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Case Series

Non tubal ectopic pregnancy: challenges in diagnosis and management

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ABSTRACT

Nontubal ectopic pregnancies (NTEP) are pregnancies that implant at sites other than the fallopian tube. Their overall incidence has been rising in recent years. NTEPs can occur at various sites such as in the cervix, ovary, abdomen, uterine cornua, interstitial part of tube, myometrium or caesarean scars. Absence of typical risk factors or tubal pathology makes the diagnosis and management of these NTEPs particularly challenging. Regardless of the location, early detection is critical for successful conservative treatment, improving outcomes and averting catastrophic complications in NTEP. This case series includes ten cases of NTEPs with unique locations and presentations. Four of them were caesarean scar pregnancies and two each of interstitial and cervical pregnancies. We also had two rarest types of NTEPs, one with intramyometrial pregnancy and the other with tubal stump ectopic pregnancy after salpingectomy done for ruptured tubal ectopic on the same side. The management of NTEPs encompasses medical treatment with methotrexate or surgical methods, most of them being uterus conserving and very rarely hysterectomy. The treatment in each case in our series was tailored according to the clinical presentation and need for conservation of future fertility. The outcome in all our cases was good in spite of difficulties faced in the diagnosis and decision for selection of the most appropriate modality of treatment. This case series emphasizes the fact that in spite of availability of advanced radiological aids, NTEPs can sometimes be difficult to diagnose. Hence a high degree of suspicion and proper counselling of the patients is needed to approach them judiciously so as to avoid severe complications.

Keywords: Non tubal ectopic pregnancy, Cervical pregnancy, Interstitial pregnancy, Caesarean scar ectopic, Intra myometrial pregnancy, Tubal stump ectopic

INTRODUCTION

An ectopic pregnancy (EP) refers to the implantation of an embryo outside of the uterus. In the general population, the overall incidence of EP is 1–2 % and rises to 2–5% among infertility patients who undergo assisted reproductive technology.[1] Ectopic pregnancy if not diagnosed and managed timely can be a potentially life-threatening condition resulting in 2.7% of pregnancy-related deaths.[2] The commonest site of EP is the fallopian tube accounting to almost 95% of cases and is commonly linked to underlying fallopian tube abnormalities.[3] Nontubal EPs (NTEP) are pregnancies that implant at sites other than the fallopian tube. These pregnancies account for 5-8.3% of all EPs, though their overall incidence has been increasing in recent years.[3] Although rare, NTEPs can occur at various sites such as in the cervix, ovary, abdomen, uterine cornua, interstitial part of tube, myometrium or caesarean scars. Rare cases of implantation sites in omental, retroperitoneal, splenic, and hepatic locations have also been reported. Absence of typical risk factors or tubal pathology makes the diagnosis and management of these NTEPs particularly challenging. Regardless of the location, early detection is critical for conservative treatment and improving outcomes in NTEP. In our case series, we have included varied cases of NTEPs managed at our hospital, also highlighting different modalities of treatment for the same diagnosis. Most of the cases were

referred to our hospital after primary management outside. We had two cases of interstitial pregnancy, one managed conservatively with methotrexate (MTX) and the other surgically. We added these cases because interstitial pregnancies pose a similar challenge in diagnosis and management as other NTEPs. Two patients with cervical pregnancy were successfully managed with suction evacuation (S/E), though one of them proved to be a near miss case. We also had the chance of managing a myometrial pregnancy, rarest and most perplexing of all NTEPs. The number of cases of caesarean scar pregnancy (CSP) referred to our hospital has risen rapidly over the last few years. We selected a few of them to elucidate the dilemma in selection of treatment modality best suited for the particular patient. The most interesting and challenging among them was a case of scar ectopic with hyper vascular retained products of conception (RPOCs). A rare case of tubal stump ectopic after salpingectomy for ruptured ectopic is also included in our case series.

This case series emphasizes the fact that in spite of availability of advanced radiological aids, NTEPs can sometimes be difficult to diagnose. Hence a high degree of suspicion is needed to approach them judiciously so as to avoid severe complications.

