

Uterine haematoma — a complication after delayed management of caesarean scar pregnancy

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Caesarean scar pregnancy (CSP) is a type of ectopic pregnancy implanted into the defect in the myometrium at the hysterotomy site from a previous caesarean delivery [1]. Untreated CSP may be associated with life-threatening complications, such as placenta praevia or accreta, uterine rupture and haemorrhage [2, 3]. Therefore, an early diagnosis is crucial to decrease maternal morbidity and mortality. There is no universal treatment option for CSP and data about the complications of treatment are scarce [4, 5]. Selective uterine artery chemoembolization with intra-arterial methotrexate (MTX) infusion followed by suction curettage is one of the treatment options for CSP and is considered as a safe method. We report a case of a complication after this treatment.

A 35-year-old patient, two CSs in history, at 8 weeks of gestation was admitted to the hospital with suspected CSP. On transvaginal ultrasound (TVUS) two gestational sacs (GS), implanted in the anterior wall of cervicoisthmic area in the caesarean scar were visualized. In the first GS a single embryo with foetal heart rate was observed, while the second GS had no embryonic structures (Fig. 1). On Colour Doppler examination a high vascular pattern was present around both GSs. The patient was informed about the recognition and possible life-threatening complications of CSP. Nevertheless, she wanted to preserve and continue the pregnancy. After two weeks the patient changed her decision and was qualified for selective uterine artery chemoembolization with intra-arterial MTX infusion followed by suction curettage. TVUS followed by magnetic resonance imaging revealed very thin myometrium in the caesarean scar site and a high risk of bladder infiltration (Fig. 2). The treatment, however, went with no complications and the patient was discharged in good condition (Fig. 3). Abnormal uterine bleeding occurred three months afterwards and a haematoma (max diameter 50 mm) in the area of evacuated CSP was found during TVUS (Fig. 4). The patient was scheduled for dilatation and curettage (D&C). After D&C the symptoms did not disappear and the haematoma reformed. The decision was made to perform vascular embolization and suction curettage to stop the bleeding. The result was satisfying and the patient was discharged without any further complications.

It is important to stress that, although selective uterine artery chemoembolization with intra-arterial MTX infusion followed by suction curettage is considered to be a safe procedure, complications may occur. In this case, the factors that could possibly

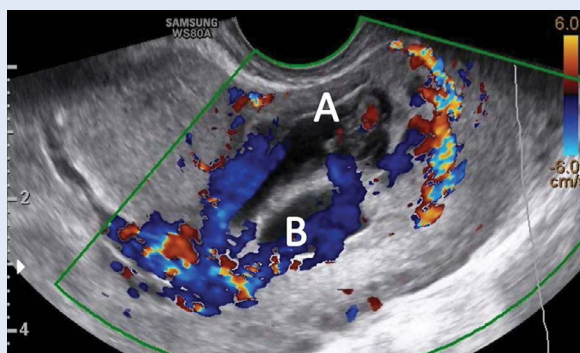


Figure 1. Transvaginal ultrasound revealed two gestational sacs at caesarean section scar site, the first (A) with a single embryo with foetal heart rate and the second (B) without embryonic structures, both with high peripheral vascularity shown on colour Doppler

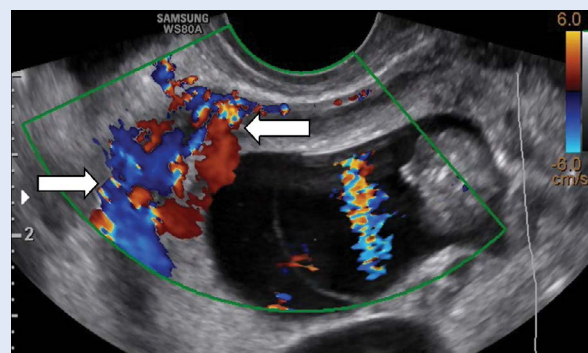


Figure 2. After two weeks thinning of the myometrium in the anterior uterine wall was seen on transvaginal ultrasound and there was a suspicion of bladder infiltration.

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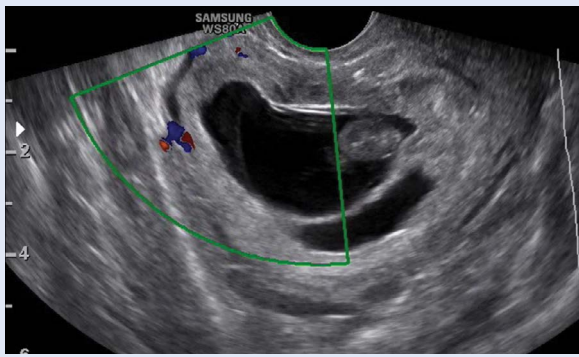


Figure 3. After selective uterine artery chemoembolization with intra-arterial methotrexate infusion no foetal heart rate and a low vascular pattern were observed

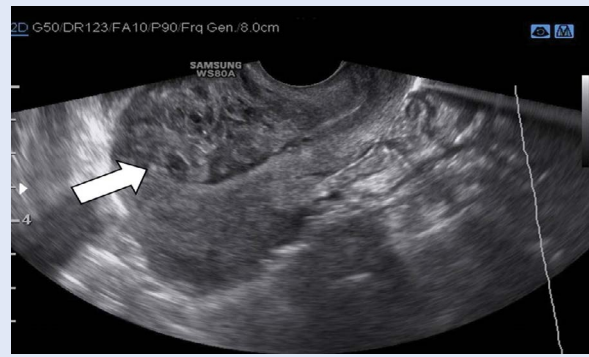


Figure 4. Haematoma in the uterus at the site of previous caesarean scar pregnancy 3 months after chemoembolization

have contributed to the formation of a haematoma were: delayed intervention, multiple pregnancy and high vascularity of gestational sacs. Early recognition and treatment of CSP are essential for successful management.

Conflict of interest

None.

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