Molar Pregnancy in Scar Ectopics

1. Hydatidiform mole in a scar on the uterus: A case report.

**Author(s):** Jiang, Hao-Ru; Shi, Wen-Wei; Liang, Xiao; Zhang, Hui; Tan, Yan

**Source:** World journal of clinical cases; Apr 2020; vol. 8 (no. 8); p. 1547-1553

**Publication Date:** Apr 2020

**Publication Type(s):** Case Reports

**PubMedID:** 32368549

Available at [World journal of clinical cases](http://www.lib.com) - from Europe PubMed Central - Open Access

Available at [World journal of clinical cases](http://www.lib.com) - from Unpaywall

**Abstract:**

**BACKGROUND**
Cesarean scar molar pregnancy is extremely rare, but the incidence has been rising due to the continuous increase in the rate of cesarean section. The presence of a hydatidiform mole in the scar left on the uterus by the procedure may lead to severe complications. We performed a literature review and found only seven reported cases of cesarean scar molar pregnancy. Accurate diagnosis and appropriate treatment are extremely important for the patients' prognosis.

**CASE SUMMARY**
A 35-year-old woman, gravida 4, para 1, complained of vaginal bleeding lasting more than 1 mo and amenorrhea lasting more than 2 mo. The patient's serum human chorionic gonadotropin was 4287800 IU/L. Ultrasound showed a 11.5 cm × 7.5 cm mass at the anterior lower wall of the uterus. The patient underwent suction evacuation, and partial grape-like tissue mixed with blood clots was removed. Uterine arterial embolization was performed to control intraoperative and postoperative bleeding. Histological examination confirmed the presence of a hydatidiform mole in uterine scar. After surgery, there was still a mass with heterogeneous intensity near the isthmus of the uterus on magnetic resonance imaging. The patient then underwent chemotherapy. During the 6-mo follow-up period, the mass disappeared and the serum human chorionic gonadotropin level gradually decreased to normal level.

**CONCLUSION**
We report a case of cesarean scar molar pregnancy successfully cured by comprehensive treatment. We found that cesarean scar molar pregnancy was subject to intraoperative bleeding, and uterine arterial embolization before surgery may be helpful.

**Database:** Medline
2. Cesarean scar choriocarcinoma: A case report and review of literature

Author(s): Kittisiam T.; Thavaramara T.; Srijaipracharoen S.; Tanjitgamol S.; Chavanisakun C.
Source: Journal of the Medical Association of Thailand; 2018; vol. 101 (no. 8)
Publication Date: 2018
Publication Type(s): Article

Abstract: Gestational choriocarcinoma [GCC] is an uncommon trophoblastic neoplasm. In an extremely rare circumstance, the GCC over the site of cesarean scar may occur. We reported a patient who presented with vaginal bleeding and rising beta-hCG level two weeks after treatment of abortion. Ultrasonography showed a small content located at lower part of uterus. Provisional diagnosis was a Cesarean scar pregnancy and the patient decided to have hysterectomy. Histopathologic examination reported small foci of choriocarcinoma at Cesarean scar. The diagnosis was stage I:3 choriocarcinoma. After surgical treatment, her beta-hCG level gradually declined to normal value. Without adjuvant treatment, she was doing well with no evidence of recurrent disease for 25 months after surgery. In conclusion, although it has been generally known that GCC usually occurs months to years after pregnancy, gestational trophoblastic disease cannot be overlooked in the case that is clinically suspicious. Surgical treatment might be effective without adjuvant chemotherapy in some selected cases; however, the beta-hCG level must be monitored closely.

Database: EMBASE

3. Caesarean scar choriocarcinoma with uterine rupture: A case report

Author(s): Li X.-M.; Liu X.-Y.; Wang X.-J.
Source: European Journal of Gynaecological Oncology; 2018; vol. 39 (no. 2); p. 294-296
Publication Date: 2018
Publication Type(s): Article

Abstract: A caesarean scar choriocarcinoma is an extremely rare for its unique position. The authors report the clinical characteristics, pathologic findings, and treatments of a patient in caesarean scar choriocarcinoma with uterine rupture. The present report outlines a case of primary gestational choriocarcinoma with uterine rupture in caesarean scar misdiagnosed as a normal caesarean scar pregnancy in a 36-year-old woman. The patient underwent resection of the scar with tumor tissue and wound repair to preserve the uterus. The blood serum level of beta-human chorionic gonadotropin (beta-hCG) declined from > 200,000 IU/l to 49,151 IU/l the day after the operation. Finally, she received two courses of combined chemotherapy with 5-fluorouracil and actinomycin D. It is difficult to make clinical diagnosis in a primary gestational choriocarcinoma of the uterine caesarean scar. Awareness of the possibility of potentially catastrophic complications as heavy bleeding or uterine rupture, and operation to resect the scar with tumor tissue and wound repair combined with chemotherapy can become an effective alternative for the treatment of caesarean scar choriocarcinoma.

Database: EMBASE
4. Three cases of cesarean scar pregnancy treated with conservative surgery

**Author(s):** Ueda H.; Yoshihara K.; Chihara M.; Ishiguro T.; Adachi S.; Isobe M.; Kobayashi A.; Nishino K.; Nishikawa N.; Sekine M.; Enomoto T.

