JOURNAL OF CASE REPORTS 2015;5(1):24-25

Ectopic Pregnancy in Tubal Remnant

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Abstract:

Recurrent ectopic pregnancy in the tubal remnant stump after ipsilateral total salpingectomy is rare and exact incidence is unknown. We present a case of spontaneous ectopic pregnancy occurring in the stump of a remnant fallopian tube following ipsilateral total salpingectomy for an ectopic pregnancy, this case demonstrates that salpingectomy does not exclude ectopic pregnancy on the ipsilateral side. Appropriate measures should be taken during surgery to prevent recurrence in tubal stump.

Key words: Ectopic Pregnancy, Salpingectomy, Tubal Pregnancy, Fallopian tube, Neoplasms, Humans.

Introduction

Ectopic pregnancy can recur in the tubal remnant stump after ipsilateral total salpingectomy. Recurrence in a patient in who have had previous ectopic pregnancy is high (8-17%) [1] but pregnancy in remnant stump is rare, few cases have been reported and exact incidence is unknown. Ampullary region of the fallopian tubes is the most common site of ectopic pregnancy (92%) followed by 2.5% in interstitial/ cornual ectopic pregnancies, while less-common forms include cervical, ovary, and peritoneal (<1%).

Case Report

We present a case of spontaneous ectopic pregnancy occurring in the stump of fallopian tube in a woman who had same sided salpingectomy for ruptured ectopic pregnancy four years back. A 27 year-old female, gravida 3, para 1, ectopic 1, was admitted as an emergency with nausea, multiple episodes of vomiting, dizziness and vague pain in abdomen. Physical examination revealed voluntary muscle guarding without rebound tenderness, moderate pallor, pulse rate of 120 beats/min and blood pressure of 90/50 mmHg. The initial impression was gastroenteritis leading to hypovolemic shock. Patient gave history of menses four days back. Immediate resuscitation steps were started. The patient was given intravenous fluids, but blood pressure did not rise and pallor was increasing.

Urine pregnancy test was found to be faintly positive, patient was referred to gynaecology side, and further history revealed that she was six weeks pregnant. Ultrasound showed empty uterine cavity and a heterogeneous area in the right adnexa of

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Received: September 24, 2014 | **Accepted:** December 26, 2014 | **Published Online:** January 20, 2015

Conflict of interest: None declared | **Source of funding:** Nil | **DOI:** http://dx.doi.org/10.17659/01.2015.0007

approximately 7x5 cm. Left adnexa and left ovary were normal. Hematological investigation revealed hemoglobin levels of 4.4 g/dL. Thus, the diagnosis was revised to ruptured ectopic pregnancy. Exploratory laparotomy was performed. Two litres of blood was removed from the peritoneal cavity, pregnancy was present in the proximal part of resected tube. Remnant of the tube was removed along with a part of cornua. Patient received six units of blood and was kept in ICU for one day. Her post-operative period was uneventful and she was discharged 7 days after the operation. Histopathology confirmed ruptured tubal gestation.

Discussion

Ectopic pregnancy can masquerade many gynaecological and non-gynaecological conditions as clinical presentation can be varied. The classic triad of amenorrhoea, abdominal pain and vaginal bleeding is presented in only 50% of patients with ectopic pregnancy. A proper menstrual history should always be taken in all women of reproductive age group. Urine pregnancy test should be done if required to exclude pregnancy. Any woman with a previous history of ectopic pregnancy is high risk for recurrent ectopic so high risk of suspicion should be kept. The mechanism by which ectopic pregnancy in the remnant tube after salpingectomy occurs is not clear. Reported hypotheses include spermatozoa pass through the patent tube, into the pouch of Douglas, and travel to fertilise the ovum on the side of the damaged tube [2]. An oocyte from the left ovary may be fertilised normally in the patent tube and then later implant in the stump via intrauterine emigration. Another possibility is that, despite the ligation of the tube following salpingectomy, some degree of patency or recanalization may occur. This thus provides a communication between the endometrial and peritoneal cavities and allows for fertilisation and implantation within the isthmic portion of the remnant tube. Transperitoneal embryo migration has been described.

Fig.1: Ectopic pregnancy in tubal remnant.

Appropriate measures should be taken during surgery to prevent recurrence in tubal stump these include complete peritonisation of the corneal incision and advancement of the round and broad ligament over the uterine cornua (modified coffey technique) [3]. Some authors also suggest cauterisation of the remaining stump.

Conclusion

Ectopic pregnancy is a risk factor for future ectopics, salpingectomy does not exclude possibility of ipsilateral ectopic pregnancy. When performing a salpingectomy, we suggest that the length of the remnant should be minimised and modified coffeys technique should be used for peritonisation of corneal stump.

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