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Misplaced: A case of cesarean scar pregnancy

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Abstract:

A 40-year-old, gravida 3 para 2 (1-1-0-2), previous primary cesarean section for nonreassuring fetal status, presented at a tertiary hospital for confirmation of cesarean scar pregnancy (CSP). Transvaginal ultrasound confirmed a CSP at 8 2/7 weeks age of gestation with good embryonic cardiac activity, raising concern for early placenta accreta spectrum. A multidisciplinary team composed of an obstetrician, advanced pelvic surgeon, urologist, and anesthesiologist managed the patient. The patient underwent total abdominal hysterectomy with bilateral salpingectomy, as the patient has a completed family size. Before the procedure, she was given cefuroxime as prophylactic antibiotic. Intraoperatively, there were dense adhesions between the posterior bladder wall and the previous cesarean section scar. Inadvertent injury to the bladder wall was incurred during adhesiolysis. Cystorrhaphy was done by a urologist, while the rest of the surgery was unremarkable, with a 450 ml estimated blood loss. The postoperative course was unremarkable. Bladder rest was achieved by maintaining an indwelling Foley catheter, which remained in place upon discharge on postoperative day 3 and was continued for 7 days thereafter. At follow-up, a successful voiding trial was conducted, confirming the return of normal bladder function.

Keywords:

Cesarean section, ectopic, placenta accreta, scar

Introduction

Ectopic pregnancy is considered an obstetric emergency due to its potential maternal mortality and morbidity, such as uterine rupture, hemorrhage, and loss of fertility.^[1] The most common location of ectopic pregnancies is the ampulla (70%), while 5% are nontubal ectopic pregnancies, including implantation in the ovary, peritoneal cavity, cervix, and previous cesarean scar.^[2] Cesarean scar pregnancy (CSP) occurs with the implantation of the embryo on a previous cesarean (CS) scar, with an incidence of 1 in 2000 pregnancies. The Philippine Obstetrical and Gynecological Society reported 32.86% and 36.24% of cesarean sections in 2019 and 2020, respectively. Although there are no specific percentages of CSP in the Philippines, the numbers show that cesarean section is becoming a prominent risk factor for CSP.^[3]

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In 2019, the Department of Health reported that ectopic pregnancy ranked 8th among the leading causes of maternal mortality in the Philippines, with 2.7% of maternal deaths.^[4] The reports did not specify the location; however, a significant portion of mothers die despite the technological advancement aiding in diagnosis, which is the transvaginal ultrasound. Filipino mothers usually have their prenatal check-up at 3.9 months age of gestation (AOG), which is late for the detection of ectopic pregnancy.^[5] The aim of this case report is to empower a physician: (1) for early detection of CSP, (2) immediate diagnosis with transvaginal ultrasound with Doppler, and (3) rapid termination of pregnancy with a multidisciplinary team approach.

Case Report

A 40-year-old, gravida 3 para 2 (1-1-0-2), married, homemaker from Taytay, Rizal, presented at our institution for confirmation of CSP.

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About 19 days before admission, the patient had onset of non-bilious and non-bloody vomiting, about half cup, occurring 3 episodes per day. The home urine pregnancy test was positive on two occasions. She consulted an obstetrician-gynecologist (OBGYN). Transvaginal ultrasound by an OBGYN sonologist (11-June-2021) showed a single live pregnancy 5 6/7 weeks AOG by crown rump length (CRL), with consideration of CSP. It was found that within the previous cesarean section scar extending into the lower uterine corpus was a gestational sac containing a yolk sac and embryo with cardiac activity – 85 beats per minute (bpm). The ovaries were normal with corpus luteum on the right, and the cervix was long (2.96 cm) and closed. She was then advised to consult at a tertiary hospital for transvaginal ultrasound with Doppler studies.

It was 18 days before admission, the patient had onset of vaginal spotting, lightly staining 1 pantyliner per day, lasting until the day of admission. She also had intermittent crampy hypogastric pain, 3/10 pain scale, with spontaneous resolution. There was no passage of meaty tissue, dysuria, hematuria, feeling of incomplete voiding, frequency, or nocturia. No history of medical consultation or medication use was noted.