**Source:** Journal of Obstetrics and Gynaecology Research; Aug 2018; vol. 44 (no. 8); p. 1598

**Publication Date:** Aug 2018

**Publication Type(s):** Conference Abstract

Available at Journal of Obstetrics and Gynaecology Research - from Wiley Online Library

**Abstract:** Cesarean Scar Pregnancy (CSP) is a rare life-threatening type of ectopic pregnancy in which implantation occurs in the previous cesarean-section scar. However, optimal treatment strategy for CSP is unclear. We report three cases of CSP treated with conservative surgery. Case 1: A 29-year-old woman with a past history of previous cesarean section was diagnosed with CSP at five weeks of gestation via ultrasound examination. She complained continual vaginal bleeding and lower abdominal pain since six weeks and we performed uterine artery embolization (UAE) followed by dilatation and curettage (D & C) at eight weeks. Case 2: A 40-year-old woman with a past history of previous cesarean section and adenomyomectomy was suspected with hydatidiform mole based on ultrasound findings at six weeks of gestation. She was referred to our hospital by ambulance due to massive vaginal bleeding, and we performed UAE followed by D&C at 10 weeks, and diagnosed no molar change pathologically. Case 3: A 33-year-old woman with a past history of previous cesarean section was diagnosed with CSP at five weeks of gestation through ultrasound examination. She had abnormal vaginal bleeding appeared at 6 weeks of gestation and was referred for the management of CSP. When she arrived at our hospital, massive blood flow but not gestational sac was detected around the scar. We performed only UAE. She was diagnosed with clinical invasive mole due to the elevated hCG level (6 days after UAE). UAE combined with D&C might be an effective uterine conservative treatment for CSP and useful for histological diagnosis of CSP.

**Database:** EMBASE

5. Placenta Site Trophoblastic Tumor and Choriocarcinoma from Previous Cesarean Section Scar: Case Reports.

**Author(s):** Nasiri, Setare; Sheikh Hasani, Shahrzad; Mousavi, Azamosadat; Modarres Gilani, Mitra; Akhavan, Setare; Vakili, Mohammad Rahim

**Source:** Iranian journal of medical sciences; Jul 2018; vol. 43 (no. 4); p. 426-431

**Publication Date:** Jul 2018

**Publication Type(s):** Case Reports

**PubMedID:** 30046213

Available at Iranian journal of medical sciences - from ProQuest (Health Research Premium) - NHS Version

Available at Iranian journal of medical sciences - from PubMed Central

**Abstract:** Choriocarcinoma and placental site trophoblastic tumor (PSTT) are rare varieties of gestational trophoblastic disease (GTD). PSTT alone constitutes about 1-2% of all trophoblastic tumors, which presents at early reproductive age and the serum beta-hCG level is much lower than choriocarcinoma. This tumor usually invades the myometrium and its depth of penetration is a prognostic factor. The first case report is regarding a 33-year-old woman with vaginal bleeding 3 months after abortion. The ultrasound exhibited heterogeneous and hypervascular mass related to previous cesarean scar. Serum beta-hCG level was 67 mIU/ml and chemotherapy was administered. However, due to severe vaginal bleeding and no regression in mass size, total abdominal hysterectomy was performed. Histopathological examination and IHC staining confirmed PSTT from
previous cesarean section. The second case report is regarding a 33-year-old woman with cervicoisthmic choriocarcinoma, which was mistaken as cesarean scar pregnancy. The ultrasonography and elevated serum beta-hCG level suggested cesarean scar pregnancy. The patient was treated with methotrexate without any effect. Eventually, cervicoisthmic choriocarcinoma was detected after hysterectomy. A diagnostic error was made leading to possible uterus perforation along with incorrect chemotherapy that resulted in a life-threatening condition. It is concluded that PSTT and choriocarcinoma are the two important differential diagnoses of sustained elevated beta-hCG when imaging evidence is also suggestive. Although PSTT and cervicoisthmic choriocarcinoma are rare, they do exist and are on the rise.

Database: Medline


Author(s): Ling, Chen; Zhao, Jitong; Qi, Xiarong

Source: Medicine; Jun 2018; vol. 97 (no. 26); p. e11312

Publication Date: Jun 2018

Publication Type(s): Case Reports Journal Article

PubMedID: 29953018

Available at Medicine - from Europe PubMed Central - Open Access
Available at Medicine - from Ovid (LWW Total Access Collection 2019 - with Neurology)
Available at Medicine - from Unpaywall

Abstract: RATIONALE The incidence of molar pregnancy in the cesarean scar is exceedingly low, however, the disease may carry a high risk of uncontrolled hemorrhage or uterine rupture. So far managements of this disease were rarely reported in literature. PATIENT CONCERNS We reported a 28-year-old woman presented to our hospital with a complaint of amenorrhea for 48 days and vaginal bleeding for 3 days. DIAGNOSIS Transvaginal ultrasonography, serum hCG and pelvic MRI confirmed the cesarean scar pregnancy. INTERVENTIONS The patient underwent bilateral uterine arterial embolization and suction evacuation. OUTCOMES The postoperative histologic examination of the tissue revealed a partial hydatidiform mole. LESSONS Molar pregnancy in the cesarean scar is tough to differentiate from normal cesarean scar pregnancy with serum hCG, sonogram or MRI. This case suggested us that it was necessary to perform a histological examination of postoperative specimen for cesarean scar pregnancy.

Database: Medline
7. Identification and treatment of gestational trophoblastic neoplasia located in the cesarean scar

**Author(s):** Wang X.; Li Y.; Yang J.; Wan X.; Xiang Y.; He Y.; Wang M.

**Source:** International Journal of Gynecology and Obstetrics; May 2018; vol. 141 (no. 2); p. 222-227

**Publication Date:** May 2018

**Publication Type(s):** Article

**PubMedID:** 29214637

**Abstract:** Objective: To identify the clinical characteristics of, and the diagnostic and therapeutic strategies for, gestational trophoblastic neoplasia (GTN) located in the cesarean scar. Method(s): The present retrospective analysis was conducted among patients diagnosed with GTN located in the cesarean scar at Peking Union Medical College Hospital, Beijing, China, between June 1, 2006, and May 31, 2016. Clinical features, diagnostic and therapeutic procedures, and outcomes were reviewed. Result(s): Of 938 women diagnosed with GTN, 31 (3.3%) patients had GTN located in the cesarean scar. Irregular vaginal bleeding was the main clinical manifestation. Twenty (65%) patients received an accurate diagnosis based on a history of molar pregnancy/a high beta-human chorionic gonadotropin level/typical imaging presentations. The remaining 11 patients were initially misdiagnosed; the definitive diagnosis was made by pathology. All patients received chemotherapy; 22 (71%) women also underwent hysterectomy or localized uterine lesion resection because of chemoresistant lesions. All patients had a complete remission; at a median follow-up of 35 months, only 1 (3%) woman had a relapse. Conclusion(s): Owing to its rarity and nonspecific symptoms, GTN located in the cesarean scar is prone to misdiagnosis. In patients without typical manifestations, the definitive diagnosis often relies on pathology. For treatment, uterine lesion resection is a useful adjunct to chemotherapy.

