Complete interstitial ectopic pregnancies are rare and pose significant diagnostic challenges, particularly in rural settings with limited access to OB/GYN care. In this case, serial β-hCG measurements and TVUS identified the ectopic pregnancy, despite the patient's benign presentation and low serum β-hCG. Timely robotic-assisted surgery prevented complications such as uterine rupture and hemorrhage, ensuring a favorable outcome. Patient education and proactive follow-up were crucial in addressing health literacy concerns and ensuring compliance with care in the rural setting.

The informed consent was signed by and publication approved by patient.

AUTHOR CONTRIBUTIONS

Qingyu Guo, a medical student at William Carey University College of Osteopathic Medicine, was actively involved in the treatment of the patient, including data collection and obtaining informed consent. Qingyu Guo also took the lead in drafting the case report, compiling clinical information, and preparing the manuscript. Rashad N. Ali, the attending physician in charge of the case, provided direct patient care and was responsible for the clinical management and treatment of the patient. Dr. Ali also contributed significantly by writing the clinical notes and offering critical interpretation of the treatment outcomes. He provided guidance and oversight throughout the drafting process of the case report.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ORCID

Qingyu Guo https://orcid.org/0009-0002-3057-0226

REFERENCES

1. Dagar M, Srivastava M, Ganguli I, Bhardwaj P, Sharma N, Chawla D. Interstitial and cornual ectopic pregnancy: conservative surgical and medical management. *J Obstet Gynaecol India*. 2018;68(6):471-476. doi:10.1007/s13224-017-1078-0
2. Mullany K, Minneci M, Monjazeb R, Coiado O. Overview of ectopic pregnancy diagnosis, management, and innovation. *Womens Health (Lond)*. 2023;19:17455057231160349. doi:10.1177/17455057231160349
3. Timor-Tritsch IE, Monteagudo A, Sharma S, Rao S, Sonographers from East River Medical Imaging, Medical Faculty from NYU Langone Health. Comparison of diagnosis and clinical outcome of interstitial pregnancy by transvaginal sonography and MRI. *Am J Obstet Gynecol*. 2019;220(5):476.e1-476.e9. doi:10.1016/j.ajog.2019.01.217
4. Moawad NS, Mahajan ST, Moniz MH, Taylor SE, Hurd WW. Current diagnosis and treatment of interstitial pregnancy. *Am J Obstet Gynecol*. 2010;202:15-29.
5. Radwan F, Steel M. Management of cornual (interstitial) pregnancy. *Obstet Gynaecol*. 2007;9:249-255.
6. Soto E, Lo Y, Friedman K, et al. Total laparoscopic hysterectomy versus da Vinci robotic hysterectomy: is using the robot beneficial? *J Gynecol Oncol*. 2011;22(4):253-259. doi:10.3802/jgo.2011.22.4.253

Received: 30 June 2024 | Revised: 16 October 2024 | Accepted: 16 November 2024 | Published online: 4 December 2024
DOI: 10.1002/ijgo.16065

Gynecology

Brazil regresses in defending the sexual and reproductive health of its girls and women

José Paulo de Siqueira Guida[1] | Fernanda Surita[1] | Sara de Pinho Cunha Paiva[2] | Rosires Pereira Andrade[3] | Silvana Maria Quintana[4] | Aline Veras Morais Brilhante[5] | Cristião Fernando Rosas[6] | Marla Niag dos Santos Rocha[7,8] | Marcia Sacramento Cunha Machado[7,9]

[1]Department of Obstetrics and Gynecology, University of Campinas, Campinas, Brazil
[2]Department of Obstetrics and Gynecology, Federal University of Minas Gerais, Belo Horizonte, Brazil
[3]Department of Obstetrics and Gynecology, Federal University of Parana, Curitiba, Brazil
[4]Department of Obstetrics and Gynecology, University of São Paulo, Ribeirão Preto, Brazil
[5]Department of Public Health, University of Fortaleza, Fortaleza, Brazil
[6]Clínica Obstétrica, Maternidade Escola de Vila Nova Cachoeirinha, São Paulo, Brazil
[7]Department of Obstetrics and Gynecology, Federal University of Bahia, Salvador, Brazil

