

Conservative management of cervical pregnancy: The utility of methotrexate treatment and uterine artery embolization

Hisashi Masuyama, Seiji Inoue, Etsuko Nobumoto, Kei Hayata, Tomonori Segawa, Yuji Hiramatsu

Department of Obstetrics and Gynecology, Okayama University Graduate School of Medicine, Dentistry and Pharmaceutical Science, Okayama, Japan

Email: masuyama@cc.okayama-u.ac.jp

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ABSTRACT

The aim of this retrospective case series report is to evaluate systemic methotrexate therapy in conjunction with uterine artery embolization (UAE) in the conservative management of cervical pregnancy. We examined clinical presentations, treatments, and therapeutic outcomes in fifteen patients with a cervical pregnancy who wished for preservation of fertility, treated at Okayama University Hospital between 1998 and 2012. Twelve patients received systemic methotrexate including five treated with UAE. One was treated with UAE alone. Two patients received neither UAE nor methotrexate because of a low human chorionic gonadotropin (hCG) level and poor blood flow around the gestational sac (GS). An increased GS size and the elevated hCG level during methotrexate therapy might be risk factors for emergent UAE. Two of six patients treated with UAE had subsequent confirmed viable pregnancies. In patients with a cervical pregnancy, methotrexate therapy in combination with UAE can be considered as an option before performing a hysterectomy with suitable counseling about the risk of loss of fertility. Careful observation of the GS size and hCG level during methotrexate therapy might be important for management.

Keywords: Cervical Pregnancy; Methotrexate; Uterine Artery Embolization; Dilatation and Curettage; Human Chorionic Gonadotropin

1. INTRODUCTION

Cervical pregnancy is a rare but potentially life-threatening

medical condition and has been reported at an incidence of 1 in 8000 - 18000 deliveries, but the incidence is increasing as a result of assisted reproductive technology [1,2]. Thus, *in vitro* fertilization and embryo transfer (IVF-ET) has been associated with an increased incidence of cervical pregnancy [3,4]. In the past, 60% of cases of cervical pregnancy were diagnosed at an advanced stage in which life-threatening hemorrhage occurred after a dilatation and curettage (D&C) or a suspected spontaneous abortion [5]. Such cases often resulted in the need for a hysterectomy and loss of the patient's fertility. The use of curettage with a Foley catheter tamponade or placement of a Shirodkar cerclage has also been reported for hemorrhage associated with a cervical pregnancy [6-9], but these procedures have not been established as safe.

Recently, the application of first-trimester transvaginal ultrasonography has led to improvements in the early diagnosis of cervical pregnancy, thereby assisting in conservative and fertility-preserving treatment [10,11]. Since Farabow *et al.* introduced systemic methotrexate (MTX) treatment for cervical pregnancy [12], MTX treatment has become an established alternative to surgical therapy [13-15]. Moreover, uterine artery embolization (UAE) has been widely used as a highly effective technique for controlling acute and chronic genital bleeding [16-18]. There have been sporadic reports of cases of cervical pregnancy with vaginal bleeding that were controlled by UAE and the administration of MTX to preserve fertility and control bleeding [19]. The risks of embolotherapy include uterine infarction or ischemia and necrosis; however, the majority of patients tolerate the procedure well [20,21]. Combined therapy with MTX has also been used and has been recommended by reports of UAE as an initial therapy to treat patients with a cervical pregnancy [22,23].

Table 1. Characteristics of patients with a cervical pregnancy.

