Persistent Ectopic Pregnancy – A Case Report

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ABSTRACT

The following case report describes a case of persistent ectopic pregnancy following laparoscopic segmental salpingectomy. The patient had an unusual presentation of acute abdomen and focal haemorrhage from omental implantation of the trophoblastic tissue.

Keywords: ectopic pregnancy, complications of ectopic pregnancy, persistent ectopic pregnancy, laparoscopy, salpingectomy

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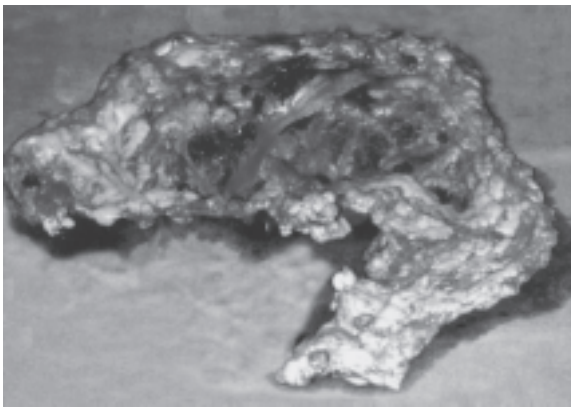

Fig. 1 Omental ectopic pregnancy.

CASE REPORT

A 36-year-old female was referred to our institution for lower abdominal pain in January 2000. The patient had one child and was keen to conserve her fertility. She was at five weeks of amenorrhoea and had a history of regular monthly menstrual cycles. The pain had been increasing in intensity over the preceding two days and there was associated shoulder tip pain. There was no associated bleeding per vaginum, nausea, vomiting, diarrhoea or fever. The examination revealed a tender lower abdomen with rebound and guarding. The ultrasound showed a thickened endometrium with no intrauterine gestational sac. There was a right ovarian cyst that resembled a corpus luteal cyst, and there was fluid in the Pouch of Douglas.

An emergency laparoscopy was done. Intra-operatively, there was about 1.0 L of haemoperitoneum. There was a ruptured and bleeding left isthmic ectopic pregnancy. There were bilateral hydrosalpinges and multiple periovarian and peritubal adhesions. There were no perihepatic adhesions. A laparoscopic segmental left salpingectomy was done. In addition, a linear salpingostomy was done on the right hydrosalpinx. The ectopic pregnancy was removed piecemeal using a 10 mm spoon forceps from the umbilical laparoscopic port. Extensive peritoneal lavage was carried out.

The patient had a pre-operative βHCG of 2034 IU/L and the postoperative value on the next day was 915 IU/L. The patient had an uneventful recovery and was discharged well on the fourth post-operative day. The histology report showed products of conception in the left fallopian tube.

Twenty-three days after the operation, the patient presented with abdominal pain and vomiting. She was pale on physical examination and the abdomen was tender and guarded. An emergency laparotomy was done in view of the acute abdomen. Intra-operatively, there was haemoperitoneum of about 1.0 L. The site of the previous ectopic pregnancy was normal and had healed. However, there was implantation of trophoblastic tissue on the omentum (Fig. 1). There was active bleeding from these implantation sites. Partial omentectomy had to be done to secure the haemostasis. An abdominal survey did not reveal any other source of haemorrhage.

The haemorrhage was significant, causing a drop in the haemoglobin to 7.6 g/dL (pre-operative haemoglobin was 11.2 g/dL). The omentum that was sent for histology revealed focal haemorrhage. Trophoblasts and chorionic villi were also seen. There were no products of conception in the remaining fallopian tube that had been removed.

The βHCG was 7664.6 IU/L pre-operatively. Intramuscular methotrexate (50 mg) was given to the patient post-operatively. The βHCG decreased to less than 2 IU/L 63 days post-operatively.

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DISCUSSION

Ectopic pregnancy is an implantation occurring outside the uterine cavity. It is an increasingly common clinical problem. The incidence of extra-uterine pregnancies has increased from 0.5% 30 years ago to 1-2%[1] in recent years. This case illustrates one of the potential problems that may arise with minimal access surgery for ectopic pregnancy. Laparoscopic treatment of ectopic pregnancy is safe and effective. It has similar outcomes as laparotomy but with a shorter hospital stay, faster recovery and lower costs[2,3]. It is likely that implantation of the omentum occurred during removal as it was done piecemeal using a laparoscopic spoon.

It is known that persistence of trophoblastic tissue occurs more often after conservative surgery, i.e. salpingostomy than the more radical procedure of salpingectomy[2]. In this case, a partial salpingectomy was done and there was no remnant trophoblastic tissue in the portion of the fallopian tube that had been removed at the subsequent laparotomy.

To prevent such a complication in future, it would be prudent to remove the ectopic pregnancy via a laparoscopic bag to reduce intraperitoneal spillage.

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