CASE SERIES

Case 1: interstitial pregnancy- medically managed

A 23 years old patient, G3P2L2, married for 4 years, presented with amenorrhoea for 2 months, bleeding per vaginum (BPV) for 8 days and pain in abdomen for 3 days. The bleeding was profuse with passage of clots. Her UPT at home was positive. She had two children with the last child birth 1 year back and she was lactating. Her general and systemic examination was insignificant except mild tachycardia. Abdomen was soft and non- tender on palpation.

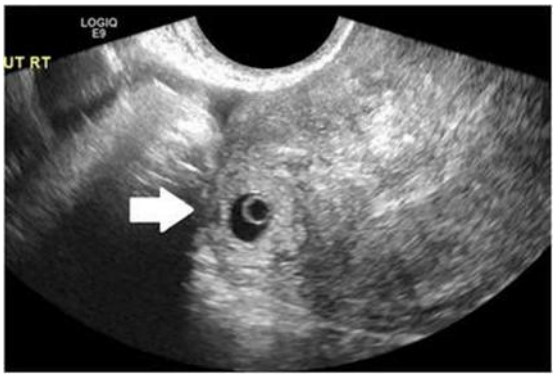

Figure 1: Ultrasound image of interstitial pregnancy at right cornu.

Her per vaginal examination revealed a 6- 8 weeks uterus with bilateral fornices non tender. Ultrasonography (USG) showed interstitial gestational sac at right cornu with a fetal pole of 6.1 weeks with absent cardiac activity and there was no haemoperitoneum (Figure 1). Her serum beta human chorionic gonadotrophin (β-hCG) levels on admission were 5153mIU/ml. We opted for medical management with MTX as the patient was haemodynamically stable and fulfilled the criteria for the same. She received MTX 1 mg/kg body weight on days 1,3, 5 and 7 along with Inj. Leucovorin on days 2,4, 6 and 8. β-hCG levels were done before each dose of MTX.

The values noted were 2523, 525 and 159 on days 3, 5 and 7 which showed a steady decline and positive response to medical treatment. Breast feeding was suspended for 2 weeks on MTX treatment. The patient was discharged on 10th day and advised to follow up weekly. β-hCG values on day 15 were 34 and by 22nd day of MTX they became insignificant. Concurrent transvaginal scan done on day 15 showed a crumpled gestational sac in right cornua of 2x2 cm which reduced to a small indiscernible cystic structure of size 0.8x 0.5 cm on 22nd day.

Case 2: interstitial pregnancy- exploratory laparotomy with excision

A 30 years old patient, G4P2L1A1 on routine USG was diagnosed to have interstitial pregnancy and was referred to our hospital. She had no complaints and was haemodynamically stable on admission.

Figure 2: Interstitial pregnancy.

Her USG suggested an empty uterine cavity with a gestational sac of 7.1 weeks with a live foetus located on the right cornu of the uterus. The myometrial layer surrounding the sac was very thin, 2 mm. The features were suggestive of interstitial pregnancy. Her preoperative profile was normal and β-hCG was 21461.

The patient was posted for exploratory laparotomy as there was risk of rupture of ectopic due to myometrial thinning. Intraoperatively, right cornual region was found to be ballooned up to size 4x3 cm due to the gestational sac covered with a thin serosa. (Figure 2).

Left adnexa were normal. Injection vasopressin was infiltrated and incision was taken on the bulge. The POCs were removed completely and the uterus was repaired in layers. β-hCG on day 3 of surgery was 1461 and

histopathology report (HPR) was suggestive of choriodecidual tissue.

Case 3: cervical pregnancy- suction evacuation

A 32 years old patient, G4P2L2A1 with previous two normal deliveries presented with 7 weeks of gestation with complaints of profuse bleeding PV with clots for 3 days. Her USG done outside was suggestive of bulky uterus with an empty endometrial cavity and an hour glass appearance due to dilated cervical canal consisting of a gestational sac of 6.3 weeks with absent fetal pole (Figure 3). On admission, the patient had severe pallor, tachycardia and BP of 100/60. Her preoperative profile was done which showed Hb level of 5.45 gm%. Rest investigations were normal. As she had profuse bleeding, she was transfused one unit of packed cells and was posted for emergency S/E. The POCs were present completely in the cervical canal, removed by suction followed by gentle curettage. The procedure was uneventful. Her anaemia correction was done with packed cell transfusions and she was discharged home on day 6 of S/E. The USG repeated after 6 weeks showed normal uterus and completely involuted cervix with no evidence of POCs. The patient underwent laparoscopic tubal ligation.

