

Tubal Ectopic Pregnancy in second trimester

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Introduction

-Ectopic pregnancy remains one of the life-threatening conditions in early pregnancy.

While ectopic pregnancies account for only 1.3–2.4% of all pregnancies, they are the leading cause of first-trimester maternal pregnancy-related mortality and account for 10% of maternal pregnancy-related deaths.

Ninety-five percent of ectopic pregnancies occur in the fallopian tubes, and these are most often discovered in the first trimester. There are only a handful of cases of second-trimester tubal ectopic pregnancies published in the literature (1). Below is one of the rare second trimester tubal ectopic pregnancy.

CASE REPORT

19 years old primip. Speaks little English and recently arrived in the UK 7 weeks prior to presentation. Presented with history of on and off, lower abdominal pain, vomiting, collapse at home, previous one episode of vaginal bleeding.

Had amenorrhea for about 4 months.

Initially her observation in ED was unremarkable.

Subsequently her GCS remained 15/15, then BP 88/56, HR 120 b/min, RR 34 b/min, O2SAT 100%.

There was generalized abdominal tenderness with guarding and rebound tenderness.

She was unable to pass urine for the pregnancy test, however reported she had a positive pregnancy test 2 weeks prior to presentation.

She was subsequently catheterized. Resuscitated with fluids. Urine pregnancy test was positive. Blood gas showed HB 67.

She was then taken to theatre where she had Laparotomy and right Salpingectomy for ruptured Ectopic. Intra op she had 3L hemoperitoneum, very distorted anatomy of right adnexa, right tubal proximal half, densely adherent to right round ligament, Middle of the right tube is swollen and dilated, about 4-5 cm in diameter, with fetus of about 16 weeks coming through the ruptured right tube, fimbrial end seen and appeared normal.

She had 4 units RBC and 2 units cryoprecipitate intra operatively.

Tested positive for covid but was asymptomatic. She was discharged 2nd day postop after an uneventful recovery with HB 108.

Histopathology report showed Specimen comprises a cylinder of light brown tissue measuring 80 x 10mm with attached fimbrial end measuring 20 x 15 x 10mm. Slicing reveals a dilated segment measuring 40mm in maximum diameter and filled with cream, haemorrhagic and membranous tissue. An obvious perforation identified at the proximal aspect of the specimen.

Microscopy blocks from the dilated portion of tube and rupture site as defined macroscopically above contain a thickened muscular wall enclosing a dilated lumen filled with numerous chorionic villi and accompanying haemorrhage. There is associated decidual change in areas. No foetal somatic elements are seen, and no evidence of gestational trophoblastic disease is identified. Sections from background Fallopian tube and fimbrial end show plicae lined by histologically unremarkable tubal epithelium, with no evidence of STIC or invasive malignancy. Overall, the features are consistent with a ruptured tubal ectopic pregnancy.

Discussion

Second trimester ectopic pregnancy is rare as most times the symptoms occur in the first trimester and use of scans aid the diagnosis.

However, when there are barriers to seeking urgent medical review, diagnosis might be delayed.

The index patient is new to the UK and speaks little English. She has not yet booked for maternity care in any Unit and with barriers in communication, this may hinder seeking urgent medical help. Such a category of patients is high risk.

Ectopic presentation is highly variable, ranging from an asymptomatic state to pelvic pain that is worse on one side, to tubal rupture with haemorrhagic shock. 75% of tubal pregnancies can be detected by transvaginal ultrasonography (2)

Patients with an ectopic pregnancy commonly present with pain and vaginal bleeding. These are common symptoms in early pregnancy (3)

Vomiting remains one of the gastrointestinal presentations in ectopic, and with history of collapse as in the index patient is a pointer to ectopic.

Unfortunately, atypical presentation is also relatively common. Ectopic pregnancy may mimic other gynaecological disorders and gastrointestinal or urinary tract disease, including appendicitis, salpingitis, ruptured corpus luteum or follicular cysts, threatened or inevitable spontaneous abortion, ovarian torsion and urinary tract infection. (3)

However, it remains difficult to diagnose an ectopic pregnancy from risk factors, history and examination alone. Clinicians should be suspicious in any woman who presents with abdominal or pelvic symptoms and should always bear in mind the possibility of ectopic pregnancy in any woman of reproductive age who presents with any of the symptoms mentioned above (3)

Conclusion

This case report shows that ectopic pregnancy in the second trimester can occur. Patients that recently arrived in the UK and have language barriers are at high risk. Gastrointestinal symptoms are recognised symptom of ectopic pregnancy, and when presented with a history of collapse there should be a high index of suspicion.

References

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