Expectant management of a caesarean scar pregnancy with high β-hCG level

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Objective

We present our experience in expectant management of a patient who had a caesarean scar with high serum beta-human chorionic gonadotropin (β-hCG) level.

Methods

Caesarean scar pregnancy occurs due to implantation within a caesarean scar that is completely surrounded by myometrium and is therefore considered by many to be a late complication of caesarean section. The incidence of a caesarean scar pregnancy varies from 1 in 1800 to 1 in 2216 pregnancies and is rising due to an increase rates of the c section. Caesarean scar pregnancies are challenging to diagnose and there is a poor knowledge about the best management for them.

Results

A 35-year-old woman, para 1, with a history of one previous caesarean section was admitted at 7 weeks' gestation with vaginal bleeding. Serum β-hCG level was 25. 9 mIU/ml. An ultrasound scan raised the possibility of a scar pregnancy and a magnetic resonance imaging (MRI) confirmed this finding. The risks of having a scar's pregnancy were explained to the patient and she decided to continue with it. The patient had a serial ultrasound scan and measurement of serum level weekly. Serum β-hCG level declined progressively and a moderate vaginal bleeding occurred at 13 weeks of gestation. Speculum examination showed a gestational mass partly protruding from the external OS of the cervix that was removed by forceps. Pathological examination confirmed the diagnosis.

Conclusion

Different medical and surgical treatments have been tried and there is not consensus in which is the best treatment for caesarean scar pregnancy. Medical methods include systemic methotrexate or local injection into the gestation sac of methotrexate, potassium chloride, hyperosmolar glucose or prostaglandins. The surgical methods include dilatation and curettage, hysteroscopic resection, uterine artery embolisation, laparoscopic resection, laparotomy and resection or even hysterectomy. If the condition is diagnosed early, the treatment options are available and can be discussed with the patient in order to preserve the uterus. A delay in the diagnosis can lead to uterine rupture, extensive haemorrhage, hysterectomy and significant maternal morbidity expectant method may be an option for those cases with no or mild symptoms, no viable embryo and decrease in serum β-hCG levels. Our case illustrates that an expectant approach can be tried successfully with a good outcome, after a thorough discussion of the risks involved and taking into account the patient's wishes.