[8]Department of Obstetrics and Gynecology, Federal University of Recôncavo da Bahia, Santo Antônio de Jesus, Brazil
[9]Department of Obstetrics and Gynecology, Escola Bahiana de Medicina e Saúde Pública, Salvador, Brazil

Correspondence
José Paulo de Siqueira Guida, Department of Obstetrics and Gynecology, University of Campinas, 101 Alexander Fleming St, Campinas, Brazil.
Email: jpguida@unicamp.br

KEYWORDS
abortion, maternal health, vulnerabilities

Brazil's legislative framework on abortion is notably restrictive, permitting the procedure only under specific circumstances: pregnancies resulting from sexual violence, situations posing a risk to the mother's life, or cases of anencephaly. In Latin America, Brazil has more restrictive legislation in contrast to Argentina and Uruguay, where abortion is allowed in any circumstance before 14 weeks. Contradicting international scientific consensus, Brazilian lawmakers are currently advancing proposals to tighten these restrictions further. One such proposal, Bill 1904/2024, seeks to prohibit abortions performed after 22 weeks of gestation and imposes severe penalties, including up to 20 years of imprisonment, for women who seek abortions following rape.

Brazil is a signatory to several critical international agreements, including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social, and Cultural Rights, and the Convention on the Rights of the Child. These treaties obligate member states to protect individuals from the physical and mental risks associated with unsafe abortions. They also mandate efforts to reduce maternal mortality, which inherently includes preventing unsafe abortion practices among girls and adolescents.

The World Health Organization does not specify a gestational age limit for abortion procedures; the Brazilian current legislation also does not establish any limit based on gestational age. Instead, it asserts that everyone has the right to benefit from scientific advancements and the right to health, which encompasses the availability, accessibility, acceptability, and quality of abortion care. This stance underscores the necessity for safe and accessible abortion services as integral to health and human rights.[1]

Brazil's current legislative trajectory, as indicated by Bill 1904/2024, poses significant risks to these rights and obligations. By potentially increasing the barriers to safe abortion services, it not only conflicts with international health guidelines but also endangers the physical and mental well-being of women and girls across the country. This movement backward in reproductive rights highlights an urgent need for a reevaluation of Brazil's commitment to the protection and promotion of women's health and rights on the global stage.

Access to safe and timely abortion services is critically hindered by systemic barriers within Brazil's healthcare system, even for those who seek to terminate pregnancies under legally permissible circumstances. This reality disproportionately affects marginalized groups, such as Black, impoverished, and very young women, many of whom are victims of chronic and intra-familial abuse.[2] These women are at a heightened risk of undergoing unsafe abortions or facing the adverse consequences of continuing pregnancies resulting from violence.

As is often the case with discussions surrounding vulnerabilities, the women and adolescents seeking abortions at more advanced stages of gestation are predominantly poor and Black, having been denied earlier access to care. These women, who require the most societal support and protection due to the violent nature of their pregnancies, face significant social and clinical risks if forced to continue unwanted pregnancies. These risks include potential psychological and physical harm and, in extreme cases, premature death due to pregnancies they neither desired nor intended to have but which were imposed upon them through violence.

The late discovery of pregnancies resulting from sexual abuse is common among girls under 14, who often lack knowledge about their reproductive health and the early signs of pregnancy.[3] This ignorance is compounded by the fact that these young victims frequently suffer abuse from their caregivers and encounter obstacles within healthcare services, such as misinformation and lack of awareness about sexual and reproductive rights among health professionals. These barriers make accessing safe abortion services at earlier stages of gestation particularly challenging. When they eventually seek help, they often also need to escape cycles of intra-familial and domestic violence, further restricting their ability to seek timely assistance.

