RECURRENT IPSILATERAL ECTOPIC PREGNANCY FOLLOWING COMPLETE SALPINGECTOMY

Ratan Das[1], Soumya Biswas[2], Utpal Roy[3]

HOW TO CITE THIS ARTICLE:
Ratan Das, Soumya Biswas, Utpal Roy. "Recurrent Ipsilateral Ectopic Pregnancy following complete Salpingectomy". Journal of Evolution of Medical and Dental Sciences 2013; Vol2, Issue 32, August 12; Page: 6011-6014.

Ectopic pregnancy is a common problem and there is a potential threat for maternal morbidity and mortality. Ipsilateral ectopic pregnancy after partial or total salpingectomy is a rare occurrence with less than a dozen cases reported in the literature in the last 20 years. We are presenting the case of a 20 year old Para 0+1 young female who presented with colicky pain abdomen, sever pallor, hypotension, and tachycardia. She had a previous right sided ruptured ectopic pregnancy and right salpingectomy done six month back. On laparotomy, there was right sided ruptured ectopic pregnancy from previous salpingectomy site. This case emphasizes that total salpingectomy too carries the potential for the recurrence of ectopic pregnancy on the same side hence the need for clinician awareness and vigilance.
KEY WORDS: Ectopic pregnancy, Salpingectomy, Maternal mortality.

BACKGROUND: Ectopic pregnancy is defined as pregnancy that implants outside the uterine cavity. Ectopic pregnancy is an important contributor to maternal mortality, morbidity and early fetal wastages. A World Health Organization analysis of maternal deaths showed ectopic pregnancy to be responsible for 4.9% of all and 6.1% of direct maternal deaths in developed countries [1]. The condition rated as the eighth most common cause of maternal death in the latest Confidential Enquiry into Maternal Deaths (CEMD) in the United Kingdom [2]. More than 90% of ectopic pregnancies occur in one of the fallopian tube. The sites of tubal implantation are ampulla (73.3%), isthmus (12.5%), fimbrial (11.6%), and interstitial (2.6%). Ipsilateral ectopic pregnancy after partial or total salpingectomy is a rare occurrence with less than a dozen cases reported in the literature in the last 20 years [3, 4, 5, 6, 7]. Ectopic pregnancy could pose a diagnostic dilemma in centres where diagnostic facilities are lacking. We present an unusual case of right ipsilateral ectopic pregnancy occurring in the stump of a previous ectopic site following complete salpingectomy.

CASE PRESENTATION: We are presenting the case of a 20 year old Para 0+1 young female from rural area in eastern India who was seen at the gynecological emergency with a three days history of colicky lower abdominal pain which became generalized a day prior to presentation. There was no history of dizziness or fainting spells. There were no gastrointestinal symptoms. She bled per vagina three weeks prior to presentation for three days which she claimed to be her menses. Her menstrual cycle was regular. She had no significant past medical history.

She was married for one year. She has a very tragic married life. She had a previous right sided ruptured ectopic pregnancy and right salpingectomy done six month back. Her husband died one month back before this tragedy.

Examination revealed that she was in painful distress. She was drowsy with sever pallor. Her pulse rate was 120 beats per minute while the blood pressure was 90/60 mmHg. Chest was

clinically clear. Abdominal examination revealed a full, soft abdomen with tenderness and rebound tenderness in whole abdomen. Vaginal examination showed a normal lower genital tract with pale vaginal mucosa. Uterine size could not be assessed properly, no pelvic masses were felt, pouch of Douglas was full and there was marked cervical motion tenderness. Her urine pregnancy test was faintly positive. Culdocentesis showed non clotted blood.

Resuscitation and laparotomy was done on emergency basis as she was haemodynamically unstable. Repeat Pfannenstiel incision through previous scar was made to enter the abdominal cavity. Laparotomy revealed huge haemoperitoneum of 2000 ml, slightly bulky uterus, and normal looking Left tube and ovary. Right ovary was healthy but right fallopian tube was absent completely. No definite tubo-ovarian mass seen, but there was constant bleeding from a raw area in the right cornual end at previous salpingectomy site.