At 15 days before admission, due to persistence of symptoms, the patient had another transvaginal ultrasound with Doppler studies by an OBGYN sonologist (June 14, 2021) showing CSP 6 1/7 weeks AOG by CRL, a well decidualized gestational sac with a yolk sac and an embryo with good cardiac activity (fetal heart rate 161 bpm). This was seen above the internal os, suggestive of a CSP, live singleton pregnancy with normal ovaries and corpus luteum on the right. Color flow mapping showed moderate color flow on the lower and up to the midsegment of the anterior myometrium, suggestive of placenta accreta. She was referred to our institution for further evaluation and management. However, the patient attended to some family concerns, hence the delay in consult.

About 1 day before admission, the patient still had the same character of symptoms. She consulted at our institution, and transvaginal ultrasound with Doppler studies was repeated by an OBGYN sonologist, showing a single, live pregnancy 8 2/7 weeks AOG by average CRL, with consideration of cesarean section scar pregnancy and possibility of placenta accreta spectrum. It was further described as within the area of the previous cesarean section scar, above the internal cervical os, separate from the endometrium, and extending into the anterior uterine corpus was a gestational sac containing a yolk sac and an embryo with good cardiac activity (fetal heart tones of 180 bpm). There was no note of myometrium in between the gestational sac and

the urinary bladder, with an area of hypervascularity at the lower pole of the gestational sac corresponding to the area of the cesarean section scar niche, which could represent an early placenta accreta spectrum. She was then subsequently admitted.

Past obstetrical and medical history revealed that she delivered to a live, term, baby boy, via spontaneous vaginal delivery in 2011 in Taytay, Rizal. On her second pregnancy, she delivered to a preterm baby girl via primary cesarean section for nonreassuring fetal status in 2013 in Taytay, Rizal. She has hypothyroidism, biochemically euthyroid since 2011, currently asymptomatic. Her last thyroid function tests were normal (thyroid-stimulating hormone 0.361, Free thyroxine 1.39), on Levothyroxine 25 µg/tablet once a day. There was no history of hypertension, diabetes mellitus, asthma, or cancer in the family. She is a nonsmoker, nonalcoholic beverage drinker, and denies use of any illicit drugs.

The patient had menarche at 12 years old, regularly menstruating, consuming 3 pads per day, lasting for 5 days, with no dysmenorrhea. She claimed to have one monogamous sexual partner, with no history of sexually transmitted diseases.

The patient's last menstrual period (LMP) was last May 7, 2021. At the time of admission, she was 8 4/7 pregnant by LMP, with an expected date of delivery on February 6, 2022.

On physical examination, she was conscious, coherent, and not in cardiorespiratory distress. She had stable vital signs, with blood pressure 110/80 mmHg, heart rate 72 bpm, respiratory rate 18 cpm, and temperature of 36.3°C, body mass index of 26. Systemic physical examination was unremarkable. The abdomen was soft, nontender, with no rebound tenderness or guarding. Speculum examination showed minimal whitish discharge, nonfoul-smelling, and no erosions or polyps. Internal examination showed cervix was soft, closed, posterior, with cervical motion tenderness, uterus asymmetrically enlarged to 12 weeks' size, nontender; no adnexal mass or tenderness bilaterally.

The admitting impression was gravida 3 para 2 (1-1-0-2) ectopic pregnancy 8 4/7 weeks AOG, probably CSP; previous cesarean section for non-reassuring fetal status; primary hypothyroidism, on levothyroxine replacement, and biochemically euthyroid; and advanced maternal age.

The plan of management was a total abdominal hysterectomy with bilateral salpingectomy, given a completed family size. The management was discussed

with the patient and relatives, and consent for the procedure was signed. Complete blood count, serum electrolytes (serum sodium, potassium, and chloride), and urinalysis were unremarkable [Tables 1-3]. Three units of packed red blood cells properly typed and cross-matched were prepared and available.

On the 1st day of admission, a multidisciplinary team, composed of obstetrics-gynecology, advanced pelvic

surgery, urology, cardiology, and endocrinology services, were put together to holistically manage the patient. She was eventually cleared by cardiology and endocrinology services for the contemplated procedure.

