Ruptured ectopic pregnancy after interval tubal ligation

Peer review status:
No

Corresponding Author:
Dr. Ruchika Sood,
PG Resident, obstetrics and gynaecology, 5/E/16, BUNGLOW PLOTS, N.I.T, 121001 - India

Submitting Author:
Dr. Ruchika Sood,
PG Resident, obstetrics and gynaecology, 5/E/16, BUNGLOW PLOTS, N.I.T, 121001 - India

Other Authors:
Prof. Bal Taneja,
Professor, M.M.I.M.S.R, Obstetrics and Gynaecology - India
Dr. Geetanjali Setia,
PG Resident, M.M.I.M.S.R., Obstetrics and Gynaecology - India

Article ID: WMC004809
Article Type: Case Report
Submitted on: 22-Jan-2015, 02:52:39 PM GMT   Published on: 23-Jan-2015, 05:40:23 AM GMT
Article URL: http://www.webmedcentral.com/article_view/4809
Subject Categories: OBSTETRICS AND GYNAECOLOGY
Keywords: Ruptured ectopic, Post sterilization, Exploratory laparotomy

How to cite the article: Taneja B, Sood R, Setia G. Ruptured ectopic pregnancy after interval tubal ligation. WebmedCentral OBSTETRICS AND GYNAECOLOGY 2015;6(1):WMC004809

Copyright: This is an open-access article distributed under the terms of the Creative Commons Attribution License (CC-BY), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Source(s) of Funding:
No funds were required during this case
Ruptured ectopic pregnancy after interval tubal ligation

Author(s): Taneja B, Sood R, Setia G

Abstract

Tubal sterilization is considered a permanent method of contraception because it is highly effective in preventing pregnancy and therefore failure is rare. Most often the pregnancy following sterilization is ectopic in location. In this paper, we report a case of ectopic pregnancy in a patient who underwent interval bilateral tubal ligation 4 1/2 years ago for contraception.

Introduction

An ectopic or extrauterine pregnancy is one in which the blastocyst implants anywhere other than the endometrial lining of the uterine cavity. Tubal sterilization is an increasingly common method of contraception. Available evidence suggests that sterilization fails in 0.13-1.3% of sterilization procedures and of these, 15-33% will be ectopic pregnancies. In this case report, we present a patient with ruptured ectopic pregnancy who had bilateral tubal ligation.

Case Report(s)

A patient 32 years old gravida 4 para 2 abortion 1, all normal deliveries, had history of overdue cycle by one and a half month 6 months back. At that time, urine pregnancy test was done which was weakly positive & Trans vaginal ultrasound showed normal study. Patient was asked to follow up after one week to repeat urine pregnancy test and ultrasound, but she had spontaneous bleeding. All of the next menstrual cycles were normal with average amount of bleeding and patient did not follow up. Patient had undergone interval bilateral tubal ligation 4 1/2yrs back which was confirmed histologically. Patient had acute pain in right iliac fossa. She was given inj. Voveron and inj. pethidine at a private hospital but had no effect. She presented in our institute the next day with complaint of dull pain in right iliac region and nausea. Urine pregnancy test was done, which was weakly positive. An ultrasound was advised which showed ?PCOD with corpus luteal cyst on left side with free fluid echo in pelvis. β-hCG levels were done which were >1000 mIU/ml. Patient was advised to follow up after two days with repeat value of β-hCG. In the evening patient again had complain of acute pain in right iliac fossa with nausea and five episodes of vomiting, for which she was given the similar injectables but with no effect. She presented to opd the next morning. On examination patient’s general condition was fair, B.P. 120/78 mmHg, PR- 120 bpm, P/A- there was marked tenderness in right iliac fossa with rebound tenderness and guarding. All required blood investigations were done and were within normal limit. Acute appendicitis was ruled out by consulting the surgeon. Patient was taken up for Exploratory Laparotomy. On exploration, there was haemoperitoneum of 300 ml. Right side fallopian tube showed an ectopic pregnancy of around 2 1/2 months which was undergoing tubal abortion. Left fallopian tube and ovary, right ovary and uterus grossly appeared normal. Right side salpingectomy was done. The post operative period was uneventful and patient was discharged on the 7th post operative day.

The tube with products of conception were sent for histopathological examination. Sections from right fallopian tube showed dilated fallopian tube containing chorionic villi embedded in haemorrhagic area and products of conception were histologically confirmed.

Discussion

Usually, patients undergoing tubal sterilization are considered to have a lower risk of pregnancy. However, tubal sterilization can fail and in cases of failure, the resulting pregnancy could very well be ectopic.

The incidence of sterilization failure has been estimated to be about 0.13-1.3% of which ectopic gestation constitutes about one third. Among 10,685 women studied, the risk of ectopic pregnancy within 10 years after sterilization was about 7 per 1,000 procedures. A prior ectopic pregnancy, documented tubal pathology, surgery to restore tubal patency, or tubal sterilization carry the highest risk of obstruction and subsequent ectopic pregnancy.

Ectopic pregnancy after tubal sterilization is not rare,
particularly among women sterilized before the age of thirty\textsuperscript{3}. This patient was twenty eight years old at the time of sterilization.

The risk of ectopic pregnancy depends on the type of tubal sterilization. Hulka reported the risk of ectopic pregnancy with sterilization failure was 59% with bipolar electrosurgery\textsuperscript{4}. The risk of ectopic pregnancy may be higher after electrocoagulation procedures than after other forms of tubal sterilization, possibly resulting from tubal recanalization or uteroperitoneal fistula formation. Also the sterilization procedure should be performed during follicular phase of the cycle.

Conclusion

The history of tubal sterilization does not rule out the possibility of ectopic pregnancy even many years after the procedure and prophylactic bilateral salpingectomy may be considered in such cases that there is no obvious tubal lesion.

The emergency department physicians should be alert to the potential of ectopic pregnancy in all females of childbearing potential presenting to the emergency department. The presence of a tubal sterilization history should not draw the physician away from establishing the diagnosis; in fact, the potential for ectopic pregnancy should be kept in mind in such a patient with a positive ß-hCG result.

References