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Case Series

Silent yet deadly: a case series of chronic ectopic pregnancies presenting atypically

Salonee Gupta*, Samir R. Mehta, Babulal S. Patel, Divya D. Patel, Manvir K. Walia, Janmay Mehta

Department of Obstetrics and Gynaecology, ESIC Model Hospital, Bapunagar, Ahmedabad, Gujarat, India

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***Correspondence:**
Dr. Salonee Gupta,
E-mail: saloneegupta9@gmail.com

ABSTRACT

Chronic ectopic pregnancy is a potentially life-threatening condition that is diagnostically challenging because of a variety of clinical presentations. Often, chronic ectopic may pose diagnostic conundrum due to unusual presentations. Pelvic inflammatory disease is a widespread female problem worldwide which could lead to ectopic pregnancy among reproductive age women. This series aims to diagnose it early and assess the co-relation between pelvic inflammatory disease and chronic ectopic pregnancy. This hospital-based case series was conducted in the Department of Obstetrics and Gynaecology, ESIC Model Hospital, Bapunagar, Ahmedabad, Gujarat over a period of 4 years from December 2021 to December 2025. A total of 7 patients were included in the study. Data was collected retrospectively and analyzed. We must keep ectopic pregnancy as differential diagnosis in all reproductive age group women presenting with pain in abdomen regardless of other symptom particularly with pelvic mass. Occurrence of ectopic pregnancy has a strong association with pelvic inflammatory disease. Negative urine pregnancy test does not rule out chronic ectopic pregnancy. Use of MTP pills without prior confirmation of intra-uterine pregnancy mask the symptoms and delays the diagnosis of an existing ectopic gestation. Pelvic inflammatory diseases have a strong causal association with chronic ectopic pregnancy.

Keywords: Chronic ectopic pregnancy, Ectopic pregnancy, Tubal pregnancy, Ectopic Pregnancy complications, Pelvic inflammatory diseases and Ectopic pregnancy

INTRODUCTION

Chronic ectopic pregnancy is a variant of ectopic pregnancy characterized by low or absent serum beta human chorionic gonadotropin (beta-hCG) levels, resistance to methotrexate and an adnexal mass with fibrosis, necrosis, and blood clots due to repeated and gradual fallopian tube wall disintegration.[1]

Chronic ectopic pregnancy is a potentially life-threatening condition that is diagnostically challenging as clinical presentations are various. Often, chronic ectopic may pose diagnostic conundrum due to unusual presentations. Culminating point is to keep ectopic pregnancy as differential diagnosis in all reproductive age group women presenting with pain in abdomen regardless of other symptom particularly with pelvic mass. Early recognition and accurate diagnosis are crucial to prevent morbidity and preserve future fertility.

Pelvic inflammatory disease (PID) is an inflammatory process of the upper genital tract, including the uterus, fallopian tubes and related pelvic organs which could lead to tubal inflammation and tubal adhesions which increase the possibility of chronic ectopic pregnancy among the reproductive age women.

CASE SERIES

This case series consist of seven patients visiting the hospital over a period of 4 years from December 2021 to

December 2025. Data was collected retrospectively and analyzed.

Case 1

A 32-year-old patient second gravida with history of 1 abortion came with the complaint of irregular periods since one and a half year and epigastric pain. Her last menstrual period was 2 days back and before that she had periods 23 days back. Patient was taking treatment for secondary infertility. On examination, her urine pregnancy test was negative and her beta HCG was 361 mIU/ml. Beta hCG was repeated after 48 hours which came out to be 360.6 mIU/ml. Ultrasonography (USG) was suggestive of increased right adnexal volume of 48×47×44 mm with increased vascularity. Magnetic resonance imaging (MRI) pelvis was suggestive of heterogenous enhancing soft tissue lesion measuring 35×38×40 mm in right adnexa in close proximity to ovary suggestive of benign lesion possibility of chronic ectopic or chocolate cyst. Laprotomy was performed in which right sided chronic ectopic pregnancy of 5×4 cm size was noted and left side fallopian tube and ovary adherent to posterior uterine wall along with omental adhesions were noted. Right salpingectomy was performed in this case. On histopathological examination, it was confirmed to be tubal ectopic pregnancy (Figure 1).

