

ASYMPTOMATIC LIVE ECTOPIC PREGNANCY: A CASE REPORT

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BACKGROUND

Ectopic pregnancy (EP) is the most dangerous cause of vaginal bleeding in pregnancy with increasing incidence due to assisted conception.

Deaths associated with EP have declined with earlier and improved diagnosis with statistics showing 10-15% of all pregnancy related deaths are due to haemorrhage from EP.

CASE

Nina, a 34year old multiparous Aboriginal woman estimated to be 5 weeks based on last menstrual period, presents to a rural clinic with complaints of mild crampy lower abdominal pain and vaginal spotting. A beta-hcg done and repeated showed a rising beta-hcg from 500 IU/L to 5500 IU/L. However, a non-conclusive bedside ultrasound was concerning of an EP.

Due to the remoteness of her location and lack of medical personnel, decision was made for transfer to the nearest regional hospital for management. Repeat beta-hcg was 17000 IU/L.

On admission, Nina remained clinically asymptomatic. Due to a delay in formal imaging from lack of ultrasound services after hours; a transvaginal ultrasound (TVS) 2 days later showed a live right tubal EP of 7 weeks gestation. Concurrently beta-hcg was 31200 IU/L.

An uncomplicated right salpingectomy was done for tubal EP with a relatively normal looking contralateral tube.

DISCUSSION

According to Winder et al. visualisation of an adnexal mass separate from the ovary on transvaginal ultrasound has been shown to have high sensitivity (84.4%) and specificity (98.9%) of EP.

Guideline published by the American and Australian College of Obstetricians and Gynaecologists concur that a serum beta-hcg greater than 1500 IU/L without visualisation of an intrauterine or extrauterine pathology may represent pregnancy of multiple gestation. As such a repeat TVS should be offered. However, in clinical deterioration, there should not be a delay in diagnostic surgical management.

The ESEP study reviewed the fertility outcome up to 36months post salpingotomy and salpingectomy by measuring the occurrence of spontaneous viable intrauterine pregnancy. The cumulative ongoing pregnancy rate was 60.7% after salpingotomy and 56.2% after salpingectomy. The study also concluded on persistence of trophoblastic tissue and a repeat incidence of EP - that in women with a tubal pregnancy and a healthy contralateral tube, salpingotomy does not significantly improve fertility prospects.

CONCLUSION

In evaluating guidelines and trial studies, a clinically stable pregnancy of unknown location could await diagnostic imaging before surgical management.

Risks versus benefits of salpingotomy and salpingectomy should be carefully weighed and discussed with patient before surgical management; where patients are clinically stable.

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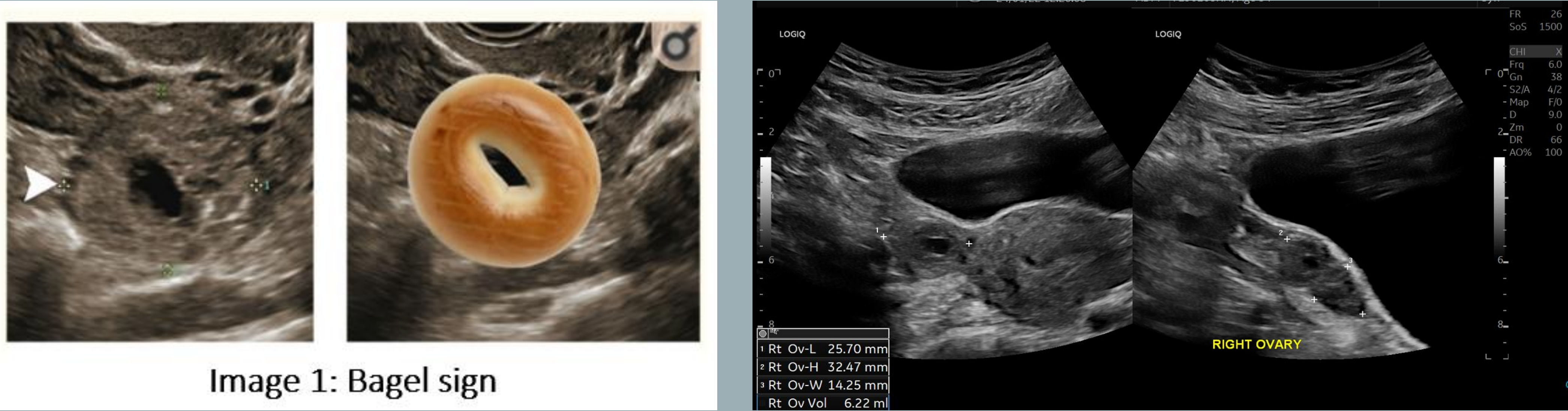


Image 1: Bagel sign