Case	Age	Gravida	para	artificial abortion	Infertility	GA (days)	GS (mm)	FHM	Blood flow around GS	hCG level (mIU/mL)	genital bleeding	No. of MTX	UGE	Other treatment
1	36	1	0	1	-	77	80	+	+	64030	Moderate	3	+	MTX injection, D&C
2	22	2	0	1	-	42	28	+	+	4015	Small	2	+	D&C
3	38	1	0	0	IVF-ET	48	9.9	-	±	8123	Small	2	-	-
4	40	1	0	1	IVF-ET	41	10.6	+	+	4133	Small	4	+	-
5	23	2	0	1	-	52	18	+	±	16967	-	2	-	-
6	34	0	0	0	IVF-ET	42	8.9	+	+	4665	-	2	+	Aspiration of GS
7	40	0	0	0	-	57	7.5	-	-	868	-	2	-	-
8	28	0	0	0	-	38	11.7	+	+	11271	-	2	-	MTX injection
9	32	5	1	4	-	56	10.5	-	+	9897	Heavy	0	+	-
10	40	2	1	0	AIH	51	21	+	±	16131	-	0	-	-
11	37	2	1	0	IVF-ET	52	19	-	+	41261	Heavy	3	2x	D&C
12	30	0	0	0	-	36	17.1	-	-	6056	Moderate	2	-	-
13	41	2	0	2	Clomid	41	16	-	-	1191	Small	0	-	-
14	31	0	0	0	Clomid	38	7	-	±	2095	Small	1	-	-
15	39	0	0	0	IVF-ET	45	13	+	+	13575	small	8	-	D&C

GA: gestational age, GS: gestational sac, FHM: fetal heart movement, hCG: human chorionic gonadotropin, MTX: methotrexate, UAE: uterine artery embolization, D&C: dilatation and curettage.

Table 2. Comparison between groups with early and late gestational age (GA) (a), small and large gestational sac (GS) (b) and low and high serum hCG levels (c).

(a)										
GA (days)	Case number	GS(mm)	FHM	Blood flow around GS	hCG level (mIU/mL)	Massive bleeding	MTX	UAE	D&C	
<45	7	14.2 ± 7.1	4	5	4775 ± 3288	0	6	3	1	
≥45	8	22.4 ± 23.8	4	7	21357 ± 20875*	2	6	3	3	
(b)										
GS (mm)	Case number	GA (days)	FHM	Blood flow around GS	hCG level (mIU/mL)	Massive bleeding	MTX	UAE	D&C	
<13	7	45.7 ± 8.1	3	6	5864 ± 3962	1	6	3	0	
≥13	8	49.5 ± 12.5	5	6	20403 ± 21575*	1	6	3	4	
(c)										
hCG level (mIU/mL)	Case number	GA (days)	GS (mm)	FHM	Blood flow around GS	Massive bleeding	MTX	UAE	D&C	
<8123	7	42.4 ± 6.8	13.6 ± 7.5	3	4	0	6	3	1	
≥8123	8	52.4 ± 11.4*	22.9 ± 23.4	5	8*	2	6	3	3	

*P < 0.05, mean ± SD, GA: gestational age, GS: gestational sac, FHM: fetal heart movement, hCG: human chorionic gonadotropin, MTX: methotrexate, UAE: uterine artery embolization, D&C: dilatation and curettage.

also used to divide the patients into two groups. The serum hCG level was significantly higher and all patients who required D&C were included in the large GS group (>13 mm; **Table 2(b)**). Two groups were also evaluated using the median value of hCG level (8123 mIU/mL). There were significant differences in blood flow around the GS, but there was no significant difference in the incidence of D&C and the requirement for UAE in the high hCG group (**Table 2(c)**). We also examined the patients who underwent UAE. The GS size and serum hCG level at admission in the UAE group were higher than in the group without UAE, but this was not sig-

nificant statistically because some patients with a small GS and/or low hCG level required UAE because of a moderate or massive hemorrhage (**Table 3(a)**). In addition, clinical data on when UAE was done in the UAE cases are summarized in **Table 3(b)**. All patients with emergency UAE except for two with UAE at admission for massive hemorrhage had an increased and/or large GS size and/or elevation of serum hCG levels at UAE compared with those seen at admission.

Of the six patients who underwent UAE, two subsequently had confirmed viable pregnancies. Of these, one pregnancy resulted in a preterm delivery at 31

Table 3. Comparison between groups with and without UAE (a) and characteristics of cases with UAE (b).