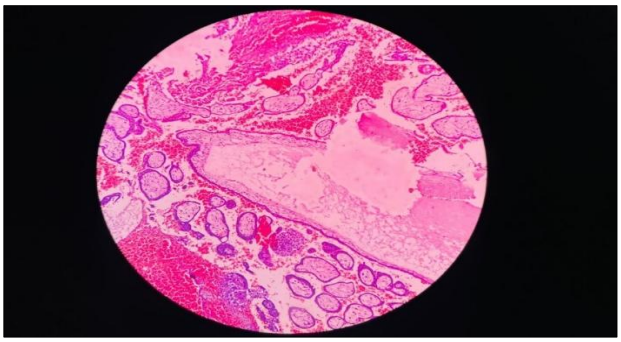

Figure 1: Histopathological image of chronic ectopic pregnancy specimen.

Case 2

A 34-year-old third gravida patient with history of 1 full term LSCS and 1 abortion came with the complain of irregular periods since last 4 to 5 months, spotting per vaginum for 15 days and lower abdominal pain for 10 days. Patient had history of dilatation and evacuation 5 days back at a private hospital in view of retained products of conception on USG. Her last menstrual periods were 15 days back and before that she had periods 30 days back. Her urine pregnancy test was negative on admission and her next day early morning urine pregnancy test was positive and her beta HCG was 404 mIU/ml. Ultrasonography was suggestive of right side haemorrhagic tubo-ovarian mass of size 42×48 mm. CECT was suggestive of right tubo-ovarian mass possibly haemorrhagic with possibility of large haemorrhagic cyst or subacute to chronic ectopic. 5×3 cm chronic ectopic pregnancy mass was noted on right fallopian tube (partially ruptured) intra-operatively (Figures 2-4). Left side tube and both ovaries were normal. Partial right salpingectomy was performed in this case. It was confirmed to be ectopic pregnancy on histopathological examination.

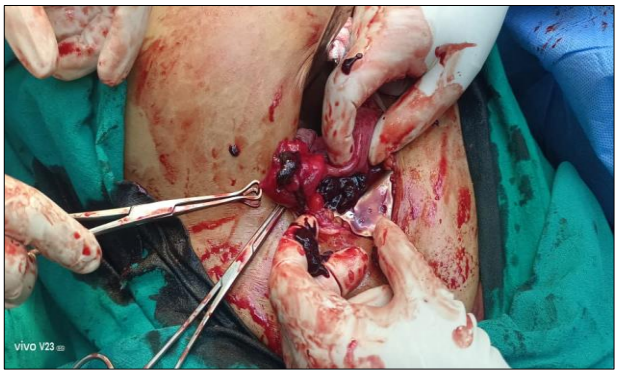

Figure 2: Right sided ectopic mass protruding from the tube.

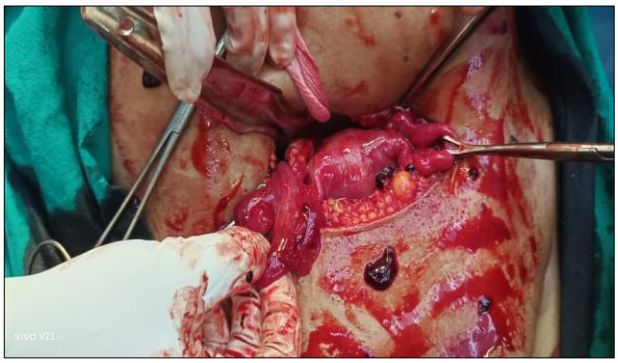

Figure 3: Dilated tube on right side and left normal tube.

Figure 4: Collection of blood clots along with specimen of fallopian tube.

Case 3

A 25-year-old patient third gravida with previous 2 spontaneous abortions came with pain abdomen for 2 days.

Patient took MTP pills 16 days back at 2.5 months of amenorrhoea. Her last menstrual period was 3 months back. She underwent hysterosalpingography 2 months back. At the time of hysterosalpingography her urine pregnancy test was positive. Her beta HCG was 1023 mIU/ml. USG suggested right side 3×4 cm right adnexal mass possibility of haemorrhagic cyst or chronic ectopic. Laprotomy was done and 3×4 cm chronic ectopic mass was noted on right side with ruptured right tube. Left side tube and ovary were normal. Right salpingectomy was done. Histopathological examination findings were confirmatory of tubal ectopic pregnancy.

Case 4

A 29-year-old patient, fourth gravida with previous 2 normal deliveries and one abortion attended gynaecology department with complain of on and off lower abdominal pain for one week and irregular periods since 3 to 4 months. Her Last menstrual period was 20 days back. she had periods 45 days back before that. The only sign that patient had was tachycardia. Her urine pregnancy test was weakly positive and beta hCG was 325 mIU/ml on admission and 620 mIU/ml after 48 hours and 678 in the next 48 hours. USG was suggestive of left side adnexal mass of 4×5 cm possibility of haemorrhagic cyst or choclate cyst or ectopic pregnancy.

