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Case Report

An unusual case of chronic ectopic pregnancy

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ABSTRACT

Thirty-seven years old P3A1L3 patient presented to our outpatient department with pain abdomen for 20 days. Thirty-five days back she had taken MTP kit and then after one week, D&C was done at a primary care centre, presuming incomplete abortion. After this, she developed abdominal distension and couldn't pass motions. Then she went to some other health care centre and few investigations were done, there. USG showed bulky, excessively enlarged uterus with echogenic material in endometrium, Molar pregnancy, Endometrial mass, Left sided grade 2 hydronephrosis. After exploratory laparotomy, left sided salpingectomy was done. Histopathology report was consistent with ectopic pregnancy.

Keywords: Chronic ectopic pregnancy, Ectopic pregnancy, Medical termination of pregnancy kit

INTRODUCTION

Chronic ectopic pregnancy (CEP) is a variant of ectopic pregnancy (EP) characterized by low or absent serum human chorionic gonadotropin (hCG) levels, resistance to methotrexate (MTX), and an adnexal mass with fibrosis, necrosis, and blood clots due to repeated and gradual fallopian tube wall disintegration. CEP may complicate the course of patients with EP and is difficult to diagnose.[1] Chronic ectopic pregnancy (CEP) is a potentially life-threatening condition that is diagnostically challenging. Clinical presentations are varied.[2] Chronic pregnancy is a variant of ectopic pregnancy presenting as chronic lower abdominal pain, menstrual irregularity and pelvic mass. Often, chronic ectopic may pose diagnostic conundrum due to unusual presentations. Culminating point is to keep ectopic pregnancy as differential in all reproductive age group women presenting with pain in abdomen regardless of other symptom particularly with pelvic mass.[3] These days taking MTP kit for termination of pregnancy has become very common. Sometimes patients take medicines, on their own or at the advice of some chemist. It is very dangerous. Many a times they even undergo dilatation & curettage without confirmation of the site of pregnancy, if there is any. When complications arise, it becomes difficult to deal with especially when the patient is having an ectopic pregnancy.

CASE REPORT

Thirty-seven years old P3A1L3 patient presented to our outpatient department with pain abdomen for 20 days. Thirty-five days back she had taken MTP kit and then after one week, D&C was done at a primary care centre, presuming incomplete abortion. After this, she developed abdominal distension and couldn't pass motions. Then she went to some other health care centre and few investigations were done, there. USG showed bulky, excessively enlarged uterus with echogenic material in endometrium, molar pregnancy, endometrial mass, left sided grade 2 hydronephrosis. Her serum beta HCG was 15,943 miu/ml. With these reports she came to the OPD.

On examination, her general appearance was not satisfactory. Her pulse rate was 78/min, respiratory rate-20/min, blood pressure 110/80 mmHg, was afebrile and had pallor of severe degree.

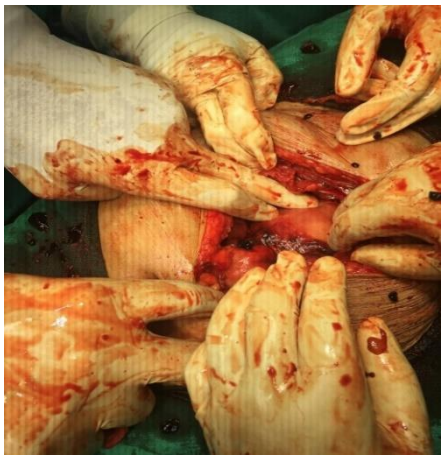

Figure 1: Opening the peritoneal cavity.

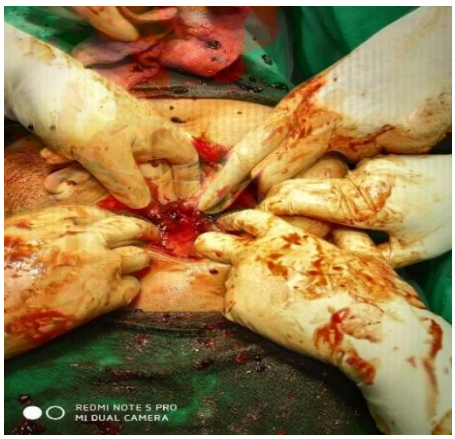

Figure 2: Inside the peritoneal cavity.

