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Case Report

Missed tubal ectopic pregnancy in hysterectomised patient: a rare case report

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ABSTRACT

Tubal ectopic pregnancy (EP) in hysterectomised patient is uncommon. It has propensity to be overlooked. We report a rare case of missed tubal ectopic in 46 years old hysterectomised patient. She presented with abdominal pain and adnexal mass on imaging. Diagnosis was only possible intraoperatively owing to overlapping symptoms and imaging features with that of ovarian tumor.

Keywords: Post hysterectomy EP, Ovarian tumor, Vaginal hysterectomy

INTRODUCTION

Ectopic pregnancy [EP] after hysterectomy is rarity and is often not considered in the differential diagnosis of adnexal mass in hysterectomised patient. It possesses diagnostic challenge by its virtue of similar complaints as that of ovarian tumor i.e., pain in abdomen with or without pressure symptoms and do not have distinct imaging properties to differentiate it from other adnexal mass. It is a life-threatening condition and timely diagnosis is life saving for the woman. Post hysterectomy EP can be divided in to early or late. Early means the immediate postoperative, where viable sperms or embryo exists within fallopian tube, resulting in implantation. On other hand late means months or years after hysterectomy. A fistulous tract between vault and peritoneal cavity with prolapsed fallopian tube allows passage for sperm and explains possibility of EP.[1]

We report a rare case of late post hysterectomy EP and associated difficulties in reaching the diagnosis.

CASE REPORT

A 46 years old female with previous 3 live children, referred case to OPD with complaints of pain in abdomen for 1 week and an episode of urinary retention 4 days back. Pain was sudden in onset, more on left side, initially mild and gradually increased in severity. She denied any history of fever, contact bleeding, loss of appetite and weight. She already had ultrasonography (USG) which revealed a large irregular, heterogenous hypoechoic mass in right adnexa measuring 8×5.3 cm. lying proximal to bladder area with bulky right ovary adjacent to mass while left ovary and uterus was absent (Figure 1). Possibility of ovarian tumor or haemorrhagic corpus luteal cyst was kept. She had history of non-descent vaginal hysterectomy 2 years back for abnormal uterine bleeding (AUB). However, she did not have any records available of past surgery. General examination was normal and on per speculum, vault was healthy without any visible growth or defect. On bimanual examination tender, irregular mass was felt in pelvis at the vault.

Blood evaluation revealed her haemoglobin (Hb) as 10.4 gm% and other biochemistry was normal. Tumor markers were normal viz CA 125=23 IU/ml, CEA=1.86 ng/ml, LDH=507 IU/ml and alpha-fetoprotein=7.84. ng/ml. Chest x-ray was normal while contrast enhanced computed tomography (CECT) of abdomen and pelvis done outside revealed poorly defined adnexal mass approx.~ 7.8×7.1×7.0 cm size. It was mixed density extending into

both adnexa, closely abutting posterior of bladder and anterior of rectum. Fat planes poorly defined with respect to bladder (Figure 2). Uterus was absent and ovaries were not seen separately from mass with minimal fluid in left iliac fossa. She required exploratory laparotomy for acute abdomen.

Intraoperatively, hemoperitoneum was evident with 400 cc of organised clots in pelvis. Right side tubo-ovarian mass ~4×5 cm was identified. It was surrounded by clots lying posterior to bladder. Tube was oedematous and enlarged too. Hance, looking at per op findings urine pregnancy test was done and it was positive. Right salpingo-opherectomy was performed with peritoneal lavage. Left ovary and tube not seen (possibly been removed with hysterectomy). Serum beta HCG was 3695 mIU/ml. Postoperatively patient had pulmonary thromboembolism on day 2 for which she was managed with Heparin under ICU setting. She was discharged after 7 days in satisfactory condition. Final histopathology confirmed EP in remnent tube.

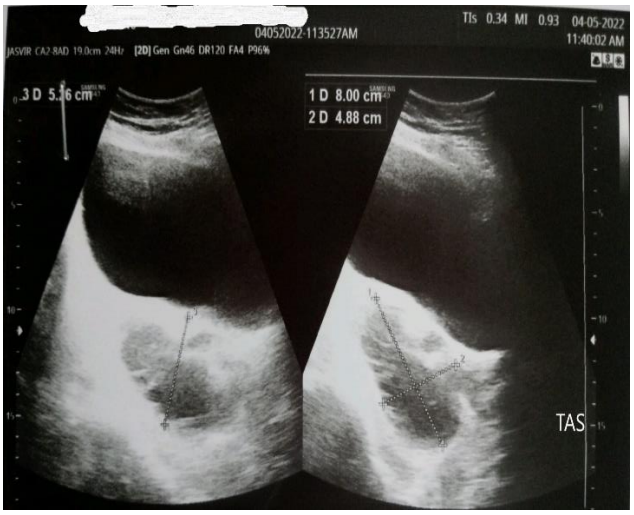

Figure 1: Trans abdominal view of adnexal mass.

