International Journal of Clinical Obstetrics and Gynaecology

ISSN (P): 2522-6614
ISSN (E): 2522-6622

www.gynaecologyjournal.com
2022; 6(3): 38-40
Received: 16-03-2022
Accepted: 19-04-2022

Dr. Gayatri Mathuriya
Associate Professor, Department of Obstetrics & Gynaecology, M.G.M. Medical College and M.Y. Hospital, Indore, Madhya Pradesh, India

Dr. Akansha Parihar
Resident, Department of Obstetrics & Gynaecology, M.G.M. Medical College and M.Y. Hospital, Indore, Madhya Pradesh, India

Dr. Mohini Rajoriya
Assistant Professor, Department of Obstetrics & Gynaecology, M.G.M. Medical College and M.Y. Hospital, Indore, Madhya Pradesh, India

Dr. Devyani Tiwari
Assistant Professor, Department of Obstetrics & Gynaecology, M.G.M. Medical College and M.Y. Hospital, Indore, Madhya Pradesh, India

Dr. Namrata Lalwani
Senior Resident, Department of Obstetrics & Gynaecology, M.G.M. Medical College and M.Y. Hospital, Indore, Madhya Pradesh, India

Corresponding Author:
Dr. Gayatri Mathuriya
Associate Professor, Department of Obstetrics & Gynaecology, M.G.M. Medical College and M.Y. Hospital, Indore, Madhya Pradesh, India

Case series of complications with multiple cesarean deliveries: A diagnostic and management challenge

Dr. Gayatri Mathuriya, Dr. Akansha Parihar, Dr. Mohini Rajoriya, Dr. Devyani Tiwari and Dr. Namrata Lalwani

DOI: https://doi.org/10.33545/gynae.2022.v6.i3a.1180

Abstract
Few issues in modern Obstetrics have been as controversial and complicated as the management of the woman who has undergone prior cesarean delivery. How a previous cesarean delivery can modify and complicate the next pregnancy in its early gestational period and can lead to strange outcomes is a topic of interest. As often quoted remark by Flamm "Once a cesarean always a controversy" this case series will unfold the surprises a case with prior cesarean delivery holds.

Keywords: Previous cesarean delivery, Placenta percreta, cesarean scar ectopic, obstetric hysterectomy

Introduction
Cesarean section is among the essential comprehensive intrapartum services in modern obstetrics. It is a life saving intervention for the foetus, the mother or both in emergency obstetric conditions. Cesarean sections are double aged sword which comes with its own kind of complications in current as well as in future pregnancies. As a major surgical procedure, Cesarean section not only predisposes short term adverse events to pregnant women i.e. higher rates of hemorrhage, transfusion received, infections, prolonged hospital stay but also long term obstetrics complications with risks in subsequent pregnancies such as Morbidly adherent placentas, Placenta previa, scar site ectopic pregnancy, uterine rupture etc. The risk of adverse outcomes following Cesarean delivery increases exponentially with increased number of Cesarean sections [1, 2].

A case with prior cesarean delivery can present with complications at any gestational age. This should be seen as a red flag sign and should be investigated and managed aggressively to prevent maternal morbidity and mortality. The most common high alert symptoms in early gestational age with previous cesarean deliveries can be bleeding per vaginum, abdominal discomfort, severe lower abdominal pain and shock might be seen in cases of impending rupture of uterus or severe antepartum hemorrhage.

Every pregnancy with previous history of Cesarean Section should be investigated and looked for Cesarean scar ectopics, Placenta accreta complex associated with it in first trimester itself by Transvaginal ultrasound. Transvaginal ultrasound is a gold standard modality in identifying these conditions and is a savior in preventing maternal morbidity and mortality [3].

Case report: 1
A young multiparous G3P2L1A0 female aged 27yrs with obstetric history of two prior Cesarean sections and single living issue presented to the emergency room with no active complaints but was being verbally referred from a peripheral centre indicating her ultrasound findings. She had history of being completely unaware of her pregnancy as overdue of her dates was a part of her irregular menstrual cycles.

She has had complaints of bleeding per vaginum associated with passing small clots with left lumbar region pain for the past 15 days. This compelled her to seek treatment for her bleeding which stopped later on and also underwent whole abdomen and pelvic ultrasound twice for 2 consecutive months by 2 different doctors as her pain in abdomen persisted. These scans missed her pregnancy. Later on, she tested her pregnancy and found herself positive. She visited a doctor for her 1st antenatal visit who performed a transabdominal scan stating "SLIUF 12weeks size in lower uterine segment, in view of history of 2 prior Cesarean sections this could represent

scar ectopic pregnancy" This missed her exact placental location and nature as was not looked for it with suspicion of MAPs. Luckily, 3 days later she again visited a different radioimaging centre where she had gone through a transabdominal followed by transvaginal ultrasound scan stating "A viable fetus of 11 weeks 6 days in cervico-isthmic region with umbilical cord seen inserting at the scar site with placenta seen anteriorly along the scar site with possible complete invasion of the serosa upto posterior echogenic bladder wall suggestive of placenta percreta".

Considering the young age and a single living issue we made a decision to operate on her and preserve her uterus for future fertility.

