Volume : 3 | Issue : 10 | October 2014 • ISSN No 2277 - 8179

An Extremely Rare Case of Bilateral Ruptured Tubal Ectopic Pregnancy With One Tubal Molar Pregnancy in A Primigravida

Medical Science

KEYWORDS : Ectopic, Bilateral, Rupture, Molar

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ABSTRACT

Bilateral ectopic pregnancy is an uncommon event with simultaneous rupture of both being rare. The rarest form of ectopic pregnancy is bilateral tubal ectopic pregnancy in which twinning occurs with pregnancy in both tubes. The fate of the two pregnancies are independent of each other .We report a case of 26 years primigravida with bilateral ruptured ectopic pregnancy. On histopatholgy report one sac showed molar pregnancy. In the past two decades there has been three fold rise in incidence of heterotrophic as well as tubal ectopic pregnancies with assisted reproduction techniques, but occurrence of bilateral tubal ectopic pregnancy is exceedingly rare. The incidence is thought to be 1 in 2, 00,000 intrauterine pregnancies and somewhere between 1 in 725 to 1 in 1580 ectopic pregnancies.

INTRODUCTION:

Bilateral ectopic pregnancy in itself is a very rare event with simultaneous rupture being rarer. It is a case that will not be encountered by most gynaecologists or surgeons in the world. The unique nature of this case is further increased as the patient was a primigravida with no risk factor for ectopic pregnancy (Tuberculosis,PID, Ovulation Induction)[3].There has been some arguments over use of laparoscopic surgery in ruptured ectopic but we preferred exploratory laparatomy over laparoscopy as patient was haemodynamically unstable and urgent action was needed. It proved to be a wise decision as we never expected to find bilateral rupture and laparatomy gave better surgical view and scope of further extending incision should the need arise.

CASE REPORT:

26 years old female, married since two years was referred with two and a half month amenorrhoea with severe abdominal pain since four hours. There was a history of on and off abdominal pain since two days and one episode of vomiting. Patient had a USG report mentioning right sided ruptured ectopic gestation of 8 weeks. Patient had no relevant past history. There was no known history or risk factor for tuberculosis, PID. There was no history of ovulation induction. On examination patient's general condition was guarded with severe pallor. Patient was conscious but disoriented. Pulse rate was 120/ minute and Blood Pressure was 80 mm Hg systolic. CVS and respiratory examination were normal. Abdomen was distended with generalized tenderness. On per speculum examination there was no bleeding. On gentle per vaginal examination uterus was 6 weeks with tenderness present. Fornicial tenderness was present.

Resuscitative measures were started with two IV access and colloids were started. Bed side investigations showed haemoglobin to be 5 gm/dl. BT/CT were within normal range. Comprehensive clinical guidelines for the treatment of ectopic pregnancy have been published by the Royal College of Obstetricians and Gynaecologists.[9] Because of its rarity, synchronous ectopic pregnancy is not covered, but the principles of treatment can still be applied. Laparoscopic surgical treatment is preferred to open procedures, because the patient recovers more quickly and subsequent rates of intrauterine and ectopic pregnancy are similar.[8] Our patient, because of her acute symptoms, was not suitable for laparoscopic surgery.

At the time of surgery, examination of the contralateral tube governs treatment.[8]

Patient was taken for exploratory lapratomy. Infraumblical vertical incision taken and abdomen opened in layers. Gross haemoperitoneum was present. Uterus delivered out and both tubes traced. Bilateral ruptured tubal ectopic present. Clamp applied on both sides. Hemoperitoneum was suctioned[approximately 1.5 litres] and clots measured around 400 grams. Tubes inspected and showed bilateral ruptured ectopic with right side showing gestational sac like structure present next to ruptured tube. Tubes were damaged completely.

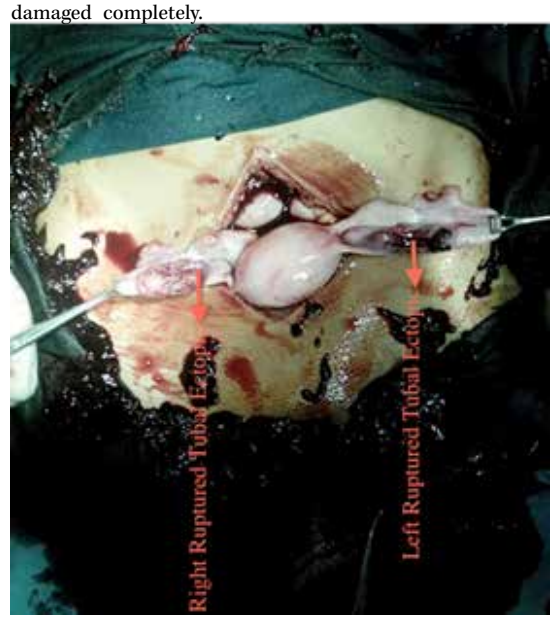

Fig.1 Bilateral Ruptured Tubal Pregnancy

Relatives were explained about the intraoperative findings and the need for bilateral salpingectomy and ensuing infertility.Bilateral salphingectomy done and sent for histopathology. Abdomen closed in layers. Patient received four unit whole blood transfusion intraoperatively and in immediate post operative period.

