Second trimester unruptured ampullary ectopic pregnancy with variable presentations: Report of two cases

Rekha Sachan, Pooja Gupta, ML Patel

ABSTRACT

Introduction: Ninety-five percent of ectopic pregnancies occur in the fallopian tube. Diagnosis and exact location of ectopic pregnancy is usually easy during the 1st trimester of pregnancy by ultrasonography. Ampulla is the most common site for ectopic tubal pregnancies. Case Series: Here we report two cases of ampullary ectopic pregnancy with variable presentation. First case was a 27-year-old female who presented with bleeding per vaginum following IUCD insertion in lactational amenorrhea period. She was diagnosed as a case of viable, unruptured, tubal ampullary ectopic pregnancy of 14 weeks gestational age with copper-T in situ. Second case presented with seven months amenorrhea with dead fetus and repeated failed attempts of induction of labour. Later on she was diagnosed as a case of 26 weeks unruptured ampullary ectopic pregnancy with a dead fetus.

Conclusion: Second trimester unruptured tubal pregnancy is rare among ectopic pregnancies. Ultrasonography is still the diagnostic modality of choice. The probability of ectopic pregnancy should be born in mind in cases of IUCD with spotting per vaginum and repeated failure of labour induction even at advanced gestational age.

Keywords: Ampullary, Ectopic pregnancy, IUCD, Intrauterine contraceptive device, Laparotomy, Ultrasonography

*********


*********

doi:10.5348/ijcri-2012-08-154-CS-1

INTRODUCTION

Ampulla is the commonest site for ectopic pregnancy [1]. Most of the tubal ectopic pregnancies rupture between 5–11 weeks of gestation [2]. Ectopic pregnancy is a leading cause of pregnancy-related death in early pregnancy [3]. However, in extremely rare conditions they may be carried upto an advanced gestational age and may be associated with diagnostic difficulty. We hereby report two cases of unruptured tubal ampullary ectopic pregnancies with variable presentations. In the first case, the woman presented with 14 weeks viable ampullary tubal pregnancy with IUCD in situ. The second case was a non-viable 26 weeks unruptured, ampullary ectopic pregnancy which was diagnosed during exploratory laparotomy, after repeated attempts of induction of labour.

CASE REPORT

Case 1: 27-year-old para 3+0 had copper-T insertion in lactational amenorrhea period approximately three months after giving birth to her third child. Approximately three weeks post insertion, she started experiencing bleeding per vaginum. She
interpreted this bleeding as resumption of her menses. However, when the spotting continued for three months, she consulted in our out patient department (OPD).

On examination pulse rate was 90 beats/minute, blood pressure was 110/70 mmHg with moderate pallor. On abdominal examination a 6x8 cm sized suprapubic mass, firm in consistency with restricted side to side mobility was present. A closed cervical os with CuT thread and slight bleeding coming through os was visible on per speculum examination. Bimanual examination revealed a slightly enlarged uterus with cervical motion tenderness with a lump of 8x10 cm palpable through right adnexa in continuation with abdominal mass.

Patient's hemoglobin was 8 g/dL, blood group was A positive, serum ß-HCG was 41,840 mIU/mL with normal liver and kidney function tests. Transabdominal sonography revealed an extrauterine gestational sac of 14 weeks 1 day with fetal heart rate of 180/min. Uterus was seen separate from the gestational sac on the left side, with minimal collection in the cavity with intrauterine contraceptive device in situ. Minimal fluid was present in the cul-de-sac.

Exploratory laparotomy revealed a right sided tubal ampullary lump of 10x12 cm with adherent right ovary, with no evidence of hemoperitoneum (Figure 1). Right sided salpingo-ophorectomy with left sided tubal ligation was done. Fetal movements were noted inside the sac. Cut section of tubal ampullary lump revealed a live fetus of about 14 weeks gestational age (Figure 2).

**Case 2:** A 25-year-old gravida 1, para 0 lady presented to our OPD with chief complaints of amenorrhea of seven months with absent fetal movements. Her previous menstrual history was normal, however, she was not sure about her last menstrual period. On general examination BP was 124/80 mmHg. Systemic examination was within normal limits.

Obstetrical examination revealed 26–28 weeks gravid uterus sized suprapubic lump, soft consistency, non-tender and external ballotment was absent. On auscultation fetal heart sounds could not be heard. On per vaginum examination, cervical os was closed, uterus seemed to be of normal size, deviated to left side and a separate mass was felt through the right adnexa which was of about 26–28 weeks size and soft in consistency. Her hemoglobin was 8.9 g/dL, blood group was B negative, liver function, kidney function and coagulation profile was within normal limits. Ultrasonography revealed single dead fetus corresponding to 26 weeks of gestational age but confirmation of exact location was not possible. A strong suspicion of pregnancy in one horn of bicornuate uterus was raised due to advanced gestational age of the fetus. Induction of labour was done with 100 µg of misoprostol four hourly up to a maximum doses of 2000 µg/m but it failed to initiate labor.

