Interstitial pregnancy is a rare form of ectopic tubal pregnancy, accounting for 2–4% of all ectopic pregnancies. The terms cornual, interstitial and rarely angular ectopic pregnancy are often used synonymously. The true interstitial pregnancy is defined by its location lateral to the round ligament in the uterotubal junction, whilst cornual and angular pregnancies are considered as intruterine pregnancies [1, 2]. Diagnosis is made by ultrasound and positive human chorionic gonadotropin (HCG) (▶ Fig. 1). Despite its rarity, there is a wide variety of treatment options but a lack of knowledge how recurrences might be prevented by the choice of treatment [1].

A literature search using PubMed and Google Scholar on recurrent interstitial pregnancy reveals that only very few cases of re-
Interstitial pregnancies have been reported. As detailed below, prior history and visible risk factors for ectopic pregnancies appear to be significant for the best choice of treatment.

Literature Search

A literature search in PubMed and Google Scholar was conducted by using the keywords “interstitial pregnancy” or “cornual pregnancy” or “angular pregnancy”. Additionally, the references of papers returned by this literature search were searched for further papers. The resulting abstracts were screened for information regarding the further reproductive outcome. In total we found 61 articles on interstitial pregnancies where further information about the reproductive outcome after treatment could be retrieved and 41 articles about interstitial pregnancies as heterotopic pregnancies where the further reproductive outcome was addressed. Only 13 of these 102 publications were related to recurrences of ipsilateral interstitial pregnancies.

▶ Table 1 shows the 13 case reports, with details presented on treatment, risk factors, time frame to recurrence and subsequent pregnancies.

General Overview

In the literature, recurrent interstitial pregnancy appears to be very rare. The only multiple case study of four cases [1] reported a prevalence of 0.3% of all women with ectopic pregnancies over a five-year period. In the largest reported series of ectopic pregnancies [3], there was no recurrence of interstitial pregnancies where the further reproductive outcome was addressed. Only 13 of these 102 publications were related to recurrences of ipsilateral interstitial pregnancies. ▶ Table 1 shows the 13 case reports, with details presented on treatment, risk factors, time frame to recurrence and subsequent pregnancies.

Risk Factors

In general, risk factors for an interstitial pregnancy and its recurrence include
1. tubal anomaly, which can be induced by endometriosis or uterine leiomyomata,
2. anatomical damage due to pelvic inflammatory disease,
3. prior ectopic pregnancies,
4. salpingectomy and
5. assisted reproductive techniques.

Eleven out of 17 cases of recurrent interstitial pregnancy showed at least one pathology or anatomical anomaly in the uterotubal junction [1, 2, 5, 11, 14, 16, 19, 20] (▶ Table 1). Furthermore, damaged tubes are found more frequently in proximal ectopic pregnancies than in distal ectopic pregnancies [3]. Additionally, salpingectomy appears to be a singular predisposition for interstitial pregnancies as Simpson et al. showed in a literature review of 46 interstitial pregnancies after ipsilateral salpingectomy [4].

In the context of risk factors it is interesting to note that tubal occlusion within the uterotubal junction after recurrent interstitial pregnancy, which was treated twice with systemic methotrexate, eventually led to a successful intrauterine pregnancy [5].

