CORNUAL ECTOPIC PREGNANCY

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Introduction

Cornual pregnancy is when implantation takes place in the most proximal part of the Fallopian tube as it passes through the myometrium [1]therefore surrounded by a thin layer of myometrium. Patients usually have delayed presentation due to the distensibility of the myometrium and tend to present usually between 9 and 12 weeks' gestation with a history of abdominal pain and vaginal bleeding[3]. The uterus ruptures in 20% of cases that progress beyond 12 weeks gestation[4]

Case Presentation

A 34yo female presented with sudden onset constant lower abdominal pain with a positive urine pregnancy test. An urgent formal ultrasound was performed which showed a cornual ectopic pregnancy.

The CRL measured 39mm which correlated to a gestational age of 10w5d +/-5d.

Management

She was planned for a laparosocpic cornual resection and taken to theatre. The left cornua was infiltrated with 0.01%vasopressin and laparoscopic left cornual resecctions with left salpingectomy was performed. The uterus was sutured with 2 layers of 1-0 vicryl intra corporeally. There was 300mls haemoperitoneum.

Results

Macroscopic histopathology showed that the specimen consisted of an intact fallopian tube (60 x 5mm), with an adjacent portion of uterus (cornual aspect) measuring 35 x 30mm. A moderate amount of bulging, membranous, placenta-like tissue is seen firmly adjacent at the cornua of the uterus measuring 40 x 30 x 25mm.

The patient recovered well post operatively. She was advised to have long acting contraception and a planned caesasrean delivery for her next pregnancy.

Conclusion

The rate of diagnosis can be improved using three criteria (on transabdominal or transvaginal ultrasound): an empty uterus, a gestational sac seen separately and a thin myometrial layer surrounding the sac (interstitial line) [6] followed by laparoscopic diagnosis. Increasingly, interstitial pregnancies are treated with laparoscopic cornuotomy which is the removal of ectopic pregnancy tissue with preservation of uterine architecture [4].

1. Poon, L. C., Emmanuel, E. , Ross, J. A. and Johns, J. (2014), How feasible is expectant management of interstitial ectopic pregnancy?. Ultrasound Obstet Gynecol, 43: 317-321; 3, 1Pisarska MD, Carson SA. Incidence and risk factors for ectopic pregnancy. *Clin Obstet Gynecol* 1999; **42**: 2–8. 5. Tulandi T, Al-Jaroudi D. Interstitial pregnancy: results generated from the Society of Reproductive Surgeons Registry. Obstet Gynecol 2004;103:47–50;6. Timor-Tritsch IE, Monteagudo A, Matera C, Veit CR. Sonographic evolution of cornual pregnancies treated without surgery. Obstet Gynecol 1992; 7. Jermy, K. , Thomas, J. , Doo, A. and Bourne, T. (2004), The conservative management of interstitial pregnancy. BJOG: An International Journal of Obstetrics & Gynaecology,