

Advanced ectopic pregnancy

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Objective:

To discuss the challenges in diagnosis and management of a rare case of an advance ectopic pregnancy

Case history:

A 36 years old nulliparous was referred to Corniche hospital with due to failed medical management of miscarriage at 18 weeks gestation. There was also suspicion of bicornuate uterus on her previous scans in referring hospital.

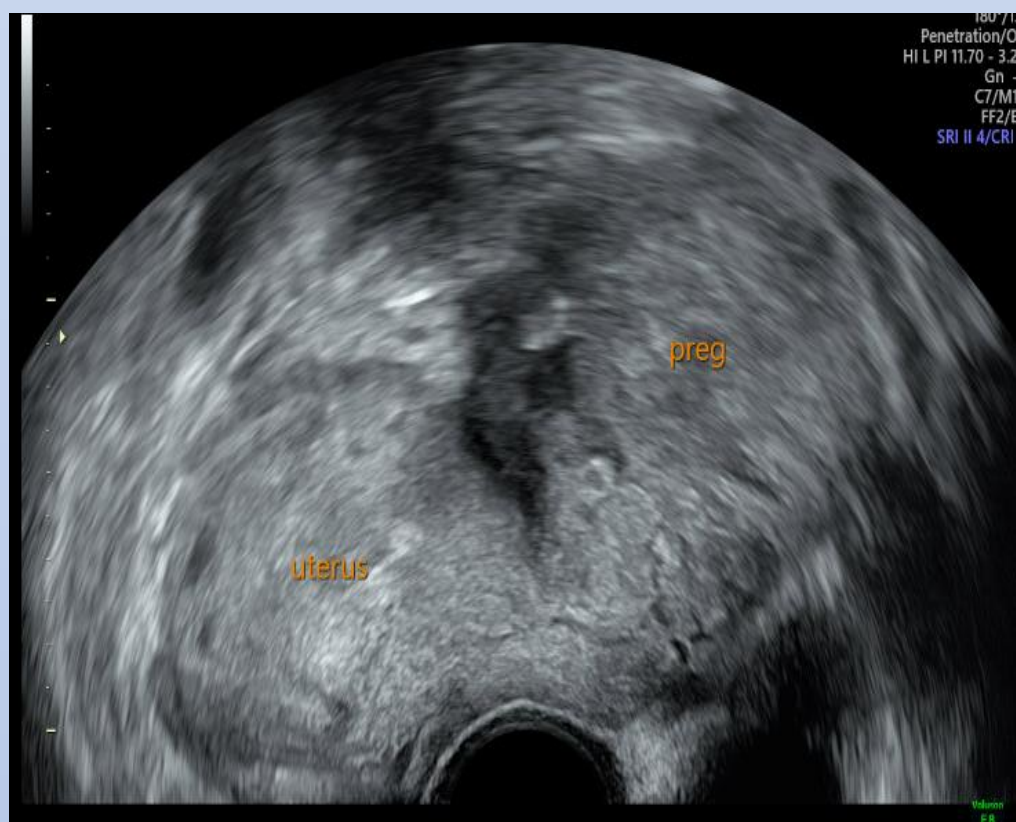
On USS at Corniche Hospital:

The uterus was normal in shape and empty. Right vary was normal. Left ovary could not be seen. A large non viable ectopic pregnancy was seen in left adnexa. The exact location could not be determined. Differential diagnosis was of interstitial pregnancy, pregnancy in rudimentary horn or abdominal pregnancy. A pelvic MRI was done, which was not helpful. Patient underwent diagnostic laparoscopy which was suggestive of the large ectopic mass in broad ligament. In view of high risk for bleeding and lack of IR support, further surgery to excise the mass was not undertaken and she was referred to Oncology centre. A CT angiogram revealed highly vascular mass with blood supply directly from left internal iliac. She underwent embolization followed by laparotomy and excision of the ectopic pregnancy.

