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Topical Epinephrine and Temporary Cervical Clamping for Haemostasis After Evacuation of A Live Cervical Ectopic Pregnancy: A Case Report

[1]Zeenie Girn, MBBS, MD, DNB, FICOG, FICMCH, FRCOG, Department of Obstetrics and Gynaecology, Suman Hospital, Model Town, Ludhiana, Punjab 141002, India

[2]Maneet Kaur, MD, Genesis Scan Centre, 586 R Model Town, Gole Market Road, Model Town, Ludhiana, Punjab 141002, India

Corresponding Author: Zeenie Girn, MBBS, MD, DNB, FICOG, FICMCH, FRCOG, Department of Obstetrics and Gynaecology, Suman Hospital, Model Town, Ludhiana, Punjab 141002, India

Email: zsarda@yahoo.com

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Conflicts of Interest: Nil

Abstract

Introduction and importance: Cervical pregnancy is uncommon, but it can bleed torrentially, and the risk is greatest when the pregnancy has to be evacuated while the woman is already bleeding. Not every hospital has interventional radiology on hand, so simple ways of controlling bleeding matter.

Case presentation: A woman in her mid-thirties (gravida 2, para 1) came to us after five days of heavy vaginal bleeding. Transvaginal scanning showed a live cervical pregnancy of 7 weeks 5 days, and serum beta-human chorionic gonadotrophin (β-hCG) was 53,832 IU/L. Hysteroscopy confirmed an empty uterine cavity. We removed the pregnancy with ovum forceps and gentle suction, packed the canal with an epinephrine-soaked gauze pledget and placed sponge-holding forceps on either side of the cervix for 15 minutes, with intravenous tranexamic acid. One bleeding point needed a single suture. Her heart rate stayed at 96–100 beats/min and blood pressure at 110/70 mmHg. She lost 150–200 mL, needed no transfusion and went home the next day. β-hCG was <5 IU/L at two weeks and the scan was normal at one month.

Clinical discussion: Balloon tamponade, cerclage, vasoconstrictor injection, cervical artery ligation and embolisation have all been used to limit bleeding at evacuation. Our approach is a temporary, suture-free version of the same idea, using items found in any gynaecology theatre. Because several measures were used together, we cannot say which one mattered most, and we do not know how much epinephrine was absorbed.

Conclusion: Topical epinephrine with temporary cervical clamping is worth considering when a cervical pregnancy has to be evacuated during active bleeding, provided the team is ready to escalate if it fails.

Keywords: Case report; Cervical pregnancy; Ectopic pregnancy; Epinephrine; Cervical clamping; Haemostasis

Introduction

In a cervical pregnancy the embryo implants in the endocervical canal. It accounts for under 1% of ectopic pregnancies, roughly 1 in 10,000 live births [1]. The danger lies in the cervix itself. Its stroma is mostly fibrous and contracts poorly compared with the uterine body 2, so once the implantation site starts bleeding there is little to stop it. Transvaginal ultrasound now detects most cases early, and keeping the uterus has become the usual aim[3,4]. Things are harder when a woman arrives already bleeding, with a live and fairly advanced pregnancy. Methotrexate is less likely to work, and evacuation can set off sudden heavy bleeding. Embolisation helps, but it is not available round the clock in many hospitals.

We report such a case, managed by evacuation with an epinephrine-soaked pledget, temporary clamping of the cervix, tranexamic acid and a single suture. Embolisation, vessel ligation and hysterectomy were not needed. We also compare our approach with other methods described for controlling bleeding in cervical pregnancy. This case report has been reported in line with the SCARE 2025 criteria [5].

Presentation of case

- **Patient information**

A woman in her mid-thirties, gravida 2 para 1, came to us with five days of heavy vaginal bleeding that had not settled with outpatient treatment. Her only previous pregnancy had ended in an uncomplicated vaginal delivery eight years earlier. She had never had a curettage, caesarean section or fertility treatment, and her medical, drug and family histories were unremarkable.

