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The Failure of Uterine Artery Embolization with Methotrexate Infusion Combined Curettage as Treatment for Cesarean Scar Pregnancy

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Abstracts

The rates of caesarean scar pregnancy have increased. An increasing incidence has been considered most likely related to much higher rates of caesarean section. It is a rare and potentially life-threatening complication of pregnancy because of misdiagnosis. Therefore, it is important to train gynecologists and sonographers in timely diagnosis of CSP and management. Here we present one cases of CSP that were treated in our department by uterine artery embolization with methotrexate infusion combined curettage. She was treated successfully by laparotomy because of profuse bleeding 21 days after UAE.

Introduction

Embryo implantation in a previous caesarean scar (CS) resulting in a caesarean scar pregnancy. CSP is rare but potentially catastrophic complication of a previous caesarean section. The first case of a CS ectopic pregnancy was reported in 1978 [1]. It has become an important and serious problem over the last 10 years, as a result of the worldwide increase in caesarean deliveries. Cesarean scar pregnancy is different from tubal, cervical, and other forms of ectopic pregnancy. Diagnosis is generally difficult, and a false-negative diagnosis may lead to major complications, including hysterectomy. The majority of CSPs are case reports or small case series reported in the literature, because of the rarity of the condition. There is no consensus on the preferred mode of treatment [2,3].

Case

The patient was a 39-year-old uniparous woman in her third pregnancy who was admitted to our department. She had an eventful past history of one LSCS, and one artificial termination of pregnancy. With a complaint of genital bleeding that had started two day earlier and amenorrhea for two months. Its suspicion of ectopic pregnancy in the cesarean scar from ultrasonography performed at another clinic center two weeks early. There was no treatment. In the examination at the time of admission, she was found to be hemodynamically stable and use of a speculum showed minimal bleeding. The B-HCG assays were 31620 mIU/mL. Transvaginal ultrasonography was performed, which showed a gestational sac of dimensions 1.5*0.9cm in the region of the uterine scar, without an embryo. It was decided to use systemic MTX treatment combined with mifepristone. The B -HCG assays after MTX doses were 29361mIU/mL. Because of the patient's declared desire to preserve her reproductive capacity, our team decided to perform local injection of MTX under ultrasound guidance. Because of the rich vascularity of the gestation sac. It could cause scar rupture and extensive hemorrhaging, even hysterectomy. So that we decided

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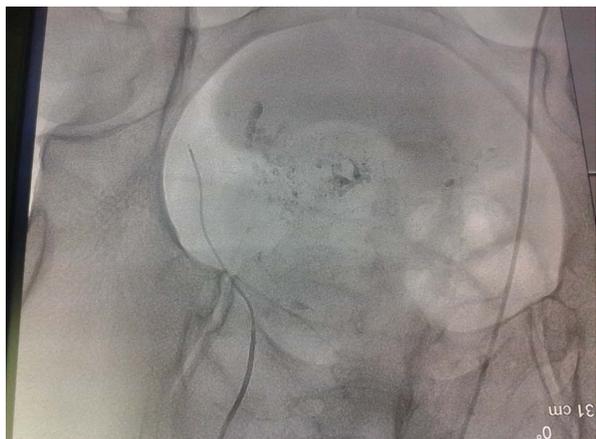


Figure 3: Bilateral uterine angiography before and after uterine artery embolization

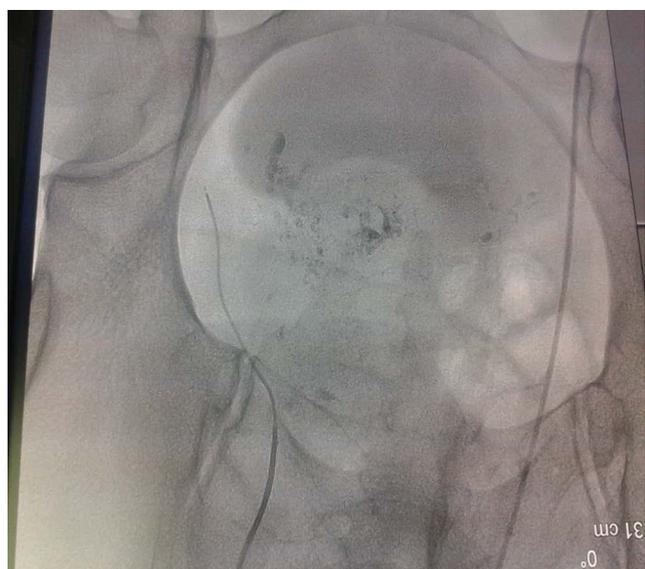


Figure 3A: Uterine arteries were enlarged by means of hypervascular infusion of methotrexate before uterine artery embolization.



Figure 3B: Unilateral occlusion was successfully performed

small case series. More research is required in this subject (Figure 3, 3A, 3B and 3C). So that setting up multicenter collaboration would encourage robust evidence-based studies essential for making recommendations for practice (Figure 4).

Conflict of Interests

No potential conflict of interests was disclosed regarding the publication of this paper by all the authors.

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Figure 3C: Bilateral arterial occlusion was confirmed after the uterine artery embolization and no extravasation was observed.

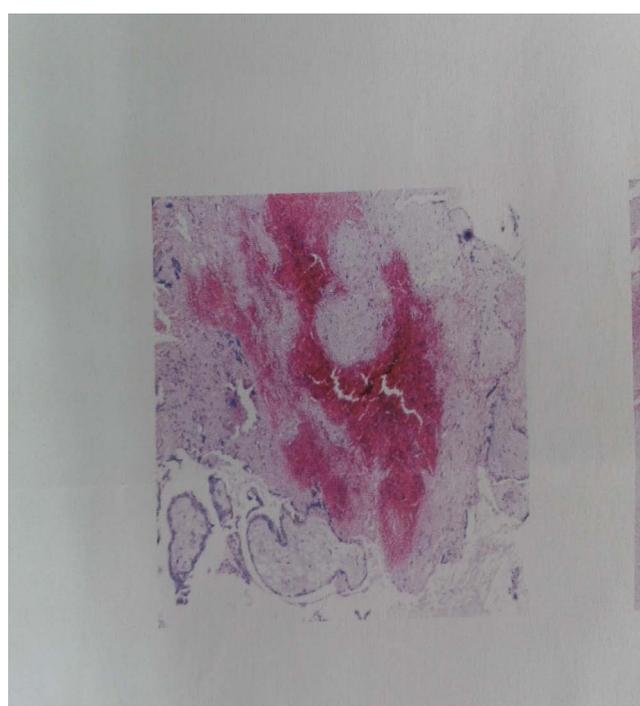


Figure 4: pathology of curettage.

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