---

8. Caesarean scar molar pregnancy: A case report

**Author(s):** Yu M.; Bowler T.; Jacobson T.

**Source:** BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2018; vol. 125; p. 33-34

**Publication Date:** Mar 2018

**Publication Type(s):** Conference Abstract

**Abstract:** Background Molar caesarean scar pregnancy (CSP) is a rare condition. Management remains unclear, owing to the infrequency of its presentation. We describe the management of a molar CSP with IV methotrexate and emergency total laparoscopic hysterectomy (TLH). Case A 38 yo G3P2 (1x SVD, 1x C/S) presented for management of suspected CSP, 6 days post D&C for suspected incomplete miscarriage. Given the appearance of the ultrasound scan, it was felt that intra-sac methotrexate would not be successful, and IV methotrexate was given as per our local protocol. Initially, her histology was reported as a partial mole, positive for P57 staining. She was discharged home with follow-up. She re-presented with heavy PV bleeding and pelvic pain. Repeat ultrasound showed free fluid in the pouch of Douglas. Management options were discussed, including uterine artery embolisation, laparoscopic resection. Due to her severe pelvic pain, we proceeded to an emergency TLH. At laparoscopy, a small mass was seen abutting, but not involving the bladder. The ureters were skeletonised and identified, and haemalocks were placed on the uterine artery bilaterally at the level of the ureter to help minimise bleeding. She proceeded to have an
uncomplicated TLH. A partial molar pregnancy with placenta percreta was confirmed on histopathological assessment. Followup bhCG fell appropriately, and was negative 1 month postoperatively. Discussion Molar CSP is an extremely rare complication of caesarean section, and has little evidence to guide management. In such situations, management should be guided by expert opinion, at a tertiary level.

Database: EMBASE


Author(s): Dağdeviren, Elif Gülşah; Dur, Rıza; Fadıloğlu, Erdem; Demirdağ, Erhan; Öztürk, Çağatayhan; Altay, Metin

Source: Turkish journal of obstetrics and gynecology; Dec 2017; vol. 14 (no. 4); p. 249-251

Publication Date: Dec 2017

Publication Type(s): Case Reports

PubMedID: 29379669

Available at Turkish journal of obstetrics and gynecology - from Unpaywall

Abstract: Cesarean scar ectopic pregnancies and molar pregnancies are two very rare obstetric pathologies. In both cases, serious morbidities are involved that require careful management. The coexistence of the two clinical conditions is far less common and there are a limited number of cases in the literature. In this case report, a 34-year-old patient with previous cesarean section was diagnosed as having a molar pregnancy in a cesarean scar through ultrasonography. The patient was asymptomatic at that time. Ultrasonography revealed a protruding mass at the cesarean section and her human chorionic gonadotropin level was measured as 59.705 mIU/mL. Due to the risk of severe bleeding, cesarean section scar excision and revision were performed via laparotomy after counselling the patient. Removal of all trophoblastic tissue was observed as a result of the frozen pathology and the operation was terminated. After the definite pathology result came as a complete molar pregnancy, the patient was followed up according to molar pregnancy follow-up protocols and cured completely. Despite the alternative treatment options (methotrexate application, curettage, uterine artery embolization) in such patients, the decision for surgery was made after counselling the patient. In this very rare clinical condition, patients should be closely monitored and the appropriate treatment option should be applied as soon as possible, taking into consideration the bleeding risks of both pathologies.

Database: Medline
10. Epithelioid Trophoblastic Tumor Around an Abdominal Cesarean Scar: A Pathologic and Molecular Genetic Analysis.

Author(s): Hsiue EH; Hsu C; Tseng LH; Lu TP; Kuo KT

Source: International journal of gynecological pathology: official journal of the International Society of Gynecological Pathologists; Nov 2017; vol. 36 (no. 6); p. 562-567

Publication Date: Nov 2017

Publication Type(s): Case Reports; Journal Article

PubMedID: 28134666

Abstract: Epithelioid trophoblastic tumor (ETT) is a rare chemoresistant gestational trophoblastic neoplasm that typically presents as an intrauterine lesion. To our knowledge, no isolated abdominal wall ETT around a Cesarean scar has been reported. Here we describe a 54-yr-old woman with a complex obstetric history who presented with a solitary abdominal wall tumor adjacent to the abdominal Cesarean section scar. The tumor demonstrated typical morphologic and immunophenotypic features of ETT. The gestational origin of the tumor was confirmed by microsatellite genotyping. The tumor enlarged despite the patient undergoing multiagent chemotherapy. Whole-exome sequencing was performed to explore the mechanisms underlying chemoresistance. The ATP-binding cassette subfamily B member 1 (ABCB1) 3435CC genotype, and a putative deleterious x-ray cross-complementing group 4 (XRCC4) Ala73Pro mutations were found. In conclusion, ETT may present as a solitary abdominal wall lesion and microsatellite genotyping could facilitate the determination of its gestational origin. More studies are required to provide mechanistic insights into the chemoresistance of ETT.

Database: PubMed

11. God's first cancer, an unusual presentation—molar pregnancy implantation in caesarean scar

Author(s): Harrington P.

