Case Reports

A case of spontaneous bilateral tubal ectopic pregnancy

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Abstract

Management of ectopic pregnancies are a relatively common occurrence in day to day practice of a general gynaecologist, but spontaneous bilateral tubal ectopic pregnancy is a rare occurrence worldwide. We report successful management of a case of spontaneous bilateral tubal ectopic pregnancy in the District General Hospital, Nuwara Eliya.

Key words: tubal ectopic pregnancy, transvaginal ultrasound, laparotomy

Introduction

In the absence of preceding ovulation induction, spontaneous bilateral tubal ectopic pregnancy is an extremely rare occurrence worldwide. We report a case of 30-year old woman, who was successfully treated for bilateral tubal ectopic pregnancy at DGH Nuwara Eliya. This was a spontaneous conception with no previous use of assisted reproductive technology procedures. She did not use any form of contraception in the interim. Prior to this she had an uneventful full term pregnancy with a normal delivery. She was a regularly menstruating female with cycles of 28 days and did not have any risk factors favouring an ectopic pregnancy.

Case report

A 30-year old multigravida, presented to the gynaecology unit in her 2nd ongoing pregnancy at 14 weeks of gestation with cramping type of abdominal pain and vomiting. She had no vaginal bleeding. She had no significant complaints previously other than mild abdominal pain with spotting experienced at 6 weeks of gestation. A transvaginal sonography at 6 weeks has revealed only one intrauterine sac with no fetal pole. On examination she was haemodynamically stable, afebrile, and not pale. She had no abdominal tenderness. Vaginal examination was unremarkable. Sonography performed after admission to the gynaecology unit revealed right adenexal mass measuring 3.5 × 2.5 cm with a cystic space containing an embryo (Figure 1) and an echogenic growth with cystic space covering 2/3 of the uterus. Moderate amount of blood was seen in the pouch of Douglas. Preoperative conclusion was leaking right tubal pregnancy with a possible intrauterine pregnancy.

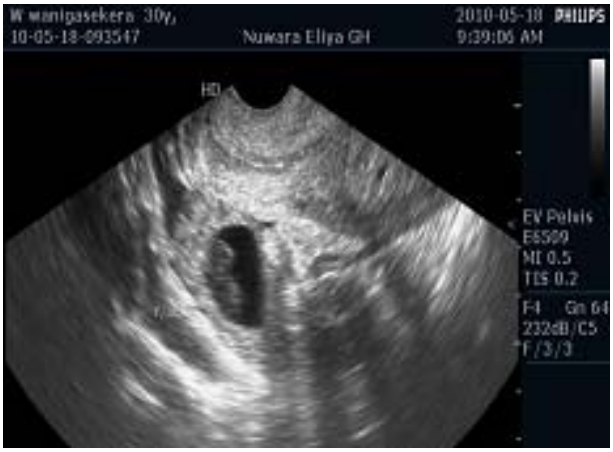

Figure 1

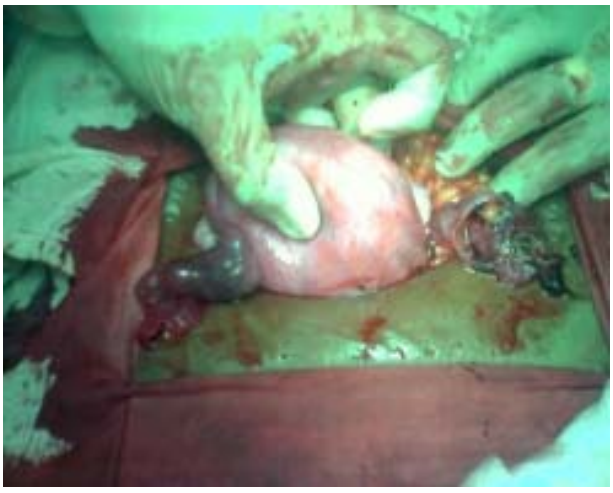

Figure 2

Emergency laparotomy was carried out under the impression of heterotopic pregnancy and about 300ml of hemoperitonium was evacuated. Ruptured left ampullary ectopic pregnancy with a mass in the right

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fallopian tube consistent with an ampullary ectopic was found (Figure 2). Bilateral ovaries appeared normal. While salphingectomy was performed in already ruptured left tube, the unruptured ectopic pregnancy in the right tube was removed through salpingotomy. Suction evacuation of the uterus was carried out before the laparotomy. All the specimens were sent for histology. The postoperative recovery was uneventful. Histology examination of the specimens of left fallopian tube and right fallopian tube contents revealed chorionic villi, confirming the bilateral tubal ectopic pregnancy. Products from the uterus showed desidualized tissue with no chorionic villi excluding the possibility of heterotopic pregnancy.

Discussion

An ectopic pregnancy is an implantation of the embryo outside the uterine cavity. The commonest place is the fallopian tube and it also can occur in the cervix, ovaries and abdomen. The majority of ectopic pregnancies in the fallopian tube implants in the ampulla 80%(from all ectopics), then the isthmus 12%, the fimbria 5% , the cornua and interstitial part of the tube 2%[1]. Out of ectopic pregnancies spontaneous bilateral tubal pregnancy is a very rare event. The incidence of simultaneous bilateral tubal ectopic pregnancies has been reported at a range from 1 in 125 to 1 in 1580 ectopic pregnancies[2].

However, ectopic pregnancies are becoming more and more common now following the use of assisted reproductive techniques in an ever aging maternal population for subfertility[3]. Like in most of the reported cases we were unable to make the correct diagnosis ultrasonically in this case even though we carried out ultrasound examination (both transvaginal and transabdominal) pre-operatively[4,5]. The most common method of treatment is surgical management with either laparoscopy or laparotomy, but our patient underwent laparotomy. Laparoscopic surgical treatment would have been a better option because of quicker recovery and the similar rates of subsequent intrauterine and ectopic pregnancies even though the patient had an uneventful recovery[6].

References

1. Speroff L, Glass RH, Kase NG. Clinical Gynaecological Endocrinology and Infertility, 6th Ed. Lippincott Williams & Wilkins (1999). p1149.
2. Adair CD, Benrubi GI, Sanchez-Ramos L, Rhatigan R. Bilateral tubal ectopic pregnancies after bilateral partial salpingectomy: a case report. *J Reprod Med* 1994; **39**: 131-3.
3. Murray H, Baakdah H, Bardell T, Tulandi T. Diagnosis and treatment of ectopic pregnancy. *Canadian Medical Association Journal* 2005; **173**: 905-12.
4. Messore M et al. Spontaneous left tubal and right interstitial pregnancy: a case report. *Journal of Reproductive Medicine* 1997, **42**(7): 445-7.
5. O'Brien MC, Rutherford T. Misdiagnosis of bilateral ectopic pregnancies: a caveat about operator expertise in the use of transvaginal ultrasound. *Journal of Emergency Medicine* 1993, **11**(3): 275-8.
6. Hajenius PJ, Mol BWJ, Bossuyt PMM, Ankum WM, Van der Veen F. Interventions for tubal ectopic pregnancy. Cochrane Database of Systematic Reviews 2000, Issue 1.