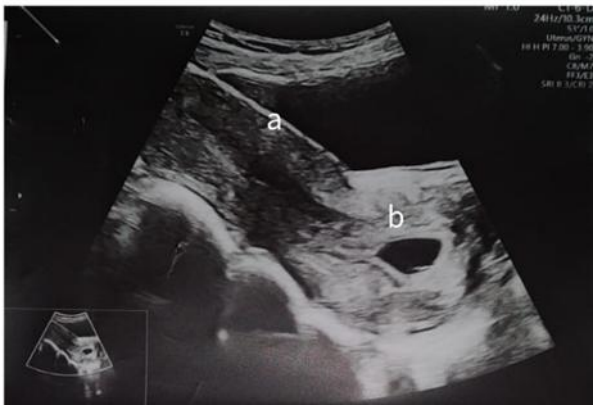

Figure 3: Ultrasound image showing (A) hour glass appearance with empty uterine cavity and (B) distended cervix.

Case 4: advanced cervical pregnancy- suction evacuation with haemorrhage

A 26 years old patient, G2P1L1 with previous LSCS presented with 3 months of amenorrhoea with continuous BPV for 15 days after consuming medical abortion pills over the counter without any prior USG. She did not give any history of passage of RPOCs. She had one child born by LSCS 11 months back. On examination, she had a 12-14 weeks uterus, cervix was ballooned up and external os was tightly closed. The uterus appeared to be perching on top of a distended cervix. Her pre operative profile was normal. USG revealed a live pregnancy of 12.6 weeks with presence of fetal movements in the cervical region with thin non decidualized endometrium suggestive of cervical pregnancy (Figure 4). After written informed consent and arranging adequate blood, she was posted for USG guided S/E. After removal of fetal parts and placenta, cervical cavity did not collapse and there was profuse bleeding during the procedure. She required 3 units of PCV and colloids to correct her hypotension. Foley's catheter balloon tamponade and vaginal packing was done to achieve haemostasis, which were removed after 36 hours. There was no active BPV in post operative period. She was discharged on day 4 of S/E. She came 3 weeks after evacuation for follow up with complaints of intermittent minimal BPV.

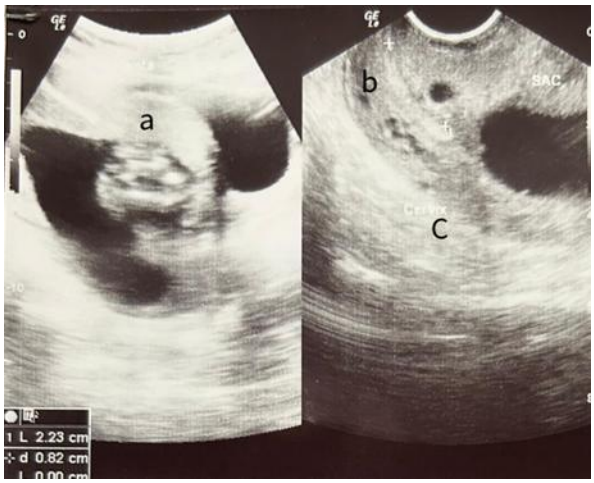

Figure 4: (A) Large cervical pregnancy; (B) empty uterine cavity; and (C) and cervix.

Her Hb was 8.8gm% and β-hCG 467.70. USG showed a heterogeneous lesion in the cervical region measuring 7.2×6.5 cm suggestive of RPOCs. A single dose of MTX 1 mg/kg body weight was given.