Source: Australian and New Zealand Journal of Obstetrics and Gynaecology; Oct 2017; vol. 57; p. 48

Publication Date: Oct 2017

Publication Type(s): Conference Abstract

Abstract: Introduction: Gestational trophoblast disease (GTD) forms a spectrum of illnesses that are rare, almost always highly curable, but not always well understood by non-specialists. The types of trophoblast disease range from the usually benign partial molar pregnancy through complete molar pregnancy and invasive mole to the malignant choriocarcinoma and placental site trophoblast tumours. All of these illnesses share the characteristic that they arise from a pregnancy. While ectopic pregnancy may occur in 11:1000 pregnancies (mortality 1.7 per 10,000 cases caesarean scar ectopic is an extremely rare condition with an incidence of between 1:1800-2216 pregnancies. The coexistence of these two conditions have not been reported in Australia with only a handful described internationally. Method(s): I present the case of a 34 year old multiparous lady presented with the unfortunate diagnosis of a molar pregnancy implanted in her caesarean scar. She was initially treated at a metropolitan centre before requiring transfer to a specialist unit. Result(s): The patient presented with a torrential vaginal bleed after failed initial management of her gestational
trophoblastic disease. She required transfer to a gynaecology centre and was administered chemotherapy. She was counselled of the need for, but declined, a hysterectomy. Discussion(s): I discuss the clinical manifestations, appropriate diagnostic tools and management of this extremely unusual and unexpected clinical case.

Database: EMBASE

12. Caesarean scar ectopic pregnancy, a case report

Author(s): Pantoja Garrido M.; Gomiz Rodriguez G.; Frias Sanchez Z.; Vico de Miguel F.J.; Pantoja Rosso F.J.

Source: Clinica e Investigacion en Ginecologia y Obstetricia; Oct 2017; vol. 44 (no. 4); p. 188-192

Publication Date: Oct 2017

Publication Type(s): Article

Abstract:Molar pregnancy is a very rare form of gestation. Current practices in its diagnosis are based on clinical manifestations, which are later confirmed by using a beta-human chorionic gonadotropin (B-HCG) blood test and transvaginal ultrasonography. The treatment is based on the removal of the trophoblastic abnormal tissue by uterine suction legrado under ultrasonographic control. Monitoring this type of gestation after treatment is of crucial importance due to the risk of malignisation and spread to other organs, requiring chemotherapy treatment in some cases. Trophoblastic implantation in uterine scar tissues is a rare and scarcely reported phenomenon that hinders the diagnosis, treatment, and follow-up of this type of pathology. Copyright © 2016 Elsevier Espana, S.L.U.

Database: EMBASE

13. Gestational trophoblastic diseases in cesarean scar: an analysis of 20 cases

Author(s): Zhang G; Pan Z

Source: Zhejiang da xue xue bao. Yi xue ban = Journal of Zhejiang University. Medical sciences; May 2017; vol. 46 (no. 5); p. 529-536

Publication Date: May 2017

Publication Type(s): Case Reports; Journal Article; Review

PubMedID: 29488721

Abstract:OBJECTIVE: To analyze the clinical features, diagnosis and treatment of gestational trophoblastic diseases in cesarean scar. METHODS: Clinical data of three cases of gestational trophoblastic diseases in cesarean scar diagnosed in Women’s Hospital, Zhejiang University School of Medicine during December 2011 and December 2016 were collected. And literature search was performed in Wanfang data, VIP, CNKI, PubMed, ISI Web of Knowledge and EMBase database. RESULTS: A total of 20 cases of gestational trophoblastic diseases were included in the analysis. Clinical features were mainly abnormal vaginal bleeding after menopause, artificial abortion or medical abortion, which might be accompanied by abdominal pain. Serum β-human chorionic gonadotropin (β-hCG) levels were increased in 19 patients. The sonographic features were increase of uterine volume, honeycomb-like abnormal intrauterine echo (or described as multiple cystic dark area, multiple anechoic area and multiple liquid dark area) or heterogeneity echo conglomeration, and no clear bound with muscular layer in some cases. There were abundant blood flow signals inside or around the lesions. The ultrasonography indicated that the lesions were located in the anterior side of the uterine isthmus with the involvement of cesarean section scar. In 12 cases with lesions in cesarean scar shown by preliminary diagnosis, 9 underwent uterine artery embolization
(UAE) for pretreatment; the blood loss greater than 1500 mL was observed in only one case without UAE; no patient received hysterectomy. In 8 patients whose lesions were not shown in cesarean scar, only one case received UAE pretreatment, and hysterectomy was performed in 3 cases due to blood loss greater than 1500 mL. Two cases were lost in follow-up and no death was reported in remaining 18 cases. The serum β-hCG levels returned to normal or satisfactory level during the follow-up in 17 cases with increased β-hCG levels before treatment and no recurrence was observed. CONCLUSIONS: The misdiagnosis rate and missed diagnosis rate of gestational trophoblastic diseases in cesarean section scar are high. The identification of cesarean section scar involvement and UAE may reduce the bleeding and avoid hysterectomy.

**Database:** PubMed

14. **Persistent trophoblastic disease at caesarean scar and its successful treatment with multiple dose systemic methotrexate after suction curettage**

**Author(s):** Polat I.; Yucel B.; Erdem B.; Gedikbasi A.; Davutoglu S.

**Source:** Journal of Obstetrics and Gynaecology; Apr 2017; vol. 37 (no. 3); p. 392-394

**Publication Date:** Apr 2017

**Publication Type(s):** Article

**PubMedID:** 27868474

**Database:** EMBASE

15. **Ectopic Molar Pregnancy: Diagnostic Efficacy of Magnetic Resonance Imaging and Review of the Literature.**

**Author(s):** Yamada, Yasushi; Ohira, Satoshi; Yamazaki, Teruyuki; Shiozawa, Tanri

**Source:** Case reports in obstetrics and gynecology; 2016; vol. 2016 ; p. 7618631

**Publication Date:** 2016

**Publication Type(s):** Journal Article

**PubMedID:** 27648323

Available at [Case reports in obstetrics and gynecology](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5398772/) - from Europe PubMed Central - Open Access

**Abstract:** Ectopic molar pregnancy is extremely rare, and preoperative diagnosis is difficult. Our literature search found only one report of molar pregnancy diagnosed preoperatively. Moreover, there is no English literature depicting magnetic resonance image (MRI) findings of ectopic molar pregnancy. We report a case of ectopic molar pregnancy preoperatively diagnosed using MRI. A literature review of 31 cases of ectopic molar pregnancy demonstrated that lesions have been found in the fallopian tube (19 cases, 61%), ovary (5 cases, 16%), cornu (3 cases, 10%), peritoneum (2 cases, 6%), uterine cervix (1 case, 3%), and cesarean scar (1 case, 3%). Abdominal pain and abnormal vaginal bleeding were reported in 70% and 61% of the patients, respectively. Twenty-one cases (67%) presented with rupture and hemoperitoneum. All patients underwent surgical resection or dilatation and curettage. Methotrexate therapy was performed in one case because residual trophoblastic tissue was suspected. A second operation was performed in one case of ovarian molar pregnancy because serum hCG levels increased again after primary focal ovarian resection. No patients developed metastatic disease or relapsed. These findings suggest the prognosis of ectopic molar pregnancy to be favorable.