Her CA-125 was normal which ruled out choclate cyst and endometriosis. Laprotomy was done in which left side 3×5 cm chronic ectopic mass adherent to left side fallopian tube and ovary was noted. Right fallopian tube and ovary were normal. Left salpingectomy was done. On histopathological examination, it was confirmed to be tubal ectopic pregnancy.

Case 5

A 38-year-old Second gravida patient with previous normal delivery came to us with complain of irregular periods since last 2 months, heavy menstrual bleeding for 20 days and lower abdominal pain for 15 days. Patient did not use any temporary or permanent method of contraception. Her last menstrual period was 20 days back. she had periods 36 days back before that. Her urine pregnancy test was positive and beta hCG was 464.1 mIU/ml on admission and 483 mIU/ml after 48 hours.

USG was suggestive of 44×50×32 mm irregular lesion with solid cystic component in left adnexa which can't be separated from ovary. 29 mm anterior wall fibroid was also noted in lower uterine segment. Magnetic resonance imaging (MRI) pelvis was suggestive of 44×32×48mm left adnexal ectopic gestation along with mild ascites predominantly haemorrhagic. Intra-operatively 10 cm sized clots with 3×2 cm sized cyst like structure (chronic ectopic) was noted in left adnexa which was adherent to ovary too. Right side tube and ovary were normal. Left sided salpingectomy was done. Histopathological examination findings were confirmatory of tubal ectopic pregnancy.

Case 6

A 35-year-old patient, third gravida with previous 1 cesarean section and 1 abortion came to us for spotting per vaginum on and off for 15 days. Her last menstrual period was 15 days back and last to last periods were 34 days back. Her urine pregnancy test was positive and beta hCG was 1034 mIU/ml on admission. USG suggested 100×53 mm mixed echogenic area in pouch of Douglas.

MRI was suggestive of large haematoma in pouch of Douglas secondary to ectopic pregnancy with possible rupture. Intra-operatively a 7×8 cm old collected blood clot was noted in pouch of Douglas, a 2×5 cm of chronic ectopic noted in left fallopian tube adherent to left ovary and posterior uterine wall, all tissues were friable and uterus was adherent to anterior abdominal wall. Right sided tube and ovary were normal.

Left sided salpingectomy was performed. It was confirmed to be ectopic pregnancy on histopathological examination.

Case 7

A 32-year-old fourth gravida with 1 normal delivery and 2 abortions came with complain of lower abdominal pain more in right iliac fossa along with heavy menstrual bleeding for 7 days after taking MTP pills 8 days back after doing urine pregnancy test which came out to be positive. She took pills without getting USG done for the location of gestational sac.

Her last menstrual period was 38 days back. on admission urine pregnancy test was negative and beta HCG was 584.6 mIU/ml. Her symptoms mimicked more like acute appendicitis or rupture of appendix.

USG suggestive of mildly inflamed appendix in right iliac fossa with adjacent wall oedema with mild free fluid in right iliac fossa, probe tenderness was present, rebound tenderness was present with possibility of appendicitis or perforation of intestine along with 10×13 mm RPOC in uterine cavity.

Computed tomography (CT) scan suggestive of lobulated hyperdense lesion of 90×56×62 mm in right adnexa possibility of chronic ectopic pregnancy with mild free fluid in perihepatic, perisplenic region along right paracolic gutter and in pelvis.

Laprotomy with right salpingectomy was performed in this patient and appendix and intestines were examined by the surgeon which were completely normal. Left side tubes and ovary were normal. Histopathological examination findings were confirmatory of tubal ectopic pregnancy. Table 1 discusses about all the cases.

Table 1: Discussion on all the cases.

