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Case Study

Spontaneous bilateral tubal ectopic pregnancy: A Case Report

[1]Dr. Isha Snehal, [2]Dr. Swati Singh, [2]Dr. Alka Singh, [3]Dr. Ravinder Ahlawat

[1]MBBS, Department of Obs/Gynae, Lady hardinage Medical College, New Delhi
[2]MBBS, MS Obs/Gynae, Department of Obs/Gynae, Civil hospital, Gurugram
[3]MBBS, MHA, Department of Health, DGHS Panchkula

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ABSTRACT

Spontaneous bilateral tubal ectopic pregnancy is the rarest form of ectopic pregnancy. The reported incidence is only 1 in 2,00,000 pregnancies. We report a case of a 36 year old, gravida 3, para 2, live 2, presented with pain abdomen. Ruptured ectopic right side was detected on ultrasound. Laparotomy was done. Right side salpingectomy was done and on inspection during laparotomy a mass of 4×3 cm was found in left tube, with thinned out bulging point suggestive of near rupture. Therefore, left side salpingectomy was also done. Histopathological specimen also confirmed the diagnosis. So, we can conclude that thorough inspection of both tubes during laparotomy and/or laparoscopy is a simple measure to avoid missing this rare life threatening condition.

Keywords: *Bilateral ectopic pregnancy, Salpingectomy, Salpingostomy*

Address for Correspondence: Dr. Swati Singh, House no.- 46, Sector- 14, Rohtak- 124001, Haryana; India

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INTRODUCTION

Spontaneous bilateral tubal ectopic pregnancy is the rarest form of ectopic pregnancy. The first case of bilateral ectopic gestation was reported by Bledsoe in 1918.[1] The reported incidence is only 1 in 200,000 pregnancies.[2] The incidence, however is on increase especially with the use of artificial reproductive technology.[3] In rare cases, the diagnosis is confirmed before surgery. The clinical presentation may vary from incidental discovery to acute emergency. We report the unusual case of bilateral spontaneous ectopic pregnancy, discovered during emergency laparotomy.

CASE REPORT

A 36 year old $G_3P_2L_2$ presented to our hospital with chief complaints of pain abdomen since last three days and history of overdue by one week. Ultrasound was done. Ultrasound revealed cysts in bilateral ovaries with free fluid in pelvis. The size of cysts were 4.6 cm × 4.6 cm and 2.2 × 2.7 cm.

Right adnexa showed a cystic lesion with Gsac of CRL 1.02 cm corresponding to gestational age 7 weeks 1 day ± 1 weeks. Cardiac activity was visualized and UPT was positive. So, diagnosis of rupture right ectopic pregnancy was made. Emergency laparotomy was done. Intraoperatively, we found rupture ectopic on right side and during inspection of left side, there was another mass of about 4×3 cm in ampullary region with a thinned out bulging point suggestive of near rupture. Patient had completed her family and wanted sterilization. Therefore, salpingectomy was done. Specimen from both tubes was sent for histopathological examination, which later confirmed bilateral tubal ectopic pregnancy.

DISCUSSION

Bilateral tubal ectopic pregnancy is rare, occurring only in around 1 of 2,00,000 pregnancies. Higher incidence of bilateral tubal pregnancies has been seen after the use of Assisted Reproductive Techniques or following ovulation induction.[4] In absence of ART or ovulation induction, bilateral tubal ectopic pregnancy is the rarest form of extrauterine pregnancy.[5] In recent years, there has been increase in ectopic pregnancies due to increase in number of women undergoing assisted reproductive techniques. Various risk factors for ectopic pregnancy has been described in literature such as PID, use of ovulation induction drugs, tubal surgeries, ART etc. Approximately fifty percent of women with ectopic pregnancies do not have any risk factor.[6] In our patient, no risk factor was present.

The clinical presentation of ectopic pregnancy is same in both unilateral or bilateral ectopic pregnancy. Clinical symptoms and β-hCG cannot differentiate between unilateral and bilateral tubal ectopic pregnancies. Thus, it is difficult to diagnose bilateral tubal ectopic pregnancy before surgery.

As the diagnose of an ectopic pregnancy often rests on an absence of an intrauterine pregnancy rather than direct visualization of the ectopic itself, ultrasonography cannot relied upon to make the diagnosis of bilateral tubal ectopic pregnancy.[7] Therefore, pre operative diagnosis is uncommon indicating limitations of ultrasonography.[8] In our case, preoperative ultrasound failed to diagnose bilateral tubal pregnancy. The most common way of diagnosing the bilateral tubal ectopic pregnancy is the direct examination of both tubes during laparotomy or surgical laparoscopy. Usually the diagnosis is made intraoperatively, as in our case.

The management depends upon the condition of the patient, extent of tubal damage and the wish for future fertility. The management of tubal ectopic pregnancy can be medical or surgical. Medical management was contraindicated in our case because of the rupture of tube. Thus, surgical intervention was required. Surgery can be radical or conservative i.e. salpingectomy (removal of affected fallopian tube) or salpingectomy (preservation of affected tube). In our case, patient had completed her family and wanted sterilisation, so salpingectomy was done on both sides. The diagnosis of bilateral tubal ectopic pregnancy later on confirmed on histopathology.

Despite the rarity of bilateral extrauterine pregnancy, the case described here, undersores the importance of identifying and closely examining both tubes at laparoscopy or laparotomy.

CONCLUSION

Ectopic pregnancy is on increase especially with patients' undergoing assisted reproductive techniques. But spontaneous bilateral tubal pregnancy is extremely rare. Also, clinical presentation of bilateral tubal pregnancy is unpredictable. Ultrasound and β-hcg values cannot differentiate between unilateral or bilateral tubal ectopic pregnancy. Thus, the most common way of diagnosing bilateral ectopic pregnancy is the direct examination of both tubes during laparotomy or laparoscopy and confirming on histopathology specimen. So, we can conclude that thorough inspection of both tubes during laparotomy and/or laparoscopy is a simple measure to avoid missing this rare life threatening condition.

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