Treatment Choice and Recurrence

There are various treatment options. Conservative approaches include methotrexate injections, which can be given systemically and/or locally. Tanaka reported in 1982 the first successful systemic methotrexate treatment of an interstitial pregnancy. He used 30 mg methotrexate intramuscularly on day 1, followed by two courses of 15 mg/d for a further five days. There were two days between the two courses [6]. The most common schedule is one or two courses with methotrexate 1 mg/kg/d systemically on day 1, 3, 5 and 7 with seven days in between. Different schedules also applied methotrexate locally in doses of 25 to 50 mg. The approximate overall success rate in various case reports is 83%, while the local treatment was considered to be slightly more successful [7]. Importantly, randomized trials comparing treatment options regarding interstitial pregnancy are missing. The randomized multicenter Demeter trial compared surgery with methotrexate 1 mg/kg/d on day 1, 4, 7, and 14 systemically in tubal ectopic pregnancies. The methotrexate schedule depended on the post-therapeutic HCG levels. While there was no significant difference regarding further fertility, the failure rate of systemic methotrexate was 21.8% [8]. Within heterotopic pregnancies, defined by the coexistence of an intrauterine and an ectopic pregnancy, the coexisting interstitial pregnancy is often treated by a local potassium chloride injection. Surgical interventions, on the other hand, primarily take place in case of failure of local treatment [7, 11]. We only found one case of recurrence after treatment of a heterotopic pregnancy by selective feticide of a heterotopic cornual pregnancy by intracardial 0.5 ml 15% KCL injection at 8 weeks of gestation. The remaining intrauterine pregnancy was uneventful and was delivered at term by a Caesarean section [11].
<table>
<thead>
<tr>
<th>Author</th>
<th>Prior obstetrical history</th>
<th>Treatment first interstitial pregnancy</th>
<th>Treatment recurrent interstitial pregnancy</th>
<th>Risk factors/uterine/tubal pathologies</th>
<th>Subsequent intrauterine pregnancy</th>
<th>Time to recurrence (month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sungurtekin and Uyar, 1998 [13]</td>
<td>2 SA</td>
<td>Methotrexate 50 mg/d i. m. + citrovorum factor 0.1 mg/kg for 5 days</td>
<td>1.2 × Methotrexate 50 mg/d i. m. + citrovorum factor 0.1 mg/kg for 5 days, due to a viable pregnancy after the first course. 2. Laparotomy and resection of a uterine cornual mass, due to suspicion of an imminent rupture.</td>
<td>Pelvic endometriosis</td>
<td>NO</td>
<td>17</td>
</tr>
<tr>
<td>Vilos, 2001 [2]</td>
<td>1 SA, 1 VD</td>
<td>Laparoscopic ligation with endoloops and resection</td>
<td>Laparoscopic ligation with endoloops and resection</td>
<td>Bilateral interstitial-isthmic tubal anastomoses</td>
<td>NO</td>
<td>10</td>
</tr>
<tr>
<td>Wittich, 1998 [14]</td>
<td>2 VD</td>
<td>Laparotomy + cornuostomy</td>
<td>Laparotomy + cornual wedge resection</td>
<td>PID, multiple leiomyomata</td>
<td>NO</td>
<td>19</td>
</tr>
<tr>
<td>Budnick et al., 1993 [15]</td>
<td>None</td>
<td>Curettage under laparoscopic guidance</td>
<td>Laparotomy + salpingectomy</td>
<td>None</td>
<td>MNS</td>
<td>8</td>
</tr>
<tr>
<td>Maruthini and Sharma, 2013 [16]</td>
<td>None</td>
<td>Laparotomy + cornuostomy + postoperatively methotrexate i. v.</td>
<td>Laparotomy and diathermic coagulation</td>
<td>Hydrosalpinges, bilateral salpingectomy, IVF</td>
<td>CS</td>
<td>12</td>
</tr>
<tr>
<td>Sagiv et al., 2001 [10]</td>
<td>None</td>
<td>Laparoscopic methotrexate injection (12.5 mg)</td>
<td>Laparoscopic cornuostomy</td>
<td>None</td>
<td>VD</td>
<td>6</td>
</tr>
<tr>
<td>Douyset et al., 2014 [17]</td>
<td>NO</td>
<td>Laparoscopic excision by Endo GIA stapling</td>
<td>Laparotomy + cornuostomy</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>van der Weiden and Karsdorp, 2005 [11]</td>
<td>None</td>
<td>Selective fetocide of a heterotopic cornual pregnancy by intracardial 0.5 ml 15% KCL injection at 8 weeks of gestation. CS of the intrauterine pregnancy at term.</td>
<td>0.5 ml 15% KCL intracardial + 40 mg methotrexate in the gestational sac, 3 courses of methotrexate oral 1.0 mg/kg + 15 mg folic acid</td>
<td>IVF, blocked tubes</td>
<td>NO</td>
<td>24</td>
</tr>
<tr>
<td>Faraj and Steel, 2008 [5]</td>
<td>None</td>
<td>Single dose systemic methotrexate</td>
<td>Suction evacuation, without pregnancy products, 2 single doses of systemic methotrexate</td>
<td>Abnormal shaped uterine cornu due to a fibroid</td>
<td>At publication Pt. was pregnant at 20 weeks of gestation after tubal occlusion</td>
<td>8</td>
</tr>
<tr>
<td>Hwang et al., 2011 [18]</td>
<td>NO</td>
<td>Cornual wedge resection</td>
<td>Cornual wedge resection</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Faleymu et al., 2008 [19]</td>
<td>Laparotomy + cornual wedge resection</td>
<td>Laparotomy with salpingo-oophorectomy</td>
<td>Septic abortion in between both interstitial pregnancies</td>
<td>None</td>
<td>None</td>
<td>60</td>
</tr>
<tr>
<td>Sahoo et al., 2009 [20]</td>
<td>12 EG 3 SA 1 VD</td>
<td>Laparoscopic endoloope resection of the ectopic pregnancy and diathermy, due to rising β-HCG titers 600 mg mifepristone oral + 100 mg MTX i. m. was given.</td>
<td>Laparoscopic right cornual excision by endoloope and diathermy. Hysteroscopy demonstrated the complete removal.</td>
<td>2 tubal ectopic pregnancies, right salpingectomy</td>
<td>None</td>
<td>12</td>
</tr>
</tbody>
</table>

