The diagnosis of a cornual pregnancy remains challenging and is considered more life threatening than other types of ectopic pregnancies as they can lead to uterine rupture and severe haemorrhage. Four out of eleven deaths from ectopic pregnancies in the CMACE report from 2000 to 2002 were attributed to cornual rupture.

Case A 33-year-old Caucasian woman attended hospital at 6 weeks gestation following an urgent referral from the BPAS Abortion Service for not being able to detect an intrauterine pregnancy on their sonogram. She previously had two normal deliveries, one spontaneous miscarriage and one medical termination 3 years ago. She had no major risk factors including fertility treatment, pelvic inflammatory disease and tubal surgery. She was not on any regular contraception and her smear tests were up to date. Upon admission, she was clinically asymptomatic and her vital observations were generally normal. Her abdominal and pelvic examinations were normal. Her initial haemoglobin was 133 g/L and her pregnancy test was positive. An immediate ultrasound scan revealed an absence of an intrauterine pregnancy but a mixed echo, round mass of 32.0 x 30.5 mm was detected separately on the right lateral side of the uterus and closely related to the ovary without any free fluid in the Pouch of Douglas. A high index of suspicion of an ectopic pregnancy was made and an initial B-HCG level was 16,026 mIU/mL. She was immediately arranged to have an emergency diagnostic laparoscopy. A diagnosis of an unruptured right cornual ectopic pregnancy was made laparoscopically and this proceeded to a laparotomy and avoidance of uterine rupture and severe haemorrhage. The patient had an uneventful postoperative recovery and she was discharged home after 2 days.

Background
The diagnosis of a cornual pregnancy remains challenging and is considered more life threatening than other types of ectopic pregnancies as they can lead to uterine rupture and severe haemorrhage. Four out of eleven deaths from ectopic pregnancies in the CMACE report from 2000 to 2002 were attributed to cornual rupture.

Case A 33-year-old Caucasian woman attended hospital at 6 weeks gestation following an urgent referral from the BPAS Abortion Service for not being able to detect an intrauterine pregnancy on their sonogram. She previously had two normal deliveries, one spontaneous miscarriage and one medical termination 3 years ago. She had no major risk factors including fertility treatment, pelvic inflammatory disease and tubal surgery. She was not on any regular contraception and her smear tests were up to date. Upon admission, she was clinically asymptomatic and her vital observations were generally normal. Her abdominal and pelvic examinations were normal. Her initial haemoglobin was 133 g/L and her pregnancy test was positive. An immediate ultrasound scan revealed an absence of an intrauterine pregnancy but a mixed echo, round mass of 32.0 x 30.5 mm was detected separately on the right lateral side of the uterus and closely related to the ovary without any free fluid in the Pouch of Douglas. A high index of suspicion of an ectopic pregnancy was made and an initial B-HCG level was 16,026 mIU/mL. She was immediately arranged to have an emergency diagnostic laparoscopy. A diagnosis of an unruptured right cornual ectopic pregnancy was made laparoscopically and this proceeded to a laparotomy and avoidance of uterine rupture and severe haemorrhage. The patient had an uneventful postoperative recovery and she was discharged home after 2 days.

Conclusion
Cornual pregnancy can be managed either by systemic administration of methotrexate or surgery. However, if the diagnosis remains unclear and a diagnostic laparoscopy is required for verification, it is generally safer to proceed to either an operative laparoscopy or laparotomy and avoid delaying the management. Depending on the patient’s obstetric history, surgical background and future plans of fertility, medical management of an unruptured ectopic pregnancy generally provides the advantage of preserving fertility, minimising haemorrhage and avoiding surgery.

Patient’s background
- 33-year-old Caucasian
- Parity: 2 previous normal deliveries with living children, 1 miscarriage and 1 medical termination
- BMI 26

- Admitted following an urgent referral from BPAS Abortion Service for not being able to detect an intrauterine pregnancy at 6/40 gestation

Gynaecological history
- No nausea or vomiting, good appetite
- No bowel or urinary symptoms
- Urine B-HCG positive
- Regular menses (4 to 6 of 30 day cycle)
- LMP 6 weeks before
- No regular contraception
- No previous surgery, no fertility treatment
- No previous pelvic inflammatory disease or sexually transmitted infection
- Normal smear test 2013 normal
- Generally fit and well
- No regular medications and no allergies

Examination
- General: Generally well with warm peripheries, haemodynamically stable
- Vital observations: Pulse 75 bpm, BP 131/85, Sat 99% air, Temp 37.2 Celsius, RR 18
- Abdomen: soft and non-tender, no guarding, rebound or percussion tenderness, bowel sounds present, no organomegaly noted
- Pelvic: no bleeding, normal cervical os without any excitation, non-bulky uterus, normal adnexas

Histological diagnosis:
- Cornual lumen distended with fresh blood clots and first trimester chorionic villi

Conclusion
Cornual pregnancy can be managed either by systemic administration of methotrexate or surgery. However, if the diagnosis remains unclear and a diagnostic laparoscopy is required for verification, it is generally safer to proceed to either an operative laparoscopy or laparotomy and avoid delaying the management. Depending on the patient’s obstetric history, surgical background and future plans of fertility, medical management of an unruptured ectopic pregnancy generally provides the advantage of preserving fertility, minimising haemorrhage and avoiding surgery.