously and was undetectable after 55 days of MTX therapy.

Keywords: Cervical pregnancy, Ectopic pregnancy, Methotrexate.

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INTRODUCTION
Following fertilization and fallopian tube transit, the embryo normally implants in the endometrial lining of the uterine cavity. The implantation of embryo other than uterine cavity is considered ectopic pregnancy. Ectopic pregnancies comprise of 2% of all first-trimester pregnancies, but accounts for 6% of all pregnancy-related deaths. Among the ectopic pregnancies, cervical pregnancy is a rare entity and the one which is difficult to diagnose and treat. The incidence of cervical pregnancy varies from 1 in 2,400 to 1 in 50,000 pregnancies. The diagnosis of cervical pregnancy is often confused with incomplete abortion.1 The patients generally report with severe degree of painless vaginal bleeding. Hysterectomy is often required as life-saving measure. However, over the last decade, medical management with systemic MTX has been used for cervical pregnancy with considerable success.

CASE REPORT
A 27-year-old patient presented with the complaint of bleeding per vagina for past 15 days. On examination, pulse of 90/min, blood pressure of 110/70 mm Hg, no pallor, or pedal edema were observed. On per vaginal examination, a healthy vagina with cervix ballooned up and smeared with blood was observed, and uterus was of 8 weeks’ size. Initial investigations revealed hemoglobin (Hb) of 8.7 gm%, total leukocyte count (TLC) of 8,200/mm3, platelet count of 3.2 lac/mm3, and beta hCG value of 2,282 mIU/mL. Following day, the patient reported with heavier bleeding. Ultrasonography was advised. Transvaginal sonography findings suggested a gestational sac of 0.6 cm diameter attached to anterior wall of cervix, fetal pole was seen with no cardiac activity. Uterus was normal in size and shape with decidual reaction of 8.8 mm. Both ovaries were normal. Correlating all the findings, the diagnosis of cervical pregnancy was made. The patient wanted to conserve fertility, therefore medical management was preferred. It was decided to put the patient on MTX and folinic acid regimen.

The following treatment schedule was followed: injection MTX [64 mg intramuscular (IM), 1 mg/kg body weight], 6 doses were given every alternate day, alternating with injection leucovorin (folinic acid) (7 mg IM, 6 doses). Keeping in mind that cervical pregnancy may give rise to sudden catastrophic hemorrhage, the patient was kept in hospital for 15 days for observation. However, during the chemotherapy, bleeding decreased considerably. Pelvic examination done on 30th day of chemotherapy showed normal cervix, uterus, and adnexa. Also, there was no evidence of gestational sac on ultrasound scan. The other lab investigations done on same day revealed Hb at 10.7 gm/dL, TLC of 5.24/mm3, platelet count of 2.2 lac/mm3. She was followed up with serum beta hCG values. The beta hCG values after initiation of chemotherapy were 858.5 mIU/mL on 15th day, 550 mIU/mL on 22nd day, 200 mIU/mL on 30th day, and negative after 55 days.

With normal clinical and ultrasound findings and negative serum beta hCG levels, the patient was considered cured after 55 days of initiation of chemotherapy. She was advised contraception for 6 months in the form of oral contraceptives in view of use of MTX.

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DISCUSSION

The cervical pregnancies constitute less than 1% of all ectopic pregnancies. Unlike intrauterine pregnancy, the evacuation of the pregnancy by curettage does not always stop the bleeding because there is little contractile muscle in the cervix. There are two main treatment options for cervical pregnancy: Surgical and medical. The surgical interventions include cervical cerclage, intracervical balloon tamponade of the cervix, vaginal packing, local hemostatic sutures, curettage, ligation of the descending branches of the uterine arteries, and bilateral hypogastric artery ligation.²,³ Often uncontrolled bleeding necessitates emergency hysterectomy.⁴ Among the medical treatment options, the most common is systemic or local administration of MTX.⁵,⁶ The presence of fetal cardiac activity or advanced gestational age is associated with higher rates of treatment failure.⁶ During MTX administration, an increase in bleeding pattern or the reappearance of vaginal bleeding may require additional intervention. Any profuse bleeding during therapeutic measures with consequent hemodynamic instability also necessitates emergency surgical intervention.

In our case, in an attempt to preserve fertility, we chose a conservative approach. Six doses of MTX alternating with folinic acid were given to the patient. Bleeding per vagina stopped after 1 week of initiation of treatment. Ultrasound was negative for cervical pregnancy after 30 days. The serum beta hCG became negative after 55 days of treatment. Although the resolution of ectopic pregnancy in our case was slow, it helped in conserving the uterus.

CONCLUSION

The use of MTX for cervical pregnancy is safe and effective in selected patients. It is simple to administer and it also preserves fertility.

REFERENCES