As β-hCG value was declining, decision to wait for autolysis of products was taken. The patient lost to follow up after that and reported after 2 months. She gave history of BPV on and off for 6 weeks after S/E following which she had resumption of regular menses with no intermenstrual bleed. β-hCG was < 2 mIU and USG pelvis revealed a normal uterus with a heterogeneous area in anterior lip of cervix measuring 6.7×4.3 cm, showing minimal vascularity within, possibly retained placental tissue. This lesion reduced to 3.8×3.6 cm in USG repeated 7 months post S/E. Though patient was asymptomatic, the resolution of cervical lesion was quite delayed in this case. The patient had an uneventful pregnancy 2 years after this cervical pregnancy.

Case 5: intramural/ intramyometrial pregnancy

A 32 years old patient, G2P1L1, married for 6 years, came with 2 months of amenorrhoea with pain in lower abdomen and spotting PV for 2 days. She had a child of age 4 years born by LSCS. Her cycles were regular and her gestation was 6.6 weeks. Her USG showed a bulky uterus with irregular crenulated sac without any fetal pole suggestive

of blighted ovum. She underwent S/E for the same at a private hospital, but no products of conception were retrieved during the procedure. Hence, she was referred to our hospital.

On admission, she was haemodynamically stable. Her vaginal examination revealed 6-8 weeks uterus with a slight bulge on the left posterolateral side and no typical cervical motion tenderness. Her USG showed an irregular sac measuring 5.5×4.5 cm placed eccentrically in the myometrium separate from endometrial cavity and fallopian tubes.

The uterine cavity was empty and endometrial thickness was 6 mm. Serum β-hCG was 1368 on admission, and 1760 and 1768 repeated on alternate days. The patient was posted for USG guided S/E SOS exploratory laparotomy after taking a written well-informed consent and arranging adequate blood. Under spinal anaesthesia, S/E was tried under USG guidance, but failed to retrieve any products. Laparotomy was performed and in situ findings were in adherence with the USG findings with only a slight bulge on the posterior surface of uterus near left cornu, bilateral adnexa were normal, previous LSCS scar was intact and no haemoperitoneum noted.

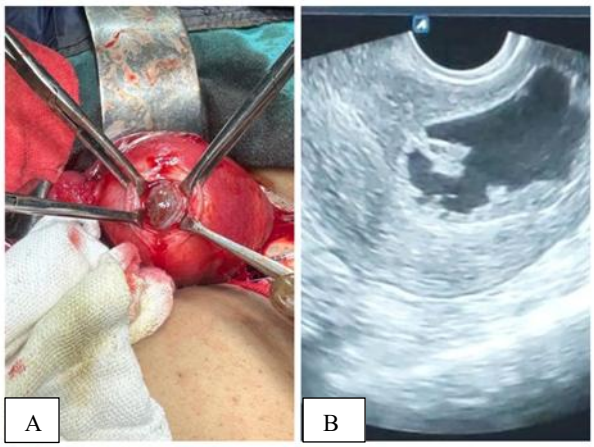

Figure 5 (A and B): Intra op picture showing sac implanted in myometrium and USG image of fundus with sac.

Following the principles of myomectomy for minimising blood loss, tourniquets were applied to the isthmus and bilateral in fundibulopelvic ligaments and injection Vasopressin was injected at the site of planned incision on the bulge. A 3 cm vertical incision was taken and the sac was enucleated intact. To confirm the location and intactness of the endometrial cavity, Hegar's dilator was passed through the cervix.

Approximately 8 mm of myometrial thickness was confirmed between the endometrial and myometrial cavity. The myometrial cavity was closed in layers. Haemostasis was confirmed after releasing the tourniquets. Post op recovery of patient was uneventful. She was discharged on day 8. Serum β-hCG levels done on day 2, 7,14 and 21 were 338,109,25 and 10 respectively. HPR confirmed trophoblastic tissue invading myometrial tissue suggestive of myometrial pregnancy.