The main surgical options include salpingectomy, cornuotomy and cornual wedge resection (Fig. 2). Regarding surgery one might expect cornual wedge resection as superior treatment and recurrent interstitial pregnancies to occur especially frequent after medical treatment, as only the cornual wedge resection, if done properly, will remove the uterotubal junction. In fact, we only found two publications on a total of two patients with recurrence after cornual wedge resection (Table 1). Thirteen other patients recurred after being treated by various kinds of surgical techniques in their first interstitial pregnancy. In those 13 patients, different surgical techniques were used. All of these procedures included at least the removal of pregnancy products and if necessary wound closure but excluded the resection of the entire uterotubal junctions as it is part of the cornual wedge resection (Table 1). However, given the diversity of treatments and the very sparse data on their further outcomes, it is difficult to judge whether those different techniques may create a predisposition for recurrent interstitial pregnancy as the possible anatomical reason for interstitial pregnancy is not removed. Randomized trials regarding the quality of different surgical techniques are missing.

**Tubal Milieu**

In three cases, there was no known anatomical anomaly or tubal damage (Table 1). In a further two cases, no information regarding risk factors was available. In addition, only three publications with recurrent interstitial pregnancy were found after prior medical treatment with systemic or local methotrexate injections. If anatomical alterations of the uterotubal junction as sequelae of conservative treatment of ectopic pregnancy would be the only reason for recurrence in interstitial pregnancies, one would have expected more case reports of recurrence [3, 5, 11].

Importantly, normal tubal function, which is needed for normal intrauterine implantation, depends on more than anatomical normality. Modifications in tubal milieu may also lead to blastocyst arrest. By now it is understood that tubal functions like smooth muscle contractility and ciliary beat activity, which are of imminent importance for a later intrauterine implantation, are triggered through a wide range of different transmitters [3, 8].

Therefore, the conservative approach with systemic or local methotrexate injections may be justified, especially at first appearance and in the absence of additional anatomy-related risk factors.

**Uterine Rupture**

The incidence of uterine ruptures in the scarred uterus appears to be low, but the fear of it remains and therefore medical treatment might be favored over cornual wedge resection [9]. Nevertheless, the actual risk of uterine rupture after medical treatment is unknown. Therefore, it is interesting to note that uterine rupture has been described in the unscarred uterus after interstitial pregnancy. As in the recurrent interstitial pregnancy after hysteroscopic resection of the first interstitial pregnancy [15] and in the subsequent intrauterine pregnancy at 24 weeks of gestation after spontaneous resolution of an interstitial pregnancy by excision of a corpus luteum [21].

**Surgical Approaches**

Regarding the chosen surgical approach – laparoscopy or laparotomy – there seems to be no difference for later recurrences. As can be seen in Table 1, seven patients recurred after laparoscopy and four patients recurred after laparotomy. Optimal suturing and a very limited use of electrocautery might be of more importance when treating interstitial pregnancy surgically, regarding later uterine ruptures [1, 3,12].

**Timeframe and Subsequent Pregnancies**

The role of the variable timeframes to recurrence in all 16 cases, ranging from 5 to 60 months, and the significance of six subsequent intrauterine pregnancies cannot be judged properly with regards to subsequent fertility or risk of recurrence, given that information about contraception and try for pregnancy was not available. It is, however, interesting to note that two women had uneventful vaginal deliveries after cornual wedge resection and one after local methotrexate injection (Table 1).

**Conclusions**

The literature review demonstrates that recurrent interstitial pregnancy is a very rare condition and more likely when additional anatomy-related risk factors for ectopic pregnancies are present, such as hydrosalpinges, blocked tubes, endometriosis, fibroids or prior tubal ectopic pregnancies. Nevertheless, it has to be addressed when counseling patients for treatment options. Therefore, at first appearance and in absence of additional anatomy-related risk factors, local or systemic methotrexate in-
jections may be the first choice. In case of anatomical risk factors, cornual wedge resection seems to be the first choice. In case of recurrence, cornual wedge resection is particularly justified in patients with anatomical alterations of the salpinges. Furthermore, surgery is needed to thoroughly inspect the anatomical conditions. The role of various other surgical treatments in recurrence, such as cornuotomy, salpingectomy, endoloop ligation and resection and curettage under laparoscopic guidance remains unclear due to sparse data.

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Conflict of Interest

The author declares that she has no conflict of interests.

References