Is there an effective and safe option for management of interstitial ectopics other than cornual wedge resection?

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Background

Interstitial pregnancies account for 2% of ectopic pregnancies

They occur when pregnancy implants in the most proximal section of the tube, surrounded by myometrium

Management of non-tubal ectopics including interstitial ectopics represents a challenge with only small case studies or series available and no standard of care.

Methods

Retrospective case note review of patients admitted to the Women's and Children's Hospital, a tertiary centre, with interstitial/cornual ectopics over an 11 year period from 2006-2017.

Total of 82 non-tubal ectopics including 34 interstitial ectopics.

References

Faraj R, Steel M. **Management of cornual (interstitial) pregnancy**. The Obstetrician & Gynaecologist 2007;9

Results

Average Age
32.3 yrs (19-43)

Parity
Nulliparous 18%
Para 1 40%
Para ≥2 33%

Average BhCG quant
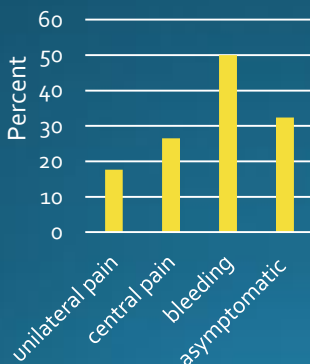16,385 (31-158,601)

Risk Factors
Ipsilateral salpingectomy 38%
IVF 15%
Structural uterine abnormalities 15%

Initial Ultrasound Dx

- Tubal/adnexal ectopic
- Intrauterine
- Incomplete miscarriage
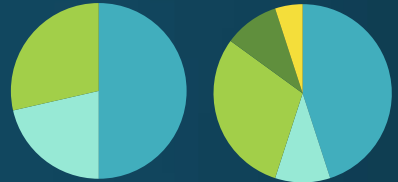- Other
- Interstitial ectopic

Presenting Symptoms

Management of Interstitial Ectopic

2006-2012   2013-2017

- laparoscopic cornual resection
- open cornual resection
- methotrexate
- laparoscopically assisted D+C
- conservative

Complications
- Failure of intended laparoscopic cornual resection 2/16 = 13%
- Future pregnancy complications from cornual resection 2/21 = 10%
- Failure of methotrexate = 3/10 = 30% (rupture with significant blood loss in 1 patient)

Conclusion

Ultrasound only correctly diagnosed interstitial pregnancies in 44%.

This audit shows a trend towards minimally invasive and non-surgical management of interstitial pregnancies. This may be an appropriate first line option when there is no haemodynamic compromise and at early gestations.