Management of cervical pregnancy with circumscuture and intracervical obturator

A gynaecologist may encounter a cervical pregnancy only once or twice in his professional lifetime, but there is no knowing at what stage of his training the first time will be. The inexperienced may be taken aback at the very considerable haemorrhage that can occur in such a case and the technique we describe in the following history is of value, not only as a first-aid measure, but also as a definitive treatment which aims at avoiding hysterectomy.

Case report

A 22-year-old unmarried foreign girl was referred to a private nursing home for termination of pregnancy on psychiatric grounds, having had 12 weeks' amenorrhoea at the time. Her only previous pregnancy had been terminated at eight weeks, two years before. At operation a soft pelvic mass the size of a 12-week pregnancy was found pushing the uterine body, a small firm mass, upwards and forwards. A thin effaced external cervical os was found to admit a finger and the pregnancy was terminated by aspiration. A large haemorrhage of about 2 l occurred, and digital examination, which disclosed a cavernous cervical canal with a closed internal os, enabled a diagnosis of cervical pregnancy to be made beyond doubt. The cervical canal and vagina were securely packed with gauze, a replacement blood transfusion was given, and the patient was transferred to the local district general hospital.

On the second postoperative day, under general anaesthetic, the packs were removed and a measured blood loss of 2500 ml ensued. This was halted by inserting a 35 FG (11-14 mm diameter) stiff polyethylene Argle suck tube into the cervical canal and compressing the cervix against this by a 5-mm mersilene Shirodkar-type circumsciture, inserted according to McDonald's technique, as high and as tightly as possible. (Even despite the tightness there was a tendency for the polyethylene obturator to slip out, and so it was tacked to the cervix with a silk stitch.) A further blood transfusion was given.

On the thirteenth postoperative day (the eleventh after the second operation) the obturator and circumsciture were removed, but a further blood loss of about 500 ml occurred shortly afterwards and they were replaced. The obturator was finally removed 31 days after its first insertion and the patient, who suffered no further bleeding, was discharged with the circumsciture in situ a few days later. She was instructed to avoid intercourse for the next three months, after which time the circumsciture was removed. The cervix was reported to appear normal at this time and the patient was menstruating regularly.

Comment

Most authorities recommend immediate hysterectomy in the management of cervical pregnancy, certainly for all cases of over eight weeks' menstrual age. Successful cases of conservative management have been reported, but in none of these was the bleeding of the torrential quantity that we encountered. We report our technique simply because it enabled us to avoid hysterectomy.

Several writers state that cervical pregnancy has been preceded by cervical trauma and specifically by therapeutic abortion, as in this case. It has even been suggested that the incidence may rise from about 1:16000 to as many as 1:1000 in communities where a liberal abortion policy is practised. Presumably a fertilised ovum failing to implant in the endometrium nevertheless finds an attractive nidus within a scarred cervical canal.

This being the case, the above technique, and the understanding that stitch and obturator must be left undisturbed possibly for several weeks, may have a useful place in modern gynaecological practice.