Acta Scientific MEDICAL SCIENCES (ISSN: 2582-0931)

Volume 7 Issue 9 September 2023

Case Report

A Live Advanced Tubal Ectopic Pregnancy-A Case Report from Dubai Hospital

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DOI: 10.31080/ASMS.2023.07.1668

Received: August 07, 2023

Published: August 23, 2023

Abstract

When the pregnancy occurs outside the uterine cavity, it is called an ectopic pregnancy. If a pregnant woman experiences amenorrhea, abdominal pain, and vaginal bleeding in the first trimester, we should suspect an ectopic pregnancy and should be confirmed by hormonal test bhcg above discriminatory zone (1500 iu/ml) and empty uterus on transvaginal ultrasound. We can manage such ectopic pregnancy by injection of methotrexate or women might need surgical intervention like laparoscopy or laparotomy which depends on the hemodynamic stability of the woman.

In this case, the report we will mention about a 27-year-old African female who presented to the emergency department of DH with gestational amenorrhea of 11 weeks and 2 days with sudden abdominal pain and vaginal bleeding of one-day duration with fainting episodes and shoulder tip pain also. This patient did not do any medical checkups before due to financial issues. She was vitally unstable. Her BHCG was 52,855mIU/ml and a transvaginal scan in emergency showed an alive fetus of 12 weeks size in the left tube and empty uterus, with the impression of unruptured ectopic. She was tachycardic, hypovolemic with severe anemia and hemoglobin of 6.2 g/dl. So the decision was taken to do laparotomy and salpingectomy urgently.

Keywords: Live; Tubal Ectopic; Pregnancy; Dubai Hospital

Introduction

Ectopic pregnancy is also called extrauterine pregnancy where the developing blastocysts occur usually in the fallopian tube or other organs like ovaries, cervix, cesarean scar, abdominal cavity, etc [1]. The incidence of ectopic pregnancy is around 1.3 to 2.4% worldwide [2]. 90 percent of all ectopic pregnancies occur in the fallopian tube and remain on other sites [3]. The clinical presentation of ectopic pregnancy is a classic triad of amenorrhea, abdominal pain, and vaginal bleeding. The diagnosis involves measurement of BHCG (2 samples 48 hours apart) in a stable patient and transvaginal ultrasound, this article involves the unusual case of advanced live unruptured ectopic pregnancy of 12 weeks size which was managed by laparotomy and salpingectomy.

Case Presentation

A 27-year-old, previously healthy, African female, G3 P2 + 0, 11 weeks 2 days gestation, presented to the Emergency department of DH on December 03, 2022, at 20:00 hrs. with sudden onset of lower abdominal pain and heavy vaginal bleeding of one-day duration, and a single episode of fainting attack on the day of presentation followed by left shoulder tip pain. Her last menstrual period was on September 15th, 2022. The pregnancy was not confirmed by any tests, and she did not receive antenatal care. She has a history of 2 previous normal uncomplicated vaginal deliveries. No known past medical, surgical, or drug history was noticed.

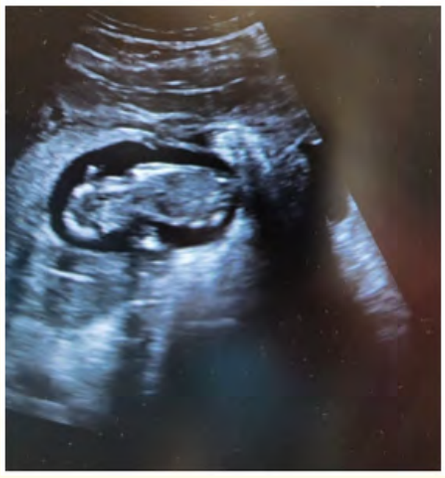
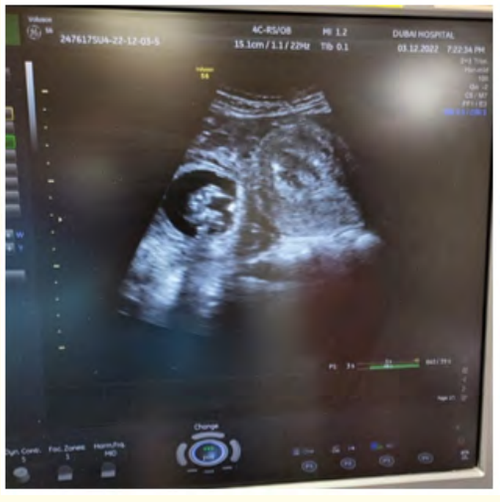


Figure 1: Preoperative bedside scan showing extrauterine fetal growth in the left fallopian tube.

On clinical examination, the patient was tachycardic with a pulse of 145 bpm with significant pallor. An abdominal and vaginal examination could not be performed due to the patient's clinical state. She was distressed with pain. Her Beta-hCG was 52,855mIU/mL and a bedside pelvic ultrasound scan revealed an empty uterus with thickened endometrium and regular contour. A left-sided ectopic pregnancy with an alive fetus was noted. The Crown Rump Length (CRL) was 12 weeks. Informed consent was taken and the patient was prepared for surgery in view of live ectopic pregnancy with tachycardia.



