



Cesarean Scar Pregnancy (CSP) and its Approach.

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Introduction

An unplanned pregnancy that develops on or near the scar from a previous caesarean delivery. For the purposes of this discussion, all pregnancies involving hysterotomies scars shall be referred to as CSPs. An intramural pregnancy, often known as a pregnancy, implanted on or in a myomectomy scar, is another possibility. Undiagnosed or incorrectly managed CSP can result in substantial morbidity and mortality for both the mother and the fetus, including uterine rupture and hemorrhage. Heavy bleeding has also been linked to myometrial thickness, peri trophoblastic perfusion, and serum -HCG levels [1-4].

Cesarean Scar Pregnancy (CSP)

A gestational sac placed in a previous CS scar is defined as a Caesarean section (CS). CSP affects 1.15 percent of women who have had past caesarean births, with a prevalence of 1:2226–1:1800. Additionally, it has been shown that after in vitro fertilization and embryo transfer, women having a history of caesarean delivery are more likely to develop CSP (IVF-ET). Due to past uterine scar tissue from a caesarean delivery, the decidua basalis is frequently missing or partially disturbed with a faulty layer of fibrinoid degeneration. Instead of enclosing or implanting into the decidualized endometrium, the pregnancy in CSP embeds in the myometrium and fibrous scar tissue. The pregnancy must be carefully controlled because it is abnormal from the moment of implantation [5-7].

Diagnosis and Treatment Modalities

In contemporary obstetrics, it is now challenging to diagnose

and treat ectopic caesarean scar pregnancy. With the growth in pregnancies ending in caesarean sections and the introduction of transvaginal ultrasonography, the prevalence of caesarean scar pregnancy diagnoses has increased as well. The range of gestational ages at diagnosis was 5 weeks, 4 days to 8 weeks, 2 days. It's crucial to make a diagnosis and designate a course of treatment early. To possibly diagnose or rule out CSEP, the doctor will examine your ultrasound for one or more of the following specific criteria. The uterus or cervix is empty, the placenta, amniotic sac, or both are caught in the scar tissue from a C-section, or there is no fetal heartbeat. Thin or absent tissue layer between the amniotic sac and the bladder; the amniotic sac is triangular or oval, indicating that it is forced into the area of the scar tissue; numerous blood vessels or blood flow; plentiful blood flow (it should be rounded). Thanks to the adoption of transvaginal probes and ultrasound scans in obstetric practice and the development of imaging technologies, early detection of this phenomenon is now feasible. Transvaginal ultrasound imaging helps to see the scar from a caesarean section, and early discovery of this kind of pregnancy necessitates a successful therapy that doesn't harm fertility. Doppler imaging and, in the most difficult circumstances, MRI are performed[8].

Heavy vaginal bleeding that is painless is the most common symptom. Because the CSP lacks any recognizable clinical indicators, endovaginally ultrasonography and color flow doppler are essential for diagnosis. For a diagnosis, the following sonographic parameters are necessary: A discontinuity on the anterior wall of the uterus

seen in a sagittal plane of the uterus running through the amniotic sac, (ii) development of the sac in the anterior wall of the isthmic portion, (iii) absence or diminished healthy myometrium between the bladder and the sac, (iv) high velocity with low impedance, and (v) all the above[9].

Because the CSP is so uncommon, there are no perfect therapeutic techniques. Sometimes, medical, and surgical therapy methods are combined. The surgical technique uses both radical and conservative therapies. When the uterus has ruptured or the bleeding is uncontrollable, a hysterectomy is the most drastic procedure. The best course of treatment should be local methotrexate therapy since it provides for the preservation of fertility in asymptomatic pregnant patients who do not also have hemodynamic issues (under ultrasound or hysteroscopy guidance). The most effective CSP treatment involves the simultaneous use of two to three techniques. Another treatment option is uterine artery embolization. UAE is well known as a conservative treatment for uterine fibroids and postpartum hemorrhage and is the most efficient approach to stop excessive bleeding during D and C for cervical pregnancy [10].

Conclusion

Due to an increase in caesarean deliveries, caesarean scar pregnancy (CSP) is becoming more common. The sickness must be identified as soon as feasible, tailored based on gestational age, and examined by a multidisciplinary team to choose the safest treatment approach to reduce related morbidity.

Acknowledgment

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Conflict of Interest

No conflict of interest.

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