CORNUAL RUPTURED PREGNANCY WITH PLACENTA INCRETA – A RARE CASE

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ABSTRACT

Cornual pregnancy is a very rare form of ectopic pregnancy that usually leads to uterine rupture with resultant life threatening hemorrhage and increased mortality. Cornual pregnancies often rupture later than other tubal pregnancies because the myometrium is more distensible than the fallopian tube. We report a case where a patient presented at 24 weeks of gestational age with ruptured cornual ectopic pregnancy and haemoperitoneum and placenta percreta. Emergency Laparotomy was done and subtotal hysterectomy was done as the placenta was deeply adherent.

Key words: Cornual pregnancy, placenta percreta

INTRODUCTION

Cornual gestation is one of the most hazardous types of ectopic gestation. The diagnosis and treatment are challenging and frequently constitute a medical emergency. Cornual pregnancy accounts for 2–4% of ectopic pregnancies and is said to have a mortality rate in the range of 2.0–2.5% .Cornual pregnancies pose a significant diagnostic and therapeutic challenge and carry a greater maternal mortality risk than ampullary ectopic pregnancy. Because of myometrial distensibility, they tend to present relatively late, at 7–12 weeks of gestation. Significant maternal haemorrhage leading to hypovolaemia and shock can rapidly result from cornual rupture.

Clinically, risk factors are as for other types of ectopic pregnancy: contralateral salpingectomy, previous ectopic pregnancy and in vitro fertilization. The eccentric position of the gestational sac and thinning of the myometrial mantle means that differentiation between eccentric intrauterine and cornual pregnancy is often difficult.
CASE REPORT

The patient was a 30 yr, unbooked, second gravid with a living child. She presented with amenorrhoea of 24+6 wks came with complaints of pain abdomen, per vaginal bleeding and absent fetal movement for one day. The patient underwent a one unit blood transfusion one day back. There was no other significant medical or surgical history. On examination patient was anxious and pale. Her pulse was 116/min B.P. was 120/70 mm of Hg. No abnormality of cardiovascular and respiratory system was detected. Per abdominal examination showed distended abdomen. Uterus was 22 weeks size, ballotable, generalized tenderness was present. Fetal heart sound not heard. Per speculum examination showed some bleeding. Ultrasound showed anterior wall rupture uterus with haemoperitoneum, mild ascites, live baby in abdomen, bilateral mild pleural effusion. Since the patient's haemoglobin was 5.5 g%, blood was arranged and laprotomy planned.

Per op findings

Abdomen was opened by midline vertical incision, 1.5 liter of haemoperitoneum was drained, rupture of right lateral cornu of uterus seen, placenta seen through uterine rent, baby in abdominal cavity, taken out, cord clamped and cut, baby showed some movement and was handed over to the pediatricians, (however the patient party chose not to resuscitate the baby). Placenta couldn’t be separated completely. Placenta increta present, corneal resection tried but bleeding from placental site continued, so subtotal hysterectomy was done, haemostasis secured & drain was placed and then abdomen was closed. Per op and post op blood transfusions were done.

Figure 1. Live fetus from ruptured cornual pregnancy.
Figure 2. Ruptured cornu with placentae inside.

Figure 3. Placentae accreta.
DISCUSSION

Cornual pregnancy is diagnosed with high clinical suspicion with ultrasonographical criteria in presence of positive hCG indicating pregnancy.
Risk factors for ectopic pregnancy include Pelvic inflammatory disease (PID), History of previous ectopic pregnancy, History of tubal surgery and conception after tubal ligation, Assisted reproductive technology, Use of an intrauterine contraceptive device (IUD), Increasing age, Smoking, Previous pelvic surgeries.
Diagnosis is mainly by ultrasound. Three criteria should be used 1). an empty uterus; 2). a gestational sac seen separately and <1 cm from the most lateral edge of the uterine cavity and; 3). a thin myometrial layer surrounding the sac. A thin echogenic line extends into the cornual region abutting the gestational sac and this is called ‘The interstitial line sign’. This interstitial line can be either the endometrial cavity or the interstitial portion of the fallopian tube
The diagnosis may be helped with the use of Doppler studies showing increase vasculature around the gestational sac. This is described as a ring of vessels (Ring of fire).
Traditionally, the treatment of cornual pregnancy has been hysterectomy or cornual resection at laparotomy. As all surgical management has been associated with decreased fertility rates and increased rates of uterine rupture in future pregnancies, more conservative approaches have been introduced into clinical practice. Systemic methotrexate is a safe and highly effective treatment for cornual pregnancy of early gestation. The Royal College of Obstetricians and Gynaecologists recommends that the women with tubal pregnancy who are most suitable for methotrexate therapy are those with a serum hCG level of <3000 iu/l and with minimal symptoms. A large ectopic
pregnancy and the presence of a heartbeat are relative contraindications to medical treatment.

In our case, the patients placenta was deeply adherent and it was not possible to remove the whole placenta because of life threatening hemorrhage, cornual resection was not an option. So, subtotal hysterectomy was done. Post operatively the patient was fine and was discharged on post op day 7.

CONSENT

Written informed consent was obtained from the patient for publication of this case report and accompanying images.

COMPETING INTERESTS

The authors declare that they have no competing interests.

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