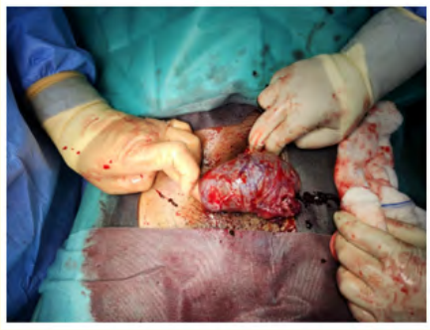


Figure 2: Intraoperative visualizationof huge reptured ectopic pregnancy.

A Pfannenstiel incision was made. Abdominal layers were opened. Intraoperatively, a huge ruptured left tubal pregnancy measuring 5x10cm with a hemoperitoneum of 2000ml was identified which was drained by suction and the clots were removed manually. The left fallopian tube was clamped, cut, and ligated and a salpingectomy was done. Bleeders were noted and secured with sutures. Oozing vessels in the broad ligament were managed with the thrombin hemostatic powder. Bilateral ovaries and the right fallopian tube were normal however these were embedded in adhesions. 2 units of packed RBC were transfused due to a hemoglobin of 6.3mg/dl. Peritoneal lavage was done and a redivac drain of size 12 was inserted. The specimen examined at the end of the procedure contained a fully formed fetus enclosed in a sac. Postoperatively, the patient was transferred to the ward after a period of observation. She received intravenous antibiotics for 24 hours. The repeated hemoglobin level post-transfusion was 7.5mg/dl. She received intravenous iron. The drain was in situ draining 100 ml of serosanguinous fluid, urine output was adequate with normal electrolytes. Post Op bedside pelvic scan showed no free fluid. Her hemoglobin at the time of discharge was 8.4g/dl. She was discharged in stable condition after a hospital course of 3 days and advised to attend early in the subsequent pregnancy for identification of pregnancy location.

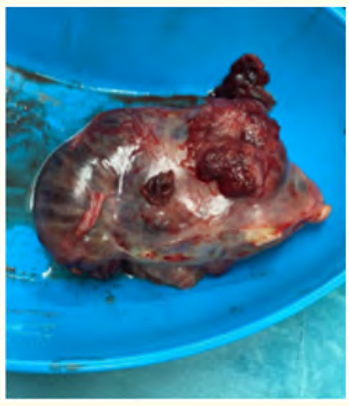


Figure 3: Specimen obtained from the surgical procedure.

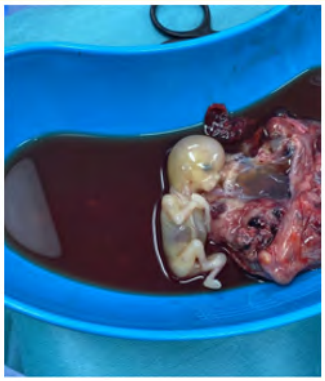


Figure 4: Specimen containing the fully formed fetus and the enclosing sac.

Discussion

Ectopic pregnancy is a well-known first-trimester pregnancy failure. It is a serious medical condition that requires prompt treatment to avoid life-threatening complications as it is responsible for 9% to 13% of all pregnancy-related deaths [2]. Maternal mortality is increased if ectopic is not diagnosed and managed timely.

The vast majority of ectopic pregnancies implant at different locations in the fallopian tube, most commonly in the ampulla (70%), followed by the isthmus (12%), fimbria (11.1%), and interstitial (2.4%) [4].

It is still unknown to know the exact cause of ectopic pregnanacy. However, following conditions have been linked with ectopic pregnancy, such as tobacco smoking, multiple sexual partners, previous ectopic pregnancy, damage to the fallopian tubes caused by pelvic inflammatory disease, or previous surgery. Diagnosing ectopic pregnancy can be difficult, but it typically involves a combination of serial serum hCG measurements and ultrasound scanning or needs diagnostic laparoscopy [5]. Ectopic pregnancy may present with a triad of symptoms including amenorrhea, vaginal bleeding, and abdominal pain. However, some women may experience other symptoms, such as shoulder pain, dizziness, fainting, or rectal pressure. Diagnosing an ectopic pregnancy can be challenging in the emergency department, it requires performing a skilled ultrasound examination and biochemical investigation i.e., Beta-hCG. This plays a pivotal role in the further management of the patient accordingly [6].

Deciding on the best treatment option depends on various factors including the patient's hemodynamic stability, BhCG level, the size of the gestational sac, and the patient's desire for future fertility. Un-ruptured single ectopic pregnancies can be successfully treated with systemic methotrexate. In our case, an emergency laparotomy and a right salpingectomy were performed due to the unstable hemodynamic status of the patient, severe anemia, and the accumulation of a large amount of intra-abdominal blood noted on the ultrasound image.

Conclusion

Ectopic pregnancy usually presents in the first trimester, and it is unusual to present late in the first trimester as unruptured like what happened in our case. Thus, in all cases of surgical abdominal emergencies during pregnancy, it is paramount to rule out ruptured ectopic pregnancy as it is life-threatening to the mother when the proper diagnosis and management are delayed.

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