Intraoperative findings fully correlated with the ultrasound findings of cervico-isthmic Cesarean scar pregnancy with placenta percreta. Fetus was attached to the scar site and was removed but the placenta was morbidly adherent which made its separation impossible and caused heavy intraoperative hemorrhage. Ultimately the decision switched to perform an obstetric hysterectomy. Patient was resuscitated with two units packed cells and fluids to maintain hemodynamic stability and sample was sent for histopathology; which was reported as "Ruptured uterus with acute inflammation and hemorrhage with degenerated placental tissue invading the myometrium with 07 weeks dead fetus".

Patient stood the procedure well and was stable post operatively and was discharge later in good condition.

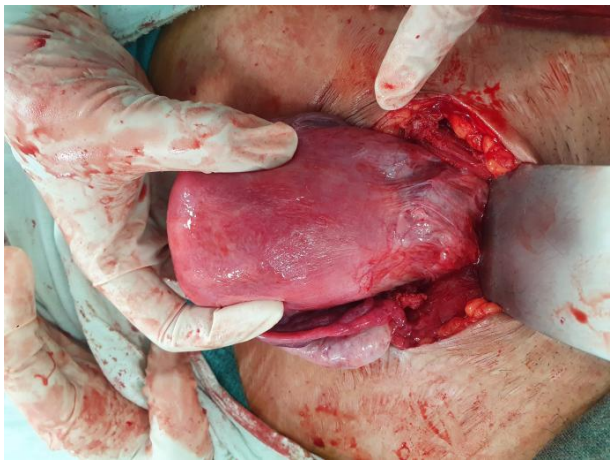

Fig 1: Intaroperative finding of scar site ectopic pregnancy in cervico-isthmic region with densely adhered bladder to the scar site

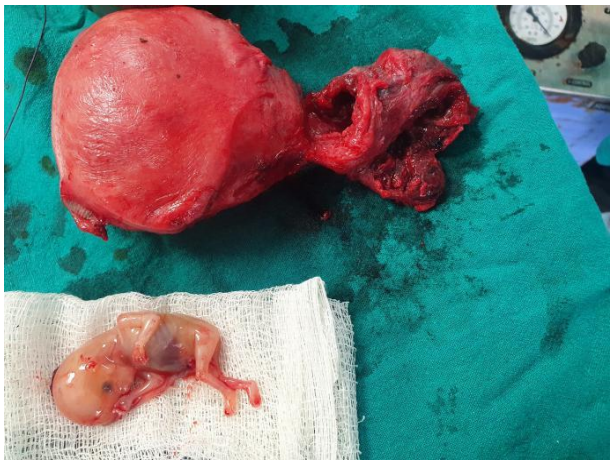

Fig 2: Post operative uterus with Hysterotomy at Cervico-isthmic region with morbidly adherent placenta in lower segment and dead fetus.

Case report 2

A young 24 years old female patient presented to the casualty in emergency hours in a condition of hypovolemic shock and active bleeding per vaginum with intrauterine Foley's catheter in situ inflated with 70-80 cc of NS done to control bleeding as she was referred from a peripheral centre with diagnosis of P2L3 with mehorrhagia with severe anaemia (6.1 gram%) with UPT negative.

On taking history, she had two previous cesarean deliveries 6 and 4 years ago, she had no history of overdue of dates, UPT negative on admission, periods were regular except for the past one month where she experienced heavy menstrual bleeding for 20-25 days. She visited a nearby doctor in her area for the above complaints and underwent a USG with findings of "Bulky uterus with endometrial thickness of 37mm, diffusely echogenic lesion of size 58×31 mm is seen showing marked vascularity with questionable nature of the lesion." After the scan, in view of above findings her endometrial biopsy was taken but this event led to catastrophic bleeding per vagina which was very difficult to control and so she was referred to our centre after primary management. She was aggressively managed and resuscitated with fluids and 5 units of blood and was stabilized hemodynamically. Her beta HCG was 39.99units on post admission day 2 but she gave a negative history of consuming abortifacient drugs .Further,MRI was done which stated "Uterus anteverted and bulky with thickened endometrium measuring 29mm. A 4.4×4.1×4.3cms lesion is seen in endometrium with increased vascularity which is consistent with neoplastic nature of the lesion.There is infiltration of the junctional zone and the anterior myometrium with loss of intervening fat plain with respect to the lesion".

In view of the above findings and suspecting endometrial neoplasm or Gestational trophoblastic neoplasia, she was electively planned for Total abdominal hysterectomy (TAH) with bilateral Salpingooopherectomy. Intraoperatively, while performing TAH, towards the end of the procedure, a mass separated spontaneously from the cervico-isthmic junction anteriorly and was expelled out which didn't bleed at all and was not at all consistent with findings of endometrial neoplasm.

TAH with left sided Salpingooopherectomy (hydrosalpinx with simple left ovarian cyst) was performed and the right sided ovary was left behind as the surgeon’s suspicion was that the patient has hidden the history of being pregnant and it was not endometrial cancer, but appeared to be oraganised mass of retained products of conception.

