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**Case Report**

# An uncommon case of vaginal bleeding

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## Abstract

The patient attended the clinic with irregular vaginal spotting; on clinical examination, a congested bulky ballooned cervix with open internal os was seen. Urine for the pregnancy test was positive. A provisional diagnosis of inevitable abortion was done. In theatre, massive bleeding was encountered and the patient collapsed. The conservative procedure of removal of product of conception was abandoned and following resuscitative measures emergency total abdominal hysterectomy was commenced. The patient recovered uneventfully. The histopathology confirmed cervical ectopic pregnancy.

**Keywords:** Hemorrhage, cervical ectopic, hysterectomy.

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## 1. Introduction

A menstruating woman complains of greater-than-usual bleeding, which is either off of her usual schedule (metrorrhagia), lasts longer than a typical period, or is heavier than usual (menorrhagia), perhaps with crampy pains and passage of clots.[1]

## 2. Case History

A female patient of 38 years old attended the gynaecology outpatient clinic with irregular vaginal spotting for the last 2 to 3 months with one episode of heavy bleeding 15 days before. There was no clear history of amenorrhoea. She did not have any abdominal pain, vomiting, fainting attack, use of medication (including contraceptives). The past surgical and medical histories were insignificant. Her obstetric history was G 4 P 3 – A 1- L 3, all at term vaginal delivery; babies are alive and healthy; last childbirth 10 yrs back; one Medical Termination of Pregnancy by suction and curettage did at 8 weeks of gestation, 3 years back.

General examination revealed mild pallor. The abdomen was soft without any lump, tenderness, or ascites. Pelvic examination; speculum- a congested bulky cervix with a mass visible through the opened external os. Bimanual examination revealed bulky uterus, ballooned cervix and fornices were free. The rectal examination revealed mucosa and parametrium were healthy and free.

The initial baseline blood investigations were within normal limits with hemoglobin of 10.5 gm/dl. USG corroborated with the clinical findings. The cervix was hugely ballooned with a mass of 7.5 X 6.5 cm of heterogenous echogenecity occupying the cervical canal. However, the uterine cavity appeared empty with thickened endometrium. No enlarged lymph node was noted and ureters were normal. Urine for a pregnancy test was done which was positive. A provisional diagnosis of cervical inevitable abortion was done.

The patient was considered for dilatation and evacuation. In the theatre during the procedure, a massive hemorrhage was encountered and the patient went into a stage of collapse. Immediate resuscitative measures were taken including blood transfusion along with tight vaginal packing with bimanual compression. The bleeding decreased in severity though continued and the procedure of D/E was abandoned. The patient's party was counseled and laparotomy was planned in the same sitting after making the patient hemodynamically stable with the arrangement of further blood products. Intraoperative blood for hemoglobin and beta hCG was also sent. A total abdominal hysterectomy was performed. During the procedure,

difficulty was encountered in dissecting the utero vesicle, rectovaginal space and parametrium due to excessive hemorrhage. It was also difficult to secure hemostasis. Tissues were found to be vascular and friable. The abdomen was closed putting a drain inside. Specimen was sent for a histopathology examination.

The patient was kept in the HDU for continued monitoring in the immediate postoperative period. She had received another three units of blood. The beta HCG value came out to be 11400 IU/ml. The drain was omitted after 24 hrs and the rest of the postoperative period was uneventful.

She was discharged on 14th postoperative day and was advised to follow up weekly with serum beta HCG in the outpatient clinic It became negative on 21st postoperative day. For the next 6 months, on follow up, all values were negative.

The specimen following operation revealed:

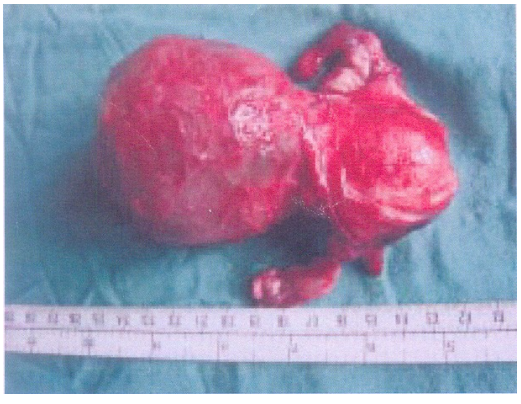

**Figure 1: Cervix was hugely ballooned, and the external os was opened**

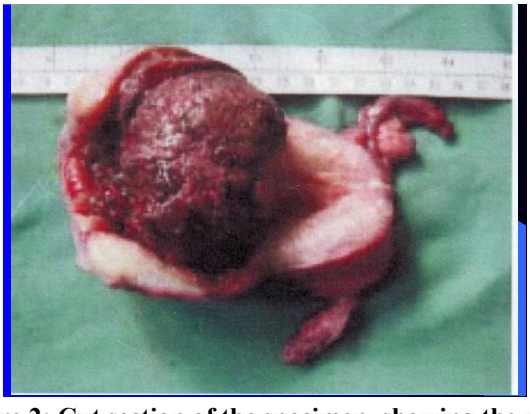

**Figure 2: Cut section of the specimen, showing the mass occupying the cervical canal. Hourglass uterine shape is seen**

Entire ballooning of cervix in below the level of the internal os. Uterine cavity is seen empty

Histopathology revealed trophoblastic invasion in the cervical stroma, intimate contact between cervix and placenta, no fetal or placental tissue in endometrial cavity, thickening of endometrium, no hydropic degeneration of trophoblast.

The final diagnosis of cervical ectopic pregnancy was made.

## 3. Discussion

Cervical pregnancy is a rare but life threatening form of ectopic pregnancy. Incidence ranges from 1:2400 to 1:50000 of pregnancies [2]. The clinical diagnostic criteria and USG criteria has been elaborated [3,4]

Predisposing factors include previous surgery (D/E. CS), multiparity, high maternal age, ART, recent use of oral contraceptives, leiomyoma and uterine congenital malformations. Our patient had few of them like previous surgery, advanced age and multiparity.

The diagnosis of pregnancy was difficult because neither history nor the USG was suggestive. Initially the case was diagnosed a case of cervical abortion because of its frequent occurrence along with atypical history and sonographic presentation. Considering the rarity of occurrence, diagnosis of cervical pregnancy was overlooked initially. However intraoperative catastrophe compelled us to reconsider rarest diagnosis of cervical ectopic. Therefore one has to be ectopic minded to make such a diagnosis [5]. Review of literature also revealed that cervical gestation had frequently been confused with spontaneous abortion in which the product of conception was retained within the cervical canal [6].

However, currently with the improvement of imaging studies like MRI and sometimes with combined diagnostic parameters like sonography MRI and endoscopy, early diagnosis of cervical ectopic is possible. At present several conservative management options, both medical and surgical, available.

Most of the centres consider few parameters before selecting a patient for conservative management. These are: patient has to be hemodynamically stable with or without bleeding, menstrual age is <9 weeks, serum beta HCG is<10,000IU /L and crown rump length less than 10 mm.[6] Medical management like systemic or local methotrexate, PGF2 alpha, KCl injection into the fetal heart has been used successfully. Conservative surgical management includes – cervical curettage, cervical packing, and ligation of cervical arteries, amputation and suturing of cervix. Brisk haemorrhage is the main threat during surgical management. This can be overcome by haemostatic cervical sutures, insertion of Foleys' catheter, vaginal packing, bilateral internal iliac artery ligation, uterine artery embolisation using gelfoam.[7,8] In a review of Ushakov, it revealed that a D/C without cervical preparation resulted in massive hemorrhage in 70.7% cases.[9]

In our case we had to reconsider the decision from conservative surgery to laparotomy and hysterectomy due to intra operative circulatory collapse. Conservative management is specially favoured when the patient is diagnosed electively during early gestational age. It is often

recommended if the patient is young, low parity, asymptomatic, and hemodynamically stable.[10]

Total abdominal hysterectomy is the last resort in a situation like uncertain diagnosis, failed conservative management, or life-threatening haemorrhage as happened in our case. Surgery in such cases is often difficult due to uncontrolled haemorrhage, tissue friability, and the close proximity of the pathology to the surrounding vital structures (urinary bladder, ureters & rectum) [11].

## 4. Conclusion

With our experience of managing the case, we suggest a hysterectomy is a safe option when the patient is parous, elderly, and profuse bleeding. However, if the patient is young, low parity, asymptomatic, or present with minimal vaginal bleeding, she may be considered for conservative medical or surgical management.

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