

ABDOMINAL ECTOPIC PREGNANCY.

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INTRODUCTION:

An ectopic pregnancy [EP] accounts for 1-2% of all pregnancies of which 90% implant in the fallopian tube. An Abdominal Ectopic Pregnancy [AEP] is defined as an ectopic pregnancy occurring when the gestational sac is implanted in the peritoneal cavity outside the uterine cavity or the fallopian tube. Implantation sites may include the omentum, peritoneum of the pelvic and abdominal cavity, the uterine surface and abdominal organs such as the spleen, intestine, liver and blood vessels. Primary abdominal pregnancy results from fertilisation of the ovum in the abdominal cavity and secondary occurs from an aborted or ruptured tubal pregnancy. It represents a very rare form of an EP, occurring at <20 weeks gestation, caused by the implantation of an abnormal placenta. It is an important cause of maternal-fetal mortality due to the high risk of a major obstetric haemorrhage and coagulopathy following partial or total placental separation. Management options include surgical therapy [laparoscopy +/- laparotomy], medical therapy with intra-muscular or intralesional methotrexate and/or intracardiac potassium chloride or a combination of both.

CASE PRESENTATION:

A multiparous woman in her early 30s presented at 8 weeks gestation by her last menstrual period with heavy vaginal bleeding and severe abdominal pain. She reported a two-week history of mild vaginal bleeding and a 48-hour history of heavy bleeding with clots. It was a spontaneous conception. She had stopping taking her oral contraceptive pill three months previously. She described early pregnancy symptoms such as nausea and vomiting. Her medical history included asthma and ulcerative colitis. Her obstetrics history included two normal vaginal deliveries at term and a miscarriage at six weeks gestation. Her gynaecological history included a diagnosis of endometriosis. Her medications included salbutamol inhaler 100mcgs four times daily and sertraline 50mgs at night. She had a regular 28-day menstrual cycle. Her cervical smear was up to date. She did not have a Mirena intra-uterine device in-situ. Her observations were stable [SpO2 98% on air, respiratory rate of 14, BP 118/75mmHg, heart rate 79 beats per minute and temperature of 36.2C]. Physical examination confirmed generalised abdominal tenderness with guarding in the right iliac fossa. Speculum and bimanual palpation confirmed heavy vaginal bleeding. The cervical os was closed. Adnexal fullness was palpable on the right.

INVESTIGATIONS:

Her haemoglobin on admission was 144g/L. Her bHCG was 5,760iu/L consistent with a viable pregnancy. A TV USS showed an endometrial thickness of 5.6mm. Towards the midline of the pelvis, a lesion was seen measuring 42x38mm. The lesion contained a cyst that appeared to contain an echogenic focus within, measuring 16mm in diameter. **[Figure 1]** The ultrasound findings raised the suspicion of a fetal pole. No fetal cardiac pulsations were seen. The mass lesion appeared to be separate from the ovaries. The appearance raised the suspicion of an ectopic pregnancy. There was no obvious free fluid seen in the pelvis.

Her repeat bHCG at 48 hours was 4,427iu/L and her repeat TV USS showed a crown-rump length [CRL] of 16.5mm [suggesting a gestation of 8+1 weeks]. **[Figure 2]** There was no free fluid. Both ovaries were normal. An ectopic pregnancy was observed on the right side, measuring 38x27mm. Her 96-hour bHCG was 3,481iu/L. **[Table 1]**

