SPONTANEOUS BILATERAL AMPULLARY TUBAL ECTOPIC PREGNANCY IN AN ETHIOPIAN WOMAN: CASE REPORT

Muhidin Abdo Banko, MD

ABSTRACT

Bilateral tubal ectopic pregnancy is the rarest form of ectopic pregnancy (1), usually occurs following ovulation stimulation. Preoperative diagnosis is very difficult. We are presenting a case of bilateral tubal ectopic pregnancy occurring spontaneously in an Ethiopian woman. The diagnosis of ectopic pregnancy was made on clinical bases and ultrasonography. However, at surgery bilateral tubal ectopic pregnancy was diagnosed & confirmed on pathological examination.

As to our knowledge there is no reported case of bilateral ectopic pregnancy in Ethiopia based on extensive literature search we did.

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INTRODUCTION

The incidence of ectopic pregnancy is about 8-11 per 1000 pregnancies. Ectopic pregnancy is still an important cause of maternal mortality. 98% of extra uterine pregnancy is tubal. Incidence of bilateral tubal ectopic pregnancy is about 1 in 725 to 1 in 1580 ectopic pregnancies and 1 in 200,000 intra uterine pregnancies[1]. The common risk factors are assisted reproductive technique, previous pelvic inflammatory disease, and previous ectopic pregnancy. Bilateral tubal ectopic pregnancies in absence of preceding induction of ovulation are extremely rare. There are no cases reported in which pre-operative diagnosis of bilateral ectopic pregnancy was made. The case reported here has occurred spontaneously. Most gynecologists are familiar with typical presentation of ectopic pregnancy and manage these cases well, unusual cases like this patient may go undiagnosed and the consequences can be devastating.

CASE REPORT

A 38 years old Ethiopian Woman Gravida 6, Para 0, Abortion 5 presented with amenorrhea of 7 weeks followed by bleeding per vagina and excruciating left lower abdominal pain since 48 hours before admission. She had myomectomy done three years back and had five spontaneous abortions all at first trimester prior to her myomectomy. Her past menstrual cycles were regular.

On examination she was conscious acutely sick looking, pale mucous membranes and tachy- cardia of 128/min her blood pressure was 90/60 mmHg respiratory rate of 28/min.

Abdomen was full and tender bilaterally on lower abdomen. Tender cervical movements and bilateral adenexal mass size 6x5cm on the right and 4x5cm on left side respectively.

Cervix closed, fullness in all the fornices with sever tenderness and blood on examining fingers.

Hematologic examination showed

WBC – 12.9x $10^3/\mu l$

Hemoglobin – 9.6 gm/dl

Haematocreat – 28.4 %; Urine HCG – Positive

Abdomino-pelvic ultrasound examination showed – normal size uterus, with endometrial thickness of 1.9cm, with smooth outline. There was free fluid collection in pelvic region and inter loop space. There was left adenexal 9.7cm by 5.3cm complex mass and right adenexal 5.1cm by 5cm mass with cystic space in it thought to a gestational sac. No fetal pole was noted.

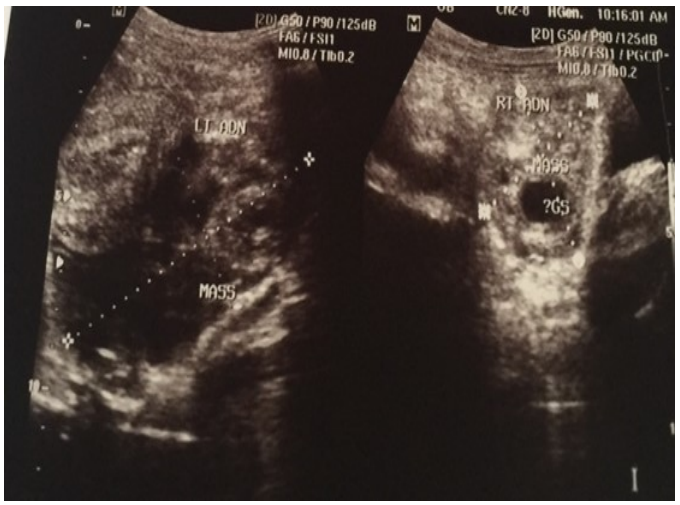

Figure 1: Left adenexa 9.7cm by 5.3cm complex mass and 5.1cm by 5cm mass with cystic space in it thought to be a gestational sac on the right adenexa. No fetal pole was noted.

