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AN UNUSUAL PRESENTATION OF ECTOPIC PREGNANCY: A CASE REPORT

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ABSTRACT An ectopic pregnancy is the one in which the fertilized ovum is implanted in a site other than normal uterine cavity. The most common site being ampullary region of fallopian tube. The most common triad by which ectopic pregnancy is diagnosed clinically in first trimester is vaginal bleeding, lower abdominal pain and amenorrhea. In this case study we report a 20-year-old woman with initial presents with giddiness and weakness and anemia, corrected by blood, fluids and parenteral iron. After 1 week she complaints of PV Spotting and irregular menses. Upon examination she was clinically stable and no guarding rigidity or tenderness was elicited. urine pregnancy test was positive and urgent ultrasonography revealed? ruptured left adnexal mass with non-visualization of left ovary. An emergency exploratory laparotomy revealed ruptured tubal ectopic with non-visualization of left ovary and adnexal structures with g sac attached to posterior surface of the uterus. Excision of the g sac and repair of the posterior surface of the uterus done.

KEYWORDS : Ectopic Pregnancy, Unusual Presentation, Exploratory Laparotomy

INTRODUCTION

Ectopic pregnancy occurs when a fertilized ovum implants outside of the uterine cavity. In India, the estimated prevalence of ectopic pregnancy is 3.12 per 1000, and ruptured ectopic pregnancy accounts for 2.7% of pregnancy-related deaths. Risk factors include a history of pelvic inflammatory disease, cigarette smoking, fallopian tube surgery, previous ectopic pregnancy, and infertility. Ectopic pregnancy should be considered in any patient presenting early in pregnancy with vaginal bleeding or lower abdominal pain in whom intrauterine pregnancy has not yet been established. The definitive diagnosis of ectopic pregnancy can be made with ultrasound visualization of a yolk sac and/or embryo in the adnexa. However, most ectopic pregnancies do not reach this stage. More often, patient symptoms combined with serial ultrasonography and trends in beta human chorionic gonadotropin levels are used to make the diagnosis. Pregnancy of unknown location refers to a transient state in which a pregnancy test is positive but ultrasonography shows neither intrauterine nor ectopic pregnancy. Serial beta human chorionic gonadotropin levels, serial ultrasonography, and, at times, uterine aspiration can be used to arrive at a definitive diagnosis. Treatment of diagnosed ectopic pregnancy includes medical management with intramuscular methotrexate, surgical management via salpingostomy or salpingectomy, and, in rare cases, expectant management. A patient with diagnosed ectopic pregnancy should be immediately transferred for surgery if she has peritoneal signs or hemodynamic instability, if the initial beta human chorionic gonadotropin level is high, if fetal cardiac activity is detected outside of the uterus on ultrasonography, or if there is a contraindication to medical management.

Case Study

A 20 years old female, presented to the emergency with complaints of giddiness and weakness history of fall. The emergency medicine on call consultants ordered immediate hemogram and NCCT brain after stabilization of her vitals. The NCCT Brain was suggestive of sub arachnoid hemorrhage and was admitted under medicine for anemia and further management of SAH and anemia (5 gram/dl). Anemia was corrected with blood products followed by parenteral iron preparations.

The patient then started complaining of pain in abdomen and PV spotting post stabilization and hence UPT was done which was positive. An examination by the gynecology on call team revealed she was 20 years old G2P1L1, previous vaginal delivery 2 years back currently with urine pregnancy test positive status with per vaginal spotting. On examination the vitals of the patient were stable with pulse 86 beats per minute, blood pressure of 100/ 70 mmhg in supine position with a saturation of 99 maintained on room air.

A per abdomen examination showed no tenderness/ guarding or rigidity. A per vaginal examination showed normal cervix and vagina and altered discharge seen and uterus of 6 to 8 weeks size with cervical motion tenderness elicited. Bilateral fornices were free.The examination was confirmed by pelvic ultrasound examination and beta Hcg.

The ultrasound revealed the following findings: Uterus normal in shape, size and echotexture. No intrauterine gestational sac seen. Right ovary normal in size, shape and location. A large well defined hyper echoic structure measuring 4.4 X 3.6X4.2 cm is noted in the left adnexa likely decidual reaction. A small crumpled cystic lesion of size 1.7X0.8X1.7 cm suggestive of crumpled gestational sac. Left ovary is not seen separately, mild free fluid in the pouch of Douglas with echoes seen. The overall impression was suggestive of ruptured left adnexal likely tubal ectopic pregnancy with mild hemorrhagic fluid within pouch of Douglas.