Seventeen days earlier she had seen another doctor about an unusually light period. A transabdominal scan at that visit showed a bulky uterus, a 9 mm endometrium and a 10 mm anterior fibroid, with normal ovaries and no free fluid. She was started on medroxyprogesterone acetate 10 mg three times a day for presumed abnormal uterine bleeding. The pregnancy was not recognised until she reached us.

- **Clinical findings**

On arrival the patient was bleeding profusely. Her vitals were stable with blood pressure of 100/60 mmHg and pulse 100 beats/min. She was afebrile, and her abdomen was soft and non-tender. On speculum examination, fresh blood and clots were coming through an enlarged, ballooned cervix.

- **Timeline**

Table 1 sets out the sequence of events.

- **Diagnostic assessment**

Haemoglobin was 107 g/L, white cell count 10.26 × 10⁹/L and platelets 297 × 10⁹/L. The international normalised ratio was 0.91, prothrombin time 11.8 s and activated partial thromboplastin time 39.4 s. Renal and liver function were normal. Serum β-hCG was 53,832 IU/L.

On transvaginal scanning the uterine cavity was empty, with an 8.5 mm endometrium and a 14 × 11 mm anterior intramural fibroid. The gestational sac sat below the internal os with absent sliding sign (Fig. 1). Mean sac diameter was 18 mm, crown-rump length (CRL) 14 mm, embryonic heart rate 162 beats/min and yolk sac diameter 4 mm. There was no free fluid. By CRL she was 7 weeks 5 days.

Our main alternative diagnosis was a miscarriage passing through the cervix. The live embryo, the choriodecidual reaction around the sac and the absent sliding sign argued against it [6,3]. We also considered an endocervical lesion and gestational trophoblastic disease.

- **Therapeutic intervention**

We explained the risk of haemorrhage and the possibility of hysterectomy, and she agreed to urgent evacuation. Consent covered hysteroscopy, suction curettage, vascular ligation and hysterectomy, and the interventional

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radiologist was on standby for embolisation. The first author, a senior consultant obstetrician-gynaecologist with 25 years of experience in gynaecological surgery, performed the procedure in the operating theatre of our hospital in Ludhiana, India, under general anaesthesia.

Under anaesthesia the cervix was ballooned, with pregnancy tissue in the canal (Fig. 2). On hysteroscopy the uterine cavity was empty and decidualised, and bleeding could be seen coming from the endocervical canal as the scope was withdrawn (Supplementary Figs. S1 and S2). The embryo and sac were removed with ovum forceps under direct vision (Supplementary Fig. S3) and then gently suctioned the canal.

The endocervical canal was packed with a gauze pledget soaked in 5 mL of epinephrine solution, made by diluting 2 mL of 1:1,000 epinephrine with 3 mL of saline (0.4 mg/mL; 2 mg in total). Sponge-holding forceps were placed on the cervix at 3 and 9 o'clock in the bilateral-contralateral arrangement (Fig. 3) [7], and she was given 1 g of tranexamic acid intravenously. After 15 minutes we removed the forceps and the pledget. A single bleeding point remained on the posterior lip, which we closed with a figure-of-eight 2-0 polyglactin 910 suture (Supplementary Fig. S4).

Throughout the procedure, including the time the pledget and forceps were in place, her heart rate stayed between 96 and 100 beats/min, blood pressure at 110/70 mmHg and oxygen saturation at 100%. The epinephrine did not raise her pulse or blood pressure. We watched for a further 15 minutes and saw no more bleeding. Blood loss was estimated at 150–200 mL, and she needed no blood products. The tissue was not sent for histology.

- **Follow-up and outcomes**

She recovered without complications. Bleeding following the procedure was minimal, and her haemoglobin the next day was 98 g/L. She went home on the first postoperative day. By two weeks her β-hCG had fallen to <5 IU/L. At one month she had had a normal period, and the uterus and ovaries looked normal on ultrasound. At 6 months follow up, patient continued to remain well with regular periods and was not planning a pregnancy at the time of follow up.

