Case Report

OBS & GYN Section

Recurrent Ectopic Pregnancy in the Fallopian Tubes

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ABSTRACT

Here, we present a case with several episodes of ectopic pregnancy in the fallopian tubes, which was treated by medical and surgical methods, and followed for two years until it ended in a term successful delivery.

Key Words: Ectopic pregnancy, Surgical method, Fallopian tubes

INTRODUCTION

Ectopic pregnancies (EPs) are gynaecologic emergencies and they remain as the important leading causes of the pregnancy-related first trimester deaths worldwide [1-2]. Ectopic pregnancies are reported in approximately 1/100 pregnancies [3] and more than 95% of EPs involve the fallopian tubes. Other sites of the ectopic implantation are less frequent [4].

The common symptoms are severe pelvic pain, acute hypovolaemic shock and the need for a blood transfusion [2].

Using ultrasound (transvaginal) laparoscopy and monitoring of the beta subunit of human chorionic gonadtrophin (βHCG) improved the management of the ectopic pregnancies [5]. Delays in the diagnosis often results in delayed treatment and are confusing [2].

Surgical and non-surgical treatments can be used, based on the physician's decision and the patient's condition. Surgical methods are still the mainstay of the management in ectopic pregnancy, and in developed societies, laparoscopic surgery is currently the gold standard [6].

The long-term complications of the treatment are as followings: ongoing pelvic pain, de novo adhesion formation, impairment of future abstinence and increased recurrent ectopic pregnancy [2].

Recurrent ectopic pregnancy constitutes approximately 15% of the cases of EPs and this percentage rises to 30% following two previous ectopic pregnancies [5].

CASE REPORT

We are presenting here, a 26-years-old nulligravida female who visited the gynaecological clinic of an academic hospital in the Golestan University of Medical Sciences, Northeast of Iran, with the chief complaint of spotting in the 6th week of gestation.

She was married 6 years ago and there was no history of any contraceptive use. Her menstruation cycle was regular and she did not have any smoking habits. She did not mention any history of abdominopelvic surgery. Her vital signs were in the normal range.

Her physical examination revealed no remarkable findings.

An ultrasound was done and ectopic pregnancy with blood in the posterior cul-de-sac was suggested. Both the tubes were found to be open in the hysterosalpingography. The pregnancy products were being excreted from the right tube's fimbria and the anatomical structure was found to be normal in the laparotomy. The milking method was done and the patient was discharged after her recovery.

Two weeks later, her serum betaHCG level showed a 50% fall, but it reached a plateau and rose a minimally, which was brought down to zero with a single dose of metotherexate therapy. After completion of the treatment, a hysterosalipingography was done, which gave a normal report.

One year later, she presented with spotting and abdominal pain during her second pregnancy and another ectopic pregnancy was diagnosed in the right fimbria again. The same presentation was seen in the laparotomy and this time, right side fimberectomy was done. No pathologic findings were seen in the histopathology exam of the resected tube.

After another year, she got pregnant for the third time and she had spotting again. According to her ultrasound report, it was a left tube ectopic pregnancy and this time, chemotherapy with metotherexate (4 days with folinic acid) was given and she was referred for In Vitro Fertilization (IVF) without exploration. The result was an ectopic pregnancy in the left tube fimbria. A laparotomy was done and fimbrectomy of the left tube with bilateral tubectomy from the proximal segment was done. Her histopathologic exam revealed no abnormal lesion.

She was followed up to for a year, when the second IVF revealed a twin pregnancy (dizygot) and a term pregnancy was terminated by caesarean section normally.

DISCUSSION

A high index of suspicion is the cornerstone in the diagnosis of ectopic pregnancy, which is a high risk condition [7]. A previous history of pelvic inflammatory disease or tubal pathology can increase the incidence rate of the ectopic pregnancy [1], although our case had not shown any underlying pathology.

It has been reported that the incidence of ectopic pregnancy has risen from 0.5% 30 years ago to 1%–2% [6] and other studies have shown that fallopian tubes were involved in more than 95% of the ectopic pregnancies [4].

This case was a very rare situation with several ectopic pregnancies, which finally ended in a successful term delivery. Laparatomy is the main method of surgery which is still used in our region due to the lack of enough experience and facility here.

As it has been shown in other reports, the appropriate treatment of a non-ruptured ectopic pregnancy could be one or more of the followings: expectant/ conservative management and medical management with methotrexate or surgery [7].

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