On the 2nd day of admission, the patient was prepared for surgery, and intravenous loading dose of cefuroxime 1.5 g intravenously was given as antibiotic prophylaxis, 1 h before procedure. She then underwent total abdominal hysterectomy with bilateral salpingectomy, adhesiolysis, and cystorrhaphy under combined spinal and epidural anesthesia. On laparotomy, there were filmy adhesions between the bilateral fallopian tubes, sigmoid colon, and pelvic side walls. Dense adhesions between the posterior bladder wall and the previous cesarean scar were likewise noted. The bladder was inadvertently injured during adhesiolysis, with an initial ~1.5 cm laceration which subsequently increased to 3.0 cm on further assessment. Cystorrhaphy was done by the urology service, while the rest of the procedure was unremarkable. Estimated blood loss was 450 ml. Gross specimen was then sent to histopathology for evaluation [Figure 1]. The patient tolerated the procedure well, with stable vital signs and no subjective complaints. She was given cefuroxime

Table 1: Complete blood count

Complete blood count (July 30, 2021)	Result
Complete blood count (July 30, 2021)	
Hemoglobin	118 g/L
Hematocrit	0.36
Red blood cell	3.96
MCH	30 pg
MCHC	0.33
MCV	91 fL
RDW	13.2
Thrombocyte	226
Differential count	
Band	0
Neutrophil	0.75
Lymphocyte	0.18
Monocyte	0.06
Eosinophil	0.01
Basophil	0

MCH: Mean corpuscular hemoglobin, MCHC: Mean corpuscular hemoglobin concentration, MCV: Mean corpuscular volume, RDW: Red cell distribution width

Table 2: Urinalysis

Urinalysis (July 30, 2021)	Result
Color	Yellow
Transparency	Slightly cloudy
Reaction	6.0
Specific gravity	1.020
Blood	Positive (++++)
Protein	Positive (+)
Glucose	Negative
Leucocytes	Negative
Ketones	Negative
Urobilinogen	Positive
Bilirubin	Negative
Nitrites	Negative
Red cells	4
White cells	2
Epithelial cells	8
Casts	0
Bacteria	273

Table 3: Serum electrolytes

Electrolytes (July 30, 2021)	Result
Sodium	135 mmol/L
Potassium	4.10 mmol/L
Chloride	103 mmol/L

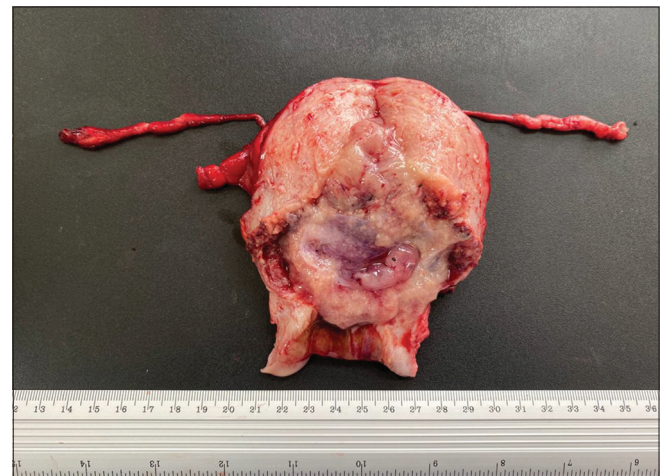


Figure 1: Intraoperative findings: Intraoperatively, there were filmy adhesions between the bilateral fallopian tubes, sigmoid colon, and pelvic side walls noted, as well as dense adhesions between the posterior wall of the bladder and the previous cesarean scar. The uterus was symmetrically enlarged, measuring 12.0 cm × 7.0 cm × 4.0 cm, with pinkish to red-tan smooth serosal surface. On the cut section, the myometrial layer found in the superior half of the uterus was 2.5 cm in thickness. At the inferior portion of the uterus, the products of conception (gestational sac and embryo) were located at the lower uterine segment along the previous cesarean scar, with placental tissues seemingly invading the endometrium and myometrium. An aspect of the lower uterine segment was noted to have an absence of the myometrial layer, with the serosal layer measuring 0.3 cm in thickness. The endometrial cavity measured 6.0 cm long. The endometrium was smooth and cream tan, measuring 1 cm. The cervix measured 3.0 cm × 3.0 cm, with a smooth pearl-white ectocervix. On the cut section, the endocervical canal measured 2.5 cm long, with trabeculated lining. The right and left fallopian tubes appeared grossly normal, with a reddish tan surface and measured 10.5 cm × 0.5 cm × 0.5 cm and 9.5 cm × 0.5 cm × 0.5 cm, respectively. Bilateral ovaries were grossly normal and were preserved

750 mg intravenously every 8 h for 3 doses as antibiotic prophylaxis, paracetamol 1 g every 8 h for 3 doses, dextketoprofen 150 mg diluted in dextrose 5% in water to run for 24 h, tramadol 50 mg every 8 h as needed for pain, dextketoprofen 25 mg tablet orally every 8 h for 5 days and tramadol + paracetamol 37.5/325 mg tablet every 8 h for 3 days then as needed for pain. Diet and ambulation were resumed.