Discussion

Previous curettage, caesarean section, cervical surgery and assisted conception all increase the risk of cervical pregnancy, but many women, including ours, have none of these [1]. Patients usually present with painless bleeding in the first trimester. Our patient's light bleeding 17 days before diagnosis was evaluated with a transvaginal scan, no speculum and clinical examination and hence was assumed to be a menstrual problem and treated with a progestogen. Her subsequent presentation and evaluation with a transvaginal ultrasound scan, serum beta hCG confirmed her pregnancy and its abnormal location. This highlights that a urine pregnancy test or serum hCG should be checked before any woman of reproductive age to rule out pregnancy even in absence of amenorrhoea.

Transvaginal scanning is the key investigation. It needs no full bladder, gives a clearer view of the pelvis and picks up small ectopic pregnancies well [8]. The features of a cervical pregnancy are a sac below the internal os, an empty uterine cavity, blood flow around the trophoblast on Doppler and a negative sliding sign [3,6].

Treatment depends on gestation, whether the woman is stable, whether there is a heartbeat, the β-hCG level and her wish for future pregnancy. Hysterectomy is now kept for bleeding that cannot be controlled any other way [4,1]. Methotrexate is less likely to succeed when there is cardiac activity, a CRL over 10 mm or a β-hCG of 10,000 mIU/mL or more [9]. Our patient had all three and was actively bleeding, so we chose surgical intervention. The main options are summarised in Table 2.

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The danger at evacuation is bleeding from the implantation site, and many ways of controlling it have been tried (Table 3). Frates and colleagues used potassium chloride, embolisation or uterine artery branch ligation before evacuation [10]. Others have tied the cervical branches of the uterine arteries vaginally and injected vasopressin[11], combined cerclage, intracervical carboprost and a balloon [12], or relied on Foley or double-balloon tamponade [13,14,15,16]. Shirodkar cerclage has been used in heterotopic pregnancy [17,18], embolisation before curettage [19], and hysteroscopic resection [20,21] have also been reported.

Our method works on the same principles as ligation and vasoconstrictor injection to reduce flow through the descending cervical branches and constrict the vessels in the implantation bed. The difference is that it is temporary, needs no suturing in an engorged cervix before evacuation, and uses only instruments and drugs available in any gynaecology theatre. We have not found a previous report combining a topical epinephrine pledget with temporary bilateral-contralateral clamping for cervical pregnancy. The clamp technique itself was described for postpartum haemorrhage [7].

Epinephrine constricts vessels through α1-adrenergic receptors, and soaked pledgets are already used to control bleeding in sinus surgery [22] and laparoscopic ovarian cystectomy [23]. The 2 mg we used, at 0.4 mg/mL, is more concentrated than the dilutions normally used for infiltration, and we cannot say how much was absorbed from such a vascular bed. Her pulse and blood pressure did not rise, which is reassuring, but one patient cannot establish safety. Anyone using the method should monitor continuously and bear in mind interactions with volatile anaesthetics. A weaker solution may well work as effectively.

This report has clear limitations. We used four measures at once and cannot tell which mattered most, and one bleeding point still needed a stitch.

Embolisation and laparoscopic ligation were ready if needed, but neither was used. The main attraction of this approach is that it can be done anywhere, without waiting for a radiologist and without the radiation and ischaemic risks of embolisation. It is an adjunct, however, and not a substitute for being prepared to control a major haemorrhage.

Conclusion

Any woman with bleeding in early pregnancy could have a cervical pregnancy, and pregnancy should be ruled out before irregular bleeding is treated with hormones. In our patient, an epinephrine-soaked pledget and temporary clamping of the cervix, together with tranexamic acid and a single stitch, controlled bleeding after evacuation of a live cervical pregnancy. Her uterus was preserved and she went home the next day. One case cannot tell us how reliable the method is, what dose of epinephrine is best or whether it affects later pregnancies. It should only be used where the team can escalate quickly if bleeding continues.