Post operative period and recovery was uneventful. Histopathology report showed bilateral ruptured ectopic pregnancy with vesicular mole on left side.Beta HCG was sent and levels were 4175 mIU/ml.X ray and thyroid function tests were within normal limits.On further weekly testing levels decreased to 381.9 mIU/ml and on further follow up reduced to 24.6 mIU/ml and finally to non pregnant levels.

DISCUSSION:

The rarest form of ectopic pregnancy is bilateral tubal ectopic pregnancy in which twining occurs with pregnancy in both the tubes. The fates of two pregnancies are independent of each other. The incidence of ectopic pregnancy is about 11/1000 pregnancy with 90% in fallopian tube. Simultaneous bilateral tubal ectopic is very rare. Incidence is about 1 in 725 to 1in 1580 ectopic pregnancies and 1 in 200000 intrauterine pregnancies[2,6,7]The common risk factors are assisted reproductive technique, pelvic infection and tubal surgery. Bilateral tubal ectopic pregnancies in absence of preceding induction of ovulation are extremely rare. While most physicians are familiar with the typical presentations of ectopic pregnancy and manage these cases well, unusual cases may go undiagnosed and the consequences can be devastating.Bilateral tubal ectopic pregnancy is very rare,and usually the result of an assisted reproduction technique[5]. Pelvic inflammatory disease, advent of antibiotics and tubal surgery are also common determining factors. However, spontaneous bilateral tubal ectopic pregnancy is exceedingly rare. Only about 250 cases of twin ectopic pregnancies have been reported in literature Of the handful of reported cases of spontaneous bilateral ectopic pregnancies, one happens to be from our Institute and may be the only reported case of bilateral spontaneous ruptured ectopic pregnancy with one tubal molar ectopic pregnancy.

Ruptured ectopic pregnancy is not an uncommon diagnosis in emergency admissions, but spontaneous bilateral ectopic pregnancy is a rare event, which is difficult to diagnose preoperatively. A high index of suspicion for an ectopic pregnancy is of great importance. The USG confirmation and clinical manifestations provided a diagnosis of ectopic pregnancy, but bilateral spontaneous tubal rupture was never suspected. This is in agreement with other reports (i.e. the use of USG is not necessary in diagnosis of bilateral ectopic pregnancy).[4]

The incidence of partial or complete hydatidiform mole is approximately 1 in 500 to 1 in 1000 pregnancies[11].Molar changes may also be found in ectopic pregnancies. Its malignant potential is similar to that of an intrauterine molar pregnancy [1]. Molar changes could be either partial or complete.Follow-up is usually done by serial serum human chorionic gonadotropin (β-hCG) titrations. Although ultrasonography is useful in the diagnosis of uterine molar pregnancies, there is a chance of missing this diagnosis in cases of an ectopic molar pregnancy.

The most common method of diagnosing the second ectopic is direct inspection of contralateral tube in the operating room or laparoscopic examination[10].

There have been very few case reports of spontaneous bilateral ectopic pregnancies.Our findings in this case is similar to those of G.A.AL Quraan et. al,who reported a right ruptured ampullary ectopic and left ruptured tu bal ectopic pregnancy.[4,8]

In our case both fallopian tubes had to be sacrificed, but with the availability of assisted reproduction techniques, she can still have future conceptions.

CONCLUSION: Bilateral tubal pregnancy in the absence of preceding induction of ovulation is the rarest form of ectopic pregnancy. It corresponds to an occurrence of one per 200,000 live births. The diagnosis of bilateral tubal pregnancy is usually made intra-operatively. This demonstrates the importance of identifying and closely examining both tubes at the time of surgery.

The principle management is the conservative approach that attempts to save the tube, rather than salpingectomy. In the other hand, it is important to remember that hemorrhage from ectopic pregnancy is the leading cause of maternal death and accounts for 4 to 10 percent of all pregnancy related deaths.

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