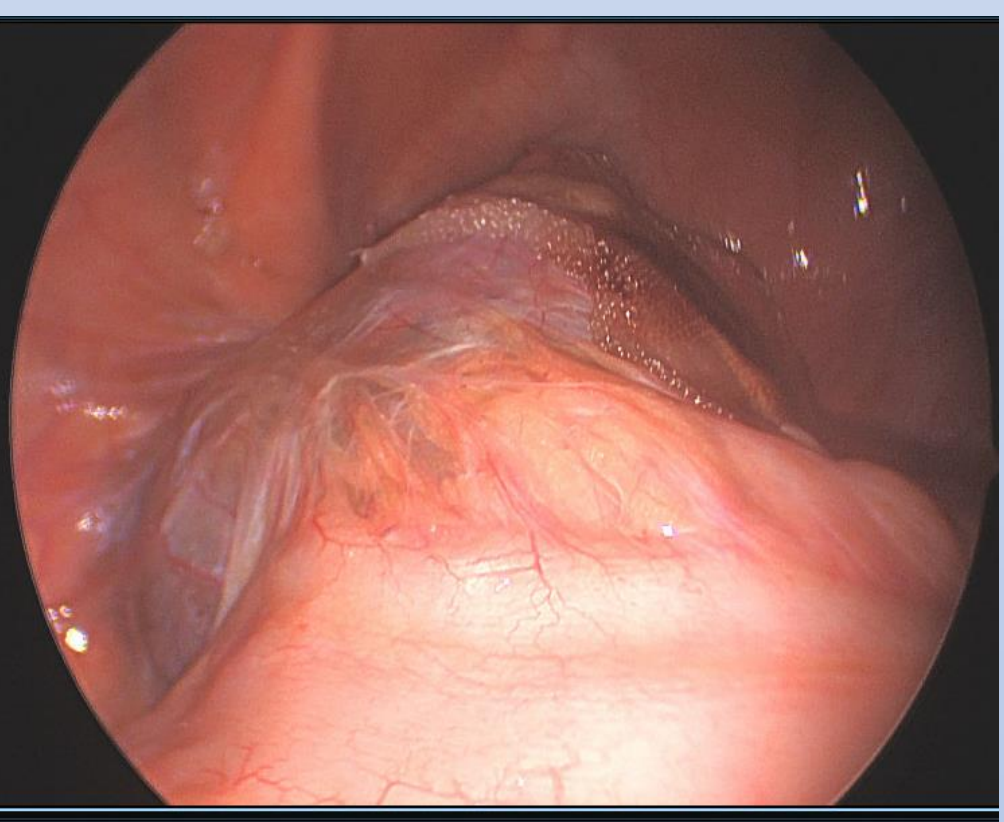
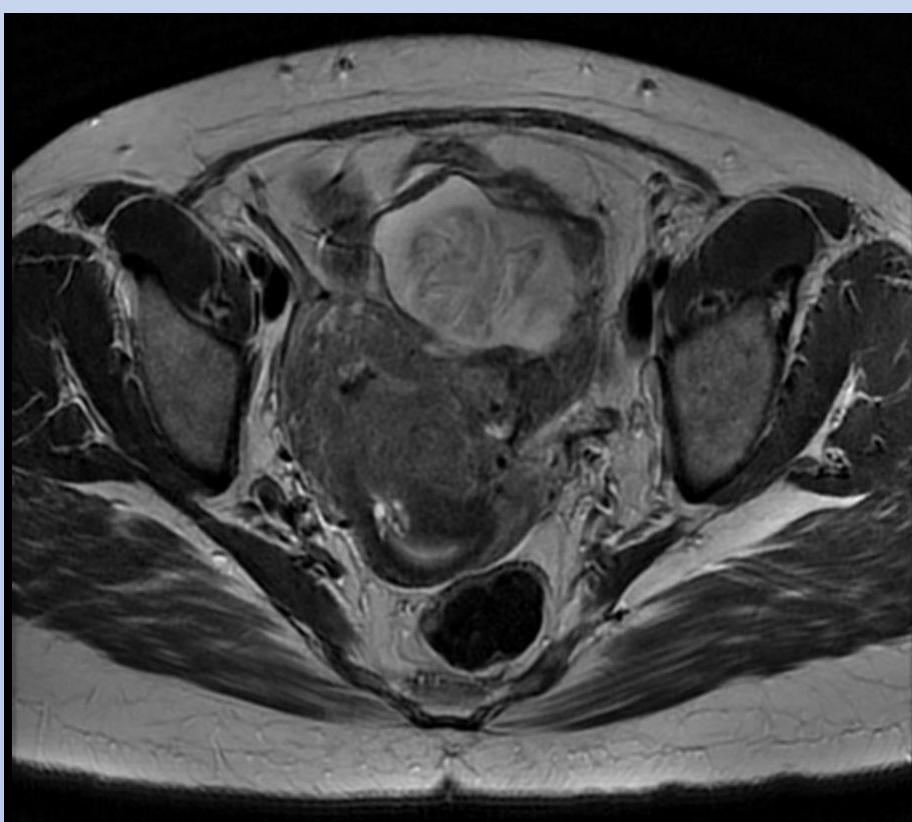
At surgery impression was of an ovarian pregnancy.

Reason for delayed diagnosis:

- First trimester USS showed fluid in cavity which was misdiagnosed to be intrauterine pregnancy.
- Ectopic was suspected by sonographer at 12 weeks however it was overruled by the Radiologist reviewing images and signing the scan. It was concluded to be a bicoruante uterus with an intrauterine pregnancy.



TVS and MRI : Empty uterus. Large heterogeneous in left adnexa consistent with ectopic pregnancy



Laparoscopy: Large retroperitoneal mass in left adnexa connected to pelvic side wall.



MRI: left iliac vessels seen supplying blood to the ectopic pregnancy



Fetus placenta and possible Ovary removed surgically

Intra – operative findings:

On laparotomy, a large (12 cm) adnexal mass on the left side that is densely adherent to the uterus, recto-sigmoid, left pelvic sidewall and left paravesical space. The mass had organized clots and a macerated fetus that is about 12-14 weeks size. The left fallopian tube was seen on top of the large mass. Ovarian tissue was detected after resection of the left pelvic mass.

The right ovary and fallopian tube appeared normal.

Histopathology:

Anatomy Markley distorted with what appears as myometrial tissue. Fallopian tube and ovary matted together and involved by the products of conception. It is likely that ectopic pregnancy involved the Isthemic uterine region or interstitial part of the fallopian tube continuing to involve the tube and partially the ovary.

Lessons learnt:

- To avoid missing a diagnosis of ectopic, it is important to follow a systematic assessment of uterus and both adnexa in first trimester.
- Still images review has its limitations. For a potentially critical diagnosis such as ectopic pregnancy, repeat USS should be considered before ruling it out on still images.