Emergency exploratory laparatomy done with pre-operative diagnoses of left sided ectopic pregnancy and right side pelvic mass. At laparotomy hemoperitoneum of 2000ml drained. Uterus looks normal, there was no adhesions or new myoma. There was ruptured ampullary mass with active bleeding and size of mass 7cm x 8cm on the left side. Even though there was actively bleeding ruptured ampullary mass seen on the left side, we then explored the rest of abdomen and pelvis beginning with the right adenexa given the pre-operative ultrasound findings. There was 5X6cm right ampullary mass with active bleeding from the fimbria.

Figure 2: Intraoperative Finding of Ampullary Tubal Mass on the Right Side

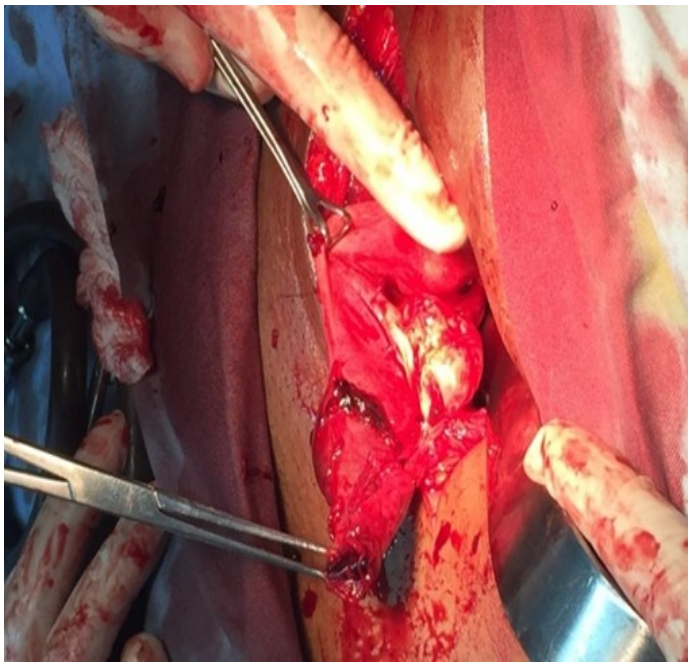

Figure 3: Intraoperative Finding of Ampullary Tubal Mass on the Left Side

Figure 4: Both left and right tubal masses after salpingectomy on both sides

In view of these findings, bilateral Salpingectomy done, hemostasis secured. The removed tissues on both sides kept for histo-pathology. Received 2 units of cross matched blood.

Post-operative follow-up was uneventful and the patient

was discharged on the third day post-operation. Had uneventful post-operative course since six weeks post-op. Currently once undergone invitro-fertilization but failed and again planned for the second trial of IVF

Histo-pathologic examination of the specimens, excised from both left and right fallopian tubes showed hemorrhagic tubal tissues with chorionic villi, on both tubes consistent with bilateral ampullary tubal ectopic pregnancies.