**Database:** Medline
16. Persistent Trophoblastic Disease at Cesarean Scar.
Author(s): Biswas, R; Saxena, P; Gupta, U; Choudhary, N; Chawla, R
Source: Kathmandu University medical journal (KUMJ); 2016; vol. 14 (no. 56); p. 376-379
Publication Date: 2016
Publication Type(s): Case Reports Journal Article
PubMedID: 29336430
Abstract: Pregnancy over the cesarean scar is the rarest cause of ectopic pregnancy and development of persistent trophoblastic disease at the scar site is extremely rare. A high index of suspicion is needed for early diagnosis and management of cesarean scar molar pregnancy. This condition is difficult to diagnose and must be considered in the patient with a history of cesarean section who has persistent vaginal bleeding or symptoms of pregnancy after suction evacuation. Diagnosis can be confirmed by measuring ß Human Chorionic Gonadotropin levels, transvaginal ultrasound with doppler flow evaluation. As this is an uncommon condition, this case report with conservative non surgical approach will add up to its clinical spectrum.
Database: Medline

17. Caesarean scar choriocarcinoma: Ultrasound and magnetic resonance imaging findings
Author(s): Bekci T.; Ozturk M.; Danaci M.
Source: JBR-BTR; 2016; vol. 100 (no. 1)
Publication Date: 2016
Publication Type(s): Article
Available at Journal of the Belgian Society of Radiology - from Unpaywall
Abstract: Primary gestational choriocarcinoma in a uterine caesarean section scar (CSS) is an extremely rare entity, and its timely diagnosis and treatment is crucial in order to prevent related complications and metastatic disease. Herein, we report on a 33-year-old female who was referred to our department with an initial diagnosis of ectopic pregnancy. Transabdominal ultrasound and magnetic resonance imaging (MRI) demonstrated a nodular mass on CSS. The final histopathological diagnosis was CSS choriocarcinoma. Copyright © 2016 The Author(s).
Database: EMBASE
18. Molar caesarean scar pregnancy: A case report

Author(s): Yu M.; Bowler T.; Jacobson T.

Source: Australian and New Zealand Journal of Obstetrics and Gynaecology; Oct 2016; vol. 56; p. 66

Publication Date: Oct 2016

Publication Type(s): Conference Abstract

Abstract: Introduction: Molar Caesarean scar pregnancy (CSP) is a rare condition. It is a rare condition and the management remains unclear. We describe the management of a molar CSP with IV methotrexate followed by emergency total laparoscopic hysterectomy (TLH). Case: A 38 year old G3P2 (1x SVD, 1x C/S) presented for management of suspected CSP, 6 days post D&C for suspected incomplete miscarriage. Given the appearance of the ultrasound scan, it was felt that intra-sac methotrexate would not be successful, and IV methotrexate was given as per our local protocol. The histology was reported as a partial mole, positive for P57 staining. She was discharged home after IV methotrexate with planned follow up. She re-presented 24 hours later with heavy vaginal bleeding and pelvic pain. Repeat ultrasound showed free fluid in the pouch of Douglas. Management options were discussed, including uterine artery embolisation and laparoscopic resection of the caesarean scar site. Due to her severe pelvic pain, we proceeded to an emergency TLH. At laparoscopy, a small mass was seen abutting, but not involving the bladder. The ureters were skeletonised and identified, and Hem-o-Lok clips were placed on the uterine arteries bilaterally to help minimise bleeding. She proceeded to have an uncomplicated TLH. A partial molar pregnancy with placenta percreta was confirmed on histopathological assessment. Follow up beta hCG fell appropriately, and was negative 1 month postoperatively. Discussion(s): Molar CSP is an extremely rare complication of caesarean section, and has little evidence to guide management. In such situations, management should be guided by expert opinion, at a tertiary level.

Database: EMBASE


Author(s): Vimercati, Antonella; de Gennaro, Alessandra Caterina; Resta, Leonardo; Cormio, Gennaro; Cicinelli, Ettore

Source: Journal of ultrasound in medicine : official journal of the American Institute of Ultrasound in Medicine; Jul 2016; vol. 35 (no. 7); p. 1608-1612

Publication Date: Jul 2016

Publication Type(s): Case Reports Journal Article

PubMedID: 27353688

Available at Journal of ultrasound in medicine : official journal of the American Institute of Ultrasound in Medicine - from HighWire - Free Full Text

Available at Journal of ultrasound in medicine : official journal of the American Institute of Ultrasound in Medicine - from Unpaywall

Database: Medline
20. Spontaneous first-trimester perforation of the uterus following Cesarean scar pregnancy choriocarcinoma

**Author(s):** Sherer D.M.; Dalloul M.; Adeyemo I.; Cho Y.; Mylvaganam S.R.; Abulafia O.; Zinn H.L.

**Source:** Ultrasound in obstetrics & gynecology : the official journal of the International Society of Ultrasound in Obstetrics and Gynecology; Apr 2016; vol. 47 (no. 4); p. 519-521

**Publication Date:** Apr 2016

**Publication Type(s):** Article

**PubMedID:** 26690679

Available at [Ultrasound in obstetrics & gynecology : the official journal of the International Society of Ultrasound in Obstetrics and Gynecology](https://onlinelibrary.wiley.com/doi/abs/10.1111/1440-0932.12688) from Wiley Online Library

