

Case Report

Cornual pregnancy-high index of suspicion

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ABSTRACT

Cornual ectopic pregnancy is a rare variant of ectopic pregnancy which requires high index of clinical suspicion and radiological support to manage. The incidence of interstitial pregnancy is rising. Traditional treatment with laparotomy, is associated with high morbidity and detrimental effects on future fertility. A diverse array of alternate treatments has been introduced over the last 3 decades, with the goal of achieving a conservative or inimally invasive management. Here we present such a case.

Keywords: Cornual ectopic, Ectopic, Interstitial pregnancy

INTRODUCTION

A cornual ectopic pregnancy is defined as a gestation that occurs within the endometrium of the horn of a unicornuate or bicornuate uterus, whereas an interstitial pregnancy occurs within the uterus at the junction of the uterus and the proximal part of the fallopian tube.¹⁻³ Interstitial pregnancy occurs when implantation occurs in the most proximal section of the tube surrounded by the myometrium.

This interstitial portion of the fallopian tube is highly vascular; rupture results in excessive intraperitoneal hemorrhage. Although these pregnancies represent approximately 2 to 4% of all ectopic pregnancies, maternal mortality is high (2% of cases) due to the risk of uterine rupture and subsequent hemorrhagic shock.¹⁻⁴ The diagnosis of an interstitial pregnancy can be made based on the following ultrasound criteria: empty uterine cavity, a chorionic sac separate and at least 1cm from the lateral edge of the uterine cavity, and a thin (<5mm) myometrial layer surrounding the gestational sac.^{1,5}

Conventional treatment for interstitial pregnancies includes systemic methotrexate, cornual wedge resection,

or hysterectomy. With the advancement of ultrasound and minimally invasive techniques, other management options now include direct injection of methotrexate into the abnormal pregnancy, combined systemic and direct injection technique, and laparoscopic cornual wedge resection.⁶

CASE REPORT

Patient 22-year-old primi gravida presented to us with 1.5 months amenorrhea and complaints of bleeding per vaginum since 3days. This was a spontaneous conception. According to last menstrual period she came at 6 weeks of gestation.

Her vitals were stable. her per abdomen examination was unremarkable. On per speculum examination, cervix and vagina were healthy with no bleeding seen. Per vaginum examination, uterus was normal size, slightly irregular, anteverted. She was admitted for further evaluation. She had an ultrasound reporting focal area of altered echogenicity with increased vascularity in left side fundal region of the uterus (possibility of h mole/invasive mole involving left corneal region of uterus. Herb hcg report was 202mIU/ml a day before admission.

A repeat scan was sent on admission which reported an area of altered echotexture and increased echogenicity and vascularity noted predominantly in fundal region slightly towards left side with et-5mm and no adnexal

mass bilaterally. A repeat b hcg was sent on day 3 which came out to be 59 mIU/ml. Due to 2 different usg reports, a MRI was ordered for a clear diagnosis. It reported a trophoblastic tissue in left cornua (Figure 1, 2).

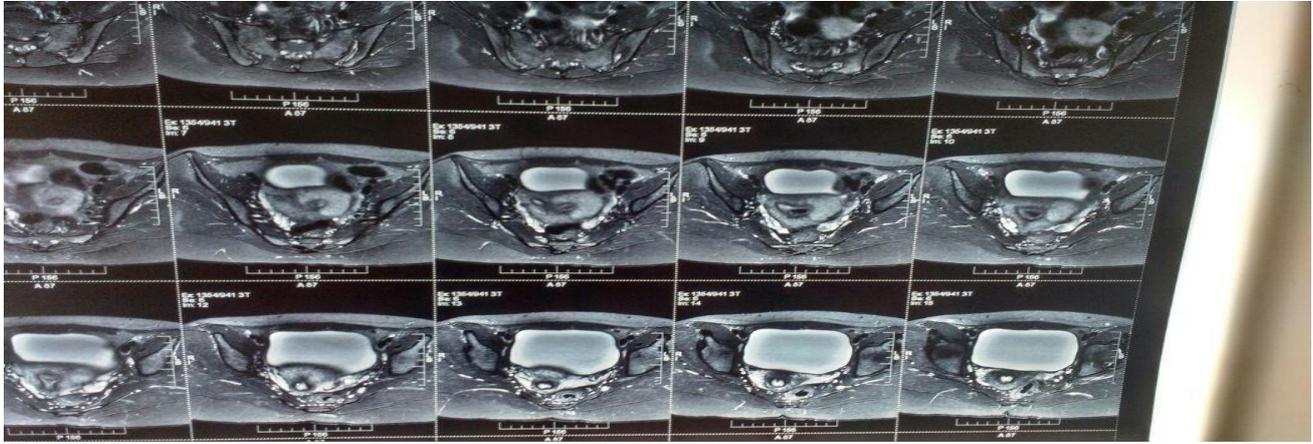


Figure 1: Showing MRI film depicting left cornual ectopic pregnancy (closer look).



Figure 2: MRI film depicting left cornual ectopic tissue.

The diagnoses of probable early pregnancy loss (EPL) and interstitial location of the pregnancy were explained to the patient. As this was a highly desired pregnancy, she declined intervention and elected for expectant outpatient management. b-hcg was re sent on day 7 which came out to be 9mIU/ml. Hence, the patient was discharged.

DISCUSSION

Interstitial ectopic pregnancy is a rare entity and hence treatment options are still being evaluated. management still broadly depends on whether the pregnancy is viable and stability of patient. Ultrasonography and a high index of suspicion have allowed for early diagnosis and increased success of conservative management for the interstitial ectopic pregnancy. Sometimes due to unclear

ultrasound findings and biochemical tests, one may have to order higher radiological modalities like MRI to have a clearer picture.

If the ectopic pregnancy is small, solid and nonviable, it can be managed expectantly because of the decreased risk of bleeding and rupture. In the event the interstitial pregnancy is medium-sized (<5cm), conservative management with methotrexate is often used with caution.⁷

Unfortunately, methotrexate treatment has been associated with a 9-65% failure rate.⁸⁻¹¹ However sometimes just wait and watch conservative policy, serial biochemical and ultrasonography may help us achieve a conservative approach leading to better future pregnancy outcomes.

CONCLUSION

Interstitial ectopic pregnancy may serve as a challenge to diagnose and manage, but a calculated approach involving clinical, biochemical and radiological approach is required for an optimized result ensuring a better future pregnancy outcome.

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