

A case of recurrent interstitial ectopic pregnancies

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Background

- Interstitial pregnancies (implantation in the most proximal part of the fallopian tube) are rare, accounting for 1-6% of all ectopic pregnancies¹.
- Timely diagnosis and management is crucial due to increased risks of rupture, haemorrhage and mortality compared with other types of ectopic pregnancy.

Patient A's First Presentation

- This case presents a 41 year old P2+1. She had had 2 previous vaginal births and 1 previous medical termination of pregnancy (TOP).
- She presented via TOP services at approximately 7 weeks' gestation having conceived on the progesterone only pill. She had no pain or bleeding.
- Routine ultrasound showed an empty uterus with a right adnexal mass measuring 39mm and a trace of free fluid. Her serum hCG was 22732.
- She was transferred to Gynaecology and rescanned. This was suspicious for a right interstitial ectopic with CRL 14mm.

- She underwent laparoscopic wedge resection of right interstitial ectopic pregnancy and right salpingectomy under GA.
- Intra-operatively the surgeon infiltrated around the ectopic with 1% lidocaine + adrenaline to minimise bleeding.
- The uterus was opened with a monopolar diathermy hook, the gestation sac exposed and removed with suction and the uterus was then closed in 3 layers with V lock suture.
- EBL 500ml.
- She was discharged home on POP and followed up with serum hCG tracking until hCG <25.
- She was advised to wait at least one year before trying to conceive again, and that we would advise birth by Caesarean section in any future pregnancies.



Image 1: Transvaginal ultrasound image of right interstitial ectopic. The empty uterine cavity can be seen to the left. Image courtesy of Dr Sarah Woldman.

Patient A's Second Presentation

- 11 months later Patient A presented at approximately 6 weeks' gestation for a reassurance scan.
- She was well and asymptomatic.
- Transvaginal ultrasound showed an empty uterus with a thickened endometrium and a live **left** interstitial ectopic pregnancy with CRL measuring 5mm.
- Serum beta hCG was 19126.
- Options for management were discussed: further wedge resection and salpingectomy versus total laparoscopic hysterectomy (TLH) with ovarian conservation.
- Factors considered: age, risk of recurrence, desire for further pregnancy (albeit would require assisted conception), high risk nature of further pregnancy (e.g. scar rupture), bleeding risk, social circumstances (patient had recently separated from her partner).
- Patient understandably shocked and upset – admitted overnight and given time to consider options.
- She ultimately decided that she had completed her family and opted to proceed with TLH.
- She underwent a straightforward TLH with ovarian conservation later that day with EBL 400ml.
- She was discharged home the following day

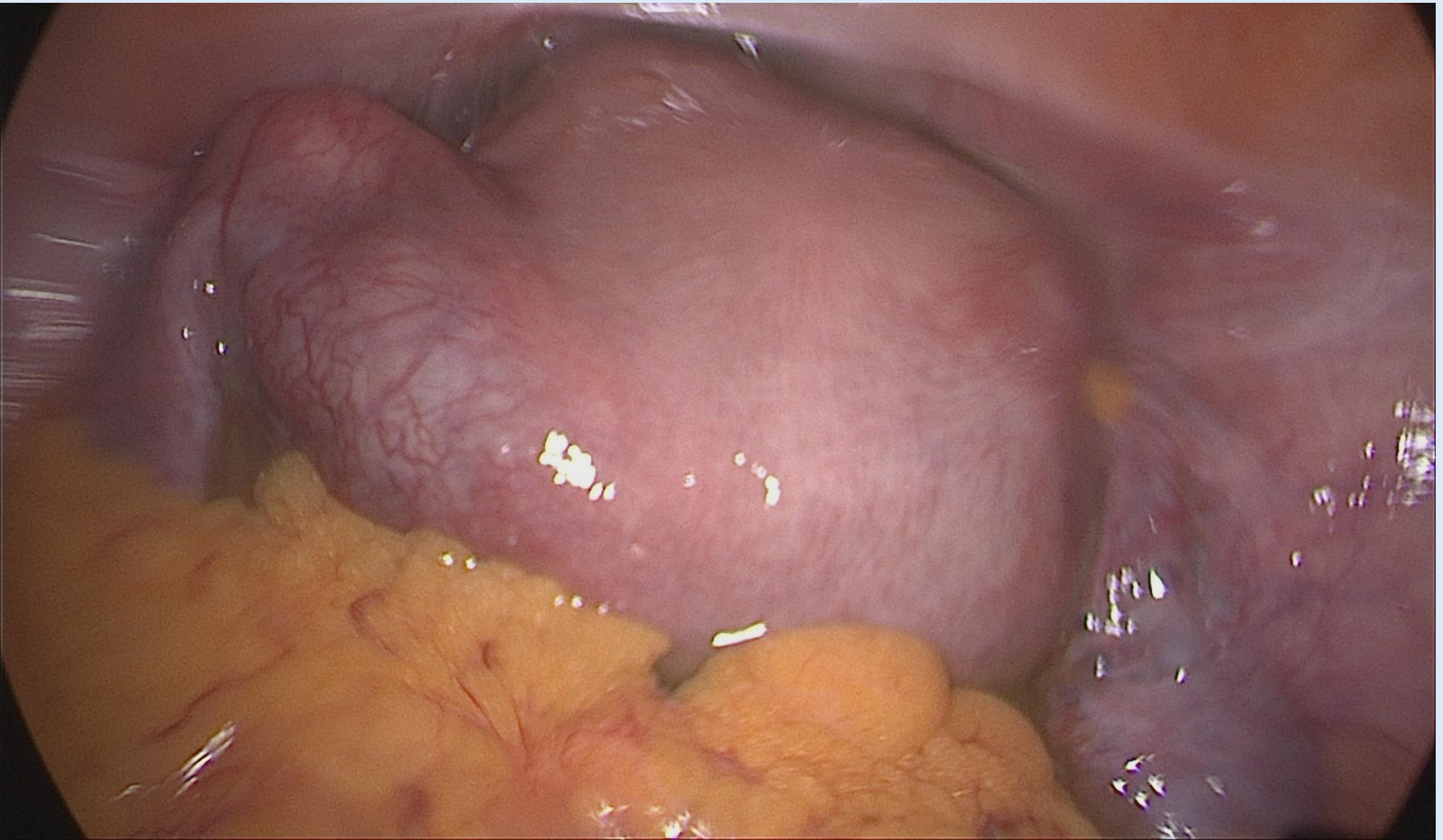


Image 2: Image of uterus taken at time of laparoscopy. Site of previous wedge resection with absent fallopian tube can be seen on the right. Left interstitial ectopic pregnancy seen on left. Image courtesy of Dr Felicity Watson.

Learning Points

- This interesting case highlights the importance of early scanning after a previous ectopic pregnancy. Early diagnosis of interstitial ectopics is crucial because of the increased risk of rupture and haemorrhage.
- Thorough scan technique is important as well as a healthy degree of suspicion for the rarer types of ectopic pregnancy.
- We must individualise our counselling and management of these patients according to their other risk factors and desire for future fertility.

References

1) RCOG Green Top Guideline No. 21 'Diagnosis and Management of Ectopic Pregnancy'.