Patient perspective

The patient said: "The next day I felt well and was able to go home. I am grateful to share my experience so that other clinicians may learn this technique to help women facing the same condition."

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Legend Tables and Figures:

Table 1: Clinical timeline

Time relative to presentation	Clinical event
About 17 days before	Light bleeding reported as menstruation; outpatient transabdominal scan; empirical medroxyprogesterone acetate.
5 days before	Onset of persistent heavy vaginal bleeding.
Admission	HR 100 beats/min, BP 100/60 mmHg, Hb 107 g/L. Live cervical pregnancy (CRL 14 mm, 7+5 weeks) on transvaginal ultrasonography; β-hCG 53,832 IU/L.
Same day (urgent operation)	Hysteroscopy; evacuation with ovum forceps and suction; epinephrine pledget, bilateral-contralateral cervical clamps and IV tranexamic acid for 15 minutes; one

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Time relative to presentation	Clinical event
	haemostatic suture. HR 96–100 beats/min, BP 110/70 mmHg, SpO_2 100%. Blood loss 150–200 mL; no transfusion.
Postoperative day 1	Hb 98 g/L; discharged after uncomplicated recovery.
2 weeks	β-hCG <5 IU/L.
1 month	Normal menstrual period; normal uterus and adnexa on ultrasonography.

Table 2: Management options for cervical ectopic pregnancy.

Modality	Selection considerations	Advantages	Limitations and risks
Systemic methotrexate	Stable patients; lower β-hCG, earlier gestation, absent cardiac activity and CRL ≤10 mm are favourable [9]	Non-invasive; preserves cervical anatomy	Higher failure with β-hCG ≥10,000 mIU/mL, gestation ≥9 weeks, cardiac activity or CRL >10 mm; haemorrhage during resolution; systemic toxicity
Local feticide (intra-amniotic KCl or methotrexate)	Viable embryo, high β-hCG, stable patient [10,24]	Rapid arrest of cardiac activity; minimal systemic exposure	Needs ultrasound-guided needle expertise; slow resorption; may need later evacuation
Uterine artery embolisation ± curettage	Active bleeding, high β-hCG, viable sac, or rescue [19]	Immediate devascularisation; reduces blood loss at evacuation	Needs interventional radiology; radiation; risk of ischaemia, ovarian impairment, intrauterine adhesions, pain
Suction evacuation + balloon tamponade	Acute bleeding, failed medical treatment, or primary surgery [13]	Rapid tissue removal; mechanical tamponade of bleeding stroma	Sudden haemorrhage during curettage; balloon displacement; infection
Hysteroscopic resection	Stable patients with clear view of the endocervix [20,21]	Direct visualisation; targeted coagulation	Difficult in a bleeding field; fluid overload; specialised equipment
Cervical artery ligation / vasoconstrictor injection before evacuation	Prophylactic devascularisation before curettage [11]	Reduces inflow; uses standard instruments	Requires suturing in an engorged cervix; vasopressin side effects

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Modality	Selection considerations	Advantages	Limitations and risks
Laparoscopic or open uterine artery ligation	Intractable haemorrhage or prophylactic devascularisation	Reduces pelvic pulse pressure; avoids radiation	Invasive; ureteric and vascular injury
Hysterectomy	Life-threatening haemorrhage refractory to conservative measures [4]	Definitive	Permanent loss of fertility; high morbidity in an engorged pelvis

Table 3: Selected published reports of procedure-based conservative management of cervical ectopic pregnancy using local or mechanical haemostatic adjuncts, compared with the present case. This is a narrative selection, not a systematic review.