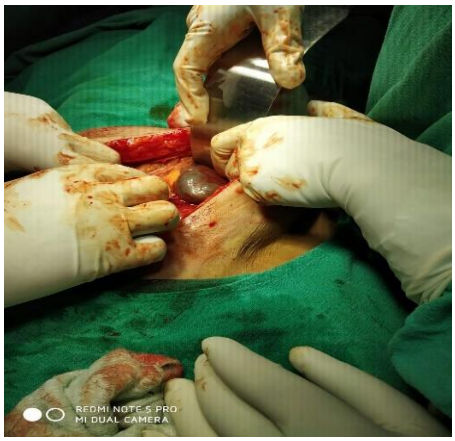

Figure 3: Fallopian tube looking like bowel loop.

On per abdominal examination-a firm mass 20-22 weeks of pregnant uterus size, firm to hard in consistency, well circumscribed, fixed and not mobile was felt. Bowel sounds were present. There was no organomegaly. On per vaginum examination-uterus was nontender, could be felt anteriorly separate from the mass.

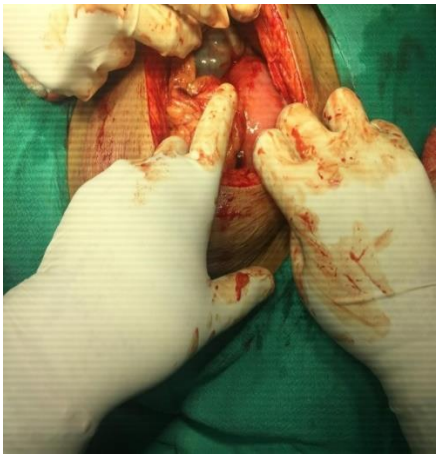

Figure 4: Bowel like structure.

Figure 5: Huge amount of blood clots.

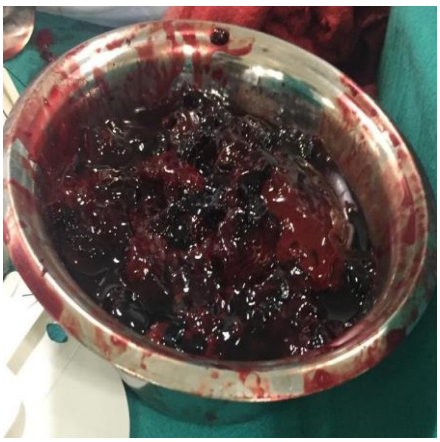

Figure 6: Removed blood clots.

There was fullness in the posterior fornix. There was no bleeding. At our place we sent her investigations, significant reports were; Hb-5.7 gm%, WBC-16,600/cmm,

Platelet count was very high (7.01 lakhs/microliter of blood), Liver enzymes-SGOT 41 U/l, SGOT-39 U/l, ALP-282 U/l. USG showed a mixed echogenic mass predominantly solid (more than14.3x12.0x12.2 cm and volume 1090 cc) in the uterine cavity. H. mole, endometrial mass, left renal hydronephrosis, CT was advised. CT abdomen showed mild hepatomegaly. Mild bulky uterus with dilated endometrial cavity containing fluid. Large ill-defined enhancing mass measuring 15x12x10 cms in pelvis predominance on left side arising from left adnexal region with mass effect in the form of compression and displacement of adjacent bowel and mesentery with compression upon left lower ureter with mild left sided hydroureteronephrosis-left sided tubo-ovarian mass. Level of CA-125 was normal. Next day, sample for Serum beta HCG level was sent, the report was 10,000 miu/ml. Measures to build up her general condition were taken, symptomatic and supportive t/t was given. One unit of blood was transfused. After one week of admission, exploratory laparotomy was done under spinal anaesthesia with two units of blood at hand. Significant operative findings were, a well-organized mass, posterior to the uterus, on left side, was present. The mass was adherent to loops of bowel anteriorly and pouch of Douglas posteriorly. Tube and ovary of right side could not be visualized. Uterus could not be mobilized; it was down below in the pelvis. On the right side of the mass, a bowel loop like structure was present ,which was bluish in colour. Blunt dissection was done to separate the bowel like loop which came out to be the left tube, behind which the left ovary was present. Somehow, pouch of Douglas could be entered, chocolate coloured huge blood clot, (around one and half kg) was there, which was removed bit by bit. The left sided necrosed dilated tube was removed. The cavity was irrigated and a drain was put. Her postoperative period was uneventful except a few episodes of fever, for which she received proper t/t.

Histopathology report

Histomorphology was consistent with ectopic pregnancy.