(a)									
UAE	Case number	GA (days)	GS (mm)	FHM	Blood flow around GS	hCG level (mIU/mL)	MTX	D&C	
-	9	45.1 ± 7.4 [36 - 57]	13.5 ± 4.9 [7.0 - 21.0]	4	6	8475 ± 6345 [868 - 16967]	7	1	
+	6	51.7 ± 13.9 [41 - 77]	26.2 ± 27.3 [8.9 - 80.0]	4	6	21334 ± 25395 [4015 - 64030]	5	3	

(b)						
Case	GS (mm)	FHM	Blood flow around GS	hCG level (mIU/mL)	Bleeding situation	
1	80/58	+/-	+/-	64030/25	at D&C after MTX 3 courses	
2	28/64	+/-	+/+	4015/422	at D&C after MTX 2 courses	
4	11/13	+/-	+/+	4133/16055	after MTX 1 course	
6	9/50	+/-	+/+	4665/1708	after MTX 2 courses	
10	10	-	+	9897	at admission	
12	19/12	-	+	41261/122	at admission and after MTX 3 courses	

GA: gestational age, GS: gestational sac, FHM: fetal heart movement, hCG: human chorionic gonadotropin, MTX: methotrexate, UAE: uterine artery embolization, D&C: dilatation and curettage, GS size: at admission/at UAE.

weeks' gestation because of preterm labor and premature rupture of membranes and the other patient had a spontaneous vaginal term delivery with placenta accreta. None of the patients required hysterectomy.

4. DISCUSSION

In this study, we analyzed the outcomes for 15 patients with a cervical pregnancy who wished for minimally invasive treatment to preserve their fertility under our protocol of conservative management for cervical pregnancy (**Figure 1**). Of this series, 12 patients received systemic MTX administration including seven with MTX alone and five were also treated with UAE. The other patient was treated with UAE alone. Two patients received neither UAE nor MTX because of a low hCG level and poor blood flow around the GS. Forty percent of the study patients had a history of at least one induced abortion, and assisted reproductive techniques were used in eight cases including six cases of IVF-ET. An increased GS size and an elevated hCG level during MTX therapy might be risk factors for emergency UAE. Of the six patients who underwent UAE, two subsequently had confirmed viable pregnancies.

MTX treatment has been used successfully for treating cervical pregnancies and has become the first line therapy for stable patients [12-15]. However, additional therapies were often required for this treatment. We found here that the group of patients with a high hCG level (>8123 mIU/mL) included all with a massive hemorrhage and a higher requirement for D&C, but there were no significant differences in the requirement for UAE. This elevated hCG level is consistent with a previous report [24]. Another report indicated that UAE

should be applied after systematic MTX therapy and—if a fetal heart beat is present—lethal intraamniotic KCL injection should be considered in cases with very high hCG level (>34,000 mIU/mL) [25]. Conversely, the hCG level at admission could not predict the requirement for UAE in our study because we observed that the patients with low hCG level after MTX therapy as well as with low initial level needed emergency UAE for a moderate hemorrhage. However, most patients requiring emergency UAE had a large GS and/or elevation of serum hCG levels at UAE compared with at admission, suggesting that careful observation might be important for conservative management.

Previous reports have suggested that UAE alone may be insufficient to treat a cervical pregnancy effectively and that concurrent medical therapy might be indicated [23,25]. In our study, only one patient had a spontaneous abortion after UAE caused by a heavy hemorrhage. In all of our patients, UAE was effective in stopping active vaginal bleeding and preserving the uterus as reported previously [17,18,26]. However, one of our patients had active vaginal bleeding 67 days after the first UAE; this was controlled successfully by additional UAE and emergency D&C of the cervical canal after the second UAE.

Viable pregnancies have been reported after UAE [25,27]. In our study, two patients subsequently had viable pregnancies although assisted reproduction techniques—one of the risk factors for cervical pregnancy—were used in eight cases including six cases of IVF-ET. Despite these observations, patients seeking fertility preservation who may undergo UAE should receive adequate prior counseling according to American college of obstetrics and gynecology (ACOG) recommendations [28]. Thus, the use of UAE for cervical

pregnancy can be considered among patients desiring future childbearing, but further studies are needed to elucidate the effect of UAE on pregnancy outcomes.

5. CONCLUSION

In conclusion, MTX therapy in combination with UAE can be considered as an option before hysterectomy, with counseling about the risk of loss of fertility in patients with cervical pregnancy. Careful observations of GS size and hCG levels during MTX therapy might be important for management. Because more cases are being detected earlier with first-trimester ultrasonography and with the increased incidence with assisted reproductive technology, cervical pregnancy is becoming a more commonly encountered clinical situation. The use of MTX in combination with UAE for the conservative management of a cervical pregnancy in patients desiring to preserve their fertility should be considered strongly.

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