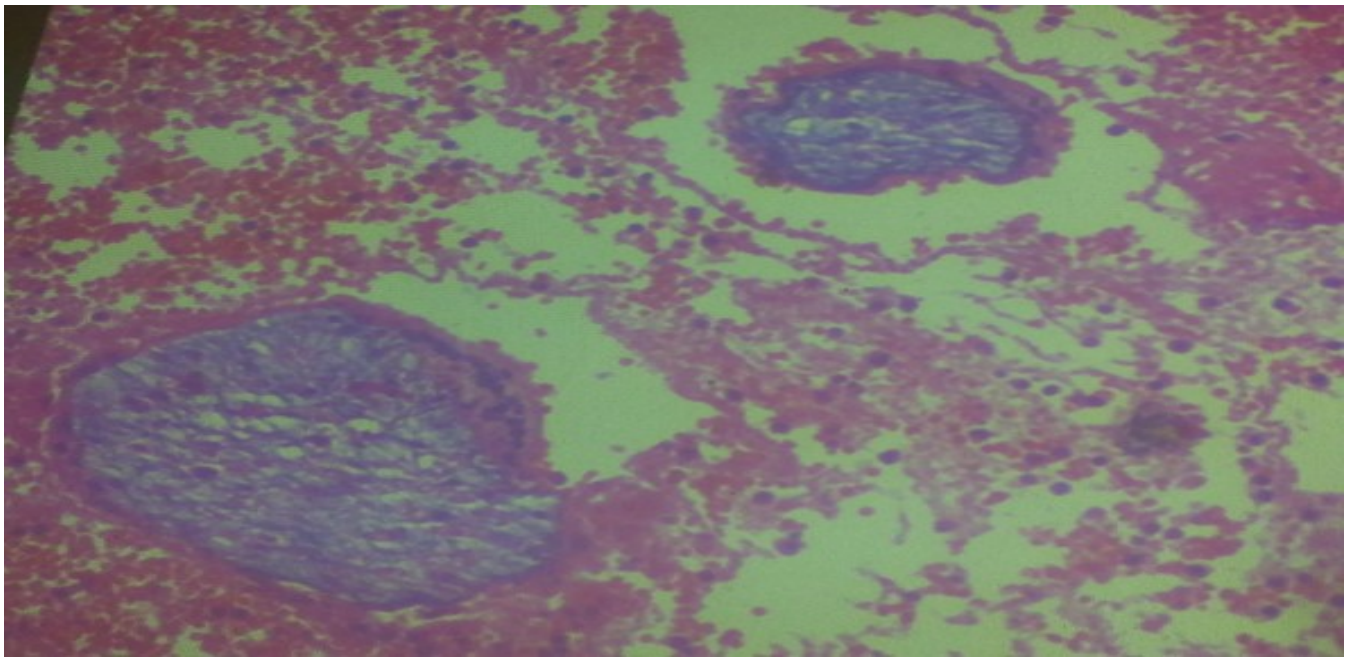

Figure 5: Histo-pathologic Finding from Left Fallopian Tube Showing Hemorrhagic Tissue with Chorionic Villi

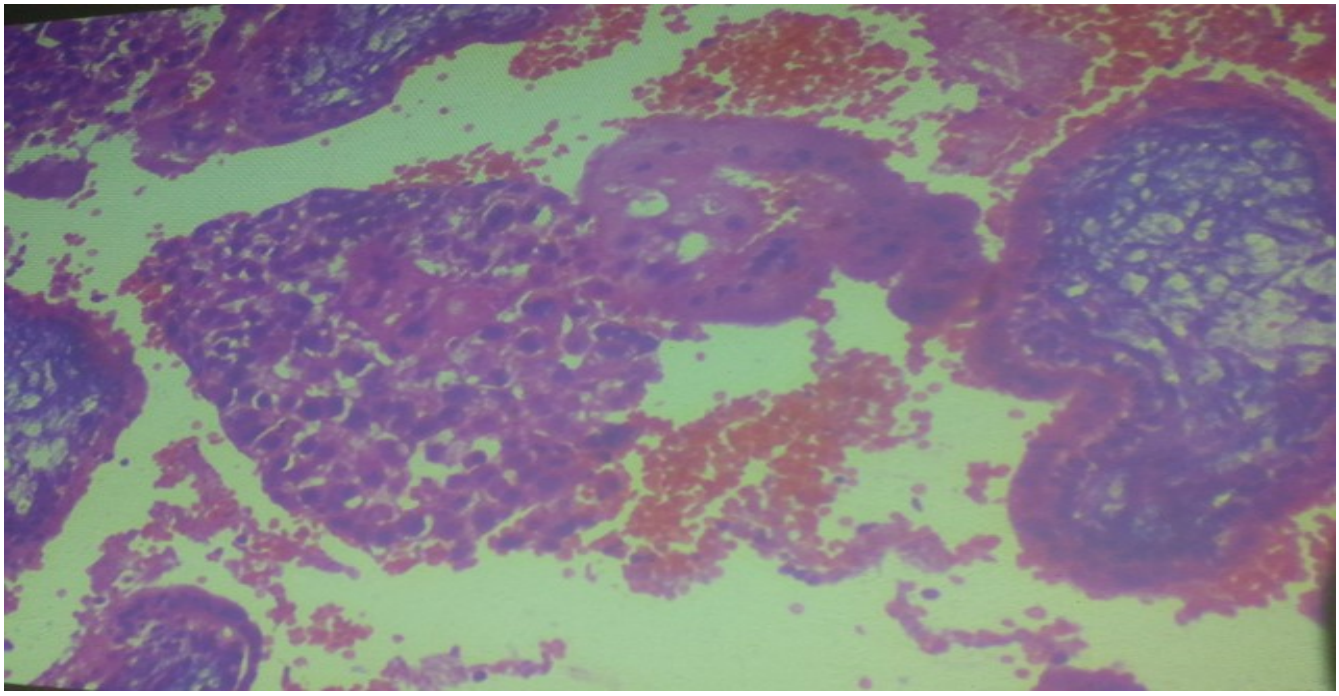

Figure 6: Histo-pathologic Finding from Right Fallopian Tube Showing Hemorrhagic Tissue with Chorionic Villi