Case 6: caesarean scar pregnancy (CSP)- subtotal abdominal hysterectomy

A 27-year-old, G3P2L2 with two previous LSCS underwent S/E for 13.5 weeks amenorrhoea with incomplete abortion at a private hospital. The patient had profuse bleeding during the procedure and intraoperatively 1-unit PCV was transfused. She was referred to our centre for continuous BPV after the procedure. On admission she had pallor and tachycardia. Per vaginal examination revealed 8-10 weeks uterus with minimal bleeding. β-hCG was 1172 and USG showed 6.4×4.7×3.5 cm mixed echogenic lesion in anterior lower uterine segment of uterus with peripheral vascularity with bulging scar suggestive of residual tissue in CSP.

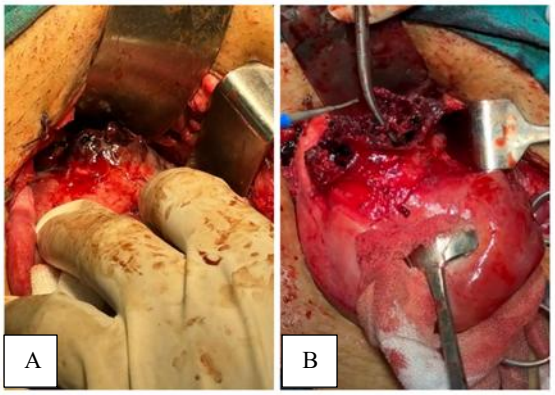

Figure 6 (A and B): Thinned out serosa, scar dehiscence and large blood clot in a CSP.

The patient was posted for exploratory laparotomy after anaemia correction. Intraoperatively isthmus was found to be ballooned up to a size of 7×6×5 cm and bladder was densely adherent to the LUS. Serosa was thinned out with a large blood clot at the scar site (Figure 6). Due to dense adhesions, the bladder was advanced and ureters were close to the mass. Uterine scar repair would have caused profuse bleeding and also bladder or ureteric injury was anticipated. Hence subtotal hysterectomy was done and the patient was discharged on 8th post operative day. Histopathology study revealed placenta previa with placenta accreta and placental tissue contained degenerated villi.

Case 7: caesarean scar pregnancy- hysteroscopy and USG guided S/E

A 28 years old patient, G2P1L1 with previous LSCS was referred to our hospital with diagnosed CSP for management. She had a history of secondary infertility and had conceived after ovulation induction. She did not have any complaints of pain in abdomen or bleeding PV. Her

USG report done outside revealed a gestational sac of 6 weeks pregnancy in lower uterine cavity near the scar. (Figure 7). The sac was above the endometrial line but not protruding out towards uterine serosa. Preoperative β-hCG value was 2441. As the scar ectopic pregnancy in this case was COS 2+ according to cross over sign (COS) criteria, a decision of hysteroscopic evacuation was taken. The hysteroscope was introduced and sac was found to be protruding into the uterine cavity. The scope was removed and S/E was done under USG guidance. On post operative day 2 her USG was repeated which showed a heterogeneous mass of size 2.8×2.4 cm at the site of the scar with no vascularity noted, most likely an organized blood clot. Post operative β-hCG was 406.5. She was discharged and followed up regularly in OPD.

Figure 7: Ultrasound image of an endogenic CSP.

Case 8: caesarean scar pregnancy- hyper vascular RPOCS

A 24-year-old, G2P1L1 with previous LSCS done 2 years back presented with a history of 3 months of amenorrhea with PV spotting for 1 day. USG done outside was suggestive of a single live intrauterine foetus of 10 weeks in the lower segment of uterus, just above the internal os. Considering the diagnosis of inevitable abortion, the patient was taken for S and E. She had profuse bleeding during the procedure. Foley's catheter was placed intracervically and inflated up to 50 cc to control the bleeding. She was transfused 1 unit of PCV and referred to our hospital with intracervical Foleys in situ with a probable diagnosis of arteriovenous malformation. On admission, she was vitally stable and there was minimal BPV.

