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RUPTURED IPSILATERAL CORNUAL STUMP ECTOPIC PREGNANCY

Gynaecology

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ABSTRACT

Ectopic pregnancy is important cause of maternal morbidity. Even after major advances in medical era ectopic pregnancy continues to be important cause of maternal morbidity. Incidence of ectopic pregnancy increases double with each ectopic pregnancy. Recurrent ectopic pregnancy in the remnant portion of the tube following a ipsilateral salphingectomy has been reported rarely.We presenting an unusual case of 25 year old woman who had ectopic pregnancy in corneal end of fallopian tube following ipsilateral salphingectomy for ruptured ectopic pregnancy presented with hemoperitoneum. This rare presentation for ectopic pregnancy yet has significant consequences owning for diagnostic dilemma and increased maternal morbidity

KEYWORDS

Ruptured Ectopic, Ipsilateral Salphingectomy, Cornual Pregnancy, Hemoperitoneum

INTRODUCTION:

Previous ectopic pregnancy, pelvic surgeries, pelvic inflammatory disease, assisted reproductive technologies has increasing the prevalence of ectopic pregnancies. The incidence of ectopic pregnancy is 1.3-2% of all pregnancies. Ectopic pregnancy occurring in stump after salphingectomy is extremely rare. Incidence of stump pregnancy is 0.4% of all pregnancies. Reporting a case of 25 years old with 5 weeks of amenorrhea has underwent right side laparoscopic salphingectomy 9 months ago presented with complaints of severe abdomen pain , outside scan showing ectopic pregnancy with free fluid in pouch of douglas.

Case report:

25 years old women with 5 weeks of amenorrhea with history of right laproscopic salphingectomy in view of right tubal ectopic pregnancy 9 months ago presented with severe abdominal pain. No History of bleeding pervaginum, giddiness, any contraceptive usage and no history of any assisted reproductive technique. History of nausea present. Patient was clinically stable, pallor present and abdomen had diffuse tenderness and guarding. On vaginal examination cervical os closed, uterus normal size, anteverted, fullness in pouch of douglas, cervical movement tenderness present. Serum beta HCG was 3776mg/dl, hemoglobin 7.9g/dl, total counts 19.3x10^3/mm3, neutrophils 91%, platelets 3.83lks, coagulation profile normal, serum creatinine 0.83mg/dl, blood group O Positive. A transvaginal scan done here revealed left adnexal mass with clots in pouch of douglas. No gestational sac seen. Hemoperitoneum present with blood in paracolic gutters reaching morisson pouch. Probe tenderness present suggestive of ruptured ectopic pregnancy. Patient and attenders have been explained about the condition and need for emergency laparotomy and salphingectomy and need for blood and blood product transfusion, chances of ICU admission.

Patient underwent Emergency laparotomy.

Intra Operative: Hemoperitoneum 900ml blood + 300gms clot. Uterus normal size. Left ovarian corpus luteal cyst of 4x3cm present which ruptured during manipulation. Right cornual stump bleeding point noted and sutured(figure1).Outside scan reports were reviewed which showed right cornual ectopic pregnancy (figure2), confirmed with intra operative findings. Villi and trophoblastic tissue in pouch of Douglas sent for histopathological examination. Mildly distended distal end of left fallopian tube, rest of left tube normal. Right ovary normal. Estimated blood loss 1.8 liters. One PINT PRBC transfused intra operatively. Post operative patient was monitored, in view of low hemoglobin second PINT PRBC transfused and patient monitored. Patient discharged in stable condition on post operative day three. On discharge, patient adviced contraception. Histopath report showing hemorrhage with few chronic villi and trophoblastic cells suggestive of products of conception with corpus luteal cyst.

DISCUSSION:

Ectopic pregnancy is a major health problem in reproductive women due to increased pelvic inflammatory disease and assisted reproductive technique. Classical triad of ectopic pregnancy includes amenorrhea, abdominal pain, pre vaginal bleeding. There is increased risk of ectopic if any previous ectopic pregnancy. As patient had a previous laparoscopic salphingectomy for ectopic pregnancy, suspicion of ectopic pregnancy with these symptoms is high. Ectopic pregnancy after salphingectomy can occur either in isthmic part where it is a gynaecological emergency with high mortality due to high risk of rupture, poor distensibility and high vascularity of the area or interstitial part of tube. Even though the ipsilateral corneal stump ectopic pregnancy is rare, need to consider because of severe maternal morbidity and diagnostic dilemma. In literature review Tucci.C et al. and Fellemban et al. have reported similar cases.[1,2]There are lot of theories on the mechanism of ipsilateral ectopic pregnancy. One theory explains that spermatozoa pass through the patent tube into the pouch of Douglas, then travel to fertilize the ovum on the side of diseased tube. The fertilized ovum then implants on the stump of previous ectopic site. Another, theory of transperitoneal migration, says the fertilized ovum on the side of the normal tube migrates and gets implanted on the tubal stump. Another theory says despite ligation lumina remain intact in the interstitial portion and distal remnant of the fallopian tube. This allows communication between the endometrial and peritoneal cavities and thus migration of the fertilized ovum or spermatozoa from the endometrial cavity to the distal remnant of fallopian tube.[3] Management of ectopic pregnancy can be expectant management with methotrexate or by surgical approach like laparoscopic salphingectomy or salphingostomy. In this case patient had 2 liters of hemoperitoneum she was not for expectant management so patient taken up for emergency laprotomy. Laparoscopic salpingectomy can be done by using diathermy, newer by using endo-loops or clips. Electrocauterization of the affected fallopian tube and mesosalpinx for haemostasis and excision of the tube is frequently performed. But there is increased recurrence in proximal tubal stump owing to incomplete removal of the tube with endo-loop due to technical difficulty Few authors have suggested the use of electrosurgery to excise the proximal tube followed by endo-loop for total salpingectomy to reduce the risk of recurrence of ectopic in tubal stump[3]. Although total salpingectomy does not necessarily eradicate all ipsilateral stump ectopic's it certainly decreases an ipsilateral tubal recurrence in proximal ordistal stump. When performing the salpingectomy, care should be taken not to leave a long stump. Generally, it is common practice to leave a small tubal stump to minimise the risk of bleeding associated with the isthmic portion of the fallopian tube. However, given the risk of recurrence in those with an history of ectopic pregnancy, most of the authors suggested that this remnant portion should be minimised. Adequate fulguration of the residual stump is advocated to prevent endosalpingoblastosis, potential fistula formation in the stump through which sperm can reach the ovum. Median time interval of a subsequent pregnancy was 18 months, comparitive with tubal ectopic pregnancies. Uterine rupture is most known complication

with corneal stump resection.[4]

Figure1: Gestational sac in right cornual end

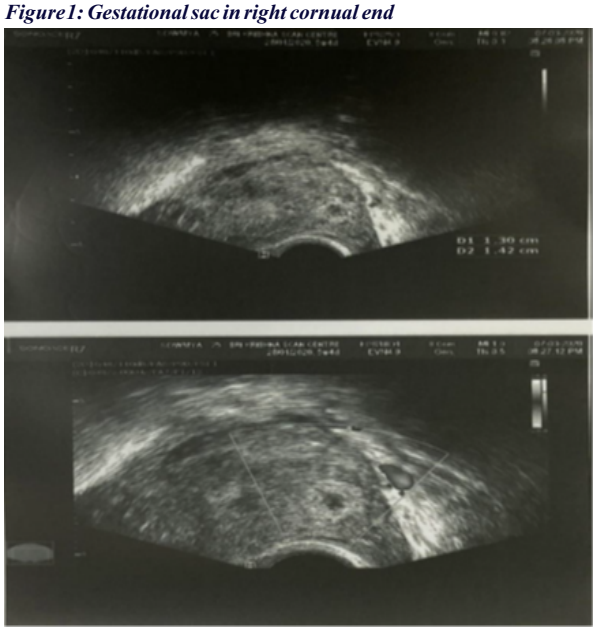
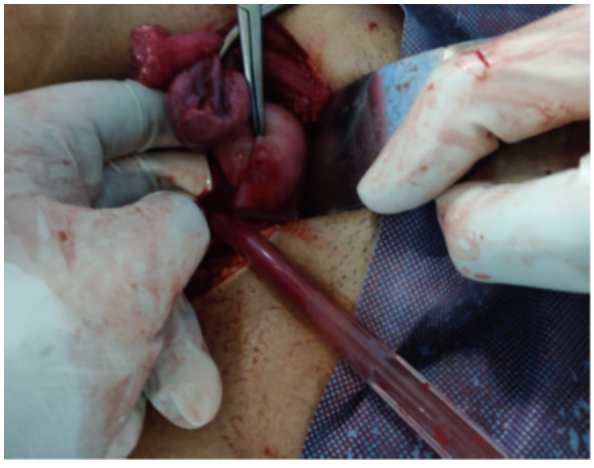


Figure2: Bleeding cornual stump sutured



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