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Cornual Ectopic Pregnancy Requiring Both Surgical And Medical Management

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BACKGROUND

Cornual ectopic pregnancies are rare and accounts for about 2-4 % of all ectopic pregnancies[1]. It is associated with high maternal mortality and morbidity due to risk of rupture and massive intra-abdominal bleeding. The diagnosis and management of cornual ectopic pregnancy is highly challenging and there are limited guidelines on management strategies.

We present a case of a live unruptured cornual ectopic pregnancy which was successfully managed but required both surgical and medical management.

DISCUSSION

Early diagnosis of cornual ectopic pregnancy will lead to better outcomes prior to rupturing. Utilising sonography and diagnostic laparoscopy might be beneficial but can sometimes be inconclusive depending on the size of ectopic gestation . The use of 3 dimensional ultrasound may be helpful in challenging cases[2]. It is important for both clinicians and sonographers to be adequately trained to identify ectopic gestation on ultrasound as cornual ectopic pregnancy could be mistaken with an uterine fibroid[3]. HCG surveillance post resection is important due to possibility of remnants or recurrence.

CASE

A 27 year old G10P2 presented at 5 weeks period of amenorrhoea with a pregnancy of unknown location with an initial serum beta-HCG of 284. This was on a background history of previous left ectopic pregnancy requiring unilateral salpingectomy. There was no previous history of sexually transmitted infection. Serial beta-HCG demonstrated appropriately rising levels up to 3680 with persistent abdominal pain, however no intra-uterine pregnancy was visualised on transvaginal ultrasound other than a small uterine fibroid over left side of uterus. No ectopic pregnancy was visualised on diagnostic laparoscopy and no product of conception was found with endometrial curette.

A live left cornual ectopic pregnancy was subsequently visualised on transvaginal ultrasound with a serum beta-HCG of 12999. A laparotomy for wedge resection of left cornual ectopic pregnancy was performed and confirmed on histopathology. Post operative serum beta-HCG surveillance initially demonstrated appropriately falling levels, however, was rising in-appropriately again 2 weeks later.

She then received medical management with a single dose of intra-muscular methotrexate based on body surface area which was successful.

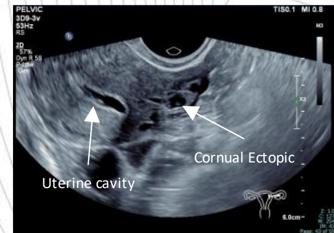

Figure 1: Transvaginal transverse view of uterus with ectopic gestation visualized on left uterine cornua

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