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Research Article

UNRUPTURED TUBAL PREGNANCY- A CASE REPORT

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A B S T R A C T

A 24 years old female with history of one & half month amenorrhoea presented with slight vaginal bleeding for 2 days. The finding of lower abdominal ultrasound was suggestive of right tubal pregnancy. On laparotomy, there was cystic mass on right adenexa near the fimbriated end of fallopian tube. The mass was clamped, cut &ligated saving the uterine tube. No postoperative complications were observed. The present case signifies the importance of ultrasound for early diagnosis of ectopic pregnancy.

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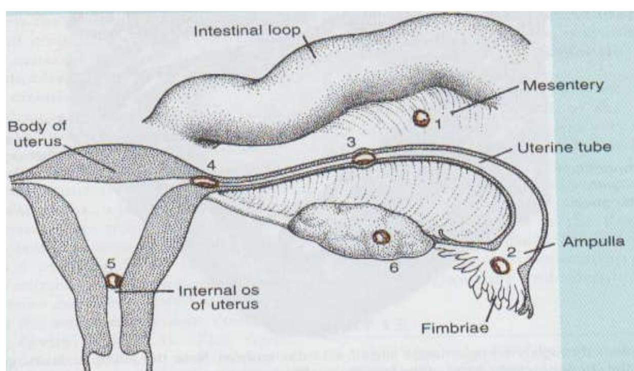
INTRODUCTION

A pregnancy that is not in the usual place within the uterus but is located in the Fallopian tube is tubal pregnancy. Tubal pregnancies are due to the inability of the fertilized egg to make its way through the Fallopian tube into the uterus. Previous pelvic inflammation damages the tubal epithelium and may predispose to delay in tubal transport .Any alteration in the normal tubal transport mechanisms can probably lead to ectopic pregnancy. Nidation of the embryo as an ectopic pregnancy most frequently occurs in the wider ampullary portion of the uterine tube, but may also occur in the narrow intramural portion or even in the ovary itself[1].



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The Abnormal implantation sites:[2] are

1. Implantation in the abdominal cavity.
2. Implantation in the ampullary region of uterine tube.
3. Tubal implantation.
4. Interstitial implantation.
5. Implantation in the region of internal os.
6. Ovarian implantation.

Most ectopic pregnancies are anembryonic, although the continuing growth of trophoblast will produce a positive pregnancy test, and may cause rupture of uterine tube and significant intraperitoneal haemorrhage. Ectopic pregnancy with live embryo is the most dangerous because they grow rapidly and may be detected only when they have eroded the uterine tube wall and surrounding blood vessels as early as 8 weeks of gestation. Cornual ectopics may present with catastrophic haemorrhage because of rich blood supply in the surrounding muscularis. Ectopic pregnancy is a potentially fatal emergency condition if early diagnosis is missed[3,4] .

Case Report

A 24 year old female came to the hospital with history of one and a half month amenorrhoea with slight vaginal bleeding for 2 days. Theurine pregnancy test was positive. The abdominal ultrasound showed a cystic structure approximately 2 mm in size the right adenexa with fetal pole like structure in it, measuring approximately 7 weeks + one day .Fetal cardiac activity was seen. In addition, no intrauterine gestational sac was visualized. Ectopic tubal pregnancy was suspected. There

were no significant past medical, surgical or gynaecological problems.

On examination patient appeared comfortable. Her blood pressure was 120/80 mmHg with a pulse rate of 80/min. There was no pallor, no cyanosis , chest was clear, temperature 37.2°C, and oxygen saturation of 99% on room air. Abdominal examination revealed no tenderness over the lower abdomen. Haemoglobin count was 12.4x 10 g/L and total white cell count was 7.0 x 10 g/L.A quantitative human chorionic gonadotropin (hCG) test was 24000 IU/L**.** She denied syncope, dyspnea, nausea, or vomiting and did not have a history of pelvic inflammatory diseases or sexually transmitted diseases (STDs).

She was admitted to the hospital. Patient was explained for laparotomy, high risk consent was taken. On laparotomy, there was cystic mass on right adenexa near the fimbriated end of fallopian tube. The mass was clamped, cut &ligated saving the uterine tube. Haemostasis was maintained.

The diagnosis of right tubal pregnancy was confirmed. Serum hCG level declined sharply afterwards and the patient discharged without incidence 5 days later.

DISCUSSION

Ectopic pregnancy is a emergency condition. It occurs in approximately 1% to 2% of all pregnancies, and >98% implant in the fallopian tube[5] .The incidence of ectopic pregnancies has been on rise. This is mainly due to increase in the incidence of pelvic inflammatory disease. Other contributing factors include advanced maternal age, assisted reproductive techniques, tubal surgery, congenital anomalies, intra-uterine device[6] .Most tubal pregnancies occur in women 35 to 44 years of age. The concept us may be arrested at any point during its migration through the uterine tube and implant in its wall[1]. It is proposed that the occurrence of multiple ovulation spontaneously or by ovulation induction there is increased the risk of ectopic pregnancy[7] .The rhythmic endometrial wave-like movements in healthy normal cycling women responsible for ectopic implantation[8]**.** The alteration of the circular muscular activity of fallopian tubes due to the abnormal progesterone concentration can result in migration of correctly placed intrauterine fertilized ovum possibly into fallopian tube[9] .

Treatment of an ectopic pregnancy depends on its clinical presentation, size and β-hCG levels. A close inspection of the abdomen and pelvis must always be done when performing surgery for an ectopic gestation, especially the contralateral fallopian tube. In several cases, the contralateral pregnancy was found days to weeks after the initial surgery[10] .Surgical management is done in acute ruptured ectopic pregnancy, in haemodynamically unstable patient or in those who have failed medical treatment or have contraindications to medical treatment. Laparoscopi is the preferred treatment as it is associated with lower cost, less operating time, shorter hospital stays and faster recovery. Salpingectomy is the recommended treatment; however, salpingostomy can be considered for women with one tube who are wishing to preserve their fertility[11] .The present case signifies the importance of early ultrasound for diagnosing ectopic pregnancy even in low-risk cases.

Conflicts of Interest

There are no conflicts of interest.

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