**Database:** EMBASE

---


**Author(s):** Qian Z.-D.; Zhu X.-M.

**Source:** European Journal of Medical Research; May 2014; vol. 19 (no. 1)

**Publication Date:** May 2014

**Publication Type(s):** Article

**PubMedID:** 24887563

Available at [European journal of medical research](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4034912/) from BioMed Central

Available at [European journal of medical research](https://www.sagepub.com/journals/med) from SpringerLink - Medicine

**Abstract:** Objective. To report the clinical characteristics, pathologic findings and treatments of a patient with a Caesarean scar choriocarcinoma. Patient history. A 22-year-old woman had a diagnosis of primary gestational choriocarcinoma in a uterine Caesarean scar misdiagnosed as a normal Caesarean scar pregnancy. The patient underwent selective uterine artery embolization coupled with methotrexate arterial injection, along with dilatation and curettage of the uterine Caesarean scar. Finally, she received eight courses of multiagent chemotherapy. The reproductive function of the patient was preserved. Conclusion(s): Primary gestational choriocarcinoma out of the uterine corpus is a rare disease. A Caesarean scar choriocarcinoma is an extremely unusual example of this entity because of its unique position. To the best of our knowledge, this is the first report of this phenomenon. Our experience and a literature review suggest that a clinical diagnosis of a primary gestational choriocarcinoma of the uterine Caesarean scar is difficult to make, and uterine artery embolization is beneficial to prevent massive bleeding before curettage. © 2014 Qian and Zhu; licensee BioMed Central Ltd.

**Database:** EMBASE
22. **Mole in the hole: A rare case of recurrent invasive vesicular mole in an ectopic pregnancy at scar site with bladder invasion**

**Author(s):** Lewis P.; Biswas S.S.

**Source:** Journal of SAFOG; Apr 2014; vol. 6 (no. 1); p. 35-38

**Publication Date:** Apr 2014

**Publication Type(s):** Article

Available at [Journal of South Asian Federation of Obstetrics and Gynaecology](https://www.unpaywall.org) - from Unpaywall

**Abstract:** Background: Cesarean scar pregnancy is a rare form of ectopic pregnancy with an incidence of 1:1800 to 1:2200 pregnancies. There is currently no consensus as to the most effective management of cesarean-scar ectopic pregnancy, and little is known about the outcome of subsequent pregnancies. Case report: We report here a very rare case of recurrent vesicular mole in an ectopic pregnancy at scar site with bladder invasion and its management. Conclusion(s): There is currently no consensus as to the most effective management of cesarean-scar ectopic pregnancy, and little is known about the outcome of subsequent pregnancies. We show that medical management was effective in this patient but further studies are needed to decide ideal management in such cases.

Copyright © 2014, Jaypee Brothers Medical Publishers (P) Ltd. All rights reserved.

**Database:** EMBASE

---

23. **Acquired uterine arteriovenous malformation in a cesarean scar pregnancy**

**Author(s):** Kim D.; Moon N.R.; Lee H.J.; Park T.C.; Kim Y.H.; Lee S.R.; Won Y.D.

**Source:** Taiwanese Journal of Obstetrics and Gynecology; Dec 2013; vol. 52 (no. 4); p. 590-592

**Publication Date:** Dec 2013

**Publication Type(s):** Article

**PubMedID:** 24411051

Available at [Taiwanese journal of obstetrics & gynecology](https://www.freemedicaljournals.com) - from Free Medical Journals . com

**Database:** EMBASE
24. Caesarean scar ectopic pregnancy in a warfarinised patient-a management dilemma

Author(s): Sandu Aana L.; Mohamed R.; Karuppaswamy J.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Jun 2013; vol. 120; p. 549

Publication Date: Jun 2013

Publication Type(s): Conference Abstract

Available at BJOG: An International Journal of Obstetrics & Gynaecology - from Wiley Online Library
Available at BJOG: An International Journal of Obstetrics & Gynaecology - from Unpaywall

Abstract: Case We report a case of a 35-year-old with three previous caesarean sections who was diagnosed with caesarean scar (CS) ectopic pregnancy. She presented with abdominal pain at 6-7 weeks of gestation. She had an IVC filter inserted in her last pregnancy due to multiple pulmonary embolisms and deep vein thrombosis. She had major laparotomy after it migrated and perforated the small bowel. The IVC filter could not be removed and thereafter warfarinised for life. Due to high risk of bleeding, surgery was a last resort. She was counselled for systematic methotrexate after liaising with haematologist. She had two doses of methotrexate and made uneventful recovery. She became pregnant again and had a successful pregnancy. Discussion Cornual molar pregnancy is very rare in occurrence. There are only four cases reported in the literature which were managed by combined surgery and systemic methotrexate. This was due to either acute presentation or delayed diagnosis of molar pregnancy after the pathology report. With the effective use of the imaging following suspicion, we were able to diagnose the molar pregnancy at the cornua earlier in the pregnancy. This enabled us to manage the cornual molar pregnancy successfully with methotrexate alone (Images available from the USS and MRI).

Database: EMBASE

**Author(s):** Ko, Jennifer K Y; Wan, Hei Lok; Ngu, Siew Fei; Cheung, Vincent Y T; Ng, Ernest H Y

**Source:** Obstetrics and gynecology; Feb 2012; vol. 119 (no. 2); p. 449-451

**Publication Date:** Feb 2012

**Publication Type(s):** Case Reports Journal Article

**PubMedID:** 22270435

Available at *Obstetrics and gynecology* - from Ovid (Journals @ Ovid) - Remote Access

[location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

**Abstract:** BACKGROUND Molar pregnancy found in a cesarean scar is exceedingly rare. It can be challenging to manage and can have potentially catastrophic consequences. CASE A 34-year-old multigravid woman presented with persistent symptoms of pregnancy after a surgical termination of pregnancy. Cesarean scar molar pregnancy was suspected on ultrasonography, and suction evacuation was performed under ultrasound guidance. This was followed by bimanual compression, oxytocin, and uterine artery embolization to reduce bleeding. CONCLUSION A high index of suspicion is needed for early diagnosis and management of cesarean scar molar pregnancy.