Her hemoglobin was 8.6 grams and total white cell counts of 7500 g/dl. Blood grouping and cross matching was done. Decision was taken to take up the patient for emergency exploratory laparotomy. During laparotomy 250 cc of intra-abdominal blood was suctioned while blood transfusion was ongoing. Left cornual end of fallopian tube seen. Left ovary and fimbrial end not visualized. Gestational sac and placenta detached from the posterior surface of the uterus. Hemostatic sutures taken over the raw surface and hemostasis achieved. Drain placed. Patient shifted to ward and discharged on post operative day 7.

Fig 1: Intraoperative Images of Ruptured Ectopic at the Cornua and the Atrophic Left Ovary.

A post operative MRI was done to visualize the left ovary which was suggestive of atrophied left ovary with left ovarian vessels ending into an ovarian vessel is ending into an ovarian morphology-like structure approximately 0.2 cc.

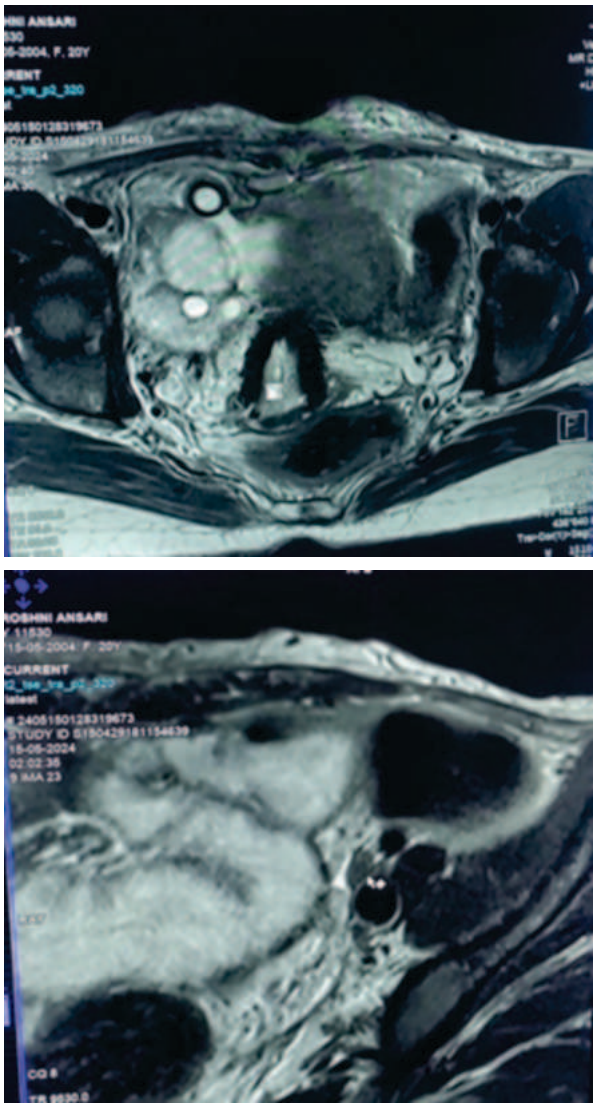

Fig 2: a) Right and Left Atrohpied Ovary b) Left Atrophied Ovary

The patient was discharged on post op day 8 and called for follow up for suture line check and suture removal.

CONCLUSIONS

Ectopic pregnancy is a first trimester pregnancy complication. The classical clinical triad of diagnosing a ectopic pregnancy being lower abdominal pain, vaginal bleeding and a period of amenorrhea. The symptoms could therefore would range from asymptomatic to being hemodynamically unstable. Differential diagnosis of abdominal pain would include appendicitis, miscarriages, pelvic inflammatory pain and ovarian torsion. The case reported above did not have the classical symptoms and would have easily been missed if would not have been picked up early.Despite their unusual presentations, timely diagnosis and treatment saved this woman. Therefore, we are reporting this case series to emphasise the importance of timely diagnosis and management of such clinical entities in pregnant women and practitioners should keep them as a differential.

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