Second trimester unruptured ectopic pregnancy: Case report

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Corresponding Author:
Dr. Sonum Gautam,
PG Resident, Obstetrics & Gynaecology, MMIMSR - India

Submitting Author:
Dr. Sonum Gautam,
PG Resident, Obstetrics & Gynaecology, MMIMSR - India

Other Authors:
Dr. Bal Taneja,
Professor, MMIMSR - Obstetrics and Gynaecology - India

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Author(s): Gautam S, Taneja B

Abstract

Ninety-five percent of ectopic pregnancies occur in the fallopian tube, ampulla being the most common site. Diagnosis and exact location of ectopic pregnancy is usually easy during the first trimester of pregnancy by ultrasonography. However in developing countries, where resources are limited, most women do not undergo ultrasound examination during pregnancy, leading to a late diagnosis. Tubal pregnancies generally rupture between 5 and 9 weeks of gestation. However, some cases of advanced tubal pregnancies have been reported with a different presentation. This event is rare because it is unusual for the fallopian tube to dilate to the point of containing a second or third trimester foetus. We report a case of unruptured advanced tubal pregnancy.

Introduction

Ectopic pregnancy is the most common life-threatening condition in early pregnancy. The vast majority of ectopic pregnancies implant in the fallopian tube which is either interstitial (2.4%), isthmic (12.0%), ampullary (70.0%) or fimbrial (11.1%). Subsequent presentation of ectopic pregnancy varies from being asymptomatic to hemodynamic instability as a result of disturbed pregnancy. Tubal pregnancy has been always considered as a complication of the first trimester pregnancy. Tubal rupture usually occurs around 5th to 9th week of gestation by causing hemorrhage and shock. It is very rare for an ectopic to progress into second trimester and remain asymptomatic. We are reporting a rare case of ampullary pregnancy which progressed unruptured until 13 weeks with live fetus in situ.

Case Report(s)

Mrs A 25 years old primigravida presented with amenorrhoea of 15 weeks 3 days with complaints of vomiting for the past 5 days. On per abdomen examination a smooth, well defined mass around 18 weeks with side to side and downward motility was palpable. Fetal heart sound was located by Doppler in this mass. There was no bleeding on per vaginum examination. Per vaginum examination revealed uterus to be of normal size, deviated to left side; with a right adnexal mass around 8cm by 6cm with positive cervical tenderness. Left fornix was clear. Ultrasonography revealed right sided live unruptured ectopic pregnancy of 13 weeks 3 days. Patient was haemodynamically stable. Routine investigations were done. ABO-Rh was B negative, Hb 12.4 gm/dl, HCV was found positive with HIV and HBsAg negative. Patient was taken for exploratory laparotomy and per operatively uterus was found to be normal size. A right sided unruptured tubal pregnancy of size 8 cm by 8 cm with increased vascularity of the gestational sac (refer to Illustration 1 and Illustration 2). Right fimbrial end, left fallopian tube and bilateral ovaries were found to be normal. Right sided salpingectomy was performed and patient shifted back in stable condition.

Discussion

Ectopic pregnancy is the leading cause of first trimester pregnancy related morbidity and mortality (38 deaths/100,000 events). Early pregnancy trans-vaginal sonographic examination helps to identify the site of pregnancy and to diagnose ectopic pregnancy early before the occurrence of tubal rupture which can be life-threatening. Trans-vaginal sonographic diagnosis is significantly reliable accordingly, undisturbed tubal pregnancy is commonly diagnosed at 6.9 ±1.9 weeks. However, in many rural areas that lack health education and proper antenatal care early diagnosis is missed and the patient is first presented when tubal rupture occurs. Lack of a submucosal layer within the fallopian tube wall allows ovum implantation within the muscular wall and the rapidly proliferating trophoblasts erode the muscularis layer, so pregnancy cannot continue and tubal rupture occurs at 7.2 ± 2.2 weeks, so the diagnosis of tubal pregnancy is expected in the first trimester either if it is diagnosed early or if the diagnosis is missed and the patient is presented by tubal rupture. The treatment of advanced tubal pregnancy is always a total salpingectomy. It is difficult to do conservative surgery in cases of large ectopic pregnancy even if the patient has desire for future child bearing due to excessive deformation of fallopian tube, so in our case salpingectomy was done.

Conclusion
Ectopic pregnancy must always be considered in patients of child-bearing age. Ultrasound examination is highly reliable for diagnosis of ectopic pregnancy at any gestational age. Second trimester unruptured tubal pregnancy is a rare ectopic pregnancy but it should always be considered as a possibility in pregnant women with second trimester symptoms like nausea, vomiting, pelvic or abdominal pain, and vaginal bleeding.

References

Illustrations

Illustration 1

Illustration 2