On the 3rd and 4th day of admission, the patient was able to tolerate regular diet, had good pain control, and was ambulating well. Her Foley catheter had clear yellow urine, minimal sediments, with urine output of 70–100 mL per hour.

On the 5th day of admission, change of dressing was done, with waterproof dressing, which showed a dry and well-coaptated wound. The patient was deemed fit for discharge with Foley catheter in place. She was advised on adequate rest and avoidance of sexual contact and strenuous activities.

Final diagnosis was gravida 3 para 2 (1-1-1-2) CSP 84/7 weeks AOG, unruptured; previous cesarean section for nonreassuring fetal status; primary hypothyroidism, on levothyroxine replacement, and biochemically euthyroid; and advanced maternal age.

On the 10th day after discharge, on follow-up with urologist, the Foley catheter was removed. Patient underwent voiding trial with subsequent spontaneous urination. On follow-up with OBGYN, the patient had no subjective complaints and was recovering well. Dressing was changed, revealing a dry and well-coated wound.

Final histopathology showed products of conception, embryo (2.9 cm), and placenta accreta [Figure 2].

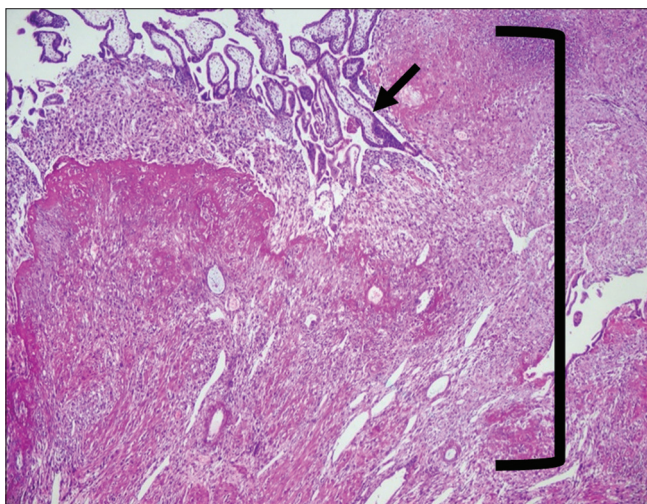


Figure 2: Histopathologic slide showing placenta accreta. Chorionic villi (arrow) invading the myometrium (bracket) of the uterus

Discussion

CSP pathophysiology is most likely due to the implantation and invasion of the blastocyst into the myometrium through a microtubular dehiscence tract or niche.^[6] There are two kinds of CS scar pregnancy; Type 1 is endogenous implantation, where implantation is on a well-healed scar of previous CS and may proceed to a viable pregnancy within the uterine cavity. However, this may lead to placentation problems later on. Type 2 is exogenous implantation, where CSP invades deeply within the defect of an incompletely healed scar. Its growth is towards the serosal surface of the uterus towards the broad ligament or the urinary bladder, leading to a bulging defect that can lead to uterine rupture and hemorrhage. This invasion into the myometrium leads to the theory that CSP is likely a precursor to and shares similar histology with placenta accreta spectrum.^[7,8] The index patient falls on the second type as evidenced sonographically.