The balloon was deflated after 24 h and USG was done which showed a normal sized uterus and a round to oval heterogeneous hyperechoic mass seen in the region of LUS and cervix measuring 6.9×6.1×4.8 cm. Doppler showed many branching vessels at the periphery of mass and encroaching within showing both venous and low flow arterial spectrum (Figure 8 A). Bilateral uterine arteries appeared to be feeding vessels as branches were seen arising from it, features suggestive of RPOCs with AV malformation developed at the site of scar ectopic pregnancy. However, MRI suggested post S/E uterine scar dehiscence with haematoma formation with excess vascularity. Her β-hCG levels were 14000, 8000 and 1000 on day 5, 8 and 15 after S/E respectively. After reviewing all clinical, radiological and laboratory findings, a decision of conservative management was taken expecting spontaneous autolysis of RPOCs and then repair of abdominal scar dehiscence. However, in spite of falling β-hCG levels, resolution of the mass and its hypervascularity was not observed even over a 4-week period. The patient continued to have irregular BPV.

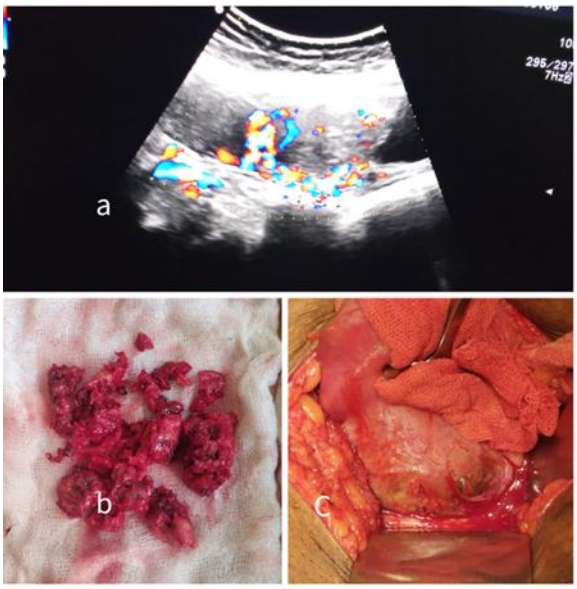

Figure 8: (A) USG image showing ring of fire appearance of hyper vascular RPOCS in CSP, (B) friable POCS removed intraop and (C) ballooned up isthmus with thin serosa.

Hence decision for exploratory laparotomy with evacuation of haematoma and repair of scar dehiscence was taken. Intraoperatively hematoma was seen over isthmic and upper cervical region of size 7 cmx8 cm with only a thin fold of peritoneum covering it (Figure 8 C). The bladder was densely adherent to the mass. After separating the bladder, a small nick was given over the lesion and friable tissue was removed piecemeal (Figure 8 B). Due to the hypervascularity of RPOCs, profuse bleeding ensued which warranted bilateral internal iliac ligation (IIAL). The uterine edges were defined after achieving haemostasis and uterus was sutured in two layers. Estimated blood loss was approximately 2 litres. 3 units of PCV were transfused intraoperatively. The post-operative course of the patient was uneventful and she was discharged on Day 8. The HPR confirmed degenerated RPOCs.

Case 9: mismanaged caesarean scar pregnancy requiring hysterectomy

33 years old, G3P2L2 with previous two LSCS took medical abortion pills in a private hospital without any

prior USG, but failed to expel POCs. Hence, she was posted for S/E, however the procedure was abandoned due to profuse bleeding. Her β-hCG value after the procedure was 34500 mIU/ml and USG showed a well- defined heterogenous area along the previous LSCS scar measuring 4.4×3.2 cm with myometrial thinning, suggestive of RPOCs secondary to scar pregnancy. Inspite of high β-hCG values, she was given a single dose of MTX and was discharged with an advice to follow up after 10 days. In her subsequent visit, β-hCG levels were found to have decreased to 5130, while the mass at scar area had increased to 5.3×4.7 cm. She was again asked to follow up after 10 days. The patient lost to follow up and reported after 20 days with profuse bleeding. Hence, she was referred to our hospital.

Figure 9: Scar ectopic pregnancy with high vascularity.

On admission her vitals were stable with mild pallor and tachycardia. Her β-hCG was 36.8 and USG revealed a large echogenic mass of size 8.2×6.2 cm in anterior wall of the uterus with a possibility of a neoplastic mass. Hence CT scan was done to confirm the diagnosis which showed a heterogeneous mass measuring 9x8.5x6.5 cm invading the myometrium and inferiorly extending to uterocervical junction. The mass was seen displacing the bladder anteriorly and multiple engorged parametrial vessels were noted. A probable diagnosis of invasive molar changes in scar ectopic could not be ruled out. Considering rapid increase in the size of the lesion and possibility of uterine perforation and haemoperitoneum, decision for exploratory laparotomy was taken.

