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Ectopic pregnancy, Late Presentation, Case Report

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Abstract:

Advanced tubal ectopic pregnancy is rare. An early diagnosis of ruptured ectopic pregnancy is necessary, because ectopic pregnancy is leading cause of first-trimester maternal death.

Our case discusses late tubal ectopic with unusual presentation, this case shows the importance of considering ectopic pregnancy in any lady within reproductive age.

Introduction:

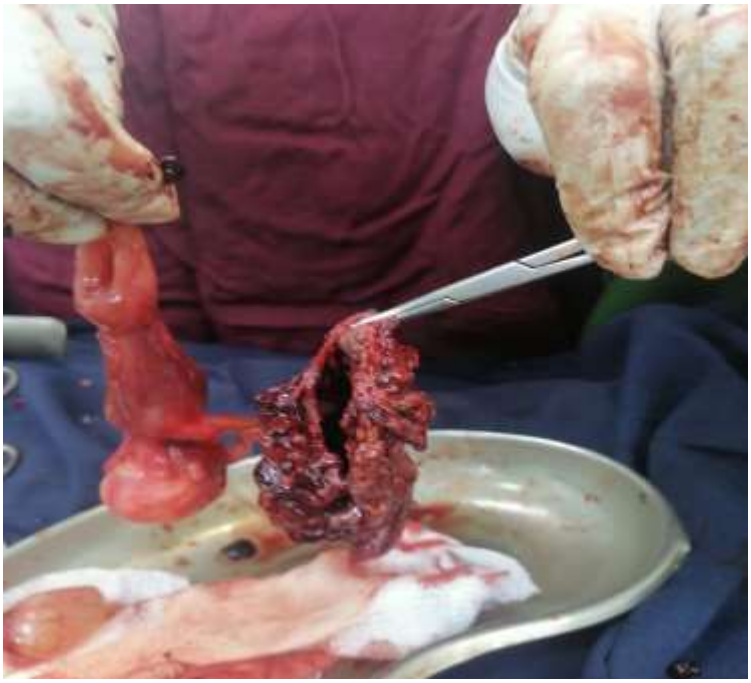
Ectopic pregnancy is implantation of fertilized egg outside the uterine cavity, commonly in the fallopian tube, but may occur in the abdomen, ovary or the cervix. Risk factors include pelvic inflammatory disease (PID), past ectopic pregnancy, endometriosis, assisted reproductive techniques (ART)smoking and others.
The incidence of ectopic pregnancy according to National Institute of Health in UK is 1 in every 90 pregnancies (1)A retrospective study of 585 women over 2.5-year period concluded that the sensitivity and specificity of ultrasound for detection of ectopic pregnancy was 88.5% and 93.1% on the first scan and 95% after an additional scan (2)
Presentation is usually by short amenorrhea, abdominal pain and vaginal bleeding. An early diagnosis of ruptured ectopic pregnancy is necessary, because it is the leading cause of first-trimester maternal death (3). And even unruptured ectopic is essential to be excluded in order to avoid it's consequences. The best treatment option is usually laparoscopic salpingectomy provided the other tube is healthy, but our case went in line with the fact that open laparotomy is still an option in emergency situations with low resource setting.

Despite the improved diagnostic modalities, ectopic pregnancy still is frequently not diagnosed. (4)

Case presentation:

43y old divorced lady P1(16Y) with clear medical background presented with sever lower abdominal pain, tenderness and fainting episodes to ER. The patient is nonsmoker, no history of PID, contraception use, or previous surgery.
On examination she was restless and pale.PR100/min, BP80/50. Her LMP was four months back (she said that her menstrual cycle was irregular), and she denied pregnancy. The patient seek medical advice many times by different doctors- before she present to ER on her last visit- and diagnosed as IBS and UTI /PID and medication was prescribed with no response. No ultrasound scan was done during her previous visits.
We did resuscitation and bedside Transvaginal scan (TVS) which showed right sided tubal pregnancy 13 weeks+4 d viable with free fluids in peritonium. Complete Blood Count (CBC) showed Hb 5g/dl with leukocytosis and no others.BG O Rh+ve.
Resuscitation done with blood and fluids; urgent laparotomy done based on diagnosis as tubal ectopic pregnancy. Intraoperative findings were distended Rt tube containing the gestational sac with the fetus, and bleeding was obvious from the tube. Incision of the tube done to evacuate the sac with the fetus (picture 1). As the contralateral tube was healthy salpingectomy to the Rt tube done, no further intervention needed, she had uneventful recovery.

Picture 1: Late tubal ectopic 13w+4d (Ruptured)



Picture 2: The Festus and the sac containing the placenta

Discussion:

Still ectopic pregnancy is associated with increased maternal morbidity and mortality in first trimester.
There is agreement that pregnancy related morbidity and mortality makes large burden on health systems and lead to significant maternal morbidity and mortality. Although there is advance in diagnostic tools but still there is missing cases due to many factors among which human factor, technical problems are the most important.
A. Shanti Sri and Anjum concluded that the classic triad of amenorrhea, vaginal bleeding or spotting and pain abdomen occurs in less than half of patients with ectopic pregnancy. (4) This fact reflects the importance of holistic mind and scheme approach when dealing with patient at ER or other level of care to avoid misdiagnosis.
A typical presentation of ectopic pregnancy is relatively common and it may mimic other gynecological conditions, gastrointestinal or urinary tract diseases, and appendicitis (5). Irregular cycle or menstruation does not exclude ectopic pregnancy.
Depending on our experience and this going with what we came across, clinical assessment together with ultrasound scan is essential in workup of patients complaining of chronic pelvic/lower abdominal pain or those who relapse after treatment.
As noted by many researchers and clinician, ectopic pregnancy not always present with full clinical picture, and may even occur in a woman without risk factors. If we wait for the full picture of ectopic to be present this will lead to serious adverse outcomes. Also, of great importance to remember that aneamia during reproductive age commonly associated with interrupted pregnancy or uterine pathology and in both doing ultrasound scan is main corner-stone in management.

Conclusion:

Advanced tubal ectopic pregnancy is rare.
Lower abdominal pain and vaginal bleeding in the reproductive age, should raise the suspicion of ectopic pregnancy even when missed period is denied.
Early diagnosis of ectopic pregnancy is associated with reduced maternal morbidity and mortality related to ectopic pregnancy.
Late presentation at first antenatal visit is still challenge in low resources setting.
Ethical considerations:
Written consent for Publication issues was taken.

Conflict of interest:
No conflict of interest

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