Report	n	Primary procedure	Haemostatic adjunct	Reported outcome
Frates et al., 1994 [10]	12	KCl injection, D&E or methotrexate	Uterine artery embolisation (4) or uterine artery branch ligation (1) before D&E	Single treatment successful in all; uterus preserved
De La Vega et al., 2007 [12]	1	Suction curettage	Cerclage, intracervical carboprost, Foley balloon tamponade	Uneventful
Davis et al., 2008 [11]	1	D&C	Transvaginal ligation of cervical branches of uterine arteries + vasopressin injection	Uneventful
Corticelli et al., 2008 [14]	1	Methotrexate, then D&C for bleeding	Foley balloon tamponade	Uneventful
Faschingbauer et al., 2011 [17]	1*	Curettage	Shirodkar cerclage	Intrauterine pregnancy delivered vaginally at 39 weeks
Moragianni et al., 2012 [15]	1*	Ultrasound-guided ring-forceps removal	Foley balloon after heavy bleeding	Intrauterine pregnancy delivered at 39 weeks
Fylstra, 2014 [13]	13	Suction curettage	Foley balloon tamponade	Uterus preserved in all
Tsakos et al., 2015 [18]	1*	Aspiration	Foley catheter + Shirodkar cerclage	Term delivery of intrauterine pregnancy
Hu et al., 2016 [19]	19	Curettage	Prior uterine artery embolisation	Successful conservative treatment in all

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Report	n	Primary procedure	Haemostatic adjunct	Reported outcome
Maglic et al., 2021 [21]	Series	Small-calibre hysteroscopy	Hysteroscopic haemostasis	Less blood loss and shorter stay than D&C
Present case	1	Ovum forceps + suction under hysteroscopic guidance	Epinephrine pledget + bilateral-contralateral clamps (15 min), IV tranexamic acid, one suture	Blood loss 150–200 mL; no transfusion; discharged day 1; uterus preserved

*Heterotopic cervical pregnancy. D&C, dilatation and curettage; D&E, dilatation and evacuation; KCl, potassium chloride.



Figure 1: Transvaginal ultrasound image of the cervical pregnancy. The reported crown-rump length was 14 mm. The top metadata strip has been cropped for de-identification; the diagnostic field has not been altered.



Figure 2: Operative appearance at examination under anaesthesia, with gestational tissue visible at the external cervical os.

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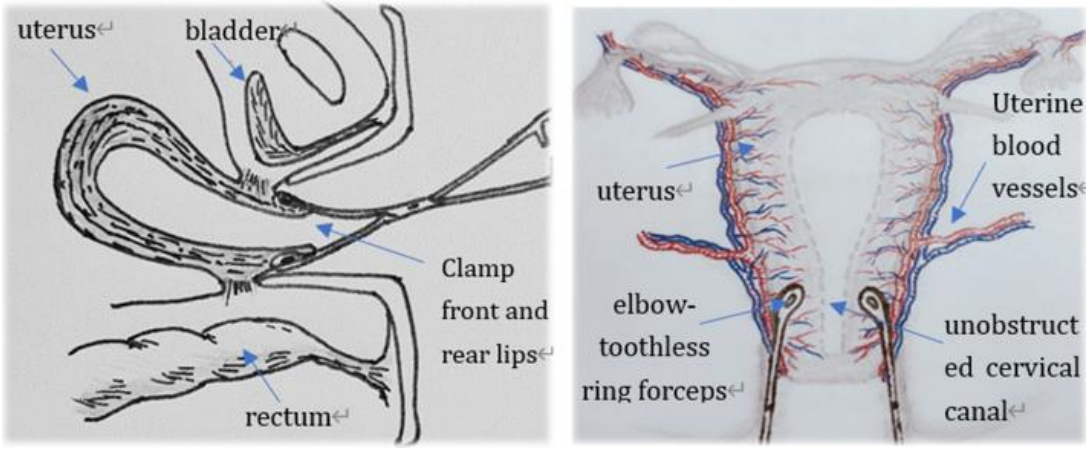


Figure 3: Schematic illustration of bilateral-contralateral cervical clamp placement. Reproduced without content changes from Fig. 2 of Zhang et al. [7] (https://doi.org/10.1186/s12884-020-03518-2) under the Creative Commons Attribution 4.0 licence (http://creativecommons.org/licenses/by/4.0/). This published technique illustration is not an image of the reported procedure.

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