The main risk factor for this patient was her previous cesarean section. Contributory factors to having risk of CSP in previous CS births include previous uterine surgeries (e.g., dilatation and curettage and endometrial ablation), manual removal of placenta, and *in vitro* fertilization.^[8] In addition, although the operative technique of the index patient could no longer be obtained, the type of technique used to close the uterus could have significant contributing factor. The single-layer technique entails the formation of a “niche”, as seen in Figure 3, which is a hypoechoic area in the myometrium located in the lower uterine segment, reflecting discontinuity. This is opposed to closing the uterus in a multiple-layer technique, where there is better apposition of the uterine edges, thereby decreasing CS scar defects.^[9]

The index patient presented with vaginal spotting and intermittent crampy hypogastric pain. Around 33% of

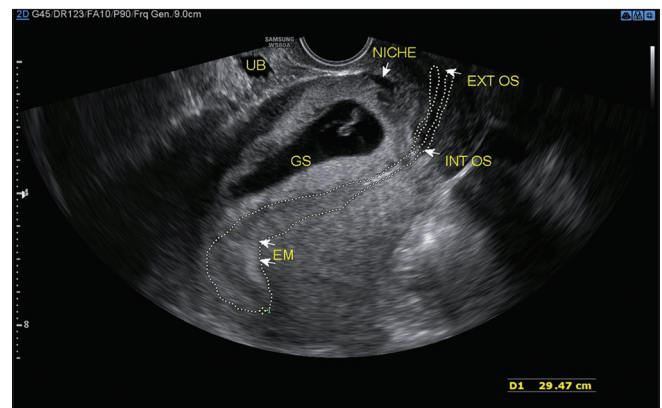


Figure 3: Transvaginal ultrasound image showing the gestational sac, niche, endometrium, internal os, external os, and urinary bladder as labeled

patients with CSP are asymptomatic. The most common presentation of CSP: vaginal bleeding (86%), vaginal bleeding with abdominal pain (9%), and abdominal pain (4.5%).^[10] Severe abdominal pain and profuse vaginal bleeding with subsequent hemodynamic instability could mean rupture of CSP.^[11] This requires the need for timely and accurate diagnosis.

Using a transvaginal ultrasound with Doppler, with diagnostic sensitivity of 90.9% and specificity of 99.9%, accurate diagnosis can be obtained; hence, it is the imaging modality of choice.^[12] Using the components created by Timor-Tritsch, obtained from 750 reports of CSP, the following sonographic criteria must be fulfilled to diagnose CSP: (1) Empty uterine cavity along with endocervical canal; (2) visualization of placenta and or gestational sac embedded in the hysterotomy scar; (3) In early gestations (<8 weeks AOG), a triangular gestational sac that fills the niche of the scar and at more than 8 weeks, this shape becomes rounded or even oval; (4) thin (1–3 mm) or absent myometrial layer between the gestational sac and urinary bladder; (5) closed and empty cervical canal; (6) presence of embryo and or yolk sac with or without cardiac activity; and (7) prominent vascular pattern at or in the area of CSP.^[9] All of these were present in our patient as seen in Figures 3 and 4.

Having confirmed the CSP, definitive treatment is individualized according to the patient's age, desire for future fertility, type of CSP, and expertise of the clinician. The Jonsen's four-box model for medical decision-making was used [Table 4].^[13] Immediate termination is often strongly recommended during the first trimester due to the sequelae of maternal morbidity and possible mortality. In type 1 CSP, there is endogenous implantation on a well-healed scar, where pregnancy is viable but may have placental issues, such as placenta accreta.^[14] A case report in the Philippine General Hospital last 2015 documented a type 1 CSP from a 27-year-old, gravida 4 para 3 (0-3-0-2)

with 3 previous cesarean deliveries for non-reassuring fetal status in 2005, followed by 2 repeat cesarean sections in 2009 and 2013. She had her first prenatal check-up at 7 weeks and 3 days AOG with an initial transvaginal ultrasound considering placenta accreta. At 8 weeks and 4 days AOG, transvaginal ultrasound with Doppler was repeated, revealing a gestational sac, with developing embryo with good cardiac activity, at the level of the uterine isthmus with significant thinning of the myometrium. The uterine serosa was deemed intact, with the bladder adherent to it but shows no invasion. The consideration was CSP. At 9 weeks and 4 days AOG, repeat ultrasound revealed ballooning of the anterior myometrium toward the bladder with expansion of only the lower uterine segment. With the confirmation of placenta previa/accreta, the patient was informed that the pregnancy may cause major hemorrhage that may require hysterectomy if the pregnancy was allowed to progress. After careful consideration, the patient decided to continue with the pregnancy. She was then referred to urogynecology, thoracic and cardiovascular surgery, and perinatology services for comanagement and preoperative planning. During the second and third trimesters, the pregnancy continued without complications with close follow-up. The patient was admitted at 34 weeks AOG for close monitoring. At 37 weeks AOG, she underwent cystourethroscopy, primary classical cesarean section, adhesiolysis, total hysterectomy with bilateral salpingectomy, cystorrhaphy, methylene blue instillation, omental flap interposition under spinal anesthesia, and delivered a live baby boy, 2600 g, 37 weeks by pediatric aging and APGAR score of 9 and 9. Final histopathology report confirmed the diagnosis of placenta accreta.^[15]

