

## A case of cesarean-scar pregnancy treated with suction curettage followed by foley – catheter tamponade

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### Objective

Cesarean scar pregnancy (csp) is a very rare and dangerous form of pregnancy because of the increased risk of rupture and excessive hemorrhage. There is currently no consensus on the treatment. Early diagnosis of the condition enables treatment with newly-applicable methods (dilatation and curettage, methotrexate therapy, lower-segment incision by laparoscopy or laparotomy, hysteroscopic excision). When the diagnosis of cesarean-scar pregnancy is late, to prevent maternal morbidity and mortality an urgent laparotomy and hysterectomy is necessary in most of the cases.

### Methods

A 36-year old, g6p4 woman came to our outpatient clinic with the symptoms of spotty bleeding and pelvic. Medical history revealed 4 previous cesarean sections, the last one being 10 years ago and a first trimester termination. Vital signs of the patient were all in normal ranges, and her physical examination was consistent with a slight abdominal tenderness without any rebound. On pelvic examination, cervix was closed and no bleeding was visible. Transvaginal ultrasound examination showed an antevert uterus, and an eccentrically located gestational sac of 30x19 mm in size with an embryo of a CRL of 16 mm (8 weeks) with no cardiac activity, lying superior to the internal cervical canal, a region matching previous kerr incisional line. Myometrium was homogenous and bilateral adnexial structures were normal (figure 1). The patient was hospitalized with the diagnosis of cesarean-scar pregnancy and she was informed about the condition. Following an informed consent, termination of pregnancy was planned. Suction curettage was performed with carmen cannules No 6 and 7 with simultaneous guidance of transabdominal ultrasonography. After the suction curettage due to active uterine bleeding, a foley catheter, filled with 30 cc serum physiologic, was placed in utero to tamponade the hemorrhage. Ultrasonography confirmed that the balloon of the catheter was located near the previous kerr incisional line (figure 2). No active hemorrhage was apparent following this procedure. Balloon was deflated and foley catheter was removed after 6 hours without any problem. 2 and 6 hours postoperatively, hemoglobin level was 12.6 g/dl and 12.4 g/dl and hematocrit was 38.6% and 38.1% respectively. The patient has been discharged on third postoperative day without any problem.

### Results

A 36-year old, g6p4a1 patient applied to our outpatient clinic, with the symptoms of spotty bleeding and pelvic pain lasting for about 2 days. Medical history revealed 4 previous cesarean sections, the last one being 10 years ago and a D&C procedure following a first-trimester abortion. Vital signs of the patient were all in normal ranges, and her physical examination was consistent with a slight abdominal tenderness without any signs of rebound.

### Conclusion

The number of cesarean-scar pregnancy cases has increased due to an increase rate of c-sections in the last years. Early diagnosis is possible with the use of transvaginal ultrasound in early gestational weeks. In our case, the embryo with no cardiac activity was consistent with a gestational age of 8 weeks and 1 day. An elective suction curettage was performed and tamponade of hemorrhage was provided by a foley catheter. No additional procedure was necessary. We conclude that suction curettage under ultrasonography guidance can be used successfully as a fertility preserving management of selected cases with cesarean scar pregnancy.