Forcing a person in extreme vulnerability to carry a pregnancy to term due to gestational age limits exposes them to severe psychological and physical risks and violates their legally guaranteed rights. These individuals often face intersecting vulnerabilities, compounded by the inadequate availability of services to address sexual violence. Notably, only 3.6% of Brazilian municipalities offer legal abortion services.[4]

Contrary to its purported aim of "protecting life," the proposed legislation exacerbates existing vulnerabilities and disproportionately affects those most in need of medical and societal support. It effectively revokes the rights of women, adolescents, and girls who are victims of sexual violence, subjecting them to further cruel violence.

In light of these concerns, we, the undersigned, who are responsible for various safe abortion services across Brazil, vehemently oppose this legislative proposal. We denounce this legal aberration to our colleagues in gynecology and obstetrics worldwide and call upon our Brazilian counterparts and the collective rights defense organizations to remain vigilant against the approval of this norm.

AUTHOR CONTRIBUTIONS

JPSG and FS wrote the first draft of the manuscript. All the other authors critically reviewed it; the final version of the manuscript was written by JPSG and FS and was approved by all the other authors.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ORCID

José Paulo de Siqueira Guida https://orcid.org/0000-0002-3648-6159

REFERENCES

1. World Health Organization. *Abortion Care Guideline*. World Health Organization; 2022.
2. Pallitto CC, García-Moreno C, Jansen HA, Heise L, Ellsberg M, Watts C. Intimate partner violence, abortion, and unintended pregnancy: results from the WHO multi-country study on Women's health and domestic violence. *Int J Gynaecol Obstet*. 2013;120(1):3-9.
3. Yánez-Sánchez P, de Lima SO, Alabarse OP, et al. Legal abortion requests and outcomes for women when the law is restrictive—experience from a referral centre in south-eastern Brazil. *Eur J Contracept Reprod Health Care*. 2024;29(3):131-137.
4. Jacobs MG, Boing AC. What do the national data say about the supply and performance of legal abortions in Brazil in 2019? *Cad Saude Publica*. 2021;37(12):e00085321.

Received: 26 September 2024 | Revised: 3 November 2024 | Accepted: 9 November 2024 | Published online: 10 December 2024

DOI: 10.1002/ijgo.16044

Gynecology

Laparoscopic ventral mesh uterorectopexy (VMUR) for simultaneously treating rectal prolapse and uterine prolapse: A minimally invasive approach with a single mesh

Yiran Liu[1,2] | **Pan Hu**[1,2] | **Lubin Liu**[1,2]

[1]Department of Obstetrics and Gynecology, Women and Children's Hospital of Chongqing Medical University, Chongqing, China

[2]Department of Obstetrics and Gynecology, Chongqing Health Center for Women and Children, Chongqing, China

Correspondence
Lubin Liu, Department of Obstetrics and Gynecology, Women and Children's Hospital of Chongqing Medical University, No.120 Longshan Road, Yubei District, Chongqing 401147, China.
Email: liulubin1975@126.com

Keywords
laparoscopic sacral hysteropexy, rectal prolapse, uterine prolaps, ventral mesh rectopexy, ventral mesh uterorectopexy

Rectal mucosal prolapse most commonly occurs in individuals aged 40–70 years, with approximately 80%–90% of affected patients being female.[1] Rectal mucosal prolapse and uterine prolapse are both classified as pelvic floor dysfunctions. Therefore, it is common to encounter patients with multiple organ prolapses in clinical practice. European pelvic floor surgeons currently prefer the ventral mesh rectopexy (VMR) technique for treating rectal mucosal prolapse.[2,3] This technique involves mobilizing only the anterior side of the rectum to the perineal body, avoiding the posterior and lateral mobilization required by traditional methods. This reduces the risk of injury to surrounding autonomic nerves and significantly alleviates postoperative constipation. It is also recommended that patients with rectal mucosal prolapse combined with multiorgan pelvic prolapse consider this technique.[4]

For patients with concurrent uterine prolapse, there have been reports of simultaneous laparoscopic sacral hysteropexy (LSH) and VMR surgery.[5,6] However, due to the significant trauma and prolonged duration of simultaneous surgery, which requires multidisciplinary consultations and collaborative efforts, the application rate is not high. Simultaneous surgery increases the use of mesh