Written informed consent for excision of mass with uterine repair SOS hysterectomy was taken. Intraoperatively, a highly vascular heterogenous mass of 10x10 cm was seen invading the LUS and urinary bladder (Figure 9). The bladder was separated by fine dissection. Due to the size and vascularity of the mass, torrential bleeding was anticipated if excision was attempted. Hence total abdominal hysterectomy with bilateral salpingectomy was performed. Her post-operative period was uneventful. β-hCG values reduced to 35.34 and 6.87 on day 3 and day 7 post operatively. Her HPR was consistent with scar ectopic pregnancy in LUS with predominantly haemorrhagic tissue. No evidence of molar pregnancy or malignancy was found.

Case 10: tubal stump ectopic

A 36 years old patient, G4P2L2E1 with previous 2 LSCS presented with one and a half month amenorrhoea with UPT positive for medical abortion. She gave history of laparoscopic salpingectomy for left sided ruptured ectopic pregnancy 9 years back, followed by 2 LSCS, but the records were not available. She was obese weighing 115 kgs and hypothyroid on 100 mcg thyroxine. Her USG showed bulky uterus and a lesion of size 2.4×1.3 cm in right adnexa with fetal pole and cardiac activity within it suggestive of right sided live tubal ectopic pregnancy of 6.4 weeks which was indenting right cornual region. She was hemodynamically stable and her blood investigations were normal.

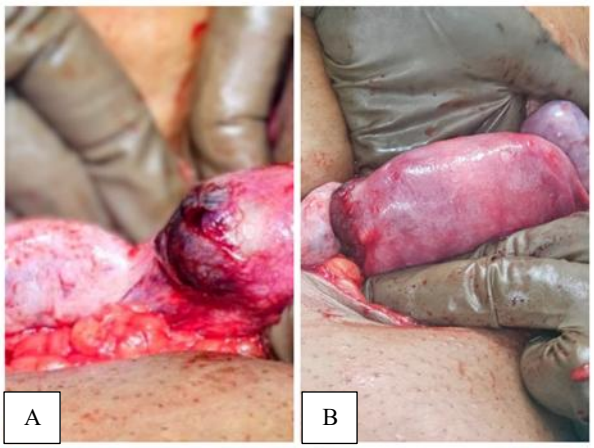

Figure 10 (A and B): Tubal stump ectopic with normal contralateral tube.

She was posted for exploratory laparotomy after arranging adequate blood. Intraoperatively a bulky uterus was seen with a bulge measuring 2.5×2.5 cm covered with a thin serosa was seen near the cornual region in the stump of right fallopian tube which was remnant after prior salpingectomy done for ruptured ectopic (Figure 10). Left tube and both ovaries were normal. The findings were contradictory to history given by the patient and USG report. A nick was given on the bulge and an intact gestational sac was expelled out. The defect was sutured and left sided tubal ligation was done. Her post-operative course was normal and she was discharged after suture removal on day 8. Her HPR was consistent with ectopic pregnancy.

DISCUSSION

The incidence of EPs is on a rise, both tubal and non-tubal. Increase in early first trimester scans due to patient awareness, infertility treatment, rising number of medical abortions etc. It has led to a substantial rise in detection of unruptured tubal and NTEPs, both posing a challenge to

the obstetrician. The spectrum of NTEPs has widened in recent years due to the advent of newer imaging technology.