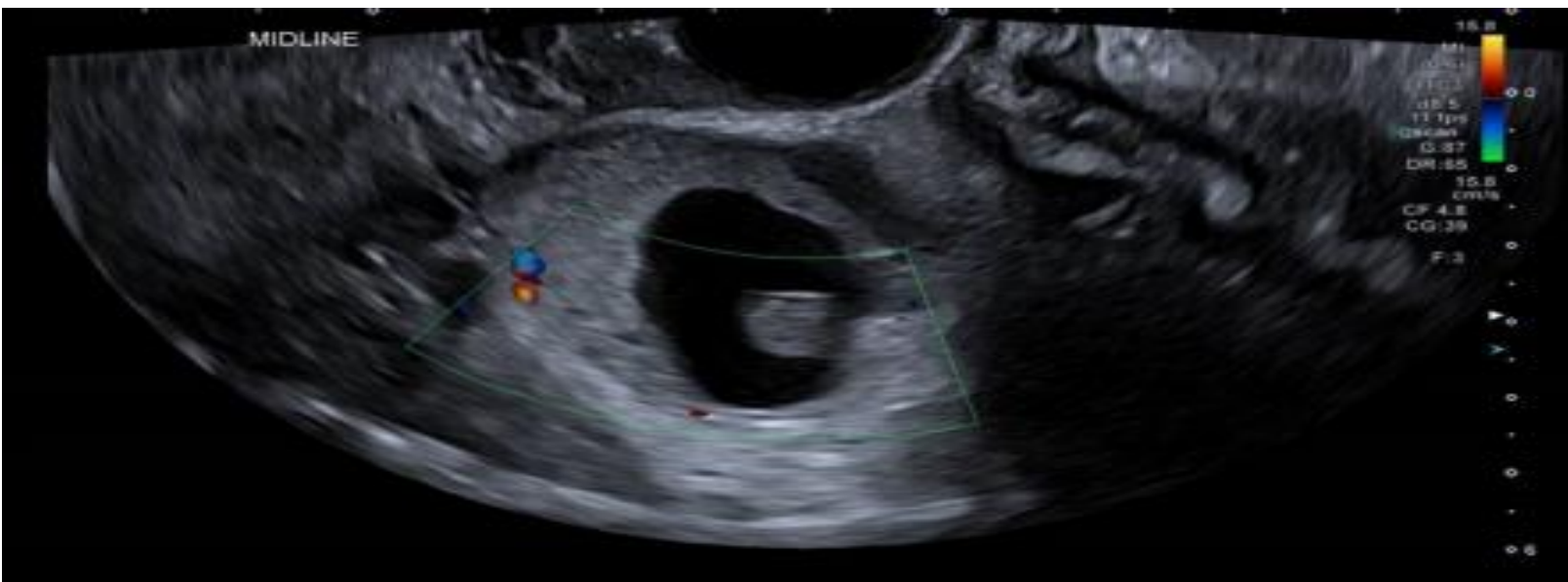


Figure 1.



Figure 2.

HOURS	BHCG	
Baseline	5,760iu/L	
48	4,427iu/L	Fall of 1,333iu/L
96	3,481iu/L	Fall of 946iu/L

Table 1.

DIFFERENTIAL DIAGNOSIS:

The clinical symptoms correlated with her sonographic findings and her bHCG suggested an ectopic pregnancy. Due to her abdominal pain and raised bHCG she was consented for a diagnostic laparoscopy.

TREATMENT:

A diagnostic laparoscopy was performed. An indwelling urinary catheter was inserted. The cervix appeared normal. An infra-umbilical incision was performed and the Veress needle inserted. Intraperitoneal entry was confirmed with Palmers, hanging drop and pressure tests. The uterus appeared of normal size and it was mobile. The fallopian tubes were normal. A mass extending from the pouch of douglas and right pelvic sidewall in close proximity to the ovary was observed. It measured 4x3cm in diameter. **[Figure 3, 4]** The upper abdomen and the liver appeared normal. Superficial peritoneal endometriosis was observed. The ectopic was separated from the pouch of douglas and the pelvic lateral sidewall. The ureter was noted. Bipolar diathermy achieved haemostasis. A pelvic drain was inserted. The estimated blood loss was 1.5L.

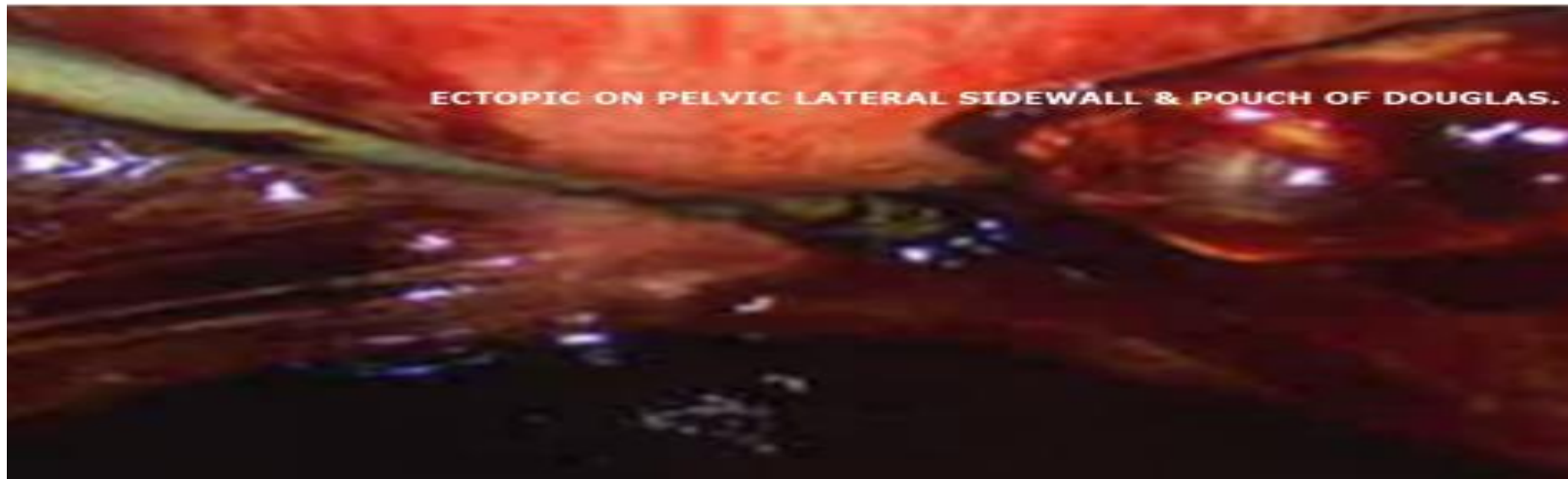


Figure 3.



Figure 4.

OUTCOME AND FOLLOW-UP:

She remained haemodynamically stable. Her haemoglobin 24-hours post-operatively was 134g/L. Her drain was removed as it contained <50mls of serosanguinous fluid. Her BHCG 48 hours later was 374iu/L. Serial monitoring of her BHCG was scheduled until it was negative. Follow up was scheduled in the Gynaecology Clinic and histology confirmed an ectopic pregnancy.