Case Report

SPONTANEOUS BILATERAL TUBAL ECTOPIC PREGNANCY

Ambreen Mumtaz and Uzma Siddique

Abstract:
Bilateral spontaneous tubal pregnancy is the rarest form of ectopic pregnancy. Bilateral tubal pregnancy in the absence of proceeding ovulation induction is rare, with an incidence of 1 in 725 to 1 in 1580 ectopic pregnancies. Preoperative diagnosis is difficult because ultrasound has its limitations. They are usually diagnosed at the time of surgery. We report a case of spontaneous bilateral tubal pregnancy. A 35 years old patient with parity 3 and 1 abortion was admitted with the complaint of pain in lower abdomen with vaginal bleeding for 1 month. Laparotomy was done for the diagnosis of single ectopic pregnancy but diagnosis of bilateral tubal pregnancy was made intraoperatively. Bilateral salpingectomy was performed without complication and histopathology report confirmed the diagnosis. This highlights the importance of closely examining both tubes at the time of surgery in order to prevent maternal morbidity and mortality.

Key Words: Ectopic pregnancy, Tubal Pregnancy, Assisted Reproductive Technique,

INTRODUCTION:

Ectopic pregnancy constitutes one of the leading causes of pregnancy-related maternal deaths. According to WHO 2007, 5% of maternal mortality in the developed countries is due to ectopic pregnancy.[1,2]

Exact incidence remains unknown as the diagnosis is often missed when the ectopic pregnancy resolves spontaneously at an early stage. Recently, the problem of ectopic pregnancy has been magnified due to advanced maternal age, pelvic inflammatory disease (PID), tubal surgery, intrauterine device, infertility and assisted reproductive technique (ART).

Spontaneous bilateral tubal pregnancy is a rare disease that occurs in 1 per 200,000 pregnancies.[1] The incidence of bilateral tubal pregnancy has been reported to be increasing as a result of increased use of induction ovulations. However, bilateral tubal pregnancy in the absence of preceding ovulation induction is a rare condition with an estimated incidence of 1 in 725 to 1 in 1580 ectopic pregnancies.[2]

Department of Obstetrics and Gynaecology, Akhtar Saeed Trust Hospital, Lahore

The rarest from of ectopic pregnancy is bilateral tubal pregnancy which occurs spontaneously.[2]

Most patients with bilateral tubal pregnancies have similar risk factors to those with unilateral ectopic pregnancy.[3,4]

CASE REPORT:

The patient was 35-year-old P3, with previous vaginal deliveries and history of miscarriage 4 months back followed by evacuation by the dai. After that, she had 2 normal menstrual cycles and in the third month, she developed pain in lower abdomen and continuous P/V bleeding for 1 month. There was no history of contraception, any abdominopelvic surgery or use of ovulation induction. However, there was history of vaginal discharge off and on for many years.

The patient was haemodynamically stable. There was tenderness in lower abdomen. On pelvic examination, uterus was bulky, tenderness was present on mobility of cervix and fullness noted in the posterior and left fornix. Bleeding was mild. Haematological evaluation showed Hemoglobin = 10gm/dl ,Hematocrit = 30% ,WBC count =

6400/mm^3 and Beta HCG was 5700iu/l. Ultrasound report revealed a left adnexal mass measuring 5.3x5.1 cm and uterine cavity was empty, with moderate amount of fluid in the pelvis. Right adnexa was unremarkable and measured 2.4 x 1.8cm. Exploratory laparotomy was performed which revealed haemoperitoneum. Left tube was swollen, bleeding and partially ruptured with 500 cc clots removed from cul-de-sac. When right tube was examined for its status, then right intact ectopic pregnancy was diagnosed (refer to diagram D1, D2). Consent for tubal ligation was taken already so bilateral salpingectomy was done. Postoperative course was uneventful. Pathology report confirmed the diagnosis of bilateral tubal ectopic pregnancy.

Picture=D-1

Picture=D-2

DISCUSSION:

Spontaneous bilateral tubal pregnancy is a rare entity[5] and more than 200 case reports of bilateral tubal pregnancy have been reported in the literature, and most cases occurred after using assisted reproductive techniques.[6]

We have reported a case of one ruptured and one intact ectopic pregnancy. Ultrasonography in our case diagnosed only a left ectopic pregnancy and right intact tubal pregnancy was missed on ultrasound. It was diagnosed on laparotomy when other tube was checked for its status as mentioned in other cases in the literature.[7]

Ultrasonography and laparoscopy both have limitations so preoperative diagnosis of bilateral ectopic remains a challenge. Most patients with bilateral ectopic have similar symptoms and risk factors to those of unilateral ectopic pregnancy. Comprehensive clinical guidelines for treatment of ectopic pregnancy have been published by Royal College of Obstetrics and Gynaecology, because of its rarity bilateral ectopic pregnancy is not covered but principles of treatment can still be applied and it ranges from bilateral salpingectomy to conservative approaches such as salpingostomy and salpingotomy.[2] Since the diagnosis of bilateral tubal pregnancy is usually made at time of surgery, there are no case reports of successful primary medical treatment with methotrexate.

In our case, we did the salpingectomy for left ruptured ectopic then other tube was checked for its status and other intact right ectopic pregnancy was diagnosed. As consent for tubal ligation was already taken so bilateral salpingectomy was done and specimen sent for histopathology.

Chances of recurrent ectopic pregnancy in the future are increased after an ectopic pregnancy. The necessity of carefully examining both adnexa, as postulated by Sherman cannot be overemphasized.[8] Cases of ectopic pregnancy have been reported

after bilateral salpingectomy. This highlights the need of high suspicion in case when tubal ligation and bilateral salpingectomy patient presents with amenorrhea.

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