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Spontaneous Bilateral Tubal Pregnancy

Aisha Syed Wali and Rozilla Sadia Khan

ABSTRACT

With the increase in incidence of ectopic pregnancy over the decades, bilateral ectopic pregnancy is also increasing. It is usually associated with assisted reproductive techniques (ART) but in recent years few cases of spontaneous bilateral ectopic pregnancy have been reported. Gynaecologists should be aware of this and that ultrasonography has limitations in diagnosis. In cases of ectopic pregnancy where contralateral adnexa is not clearly identified on ultrasound and fertility needs to be conserved, patient should be managed by experts in well equipped centres. A case of spontaneous bilateral tubal pregnancy that remained undiagnosed till laparotomy, is described.

Key words: Ectopic pregnancy. Bilateral tubal pregnancy. Spontaneous bilateral ectopic pregnancy.

INTRODUCTION

There has been a high increase in incidence of ectopic pregnancy over the last three decades and it remains an important cause of maternal mortality in first trimester of pregnancy.

Spontaneous bilateral ectopic pregnancy is a rare entity and few cases have been reported in literature. Incidence is 1 in 750 to 1 in 1850 ectopic pregnancies, usually associated with ART.¹⁻⁴ Spontaneous bilateral ectopic pregnancy is not suspected in the absence of ART. The ultrasound has limitations in the diagnosis. As a result, bilateral ectopic pregnancy is mostly encountered unsuspected at laparotomy. Conservation of fertility becomes an issue as bilateral salpingectomy is often required in given circumstances. Effort should be made to see the integrity of contralateral adnexa on ultrasound in all cases of ectopic pregnancy.

This report describes the occurrence of spontaneous bilateral tubal pregnancy in a second gravida nulliparous young lady.

CASE REPORT

A 23 years old lady, P 0+1, presented in outpatient clinic with amenorrhea of 2 months, mild vaginal bleeding and lower abdominal pain for 2 weeks. There was history of admission in a tertiary care hospital where she was diagnosed as a case of ectopic pregnancy (β -hCG 1218 mIU/ml, haemoglobin 10.6 g/dl and left adnexal mass 3.0 x 3.2 cm). She was managed medically with a single dose of Methotrexate intramuscularly. The pain persisted for the following 3 days, β -hCG plateaued

(1041 mIU/ml) and left adnexal mass increased to 6.7 x 3.9 cm, hence laparotomy was decided. The patient was not convinced. She left against medical advice and presented to the authors.

The patient was vitally stable and asymptomatic. On vaginal examination, uterus was bulky, there was no cervical excitation and mild tenderness in left fornix was present. Haemoglobin was normal and β -hCG had come down to 534 mIU/ml. The transvaginal scan showed left adnexal mass of 5.5 x 2.5 cm with minimal fluid in the pouch of Douglas.

She was managed conservatively and 3 days later the pain had increased with slight increase in size of left adnexal mass and moderate amount of free fluid in the pouch of Douglas. β -hCG was 424 mIU/ml. In view of symptoms, laparotomy was decided but the patient did not agree.

Six days later patient returned with persistent pain. Repeat transvaginal scan showed same findings as 6 days earlier while β -hCG had come down to 72 mIU/ml, haemoglobin was 10.8 g/dl. Although vital signs were normal, there was guarding in the lower abdomen and cervical excitation had become evident. At laparotomy, there was about 600 ml haemoperitoneum and ruptured ectopic pregnancy in ampullary region of left tube with oozing of blood. Right tube was intact with organized haematoma at ampulla with fimbria distorted and embedded in haematoma. Right tube could not be conserved as it was not possible to secure haemostasis after salpingotomy. Bilateral salpingectomy was done.

In the past, there was a miscarriage followed by Dilatation and Evacuation (D & E), 8 months earlier. There was no history of pelvic inflammatory disease, endometriosis, contraception or pelvic surgery in the past.

The patient recovered well with complete resolution of pregnancy. Histopathology confirmed bilateral ectopic

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pregnancy. She was counselled and referred to ART clinic for future pregnancy.

DISCUSSION

Spontaneous bilateral ectopic pregnancy is the rarest entity amongst different types of ectopic pregnancy and only few cases are reported in the literature.^{1,2} The incidence of iatrogenic bilateral ectopic pregnancy is increasing with the wider introduction of assisted reproductive techniques.³ Overall incidence of bilateral ectopic pregnancy is estimated to be 1/200,000 uterine pregnancies and 1/725 - 1/1580 ectopic pregnancies.⁴

We have reported a case of one ruptured and one intact ectopic pregnancy. Three such cases have been reported earlier.⁵⁻⁷ The common event amongst these 3 case reports was inability of ultrasound to diagnose bilateral ectopic pregnancy, the scenario that we faced in this case where multiple transvaginal scans were performed pre-operatively. Hence, pre-operative diagnosis of bilateral ectopic pregnancy remains a challenge as ultrasonography and laparoscopy both have limitations.⁸

High-level expertise and advanced resources are required to manage such cases that may not be available at all times. This is especially true when conservation of fertility is required, as was in this case when a young woman had no live issue.

Laparoscopic conservative surgery is the management of choice for unruptured bilateral tubal pregnancies as for unilateral ones. The management of both ruptured or one ruptured and one intact or chronic ectopic pregnancy depends upon patient's condition, need for conservation of fertility and availability of expertise and resources.⁹

The dilemma does not end here as the chances of recurrent ectopic pregnancy in future are increased after an ectopic pregnancy. A case of ectopic pregnancy has been reported after bilateral salpingectomy. This highlights the need of high suspicion in cases of

abdominal pain with amenorrhoea even after bilateral salpingectomy or tubal ligation.¹⁰

Spontaneous bilateral ectopic pregnancy is rare and usually it is not possible to diagnose it pre-operatively in a asymptomatic patient. Efforts should be made to look for both adnexa in intact as well as in ruptured cases of ectopic pregnancy. Where future fertility is desired conservation of one or both tubes should be the main objective of the management, and is dependent upon availability of skills and expertise in the field.

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