The haemoperitoneum was sucked and haemostasis was secured at the cornual end by box suture with no 1-0 catgut. Abdominal wall was closed in layers. Post operative period was uneventful except fever (102 F) on 2nd day. She was transfused total 6 units of blood both in per operative and post operative period. She was discharged on the 7th postoperative day. She was counselled about possibility of repeat ectopic pregnancy.

DISCUSSION: Ectopic pregnancy has been described as the great masquerade. The classic triad of amenorrhoea, abdominal pain and vaginal bleeding is presented in only 50% of patients with ectopic pregnancy. Ectopic pregnancy is diagnosed in 6–16% of women who present to emergency department, with vaginal bleeding, abdomino-pelvic pain or both. The incidence of recurrent ectopic pregnancy is approximately 10–15% and this likelihood increases to 30% following two ectopic pregnancies. Frequency of ectopic pregnancy is around 1% - 2%. A review of medical and surgical management of ectopic pregnancy described the recurrent ectopic rates after single dose methotrexate, salpingectomy, and linear salpingostomy as 8%, 9.8%, and 15.4% respectively.

There are multiple theories postulated about the basis of recurrent ipsilateral ectopic pregnancies [8, 9]. One theory suggests that despite surgical excision, the lumina remain intact or recanalized in the interstitial portion and remnant of the fallopian tube. This permits communication between the endometrial and peritoneal cavities and hence passage of the fertilized ovum or sperm from the uterine cavity to the remnant of fallopian tube. Another possibility suggests that spermatozoa pass through the contralateral patent tube into the pouch of Douglas, then journey to fertilize the ovum and implant on the side of the previous ectopic, within the tubal stump. The third assumption is based on transperitoneal migration whereby the fertilized ovum on the side of the normal tube migrates and gets implanted on the tubal stump.

Ectopic pregnancy could pose a diagnostic dilemma where diagnostic facilities are not available. Every woman with a previous ectopic pregnancy would be at high risk for recurrence and that would be the condition to be ruled out if a pregnant woman presented at early gestation with abdominal pain.

Management of ectopic pregnancy can be expectant, medical or surgical. There is a great deal of variation in surgical treatments of tubal pregnancies. Although there is general agreement that, where feasible, the laparoscopic approach is to be preferred over laparotomy, there is less agreement on the specific procedures. The main area of debate still centers on the relative merits of salpingectomy versus salpingostomy, in terms of subsequent fertility and ectopic

recurrences. Laparoscopic treatment of ectopic pregnancy is associated with shorter hospital stay, less operative time, reduced blood loss, less analgesic requirement, faster recovery and less cost. The RCOG greentop guideline recommends that "Laparoscopic salpingotomy should be considered as the primary treatment when managing tubal pregnancy in the presence of contralateral tubal disease and the desire for future fertility" [10]. Operative morbidity is comparable for both procedures. The risk of salpingostomy is the increased chance of persistent or recurrent ectopic pregnancy.

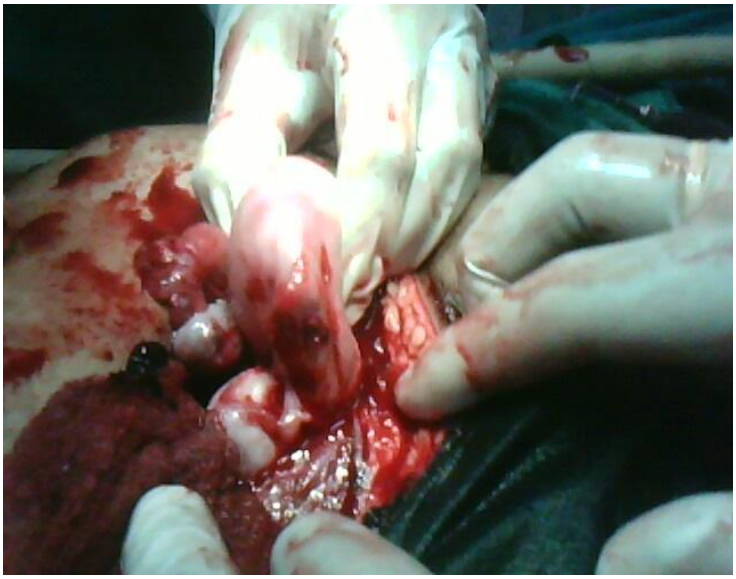
Although a salpingectomy does not necessarily eradicate all ipsilateral ectopics, it certainly minimises a tubal recurrence on the same side. On the other hand, it is erroneous to believe that total salpingectomy is always as complete as the word implies. In our case, the girl has right ipsilateral ectopic pregnancy in the stump of previous ectopic site following complete salpingectomy. In a way, we can say this girl was lucky. She had the ectopic pregnancy on the same fallopian tube previously affected. She still has more than 80% chance of intrauterine pregnancy as her contralateral tube is healthy.