In Type 2, there is exogenous implantation, where CSP invades deeply within the defect of an incompletely healed scar and growth is toward the serosal surface of the uterus towards the broad ligament or urinary bladder, leading to a bulging defect that can lead to uterine rupture and hemorrhage. This led to the theory that CSP likely shares similar histology with placenta accreta spectrum. As type 2 CSP has a poorer prognosis, termination of pregnancy at an earlier AOG can reduce morbidity. Another case report from the Philippine General Hospital last 2018 presented a type 2 CSP from a 32-year-old gravida 6 para 5 (5-0-0-5) where 4 previous pregnancies were delivered vaginally and the last was born through cesarean section for a large baby in 2016. Type II CSP was confirmed via transvaginal ultrasound with Doppler at 11 weeks AOG, where the mass occupied the full thickness of the anterior lower uterine segment, bulging out to the posterior urinary bladder wall. The patient and her family decided to continue with expectant management despite the enlarging CSP and extensive discussion on the risk of uterine rupture

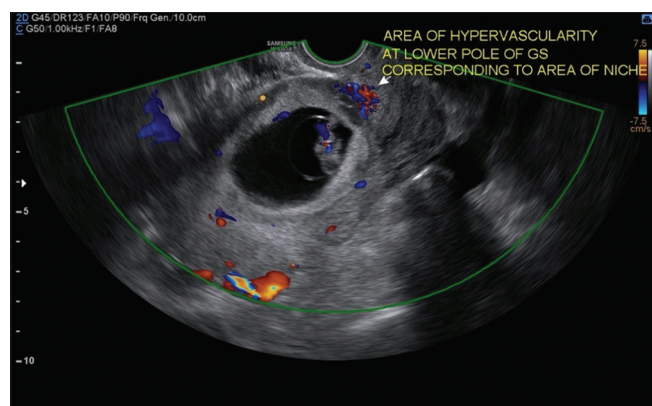


Figure 4: Transvaginal ultrasound image showing the area of hypervascularity at the lower pole of the gestational sac corresponding to the area of the niche

Table 4: Jonsen's four-box model for medical decision-making with applicable questions answered relating to the index patient (italicized)^[18]

Medical indications	Patient preferences
<i>The principle of beneficence and nonmaleficence</i> 1. What is the prognosis, including survival, function, and quality of life? <i>She could have uterine rupture and hemorrhage if the CSP was allowed to progress. Due to the type of CSP, Type 2, she was high risk for the said morbidities</i> 2. How certain or uncertain is the prognosis? <i>With the TVS findings, the prognosis is certain</i> 3. What are the treatment options? <i>Medical treatment is not an option due to the presence of fetal heartbeat. Hence, surgical management is the treatment of choice. TAHBS was chosen due to completed family size</i> 4. What are the potential benefits and burdens of disease-focused treatment? <i>She can benefit with the treatment as it would reduce changes of uterine rupture, hemorrhage and possible encroachment of the placenta accreta to the bladder wall. The burdens entail the possibility of uncontrolled hemorrhage, urinary tract, or bowel injury</i> 5. What are the potential benefits and burdens of palliative-focused treatment? <i>Not applicable</i>	<i>The principle of respect for autonomy</i> 1. How much information does the patient want about prognosis? <i>All information was disclosed to the patient, including laboratory results, prognosis, treatment options</i> 2. How involved does the patient want others (friends, family) to be in decision-making? <i>The family was involved in the decision-making</i> 3. Does the patient have decision-making capacity? <i>Yes, she has the capacity to decide</i> 4. If the patient does not have decision-making capacity, who is the appropriate surrogate decision maker? <i>Not applicable</i> 5. Has the patient previously expressed preferences in an Advance Directive or POLST? <i>Not applicable</i>
Quality of life	Contextual features
<i>The principles of beneficence, nonmaleficence, and respect for autonomy</i> 1. What are the most important things for the patient at this time (e.g., survival, pain control, family wellbeing, etc.)? <i>It was more important to save the life of the patient and to reduce morbidity as much as possible</i> 2. What is the patient hoping for? <i>She is hoping for a successful operation</i> 3. What is the patient fearful of? <i>She is fearful of the possible complications of the surgical procedure</i> 4. What is the patient expecting? <i>She is expecting successful recovery</i> 5. If tradeoffs between duration and quality of life need to be made, which side should be more heavily weighted? <i>Not applicable</i> 6. Are there quality-of-life states (e.g., permanent coma) where it would not make sense to continue life-sustaining treatment or disease oriented care? <i>Not applicable</i>	<i>The principles of justice and fairness</i> 1. Is significant moral distress among staff members present, and how is this affecting care? <i>Not applicable</i> 2. Are there important family dynamics that must be considered? <i>None</i> 3. Are there financial or economic factors that must be considered, such as access to hospice care? <i>None</i> 4. Are there religious or cultural factors? <i>The patient is Catholic and was wary about the procedure since the fetus has a heartbeat. However, benefits versus the risks were explained</i> 5. Are there problems related to the allocation of resources? <i>None</i> 6. How does the law affect treatment decisions? <i>Not applicable</i> 7. Is there any conflict of interest present? <i>Not applicable</i>