**Database:** Medline

26. Molar pregnancy in a cesarean section scar of uterus

**Author(s):** Jin F.-S.; Wu G.-J.; Hwang K.-S.; Ding D.-C.

**Source:** Journal of Medical Sciences; 2011; vol. 31 (no. 4); p. 173-176

**Publication Date:** 2011

**Publication Type(s):** Article

**Abstract:** We present a case of molar pregnancy at the site of a cesarean section scar. A 44-year-old woman, gravida 2, para 2, presented with irregular vaginal bleeding for 1 month, and intermittent lower abdominal pain for a few days. Her serum hCG level was inappropriately high. Transvaginal sonography showed a fetal pole, approximately 6 weeks of gestation, with no evidence of fetal heartbeat, and presence of a gestational sac with an irregular surface surrounded by a heterogeneous placenta containing multicystic sonolucent space. The gestational sac was located at the site of a scar from a previous cesarean section. The patient underwent suction curettage and the pathology revealed partial mole. She was followed up at the local medical center. The serum hCG level decreased gradually during the follow-up period. Early diagnosis is important in a case of molar pregnancy in a cesarean section scar to prevent serious complications such as severe bleeding that can be life-threatening. We reported this case to accumulate experience that may improve the understanding of this disease, and allow development of an appropriate management plan. © 2011 JMS.

**Database:** EMBASE
27. Ectopic molar pregnancy in a cesarean scar.

**Author(s):** Wu, Chia-Fang; Hsu, Chin-Yuan; Chen, Chih-Ping

**Source:** Taiwanese journal of obstetrics & gynecology; Dec 2006; vol. 45 (no. 4); p. 343-345

**Publication Date:** Dec 2006

**Publication Type(s):** Case Reports Journal Article

**PubMedID:** 17175496

Available at [Taiwanese journal of obstetrics & gynecology](https://www.tjog.org.tw) from Free Medical Journals . com

Available at [Taiwanese journal of obstetrics & gynecology](https://www.tjog.org.tw) from PubMed

Available at [Taiwanese journal of obstetrics & gynecology](https://www.tjog.org.tw) from ScienceDirect

Available at [Taiwanese journal of obstetrics & gynecology](https://www.tjog.org.tw) from Unpaywall

**Abstract:**

**OBJECTIVE** To report a case of cesarean scar molar pregnancy.

**CASE REPORT** A 31-year-old, gravida 8, para 1, female patient underwent suction curettage for a diagnosis of molar pregnancy. However, she had persistent vaginal spotting and residual decidua tissue in a cesarean scar. She was successfully treated with repeat suction curettage.

**CONCLUSION** Cesarean scar pregnancy is difficult to diagnose and must be considered in the patient with a history of cesarean section who has persistent vaginal bleeding after suction curettage. To our knowledge, this is the first report of molar pregnancy in a cesarean scar.

