EXPECTANT MANAGEMENT OF BILATERAL CORNUAL ECTOPIC PREGNANCY RESULTING IN LIVE BIRTH: A CASE REPORT

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Introduction

- Cornual ectopic pregnancies account for 2-4% of all ectopic pregnancies and carry significant morbidity due to risk of uterine rupture and hemorrhage[1]
- Several treatment options for cornual ectopic pregnancy, however there are no clear guidelines for management in the setting of highly desired pregnancy and desire for future fertility
- Risk factor for cornual ectopic include use of ART and uterine structural anomalies[2]
- Mosaic Turner syndrome is reported to be associated with a higher rate of Mullerian anomalies (13-17%) compared to the general population (4-7%)[3,4]

Objective

To review a case that demonstrates expectant management of bilateral cornual ectopic pregnancy in a patient with mosaic Turner syndrome and Mullerian anomaly.

References

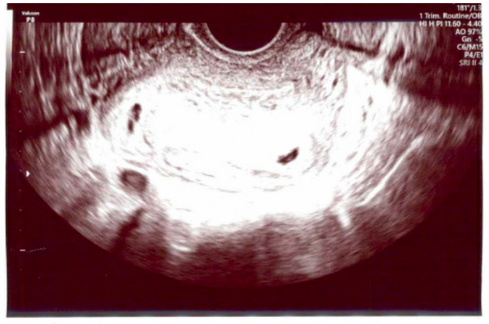
Case Presentation

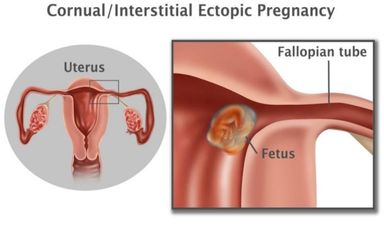
Patient:

- 33 year old G0P0 with PMH oligomenorrhea and vaginismus. Has significant exercise history
- Presented for fertility consultation with REI. Lab testing with normal gonadotropins and AMH 1.63. Declined genetic carrier screening and cavity/tubal assessment
- Trialed several cycles of ovulation induction with clomiphene citrate and letrozole with no success. Eventually started monitored injection gonadotropins
- Total of 2 mature and 1 immature follicle measuring 16.5 mm, 14 mm, and 12.5 mm. Trigger shot administered and pregnancy resulted
- Presented in early pregnancy with vaginal bleeding

Diagnostics:

- Transvaginal ultrasound: dichorionic-diamniotic twin gestation in a bicornuate uterus. Pregnancy in right (Twin 1) and left (Twin 2) uterine horn. Concern for dual cornual ectopic pregnancy.





Management:

- Referral to MFM. Offered pregnancy termination due to life-threatening risk of cornual ectopic rupture
- Patient opted for expectant management with close follow up. Monitored with weekly ultrasounds and strict return precautions

Outcome:

- Twin 2 eventually met criteria for early pregnancy loss due to persistent absent fetal cardiac activity
- Twin 1 remained viable and cornual positioning resolved. Singleton pregnancy continued to 32 weeks gestation. Delivered via primary Cesarean for for severe fetal growth restriction and abnormal dopplers

Incidental Mosaic Turner Diagnosis

- Detailed history revealed patient with myxomatous mitral valve
- Genetic testing during pregnancy revealed 45XO/46XX consistent with mosaic Turner

Discussion

- This case demonstrates that a cornual ectopic pregnancy can be safely expectantly managed, resulting in live birth
- For this patient, use of ART and underlying Mullerian anomaly related to a genetic variant contributed to risk of developing cornual ectopic
- REI physicians are often the first to perform early scans in pregnancies conceived via ART, so must have an early and high suspicion of cornual ectopics and be able to counsel patients
- Although this patient was diagnosed during pregnancy, patients with mosaic Turner syndrome should be assessed for Mullerian anomalies during their workup