DISCUSSION

The clinical features of CEP are similar to those of acute ectopic pregnancy, with amenorrhoea, abdominal pain and abnormal vaginal bleeding being common. Nevertheless, its clinical presentation is generally mild, and symptoms are subtle.[4] One differing feature is the recurrent presence of a pelvic mass on examination or gynaecological ultrasound. In addition, duration of symptoms is often longer in CEP, with more remote onset of pain in general and longer amenorrhoea.[5] In our case, the patient presented with acute abdominal pain and 3 weeks of vaginal bleeding. CEPs may persist without rupture; long enough for the trophoblast to degenerate, cease production of bhCG, detectable only with very sensitive bhCG assays.[6] Tempfer et al did Systematic literature review. The most common presenting symptom was abdominal pain (284/399-71%), followed by irregular vaginal bleeding (219/399-55%), and fever (20/399-5%). 73/399 (18%) women were asymptomatic. An adnexal mass was seen in 144/298 (48%) cases with perioperative ultrasound examination and with a mean largest diameter of 6.8 cm. According to available data,89% underwent surgery as first-line therapy. Their conclusion was that CEP is a variant of EP with low or absent trophoblast activity. A prolonged clinical course is typical and surgery is the mainstay of treatment. Drakopoulos, et al reported that the patient presented with acute abdominal pain and 3 weeks of vaginal bleeding, The most reliable differentiating feature seems to be the operative findings of haematosalpinx and adhesion formation, incorporating uterus, bowel and the surrounding organs. The final diagnosis is histopathological.[7] As CEP can potentially rupture the tube, it represents a life-threatening condition which mandates timely diagnosis.[3] Shivhare et al presented an unusual case of chronic ectopic with negative urine pregnancy test, who presented with pain in right hypochondrium. The patient had bilateral adnexal mass with omental deposit on imaging masquerading adnexal malignancy, leading to decision for surgical management. Brennan et al presented the cases of two women with chronic ectopic pregnancies who presented with acute tubal rupture and hemoperitoneum despite negative beta-human chorionic gonadotropin (beta hCG) pregnancy tests. Porpora MG et al reported unsuspected chronic ectopic pregnancy in a patient with chronic pelvic pain.

Ugur et al did a clinical analysis of 62 cases of chronic ectopic pregnancy and reported that Chronic ectopic pregnancy is a form of tubal pregnancy in which salient minor ruptures or abortions of an ectopic pregnancy instead of a single episode of bleeding, incites an inflammatory response often leading to the formation of a pelvic mass. Its clinical features are often confusing, and laboratory evaluations are often misleading. Surgery for chronic ectopic pregnancy is frequently difficult since chronic inflammatory changes and adhesions distort the normal anatomy. In their retrospective study, its incidence was found to be 20.3%. A pelvic mass of varying sonographic appearance, mostly with a non-homogenous echo pattern, was demonstrated in all the patients in whom transvaginal sonographic evaluation was performed preoperatively. Although most of the patients had a positive serum beta HCG value, Laparotomy resulted in salpingectomy, salpingo-oophorectomies or total abdominal hysterectomies with salpingo-oophorectomy. They concluded that chronic ectopic pregnancy is not rare although little is mentioned about it as a clinical entity in the gynaecological literature. Bedi et al compared chronic ectopic pregnancy with acute ectopic pregnancy and reported that an ectopic tubal pregnancy that undergoes repeated minor ruptures instead of a single episode of rapid bleeding frequently develops into a pelvic hematocele. The hematocele, which contains old blood, clots and gestational tissue, is surrounded by adhesions and is misleadingly called a "chronic" ectopic pregnancy. The term "chronic" describes only the appearance of the pelvic mass and does not necessarily imply chronicity of

duration. Fifty percent of their patients with chronic ectopic pregnancy had a negative serum beta human chorionic gonadotrophin (HCG). This entity has a sonographic appearance distinctly different from acute ectopic pregnancy. In our case the history was very much distorted. Investigation reports were such that decision for exploratory laparotomy was taken, pouch of Douglas was evacuated of huge blood collection and left sided salpingectomy was done carefully. Histopathology report was consistent with ectopic pregnancy.

CONCLUSION

Proper history taking is a must and so is proper work up. There were many things in this case-unsupervised termination of pregnancy by MTP kit, then D & C at some hospital without ascertaining its need. Further complications occurred after the procedure; she might have suffered perforation on left postero lateral wall of the uterus. As she had severe pain abdomen with vomiting and was unable to pass motion and urine, she visited some other hospital. The very next day of discharge from there, she came to our institution. Had she taken proper medical advice, this whole episode would not have happened. Moreover, her ectopic pregnancy would have been diagnosed in time.

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