CSP: Cesarean scar pregnancy, POLST: Physician order for life-sustaining treatment

and catastrophic morbidity. The patient was admitted for close monitoring. On the 4th day of admission, at 12 2/7 weeks AOG, the patient developed mild hypogastric pain and vaginal bleeding. At this point, the patient and her family consented to the termination of pregnancy since she has completed family size. She eventually underwent exploratory laparotomy, bilateral internal iliac artery ligation, total hysterectomy, and bilateral salpingectomy under epidural anesthesia with blood loss of 1100 mL.^[16]

As for the medical approach, the use of systemic or local Methotrexate is advocated, which is a folic acid antagonist that inhibits DNA synthesis and cell proliferation, thereby ceasing fetal cell growth. There are criteria that need to

be fulfilled before a patient can become a candidate for Methotrexate use: (1) Hemodynamic stability; (2) human chorionic gonadotropin (BHCG) <5000 IU/L; (3) No fetal heartbeat; (4) Ectopic mass <3.5 cm; and (5) Compliant to regimen and follow-up.^[17] Due to the presence of a fetal cardiac activity, the patient did not fulfill the criteria. No BHCG was extracted for the index patient.

The index patient has a completed family size and has a type 2 CSP that could lead to significant morbidity if allowed to progress. Hence, the patient agreed to terminate the pregnancy with a surgical approach. It was important to build a multidisciplinary team that is composed of an OBGYN, surgeon and medical specialists, anesthesiologist, and nursing staff, including

an available blood bank and pathologists. A competent and reliable multidisciplinary team could readily address any problems that may arise during the course of management of a patient with CSP, and could save the life of the mother.

Summary

Due to the high risk of maternal mortality and morbidity, such as uterine rupture and hemorrhage, it is the aim of this case report to empower a physician: (1) For early detection of CSP; (2) immediate diagnosis with transvaginal ultrasound with Doppler; and (3) rapid termination of pregnancy with a multidisciplinary team composed of an OBGYN, anesthesiologists, surgeon and medical specialists, and nursing personnel. Having this will ensure a safer and better outcome for patients with complicated pregnancies like CSP, because no mother should die while giving life.^[18]

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given her consent for her images and other clinical information to be reported in the journal. The patient understands that her name and initials will not be published and due efforts will be made to conceal her identity, but anonymity cannot be guaranteed.

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Authorship contributions

Hannah Yzabelle L. Chua - Conceptualization, Writing-Original Draft, Writing-Review and Editing.

Marivic Agulto-Mercadal - Writing-Review and Editing, Supervision.

Judy Fuentes - Writing-Review and Editing, Supervision.

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Conflicts of interest

There are no conflicts of interest.