The diagnosis of EP is preceded by pregnancy of unknown location (PUL). PUL is defined as a positive serum β-hCG in the absence of ultrasound findings indicative of intrauterine or extrauterine pregnancy. Approximately 30% of patients with PUL develop an ongoing intrauterine pregnancy, while the majority (50–70 %) are diagnosed with failing pregnancies, either miscarriages or EPs.[4]

Interstitial ectopic pregnancies are reported in up to 2- 4% of all ectopic implantation sites.[5] They can be managed medically with systemic MTX treatment, direct injection of MTX into the gestational sac and combined systemic and direct injection technique or surgically by laparoscopically assisted transcervical suction evacuation and hysteroscopic-guided removal of conception products for unruptured cases. However, ruptured cases are managed with cornuostomy, cornual resection or hysterectomy.[5] In our case series, one patient with interstitial pregnancy was successfully managed with multi- dose MTX treatment while the other needed excision as the size of the sac was larger with extreme thinning of myometrium and high β-hCG value.

Cervical ectopic pregnancy has an incidence of <1%.[6] It is commonly confused with incomplete abortion. The treatment options for cervical pregnancy include injection MTX, USG guided intra-amniotic KCl or MTX injection, suction evacuation and hysterectomy. Preoperative uterine artery embolization (UAE) and intraoperative ligation of cervical, uterine and internal iliac arteries and tamponade with foley's catheter can be used to minimize the blood loss during surgical procedure. A typical hour glass appearance on USG, an empty uterine cavity and closed internal os helped us to diagnose cervical pregnancy. One of our patients was in haemorrhagic shock and had to be taken for emergency S/E but no adjuvant procedure was needed for control of bleeding in this case. However, in second case, due to large gestational sac distending the cervical canal, the patient bled profusely and required balloon tamponade to control bleeding. But we were able to conserve uterus in both cases.

Intra-myometrial pregnancy is defined as a presence of conceptus within the myometrium and separated from the endometrial cavity and both fallopian tubes. The intra-myometrial pregnancy is the rarest and its incidence is less than 1% amongst the EPs.[7] It can be partial where the gestational sac invades the myometrium but also partly protrudes into uterine cavity or complete where the gestational sac completely implants within the myometrium, without visible communication with the uterine cavity.[8] Our case was a complete intra-myometrial pregnancy located near the left cornu. There is a thin line of differentiation between angular, interstitial and intramural pregnancy. Various techniques can be used for intra-myometrial pregnancy, like mini laparotomy, hysterotomy, operative laparoscopy and hysteroscopic evacuation and even medical management with methotrexate can be done. We chose mini laparotomy over medical management as the size of sac was more than 5 cm and thick myometrium between endometrial cavity and sac made hysteroscopic resection impossible.

The occurrence and detection of caesarean scar pregnancy have increased significantly in the past few years. It comprises 6.1% of all ectopic pregnancy.[9] CSP can be classified as exogenic or endogenic depending on residual myometrial thickness. COS criteria on USG also helps to decide management by vaginal or abdominal route.[9] Medical treatment includes injection MTX by intramuscular or intrasac method and surgical options include hysteroscopic S/E, laparoscopic or open removal of CSP with revision of scar, and hysterectomy. Haemostatic measures including balloon catheter for tamponade and UAE can be used. We had two cases of CSP who needed hysterectomy due to large lesions and dense adherence to the bladder. Only one case was endogenic and was successfully treated with USG guided S/E. The remaining three cases were referred to our hospital after undergoing S/E at private hospitals. The most challenging was the case where RPOCs developed hypervascularity after S/E instead of undergoing autolysis, which warranted bilateral IIAL to control blood loss.

Tubal stump EPs are very rare, and account for 0.4% of all ectopic pregnancies.[10] The diagnosis on USG is sometimes difficult as the ovary is closely situated and ovarian follicles can be confused as stump ectopic. It can also be misdiagnosed as interstitial pregnancy or ampullary EP. The gold standard of management is surgery, whether laparoscopy or laparotomy, and excision of the stump, as done in our case. The management options also include management with MTX injection but chances of rupture of stump pregnancy is high.

CONCLUSION

Non tubal EPs pose a challenge to the obstetrician with regards to diagnosis as well as management. A high degree of suspicion and proper utilization of radiological aids can avert catastrophic events. The importance of first trimester ultrasound before embarking on any method of termination of pregnancy cannot be emphasized more. Counselling of patients and shared decision making about various treatment modalities available and their regular follow up increases the chances of conservation of uterus.

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