EP 16.11
A CASE OF A CORNUAL ECTOPIC PREGNANCY: A NEAR MISS?
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• Ectopic pregnancies occur in 1-2% of all pregnancies and cornual ectopic pregnancies occur in 2-4% of all ectopic pregnancies. Mortality is 7 times higher than tubal ectopics.
• It is a diagnosis that is encountered rarely throughout most clinicians’ career and can therefore result in potential misdiagnosis and mismanagement.
• This case described the case of a woman who represented with continuous bleeding after she was diagnosed as a complete miscarriage in the Early Pregnancy Unit (EPU) 2 months prior to that.

This is a 37 years old woman of Pakistani origins with no significant medical history. She had a previous early pregnancy miscarriage followed by a neonatal death due to pre-term complications before she had a SVD at term and a LSCS at 34 weeks. LMP was known with a regular period cycle of 28 days. This is a spontaneous conception.

1st ER: 9 weeks 1 day – Painless mild vaginal bleeding. TAS: Gestational sac seen with an embryo measuring 8 weeks with uncertain fetal heart visualisation. Arranged for early pregnancy ultrasound 2 days later.

1st EPU: 9 weeks 2 days – Reported passing products of conception. Picture recorded on phone. ET: 6.5mm with intact midline (Figure 1). Diagnosed as complete miscarriage and discharged.

2nd ER: 57 days post-miscarriage – Intermittent bleeding with heavy bleeding and occasional clots. ‘Negative’ UPT. TAS: Irregular sac with possibility of bleeding within it (Figure 2). BhCG: 245IU/L. Arranged for an early pregnancy ultrasound 5 days later.

2nd EPU: 62 days post-miscarriage – Mild cramps with minimal bleeding. TVUS: 32.3mm gestational sac with 10.3mm fetal pole (=7 weeks 1 day) (Figure 3). Normal adnexae. Location of sac appeared either high in fundus (?double cavity - intact endometrium seen on right aspect) or in left cornua. Comfortable throughout examination.

Treatment: Endometrial curettage. It was not possible to access left cornua via cervical suction curettage. Laparoscopic left cornual hysterotomy (Figure 4). Methotrexate IM post-operatively.

Follow-up: BhCG levels ensured resolution of possible ectopic tissue remnants. Advised that she will need Caesarean section in future pregnancies due to uterine rupture risk.

• Improved artificial reproduction techniques has seen the rising of cornual ectopic pregnancies.
• Thinning of the myometrial mantle less than 5mm and the interstitial line sign are useful diagnostic signs.
• For those who rarely encounter cornual ectopic, a systematic approach in scanning and recording data will aid in clarification of ambiguous cases post-event.

DISCUSSION

• Cultural custom dictated that she wait at least a month before she resumed sexual intercourse. She reported 2 occasions of protected sexual intercourse which were near in dates to her 2nd ER presentation i.e. unlikely new pregnancy.
• Serum BhCG levels confirmed a false negative UPT on the background of a suspicious transabdominal scan finding.
• Thankfully, in this case, the fetus had stopped growing which contributed to the patient’s stable conditions.
• As the second presentation happened about 2 months later, it was difficult to confirm or rule out if the cornual pregnancy was developing at the same time as the other pregnancy or this was missed altogether.
• It was also unlikely that it was missed as she had been scanned by the same operator i.e. same scanning techniques. However, records of the first scan did not properly reflect the thoroughness.
• This case stressed the importance of not just always doing a scan systematically but also to record multiple angles so that it can be looked back to shed clarity in an ambiguous case such as this.
• It is also important to not simply dismiss that all heavy vaginal bleeding are simple miscarriages. It is imperative to realise that urine pregnancy tests should be supplemented with serum pregnancy hormone levels when there is doubt.

CONCLUSION

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