References

- Wang S, Beejadhursing R, Ma X, Li Y. Management of Caesarean scar pregnancy with or without methotrexate before curettage: Human chorionic gonadotropin trends and patient outcomes. *BMC Pregnancy Childbirth* 2018;18:289.
- Habana M, Macayaon A, Amorin H, Añonuevo A, del Prado J, Irabon I, *et al.* 2020 POGS report on obstetrical and gynecological indicators of health care. *Philipp J Obstet Gynecol* 2020;46:29. Available from: https://www.pogsjournal.org/temp/PhilippJObstetGynecol46129-955252_023912.pdf. [Last accessed on 2022 Jul 18].
- Epidemiology Bureau, Department of Health. The 2019 Philippine Health Statistics. Manila: Department of Health; 2019. Available from: https://doh.gov.ph/sites/default/files/publications/2019PHS_Final_092121.pdf. [Last accessed on 2022 Jun 05].
- National Statistics Office. National Demographic and Health Survey 1998. Manila: National Statistics Office; 1998. Available from: <https://dhsprogram.com/pubs/pdf/FR103/FR103.pdf>. [Last accessed on 2022 Jun 05].
- Cunningham FG, Gant NF, Leveno KJ, Gilstrap LC III, Hauth JC, Wenstrom KD, editors. *Williams Obstetrics*. 25th ed. New York: McGraw-Hill; 2018.
- Clemente M, Amosco M, Octavio M, Bravo S, Villanueva-Uy E. Maternal and neonatal outcomes of pregnant women with clinically confirmed COVID-19 admitted at the Philippine General Hospital. *Acta Med Philipp* 2021;55:188. Available from: <https://actamedicaphilippina.upm.edu.ph/index.php/acta/article/view/2863>. [Last accessed on 2022 Jun 04].
- Fylstra DL. Ectopic pregnancy within a cesarean scar: A review. *Obstet Gynecol Surv* 2002;57:537-43.
- Shahid A. Clinical dilemmas and risks of misdiagnosis and mismanagement associated with endogenous caesarean scar pregnancy: A case series and literature review. *Glob J Reprod Med* 2017;12. Available from: <https://juniperpublishers.com/gjorm/GJORM.MS.ID.555602.php>. [Last accessed on 2022 Jun 04].
- Timor-Tritsch IE, Monteagudo A, Goldstein S. How to identify and manage cesarean scar pregnancy. *OBG Manag* 2014;26:19-28.
- Vervoort AJ, Uittenbogaard LB, Hehenkamp WJ, Brölmann HA, Mol BW, Huirne JA. Why do niches develop in Caesarean uterine scars? Hypotheses on the aetiology of niche development. *Hum Reprod* 2015;30:2695-702.
- Gonzalez N, Tulandi T. Cesarean scar pregnancy: A systematic review. *J Minim Invasive Gynecol* 2017;24:731-8.
- Perez P, Pichay R. The wayward seed: An ectopic gestation in a cesarean section scar. *Philipp J Obstet Gynecol* 2014;38:26-7.
- Sivalingam VN, Duncan WC, Kirk E, Shephard LA, Horne AW. Diagnosis and management of ectopic pregnancy. *J Fam Plann Reprod Health Care* 2011;37:231-40.
- Elep R, Dalawangbayan M. Evolution of a cesarean scar pregnancy into a placenta accreta at term: A case report. *Philipp J Obstet Gynecol* 2016;41:30.
- Zayco-Magno M, Panlilio R. Pregnancy as a ticking bomb: A sonographic review of type II cesarean section scar pregnancy. *Philipp J Obstet Gynecol* 2019;43:42.
- Philippine Obstetrical and Gynecological Society (Foundation), Inc. *Clinical Practice Guidelines on Ectopic Pregnancy*. Manila: Philippine Obstetrical and Gynecological Society; 2016.
- World Health Organization. No Woman Should Die While Giving Life: Safe Motherhood Month Calls for Zero Home Deliveries. Brazzaville: WHO Regional Office for Africa; 2015. Available from: <https://www.afro.who.int/news/no-woman-should-die-while-giving-life-safe-motherhood-month-calls-zero-home-deliveries>. [Last accessed on 2022 Jun 06].
- Jonsen's Four Box Model for Medical Decision-Making. UpToDate; 2022. Available from: https://www.uptodate.com/contents/image/print?imageKey=PALC%2F95987&topicKey=PALC%2F2202&source=see_link. [Last accessed on 2022 Jul 18].