Abstract:
Cervical pregnancy is one of the most dangerous forms of ectopic pregnancy. The incidence is increasing and it should be included in the differential diagnosis of vaginal bleeding in the first trimester. We report a case of cervical ectopic pregnancy from our institution. A 37 years old G2 P1 L1, a case of previous caesarean section was admitted with two months amenorrhoea and spotting per vaginum. She was found to have ectopic in cervical canal and was managed with emergency hysterectomy. Included in this case report are discussions of incidence, causes, current concepts in the diagnosis and management of cervical pregnancy.

Keyword: cervical pregnancy, hysterectomy

Introduction: Cervical pregnancy refers to an uncommon form of ectopic pregnancy implanted in the cervical mucosa. It is estimated that 0.15% of all ectopics are cervical pregnancies. Although the advent of ultrasound has made the diagnosis more accurate, it is still a problem in developing countries where access and experience is limited. Both conservative treatment with cytotoxic drugs and more radical interventions like hysterectomy has been described in the management of cervical pregnancies. We describe here our experience with one case of cervical pregnancy. Case report: A 37 years old Mrs. M, G2P1L1, previous Lscs with two months amenorrhoea was admitted with complaints of lower abdominal pain and spotting pv for the past ten days. Her menstrual cycles were regular and married since twelve years. Her last child birth was 10 years back and it was a full term LSCS. No significant past history. On examination: general condition was fair and her BMI was 32.5 Vitals were stable. Per abdominal examination: soft, obese suprapubic transverse scar present, no tenderness, no guarding, no rigidity. Local examination: normal external genitalia, no active bleeding. Bimanual pelvic examination: Uterus enlarged-12 weeks size, cervix soft ballooned out, effaced external os.
open Spotting pv present Investigations: All basic investigations were done and were within normal limits. Urine pregnancy test- positive Serum Beta-HCG: 9996 miu/ml Ultrasound revealed gestational sac of age 13-14 weeks in the cervical canal with fetal pole and cardiac activity and the same was confirmed with MRI

MRI picture
Patient was counselled regarding danger of continuing pregnancy and was advised termination. She was planned for conservative management and was given one injection of intra-muscular methotrexate. But the next day morning she started bleeding profusely and was taken up for emergency hysterectomy. Per operatively the uterus was enlarged more in the lower portion along with the cervix, and the cervix was ballooned out and enlarged to about 10 * 10 cms. Hysterectomy proceeded step wise. After clamping uterine vessels, lower portion of uterus and ballooned portion of cervix were opened and products of conception- small fetus with placenta removed.

Intraop picture

Discussion:
Great majority of certified obstetricians will never see a cervical pregnancy. In the minority who encounter this complication will probably wish they had not. Sporadic reports have appeared in obstetric literature since Tarnier reported the first proven case in 1886. Cervical pregnancy is a rare condition – life threatening if not diagnosed and treated early. Incidence:

Incidence:
<1% of all ectopics, 1 in 2400 or 1 in 50000 of pregnancies. Too rapid transport of fertilised ovum. Poorly prepared endometrium. Previous endometrial curetage. Asherman’s syndrome, IUCD usage. Previous LSCS. Manipulations of cervical canal as in embryo transfer. **Diagnostic criteria:**

**CLINICAL CRITERIA:**
- Uterus smaller than surrounding cervix
- Expanded or ballooned out cervix
- Internal os not dilated, external os opens earlier
- Products of conception entirely within the cervix below the internal os
- No products of conception in uterine cavity after curettage
- No sliding of gestational Sac on pressure with probe

**ULTRASOUND CRITERIA:**
- Echo free uterine cavity
- Hourglass uterine shape
- Ballooned cervical canal
- Gestational sac in endocervix with placental tissue
- Closed internal os

**DIFFERENTIAL DIAGNOSIS:**
- Complications of intrauterine pregnancy
- Trophoblastic tumours
- Cervical cancer
- Cervical or prolapsed submucous leiomyoma
- Placenta previa

**MANAGEMENT:**
- Conservative treatment:
  - Gestational age < 12 weeks
  - Hemodynamically stable


Finally HYSTERECTOMY IF ALL CONSERVATIVE MEASURES FAIL.

**CONCLUSION:**
- Cervical ectopic pregnancy has the highest rate of incorrect diagnosis.
- The most common misdiagnosis is cervical stage of a miscarriage.
- Increased clinical awareness, transvaginal ultrasound, betaHCG estimation in suspected cases helps in early diagnosis.
- Hence cervical ectopic must be included as one of the differential diagnosis of first trimester bleeding.
- Early diagnosis combined with newer medical and surgical procedures can help in preservation of fertility.

**REFERENCES:**


