

A case report of Complex Ruptured Tubal Ectopic Pregnancy in a Hemodynamically Stable Patient

Dr Fatema Zohora, Dr Sabine Hashemi , Dr Fatimah-Al-Rufaye, Dr Shaimaa Badr,Dr Raunak Mukherjee,Mr Francis Afadapa, Miss Srabani Mukherjee

Ectopic pregnancy (EP) ruptures are the leading cause of maternal mortality within the first trimester of pregnancy with a rate of 9%–14% and an incidence of 5%–10% of all pregnancy-related deaths. A gestational sac (GS) that implants in a location that is not the uterus is defined as an EP. Women with an EP may have nonspecific symptoms such as lower abdominal pain and vaginal bleeding, often presenting clinically similar to appendicitis, urinary calculi, early pregnancy loss, or trauma. Women with this presentation in the first trimester have an EP prevalence in emergency departments as high as 18%, which can be easily misdiagnosed as the previously described clinical mimics

The likelihood of ectopic pregnancy is heightened by several risk factors, such as a history of previous ectopic pregnancy, Pelvic Inflammatory Disease (PID), tubal surgery, infertility treatments, and the use of Intrauterine Devices (IUDs) Recognizing these risk factors early on and promptly evaluating women with compatible symptoms can facilitate early detection and management, reducing maternal mortality and morbidity.

Objectives:

In EP, the estimated incidence in the general population is 1%–2%. It is a life-threatening emergency in a first-trimester pregnancy. This was a case of hemodynamically stable patient who required surgery involving 2 specialties.

Case report:

A 30-year primigravida went for a private scan at around 7 weeks of gestation for viability check on a Friday evening. She went to her doctor about a week ago where she was given lactulose as she was constipated for a week. On Friday evening, we got a call from the private sonographer that she is suspecting right sided ectopic pregnancy with dermoid cyst and hydrosalpinx with free fluid in the pouch of Douglas. Hence, we accepted the referral and when she reached to our Emergency department, she was vitally stable. On examination, she was slightly tender on the suprapubic area more on the right sided abdomen without any cervical excitation during bimanual examination. Her bloods were unremarkable and Bhcg were 7885.

She was reviewed by the consultant on the next morning and had been taken to the theatre in the afternoon as there was no departmental scan available over the weekend. Please note, her vitals and bloods were stable that time.

Intra-operative: Laparoscopic
Right sided salpingectomy was done and surgeon had to call as the tubal pregnancy was completely ruptured but the omentum and part of the small bowel compressed the ruptured tubal part. Small bowel were adherent to the ruptured ectopic mass where distal ileus was also involved. Acute fibrinous adhesions found to that mass which was bluntly dissected. Hemoperitoneum was noticed.



Pic A:ruptured Ectopic



Pic B:Bowel attached with the ruptured ectopic

Discussion:

EP affects up to 2% of gestations. While fallopian tube involvement is the most common (95%), abdominal, cervical, ovarian, and caesarean section scar implantation have also been reported. Risk factors predisposing women to ectopic pregnancies hinge on disrupted fallopian tube anatomy. This can be congenital, but often results instead from prior tubal ectopic pregnancies, medical termination of pregnancy, prior miscarriages, and sexually transmitted infections. While this lady was completely stable and no departmental scan was available during the decision, taking her to the theatre only the basis of lower abdominal pain was a good decision

Conclusion:

This case was not an usual presentation of an ectopic pregnancy, and thus should be retained for differential diagnosis in all reproductive age women with uncertain clinical presentation and hemodynamic stability. A smart elicitation of history and some tests including urine pregnancy test can save many mothers from dying if the clinician is ectopic minded.