Post-operatively, she was again asked thoroughly and strictly about the history of consuming abortifacient drugs to which she agreed. Few days later, her Histopathology report was suggestive of “Retained products of conception with adenomyosis”. Retrospectively, it became clearer that the patient had history of previous two Cesarean sections so the products of conception were adhered and was infiltrating anteriorly to the previous scar of myometrium and was not expelled per vaginally when she took the abortifacient pills one month back but rather bled profusely on manipulation .It was later organised into a mass which was mistaken as a neoplastic endometrial mass in MRI present anteriorly at the site of previous scar. This could have been a scar site pregnancy. The patient being negligent, hiding the history and the history being complicated by previous 2 Cesarean sections, profuse bleeding, shock, UPT negative with MRI report suggesting neoplasm had to undergo hysterectomy at a young age, but the positive aspect is that the patient stood the procedure well and was discharged in a healthy condition.

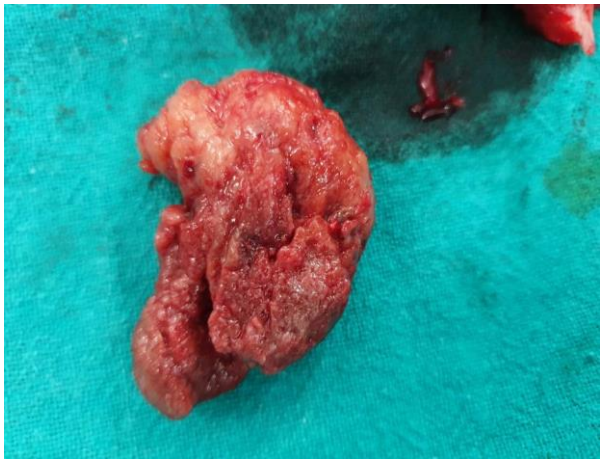

Fig 3: Retained products of conception organised into a mass mistaken as neoplastic mass in MRI.

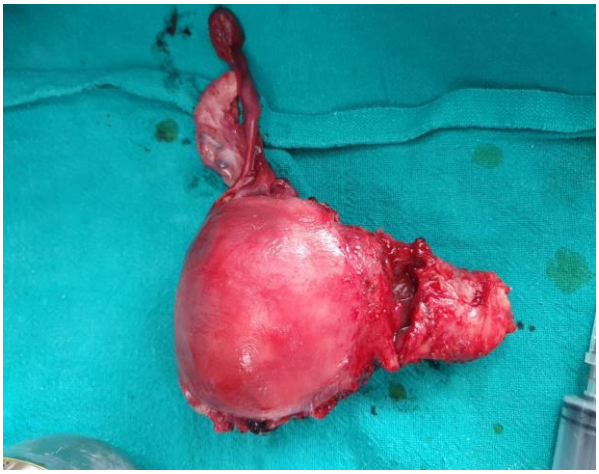

Fig 4: Post hysterectomy sample of uterus showing defect at anterior cervico-isthmic junction where the mass was adhered.

Discussion

High rates of maternal mortality due to common preventable causes like hemorrhage, eclampsia, sepsis calls for safe procedures like cesarean section. Although, theoretically the procedure is intended to protect against the adverse maternal outcome, the increase in cesarean rates is being associated with adverse outcomes of subsequent pregnancies such as maternal mortality, blood transfusion, admission in critical care and hysterectomy at early ages.[4]

Both the cases described above were of patients who had history of previous two Cesarean sections and landed up into hysterectomy at a very young age due to the complications the uterine scars can lead to. Every case with prior Cesarean section is unique in its own way and should always be handled with utmost precautions and high suspicion for any complication. Simple imaging modalities like Transvaginal ultrasound can prevent further complications by diagnosing them at an early gestational age. As Cesarean section is itself an intervention to prevent maternal morbidity and mortality, it's future complication cannot be prevented completely but can be cured well if investigated and identified at an early gestational age.

References.

1. Sheffield JS. Williams obstetrics (24th edition.). New York: McGraw-Hill Education, 2014.
2. Kietpeerakool C, Lumbiganon P, Laopaiboon M *et al*. Pregnancy outcomes of women with previous caesarean sections: Secondary analysis of World Health Organization Multicountry Survey on Maternal and Newborn Health. Sci Rep 9, 9748 (2019). https://doi.org/10.1038/s41598-019-46153-4
3. https://appliedradiology.com/communities/Breast-Imaging/cesarean-scar-ectopic-pregnancy Cesarean scar ectopic pregnancy By Sarah Fenerty, MD; Sonia Gupta, MD; Jordan Anoakar, MD; Tejas Patel, MD, MPH, MBA.
4. Section and Adverse Maternal Outcomes Accordingly With Robson Classification: Systematic Review and Meta-Analysis Shazia Jamshed1,2†, Shuo-Chen Chien3,4, Afifa Tanweer5, Rahma-Novita Asdary6, Muhammad Hardhantyo 7,8,9, David Greenfield10,11, Chia-Hui Chien 3,4,12, Shuen-Fu Weng13,14†, Wen-Shan Jian 4,15 * and Usman Iqbal 4,6,16.