CONCLUSION: Ectopic pregnancy is a common problem and there is a potential threat for maternal morbidity and mortality. Since ectopic pregnancy cannot be diagnosed in the community, all sexually active women with a history of ectopic pregnancy, lower abdominal pain and vaginal bleeding should have early access to Ultrasonography to verify a viable intrauterine pregnancy. We have described a situation where there was ipsilateral recurrent ectopic pregnancy, which required repeat surgical intervention. This case emphasises that total salpingectomy too carries the potential for the recurrence of ectopic pregnancy on the same side hence the need for clinician awareness and vigilance.

REFERENCES:

1. Khan KS, Wojdyla D, Say L, Gülmezoglu AM, van Look PFA. WHO analysis of causes of maternal death: a systematic review. The Lancet. 2006; 367(9516):1066–1074.
2. Saving mothers' lives: reviewing maternal deaths to make motherhood safer - 2003–2005. The seventh report on confidential enquiries into maternal deaths in the United Kingdom in The Confidential Enquiry into Maternal and Child Health, G Lewis, Ed. London: CEMACH; 2007.
3. Zuzarte R, Khong CC. Recurrent ectopic pregnancy following ipsilateral partial salpingectomy. Singapore Med J 2005; 46 (9)**:** 476.
4. Adebamowo A, Fakolujo O. Second ipsilateral ectopic gestation after total salpingectomy: a case report. Afr J Med Med Sc 2000; 29 (1): 63–64.
5. Mathew M, Kumari R, Gowri V. Three consecutive ipsilateral tubal pregnancies**.** Int J Gynaecol Obstet 2002; 78 (2): 163–164.
6. Faleyimu B, Igberase GO, Momoh MO. Ipsilateral ectopic pregnancy occurring in the stump of a previous ectopic site: a case report**.** Cases J 2008; 21 (1): 343.
7. Malhotra V, Chauhan M, Ahuja K, Nanda S, Kumar S. Recurrent ectopic pregnancy after ipsilateral salpingectomy: Report of a rare case. Journal of Gynecologic Surgery 2011;27(3):151-153

8. Bouyer J, Coste J, Fernandez H, Pouly JL, Job-Spira N. Sites of ectopic pregnancy: a 10 year population-based study of 1800 cases. Hum Reprod 2002; 17 (12): 3224–3230.
9. Tulandi T. Reproductive performance of women after two tubal ectopic pregnancies. Fertil steril.1988; 50:164.
10. RCOG greentop guideline no 21. London: RCOG.



Picture showing oozing from previous ectopic site

AUTHORS:

1. Ratan Das
2. Soumya Biswas
3. Utpal Roy

PARTICULARS OF CONTRIBUTORS:

1. RMO cum Clinical Tutor, Department of Obstetrics and Gynaecology, Malda Medical Collge.
2. RMO cum Clinical Tutor, Department of Anaesthesiology, Malda Medical Collge.
3. RMO cum Clinical Tutor, Department of Anaesthesiology, Malda Medical College.

NAME ADRRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Ratan Das,
RMO cum Clinical Tutor,
Department of Obstetrics and Gynaecology,
Malda Medical College,
Malda, West Bengal, India.
Email – ranta1982@gmail.com

Date of Submission: 29/07/2013.
Date of Peer Review: 30/07/2013.
Date of Acceptance: 31/07/2013.
Date of Publishing: 08/08/2013