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A Case Report of Cervical Encerclage with Successful Vaginal Delivery.

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ABSTRACT

Cevical encerclage is a procedure done to prevent cervical incompetence in a women with previous 2 or more loss to prevent premature delivery of the fetus. In women with a prior spontaneous preterm birth and who are pregnant with one baby, and have shortening of the cervical length less than 25 mm, a cerclage prevents a preterm birth and reduces death and illness in the baby [1]. Cervical incompetence is defined as painless dilatation of cervix resulting in 2nd trimester miscarriage. The estimated incidence varies geographically and generally thought to be around 1-1.5% of all pregnancies [2]. Here I present a case report of a cervical incompetence patient with successful pregnancy and successful delivery.

Keywords: cervical encerclage, cervical incompetence, 2nd trmesster miscarriage.

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INTRODUCTION

Definitions of cervical incompetence vary, but one that is frequently used is the inability of the uterine cervix to retain a pregnancy in the absence of the signs and symptoms of clinical contractions, or labor, or both in the second trimester [3]. Cervical incompetence may cause miscarriage or preterm birth during the second and third trimesters4. Another sign of cervical incompetence is funneling at the internal orifice of the uterus, which is a dilation of the cervical canal at this location [4].

Case Report

28 year old female, $G_4P_1L_1A_2$ with previous normal vaginal delivery with last child birth 3 and half years back with gestational age 26 weeks + 3days as per LMP with regular cycles booked and immunized outside referred to us as cervical incompetence and she was able to perceive fetal movements well and presented with white discharge not associated foul smelling and itching. No C/O pain abdomen or bleeding P/V. Normal bladder and bowel habits. Obstetric H/O 1st pregnancy spontaneous conception and all three trimesters uneventful and delivered an alive term female baby of 3kg with good APGAR score.2nd pregnancy conceived after 3 years of previous delivery induced abortion done at45 days and D& C was also done . 3rd pregnancy conceived 8 months after previous abortion and at 22 weeks of gestation she presented with severe pain abdomen and she expelled an alive boy baby and the placenta was adherent and manual removal of placenta done under sedation. The reason for this expulsion was not known. She was also diagnosed to have GDM in that pregnancy. Now the present pregnancy, she conceived spontaneously after 6 months of previous loss. First trimester was uneventful and she was started on aspirin prophylactically. Now by 26 weeks of gestation referred to us as cervical incompetence.
On Examinaton,

Her general condition is fair, afebrile, not anaemic, no pedal edema, spin, Breast and Thyroid were normal.

Systemic Examination, CVS and RS were normal.

Abdominal examination: uterus corresponds to 28 wks relaxed and fetal parts felt. On Speculum Examination, Profuse discharge cervical Os open membranes present.

On Pelvic Examination,cervix 25% effaced , Os admits 1 finger , membrane present and vertex at brim.

Her USG showed Short cervix of 1.75cm. and the cervix is 'U' shaped. We planned for emergency encerclage after giving a prophylactic course of antibiotics and a course of steroids.

Procedure

Under spinal anaesthesia. Per speculum examination: External Os patulus cervical length 1.2 cm, bulging membranes seen at level of internal Os. After giving a head low position to facilitate the ascent of bulgig membranes, Purse string suture with 1-0 Prolene applied just at the level of internal Os. We followed MC donald's Procedure.

USG after the procedure showed mild funneling of the uterus. Patient was discharged after a week and she was advised to avoid coitus and physical activity. She was advised to report if any draining P/V noted. She came for regular follow up. When the patient reached term pregnancy i.e., 37 completed weeks patient was admitted for cerclage removal. Cerclage were removed. She went into spontaneous labour and delivered an alive term boy baby of 3 kg with good APGAR score.

DISCUSSION

In our case patient presented with typical history of previous loss with Dilatation and curettage history and another 2nd trimester loss with manual removal of placenta which seems to be the risk factors for cervical incompetence. She also presented with bulging membranes and USG showed short cervix and 'U' shaped cervix .In this case of cervical incompetence we used the MC Donald's procedure to close the cervix.

And we followed her and assisted her to take her pregnancy till term. Cervical insufficiency can be treated with either activity restriction or surgically with cerclage.[5] Limited data are also available on use of vaginal pessary and progesterone therapy in treatment of selected patients [6,7]. The controversy comes from many studies and routine practice often including patients without a clear diagnosis who likely do not have true cervical insufficiency.[8] The purpose of cervical cerclage is to increase the mechanical strength of the cervix, thereby preventing painless passive dilatation and premature delivery prior to viability [8].

CONCLUSION

The success rate for cervical cerclage is approximately 80-90% for elective cerclages, and 40-60% for emergency cerclages [9]. A cerclage is considered successful if labor and delivery is delayed to at least 37 weeks (full term). [9] Cervical insufficiency is due to a anatomical weakness of cervix that leads to preterm delivery or 2nd trimester loss otherwise it is a healthy pregnancy. So if we carefully select the patient and give them the surgical management in right time we can have a successful pregnancy.

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