S. no.	Age of the patient (in years)	Obstetric history	Presenting complaint	Urine pregnancy test	Serum beta hCG (in mIU/ml)	Adhesions	Surgery performed (laprotomy)	Number Of PCV used
1	32	G2A1	Irregular menses for 1.5 year, epigastric pain	Negative	On admission -361, after 48 hours 360.6	Yes	Right salpingectomy	0
2	34	G3P1L1A1 (FTCS)	Lower abdominal pain for 10 days, spotting p/v for 15 days, irregular menses	Negative	404	No	Partial right salpingectomy	2
3	25	G3A2	Pain abdomen for 2 days	Positive	1023	No	Right Salpingectomy	2
4	29	G4P2L2A1 (2 FTND)	On and off abdominal pain for one week, irregular menses for 3 to 4 months	Weak positive	325	Yes	Left salpingectomy	1
5	38	G2P1L1 (FTND)	Lower abdominal pain, heavy menstrual bleeding for 20 days	Positive	464.1	Yes	Left salpingectomy	2
6	35	G3P1L1A1 (FTCS)	Spotting p/v on and off for 15 days	Positive	1034	Yes	Left salpingectomy	1
7	32	G4P1L1A2 (FTND)	Lower abdominal pain (right iliac fossa pain) for 6 days, heavy menstrual bleeding p/v for 6 days	Positive	584.6	No	Right salpingectomy	2

DISCUSSION

Out of 7 patients, 4 patients presented with irregular menses, 2 patients present with heavy menstrual bleeding, 1 patient present with lower abdominal pain only. 2 patients came with unique presentation, one with right iliac fossa pain mimicking appendicitis and other with epigastric pain. Out of 7 patients urine pregnancy test was negative in 2 patients and weak positive in 1 patient and positive in 4 patients. Intra-operative adhesions were present in 4 patients out of 7. Among 7 patients, 3 underwent right salpingectomy, 1underwent right partial salpingectomy and 3 underwent left salpingectomy. Out of 7 patients, 1 patient had history of MTP pills taken within 1 month which delayed the diagnosis and 1 patient underwent DnE few days back. 5 patients out of 7 had history of discharge per vaginum and history of chronic lower abdominal pain thus, suggesting pelvic inflammatory diseases. PID changes like destruction of ciliated epithelium, fibrosis, scarring, strictures and peri-tubal adhesions delay or prevent normal embryo transport thus increasing the chance of tubal implantation. Chronic inflammation in the tubes results in incomplete trophoblastic invasion resulting in persistent low grade bleeding rather than rupture. Clinical presentation is generally mild and symptoms are subtle.[2] Chronic ectopic patients are usually vitally stable and presents with irregular menses and chronic abdominal pain. Some clinical features of chronic ectopic pregnancy are similar to those of acute ectopic pregnancy, like amenorrhoea, abdominal pain and abnormal vaginal bleeding being common. chronic ectopic pregnancy results from small recurrent bleed into pelvic peritoneal cavity which forms an organized clot in between the pelvic structures which is called pelvic hematocele.[3] 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 haematocele. The haematocele, 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 hCG. This entity has a sonographic appearance distinctly different from acute ectopic pregnancy.[4]

Sometimes the bleeding is confined to the tube itself with no peritoneal communication leading to the formation of a hematosalpinx.[5,6]

According to data from the PEACH study, using condoms consistently during follow-up was linked to lower chances of PID and infertility.[7] The lowering burden of ectopic pregnancy may coincide with the declining PID rate because the infection-induced selective loss of ciliated epithelial cells along the fallopian tube epithelium could hamper ovum transport and result in ectopic pregnancy.[8,9] In addition to that, condom use was also associated with a reduction in ectopic pregnancy risk.[10]

Recently in JACEP open Kleinschmidt et al found an overall false negative rate of approximately 1.6% out of over 11,000 patient visits. Interestingly the false negative rate was approximately 3.6% in a subset of patients with "high-risk complaints," including pelvic pain,cramping, and vaginal bleeding.[11]

CONCLUSION

Proper history taking is a must and so is proper work up. Chronic ectopic pregnancy should be the provisional diagnosis in a young woman with abnormal uterine bleeding and/or abdominal pain, if the ultrasound shows a heterogenous mass in the pouch of Douglas and/or adnexa with no internal vascularity, to plan optimal surgery. Negative urine pregnancy test does not rule out chronic ectopic. False negative rate of urine pregnancy test is around 1%. Serum beta hCG is more reliable for the diagnosis of pregnancy. Adhesions were present in many patients which required meticulous dissection. Use of MTP pills without prior confirmation of intra-uterine pregnancy mask the symptoms and delays the diagnosis of an existing ectopic gestation thereby contributing its progression into a chronic form. Pelvic inflammatory diseases have a strong causal association with chronic ectopic pregnancy. Effective interventions and strategies should be established for early diagnosis. Use of condom reduces the incidence of pelvic inflammatory diseases and chronic ectopic pregnancies.

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