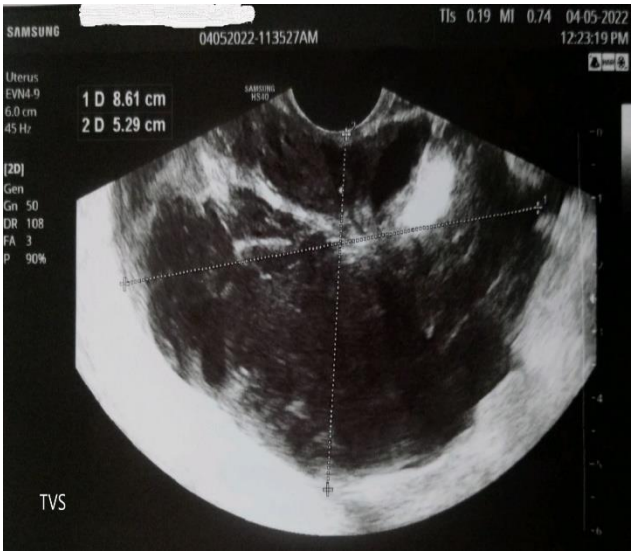

Figure 2: Transvaginal view of adnexal mass.

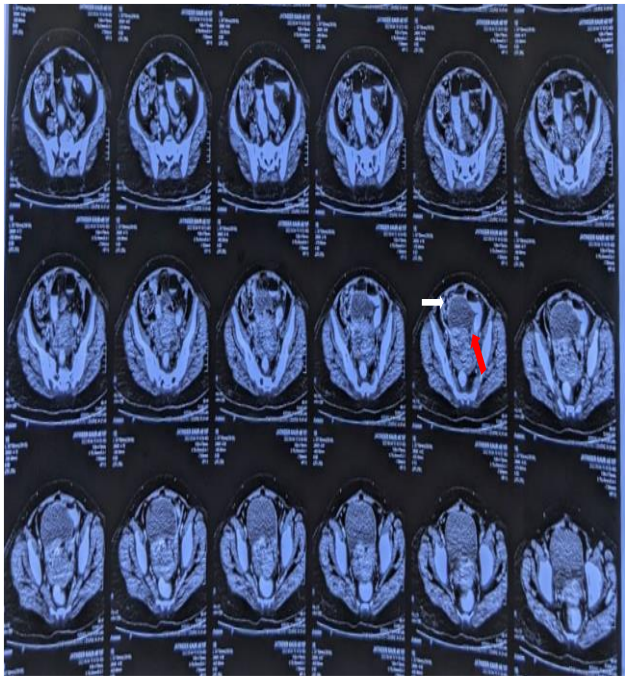

Figure 3: CECT showing adnexal mass (red arrow) abutting posterior of bladder (white arrow).

DISCUSSION

EP accounts for 2% of all pregnancies, However, post hysterectomy EP is rare. Evidence suggests that there can be early or late presentation depending upon the timing between surgery and presentation of EP.

Early presentation can be due to existing viable sperms in tube which fertilizes ovum or gestational sac trapped in the fallopian tube at the time of hysterectomy. The usual presenting symptoms of EP like pelvic pain and mass has very high chances of being overlooked in post operative period. The diagnosis will need additional imaging or only possible during repeat surgery.[1,2]

EP has been reported to occur as late as 12 years after hysterectomy, "late presentation". It is common after vaginal hysterectomy (VH).[1] In surgical closure of vault during VH, the risk of adnexal structure being bundled up with vault is high. Again, there are high chances of fallopian tube prolapse into vaginal cuff during VH. These will favour fistulous tract formation though vault.[3] Shao et al reported VH as antecedent event in 50% cases.[2] Our patient also had non-decent VH. In abdominal hysterectomy, the subtotal variety has higher reported incidence of post hysterectomy EP as compared to total as the cervix may provide a conduit for the sperm.

Our patient had late presentation approximately after 2 years of non-decent VH. The main symptoms were abdominal pain, an episode of urinary retention with presence of adnexal mass. which can be possible with ovarian tumor (benign or malignant) causing compression. In a metanalysis, Shao et al also concluded that 93% of

women have pain in abdomen. They also described that most of them were investigated with USG with nonconclusive report.[2] Similarly, our patient had USG suggesting presence of "heterogenous mass". It does not have specific features of pregnancy. i. e., presence of cardiac activity or presence of sac with or without node.

Again, our patient had tenderness with bimanual examination that was believed to be due to ovarian tumor or tubo-ovarian mass due to infection. So, the nature of complaints and old age were pointing towards ovarian pathology.

The overlapping symptomatology and imaging features delayed diagnosis of ectopic. Urine pregnancy test was also delayed till intra operative period because ectopic was least under consideration owing to history of hysterectomy. However, early surgical intervention was possible prior to destabilisation of patient due to persistent pain.

CONCLUSION

EP after hysterectomy is rare, often missed. The bilateral salpingectomy can be recommended as standard of care whenever hysterectomy is been done in reproductive age group. This will prevent such life-threatening accidents with propensity to be overlooked.

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Ethical approval: Not required

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