DISCUSSION

Many risk factors for ectopic pregnancy are recognized that includes PID (Pelvic inflammatory disease), previous tubal surgery and assisted reproductive technique. In the absence of known risk factors suspicion must remain high, as there are many reported cases of ectopic pregnancies, including bilateral tubal ectopic in which none of the traditional risk factors are identified.[2].

Incidence of bilateral ectopic is between 1 in 125 and 1 in 1580 extra uterine pregnancies (1) and 1 in 200,000 live births. To date more than 200 cases of bilateral tubal ectopic pregnancies have been reported[3]. There are 3 possible explanations for bilateral ectopic pregnancy: A. simultaneous multiple ovulation B. sequential impregnation C. transperitonial migration of trophoblastic cells from one extrauterine pregnancy to the other tube with implantation there[3].

Bilateral tubal ectopic pregnancy is difficult to diagnose pre-operatively indicating limitations of ultrasonography[4].

Himangin B, Behera Rectal reported a case of spontaneous bilateral tubal ectopic in which left tubal pregnancy was intact and right tubal ectopic was ruptured. Three quarter of both the tubes being damaged bilateral Salpingectomy was done. Jorge martinet et al, reported a case of bilateral tubal ectopic where USG showed normal uterus with an echogenic normal uterus with an echogenic image in left tube (15mmX 13mm) and in right tube (23mmX20mm). At laparoscopy right tube appeared as ectopic and left tube as hydrosalpinx, bilateral Salpingectomy were performed and pathology reports suggest bilateral tubal ectopic pregnancy[5]. Usually the diagnosis of bilateral ectopic pregnancy is made intra operatively.

The appropriate surgical procedure after an incidental finding of unilateral or bilateral ectopic pregnancy must be considered in these patients; and the choice of fertility preserving surgery must be weighed against to increased risk of recurrence[6]. Existing studies underline the need for a good case selection. Our patient, because of her acute symptoms and intra operative finding was not suitable for either conservative surgery or medical management.

CONCLUSION

⇒ We should give emphasis to look both adnexae during surgery for ectopic pregnancy.

⇒ This case demonstrates the importance of thoroughly examining the entire pelvis at the time of exploratory laparotomy undertaken for a suspected ectopic pregnancy.

⇒ The patient who has had one ectopic pregnancy is at risk of having another in the future and also at the same time. The diagnosis of bilateral tubal ectopic pregnancy is usually made intraoperatively, this underscores the importance of identifying and closely examining both tubes at the time of surgery even in the presence of significant adhesion because undiagnosed ectopic pregnancy is an important cause of maternal mortality.

REFERENCES

1. Adair CD et al. Bilateral ectopic pregnancies after bilateral partial Salpingectomy. A case report. Journal of reproductive medicine, 1994;39(2)131-3.
2. GAAl-Quraan. G.A et al. Spontaneous ruptured and intact bilateral tubal ectopic pregnancy: Eastern Mediterranean can health journal. 2007; 13:972-974.
3. Tabachnikolf R.M. Bilateral tubal pregnancy: A report of unusual case. J Repord MED. 1998; 43:707-709
4. Goes E. ultrasound studies in ectopic pregnancies. Journal Belge de Rediologie. 1998; 81:14-16
5. Hi mangini B. spontaneous bilateral tubal ectopic pregnancy: pravara MedRev. 2010; 5:19-21
6. Fish back HR. Bilateral simultaneous tubal pregnancy AMJ obstet Gynecol.1939; 37:1035
7. Rahul DM, et al. Bilateral tubal pregnancy: A Diagnostic dilemma open
8. Ashis KR. Arare case of spontaneous Bilateral Tubal Ectopic Pregnancy Indian medical Gazette.2014;1.33-34
9. Ryan Seldan Bilateral Tubal Ectopic pregnancy: Atale of caution. Academic Emergency medicine. 2000; 7:1160-1163.