ORIGINAL RESEARCH PAPER

Obstetrics & Gynaecology

DIAGNOSTIC DILEMMA IN A CASE OF ECTOPIC PREGNANCY

KEY WORDS:

Dr Yogita Shankar Satpute Post Graduate Student, Dept of OBGY, VDGMC, Latur.

Dr Anita Gynoba Pawar Associate professor, Dept of OBGY, VDGMC, Latur.

INTRODUCTION

- Following fertilization and fallopian tube transit, the blastocyst normally implants in the endometrial lining of the uterine cavity. Implantation elsewhere is considered ectopic.
- Rate of ectopic pregnancy is 11 per 1000 pregnancies, which results in 0.2/1000 maternal mortality.
- Complications arising from ectopic pregnancy remains the leading cause of maternal mortality during first trimester. Whereas the use of ovulation inducing drugs and ARTs has increased significantly in recent years, thereby increasing the risk of ectopic pregnancy;
- contemporary methods permit more accurate and earlier diagnosis. Yet, diagnosis of ectopic pregnancy remains a diagnostic dilemma.
- Here we discuss a case where a patient suspected to have left sided ruptured ectopic pregnancy was infact an ovarian pregnancy.

CASE HISTORY

A 22 year old G3P1L1A1 with 6 + 5 weeks of GA with previous 1 LSCS came with

- c/o p/v spotting since 12 days
- c/o p/v bleeding since 1 day (1-2 pad soakage)

transvaginal sonography 1 day prior to admission s/o "complex left T-O mass lesion with UPT +ve is highly s/o left ectopic pregnancy with no e/o intrauterine Gsac and ET – 8 mm"

On Examination

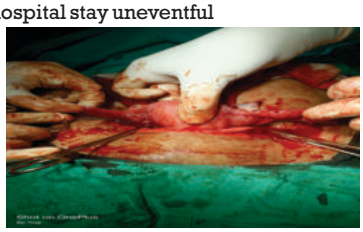
General and systemic examination within normal limits
Per abdomen – soft, tenderness over right iliac fossa, scar of LSCS +
Per speculum – Cervix, vagina healthy, minimal bleeding through os +
Per vaginum – uterus normal size, A/V A/F , left fornicial fullness

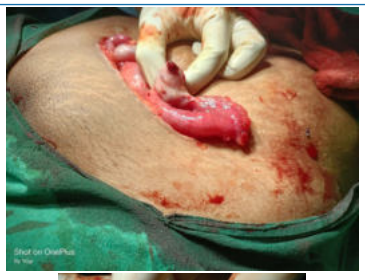
USG obs – 8.6 x 6 cm lesion in left adnexa with left ovary seen separately. Right ovary visualized normal. Hemoperitoneum is seen. Uterus mildly bulky with ET – 7 mm. no intrauterine G sac seen. I/V/O UPT positive left sided ruptured ectopic pregnancy.

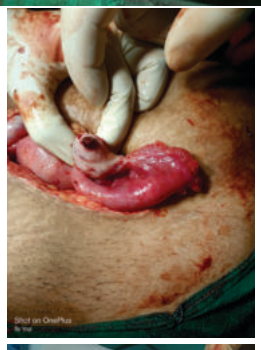
Management

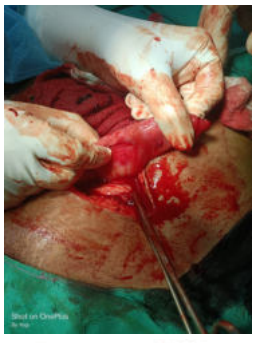
Written informed consent taken for emergency exploratory laparotomy 50 ml of hemoperitoneum seen, both tubes inspected and found intact, e/o hemorrhage on posterior surface of left ovary; 3x2 cm clot retrieved, 200 gms of clots removed from POD.

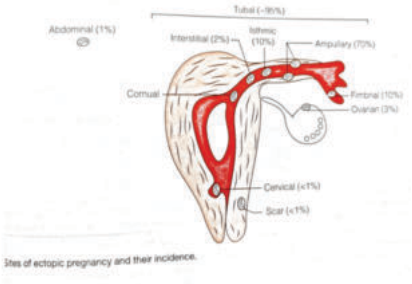
1 BT transfused post operatively
Rest of the hospital stay uneventful











Sites of ectopic pregnancy and their incidence.

DISCUSSION

Diagnosis of ovarian pregnancy is made at the time of surgery and confirmed with histopathological report

Speigelberg criteria

- ipsilateral tube is intact and distinct from ovary
- ectopic pregnancy occupies the ovary
- ectopic pregnancy is connected by uteroovarian ligament
- ovarian tissue can be demonstrated histologically amid placental tissue

CONCLUSION

The presenting complaints and findings of ovarian pregnancy can mimic those of ruptured tubal ectopic pregnancy. Moreover, an early ovarian pregnancy maybe considered to be hemorrhgic corpus luteum cyst. Possibility of ovarian pregnancy should be kept in mind as it has repercussions on fertility. Though Ovarian pregnancy is a rare type of ectopic, it is the most common type of non tubal ectopic.

REFERENCES

1. Shaw's textbook of Gynaecology, 17th edition, page no 441
2. Williams Gynaecology 3rd edition page no 216
3. Berek and Novak's gynaecology 16th edition page 2624
4. Jha S, Bosworth K, Quadri A, Ibrahim A. Ovarian ectopic pregnancy. BMJ Case Rep. 2011 Nov 15;2011:bcr0820103250. doi: 10.1136/bcr.08.2010.3250. PMID: 22674594; PMCID: PMC3229317.
5. Scutiero G, Di Gioia P, Spada A, Greco P. Primary ovarian pregnancy and its management. JSLS. 2012 Jul-Sep;16(3):492-4. doi: 10.4293/108680812X13462882736385. PMID: 23318082; PMCID: PMC3535796.
7. Meena P, Bhojwani P, Verma G.S. Ovarian ectopic pregnancy: a case report with review of literature. Obs Rev:J obstet Gynecol 2017;3(3):25-32.doi:10.17511/joog.2017.i03.03.