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CESAREAN SCAR ECTOPIC PREGNANCY: 5 YEARS EXPERIENCE

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Introduction. As the frequency of Cesarean Scar Ectopic Pregnancy (CSEP) is increasing due to the increase in number of Cesarean Sections, it has become imminent to analyze and discuss the optimal interventions available to identify & manage CSEP & its complications. Based on ultrasonographic characteristics at the time of diagnosis cesarean scar ectopic pregnancy is divided into 3 sub-groups; each with a different prognosis. The gestational sac's position and the quantity of myometrium still remaining is used to classify the condition. Less than half of the myometrium penetration is referred to as Grade I. In ectopic pregnancies with Grade II cesarean scars, the gestational sac penetrates more than half of the myometrium. The gestational sac protrudes outside the myometrium in Grade III cesarean scar ectopic pregnancies. The gestational sac is very vascular & the pregnancy is challenging to detect in grade IV CSEP. Therapeutic termination is presently the gold standard of care for ectopic pregnancies caused by cesarean scars. However, management of CSEP also includes other medicinal, surgical or combined interventional approaches.

Aim: the aim of the study is to evaluate 5 years experience (between years 2018-2022) in diagnosis and treatment of ectopic pregnancy developing in a Caesarean section scar.

Materials and methods. The study included 7 women, diagnosed with CSEP in the first trimester, which was confirmed by ultrasound and treated at Minsk City Clinical Hospital No.1 (Belarus) during 5 years between 2018 and 2022. The clinical presentations, imaging findings, and treatment outcomes of all these pregnancies were analyzed.

Results and their discussion. The age range of patients was between 23 to 42 years. The gestation age ranged between 5 to 9 weeks. Along with a history of previous cesarean delivery and minimum 2 pregnancies, maximum up to 5.

The main complaints of the patients were vaginal bleeding and recurrent abdominal pain in 6 (85.7%) of cases, while remaining was asymptomatic. Three patients (42%) didn't have any other concomitant diseases but others reported Coagulation factor 7 deficiency, Bacterial vaginosis and Uterine fibroids.

As the Gold standard in detecting suspected CSEP, Transvaginal ultrasonography was performed and 57.14% patients USG showed embryo in gestational sac along with fetal heart activity, 28.57% patients had presence of only gestational sac and 14.28% showed presence of only the yolk sac. The thickness of the cesarean scar ranged between 2 to 12 mm in 57.14% cases; no information was available for the remaining. Since there is no standardized protocol for the management of cesarean scar ectopic pregnancy in Belarus, the most accurate medicinal intervention included curettage of the uterus and laparotomy in 42.85% cases, curettage of the uterus with hysteroscopy in 14.28% cases, uterine metroplasty in 71.42% cases, laparoscopy in 14.28%; all leading to termination of the pregnancy after gaining consent from the patients. The estimated blood loss was between 70 to 1300 ml. Post interventional complications included vaginal bleeding after curettage of the uterus in 28.57% cases.

Conclusion: according to the protocols followed by European countries, United States of America and South East Asia, these methods coincide with the accurate & best possible management of Cesarean Scar Pregnancy.