Exploratory laparotomy was done and per operatively uterus was found to be of normal size and right sided mass suggestive of unruptured, ampullary tubal ectopic pregnancy of about 20x16 cm size with prominent vessels, invading the broad ligament was present. Only a small fimbrial distal portion of the tube with adherent right ovary was visualized (Figure 3). Left side tube and ovary was normal (Figure 4). Right sided salpingo-ophorectomy was done. Cut section of specimen showed a dead fetus of around 700 g with fully developed placenta and decreased liquor (Figure 5). There was no evidence of hemoperitoneum.

**DISCUSSION**

Ectopic pregnancies account for 3–4% of pregnancy-related deaths. During 1999–2008, the ectopic pregnancy mortality rate in the United States was 0.6 deaths per 100,000 live births. The Centers for Disease
Control and Prevention reported a higher rate in Florida, 2.5 deaths per 100,000 live births during 2009–2010. The 11 ectopic pregnancy deaths in Florida during 2009-2010 contrast with a total of 14 deaths identified in national statistics for 2007 [4]. In the developing countries, hospital based studies have reported ectopic pregnancy case fatality rate of about 1–3% which is 10 times higher than that reported from developed countries [5]. After a 10-year population based study of 1800 cases concluded that only 4.5% ectopic pregnancies were extratubal ectopic pregnancies (ovarian and abdominal) and about 73% tubal pregnancies were ampullary [6]. Late diagnosis of ectopic pregnancy leads to major complications in almost all cases and needs emergency surgical intervention. However, in both the cases inspite of prolongation of ectopic pregnancy up to 14 weeks and 26 weeks of gestational age, the patients were hemodynamically stable. We have reported a rare case of viable tubal ampullary ectopic pregnancy of 14 weeks gestation with copper-T in situ. Another case was reported by Rujin et al. [7] in which a patient had large intact tubal pregnancy of 10 weeks gestation. As literature supports, IUCD used for contraception does not increase the risk of ectopic pregnancy [8]. In our case the patient presented with viable ectopic pregnancy of 14 weeks with IUCD in situ which is rare. Amenorrhea of 6–8 weeks with spotting and pain in abdomen is the hallmark of ectopic pregnancy [8]. One should not forget that if a woman with IUCD in situ presents to us in lactational amenorrhea period with spotting per vaginum, ectopic pregnancy should be ruled out because spotting is often considered side effect of IUCD by gynecologists.

In the second case, the diagnosis of ectopic pregnancy was difficult as patient presented to us at advanced gestational age. In the 1st trimester of pregnancy ultrasound examination is very reliable in diagnosing ectopic pregnancy [9]. In the 2nd trimester it is difficult to determine the exact location of pregnancy by ultrasonography [10]. Wabong et al. reported a case of 26-week ectopic pregnancy which was diagnosed as intrauterine pregnancy with dead fetus after several unsuccessful attempts of induction of labor. Finally they resorted to lapotomy which was diagnostic of ectopic pregnancy [11]. Similarly, in our case diagnosis was confirmed by lapotomy. It is difficult to do conservative surgery in such type of large ectopic pregnancy even if the patient has desire for future child bearing due to excessive deformation of fallopian tube, so in our case salpingo-oophorectomy was done. Hence, the authors recommend that the probability of ectopic pregnancy should be borne in mind in cases of repeated failures of labour induction even at advanced gestational age.

**CONCLUSION**

There has been a rise in the incidence of ectopic pregnancies since 1970s. Second trimester unruptured
tubal pregnancy is a rare ectopic pregnancy. Ultrasonography is still a diagnostic modality. Probability of ectopic pregnancy should be born in mind in cases of IUCD with spotting pervaginum and repeated failure of labour induction even at advanced gestational age.

*********

**Author Contributions**
Rekha Sachan – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published
Pooja Gupta – Substantial contributions to Drafting the article, Final approval of the version to be published
ML Patel – Substantial contributions to conception and design, Acquisition of data, Revising it critically for important intellectual content, Final approval of the version to be published

**Guarantor**
The corresponding author is the guarantor of submission.

**Conflict of Interest**
Authors declare no conflict of interest.

**Copyright**
© Rekha Sachan et al. 2012; This article is distributed under the terms of Creative Commons Attribution 3.0 License which permits unrestricted use, distribution and reproduction in any means provided the original authors and original publisher are properly credited. (Please see www.jcasereportsandimages.com /copyright-policy.php for more information.)

**REFERENCES**