**Database:** Medline
<table>
<thead>
<tr>
<th>#</th>
<th>Database</th>
<th>Search term</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medline</td>
<td>(scar ADJ2 ectopic*).ti,ab</td>
<td>162</td>
</tr>
<tr>
<td>2</td>
<td>Medline</td>
<td>(&quot;molar pregnancy&quot;).ti,ab</td>
<td>1038</td>
</tr>
<tr>
<td>3</td>
<td>Medline</td>
<td>exp &quot;HYDATIDIFORM MOLE&quot;/</td>
<td>5001</td>
</tr>
<tr>
<td>4</td>
<td>Medline</td>
<td>(&quot;Hydatidiform Mole**&quot;).ti,ab</td>
<td>3223</td>
</tr>
<tr>
<td>5</td>
<td>Medline</td>
<td>((partial OR complete) ADJ2 mole*).ti,ab</td>
<td>4790</td>
</tr>
<tr>
<td>6</td>
<td>Medline</td>
<td>(&quot;Gestational trophoblastic disease&quot;).ti,ab</td>
<td>1347</td>
</tr>
<tr>
<td>7</td>
<td>Medline</td>
<td>exp &quot;GESTATIONAL TROPHOBLASTIC DISEASE&quot;/</td>
<td>5698</td>
</tr>
<tr>
<td>8</td>
<td>Medline</td>
<td>(2 OR 3 OR 4 OR 5 OR 6 OR 7)</td>
<td>10378</td>
</tr>
<tr>
<td>9</td>
<td>Medline</td>
<td>exp &quot;PREGNANCY, ECTOPIC&quot;/</td>
<td>14544</td>
</tr>
<tr>
<td>10</td>
<td>Medline</td>
<td>(ectopic* ADJ2 pregnanc*).ti,ab</td>
<td>9880</td>
</tr>
<tr>
<td>11</td>
<td>Medline</td>
<td>(&quot;cesarean scar pregnanc**&quot;).ti,ab</td>
<td>401</td>
</tr>
<tr>
<td>12</td>
<td>Medline</td>
<td>(&quot;caesarean scar pregnanc**&quot;).ti,ab</td>
<td>131</td>
</tr>
<tr>
<td>13</td>
<td>Medline</td>
<td>(9 OR 10 OR 11 OR 12)</td>
<td>17709</td>
</tr>
<tr>
<td>14</td>
<td>Medline</td>
<td>(8 AND 13)</td>
<td>414</td>
</tr>
<tr>
<td>15</td>
<td>Medline</td>
<td>(scar).ti,ab</td>
<td>41371</td>
</tr>
<tr>
<td>16</td>
<td>Medline</td>
<td>exp CICATRIX/</td>
<td>38716</td>
</tr>
<tr>
<td>17</td>
<td>Medline</td>
<td>(15 OR 16)</td>
<td>68379</td>
</tr>
<tr>
<td>18</td>
<td>Medline</td>
<td>(14 AND 17)</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Database</td>
<td>Search Term</td>
<td>Results</td>
</tr>
<tr>
<td>---</td>
<td>----------</td>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td>19</td>
<td>Medline</td>
<td>(1 AND 8)</td>
<td>2</td>
</tr>
<tr>
<td>20</td>
<td>Medline</td>
<td>(8 AND 17)</td>
<td>40</td>
</tr>
<tr>
<td>21</td>
<td>EMBASE</td>
<td>(scar ADJ2 ectopic*).ti,ab</td>
<td>297</td>
</tr>
<tr>
<td>22</td>
<td>EMBASE</td>
<td>(&quot;molar pregnancy&quot;).ti,ab</td>
<td>1452</td>
</tr>
<tr>
<td>23</td>
<td>EMBASE</td>
<td>exp &quot;HYDATIDIFORM MOLE&quot;/</td>
<td>5792</td>
</tr>
<tr>
<td>24</td>
<td>EMBASE</td>
<td>(&quot;Hydatidiform Mole**&quot;).ti,ab</td>
<td>3403</td>
</tr>
<tr>
<td>25</td>
<td>EMBASE</td>
<td>((partial OR complete) ADJ2 mole*).ti,ab</td>
<td>5073</td>
</tr>
<tr>
<td>26</td>
<td>EMBASE</td>
<td>(&quot;Gestational trophoblastic disease&quot;).ti,ab</td>
<td>1885</td>
</tr>
<tr>
<td>27</td>
<td>EMBASE</td>
<td>exp &quot;GESTATIONAL TROPHOBLASTIC DISEASE&quot;/</td>
<td>14796</td>
</tr>
<tr>
<td>28</td>
<td>EMBASE</td>
<td>(22 OR 23 OR 24 OR 25 OR 26 OR 18501 OR 27)</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>EMBASE</td>
<td>exp &quot;ECTOPIC PREGNANCY&quot;/</td>
<td>19125</td>
</tr>
<tr>
<td>30</td>
<td>EMBASE</td>
<td>(ectopic* ADJ2 pregnanc*).ti,ab</td>
<td>13094</td>
</tr>
<tr>
<td>31</td>
<td>EMBASE</td>
<td>(&quot;cesarean scar pregnanc**&quot;).ti,ab</td>
<td>615</td>
</tr>
<tr>
<td>32</td>
<td>EMBASE</td>
<td>(&quot;caesarean scar pregnanc**&quot;).ti,ab</td>
<td>209</td>
</tr>
<tr>
<td>33</td>
<td>EMBASE</td>
<td>(29 OR 30 OR 31 OR 32)</td>
<td>21213</td>
</tr>
<tr>
<td>34</td>
<td>EMBASE</td>
<td>(scar).ti,ab</td>
<td>59531</td>
</tr>
<tr>
<td>35</td>
<td>EMBASE</td>
<td>exp SCAR/</td>
<td>73235</td>
</tr>
<tr>
<td>36</td>
<td>EMBASE</td>
<td>(34 OR 35)</td>
<td>100261</td>
</tr>
<tr>
<td>37</td>
<td>EMBASE</td>
<td>(28 AND 33 AND 36)</td>
<td>50</td>
</tr>
<tr>
<td>38</td>
<td>EMBASE</td>
<td>(21 AND 28)</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Database</td>
<td>Query</td>
<td>Count</td>
</tr>
<tr>
<td>---</td>
<td>------------</td>
<td>----------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>39</td>
<td>EMBASE</td>
<td>(22 AND 36)</td>
<td>22</td>
</tr>
<tr>
<td>40</td>
<td>Medline</td>
<td>(2 AND 17)</td>
<td>17</td>
</tr>
<tr>
<td>41</td>
<td>Medline</td>
<td>(&quot;hydatid mole&quot; OR &quot;mola hydatidosa&quot;).ti,ab</td>
<td>143</td>
</tr>
<tr>
<td>42</td>
<td>Medline</td>
<td>(17 AND 41)</td>
<td>1</td>
</tr>
<tr>
<td>43</td>
<td>EMBASE</td>
<td>(&quot;hydatid mole&quot; OR &quot;mola hydatidosa&quot;).ti,ab</td>
<td>76</td>
</tr>
<tr>
<td>44</td>
<td>EMBASE</td>
<td>(36 AND 43)</td>
<td>0</td>
</tr>
<tr>
<td>45</td>
<td>Medline</td>
<td>(scar ADJ2 molar).ti,ab</td>
<td>6</td>
</tr>
<tr>
<td>46</td>
<td>EMBASE</td>
<td>(scar ADJ2 molar).ti,ab</td>
<td>5</td>
</tr>
<tr>
<td>47</td>
<td>PubMed</td>
<td>(&quot;molar pregnancy&quot;).ti,ab</td>
<td>1082</td>
</tr>
<tr>
<td>48</td>
<td>PubMed</td>
<td>(&quot;Hydatidiform Mole*&quot;&quot;).ti,ab</td>
<td>5633</td>
</tr>
<tr>
<td>49</td>
<td>PubMed</td>
<td>(&quot;Gestational trophoblastic disease&quot;).ti,ab</td>
<td>2019</td>
</tr>
<tr>
<td>50</td>
<td>PubMed</td>
<td>(&quot;partial mole&quot; OR &quot;complete mole&quot;).ti,ab</td>
<td>511</td>
</tr>
<tr>
<td>51</td>
<td>PubMed</td>
<td>(&quot;hydatid mole&quot; OR &quot;mola hydatidosa&quot;).ti,ab</td>
<td>114</td>
</tr>
<tr>
<td>52</td>
<td>PubMed</td>
<td>(47 OR 48 OR 49 OR 50 OR 51)</td>
<td>7104</td>
</tr>
<tr>
<td>53</td>
<td>PubMed</td>
<td>(scar).ti,ab</td>
<td>69320</td>
</tr>
<tr>
<td>54</td>
<td>PubMed</td>
<td>(52 AND 53)</td>
<td>38</td>
</tr>
</tbody>
</table>