International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Bendre K et al. Int J Reprod Contracept Obstet Gynecol. 2023 Sep;12(9):2850-2851
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20232751

Case Report

A rare case of an ovarian ectopic pregnancy

Kirti Bendre*, Sharvari Kulkarni, Sulbha Gejele

Department of Obstetrics and Gynecology, K. J. Somaiya Medical College, Mumbai, Maharashtra, India

Received: 03 July 2023
Accepted: 02 August 2023

***Correspondence:**
Dr. Kirti Bendre,
E-mail: kirtibendre28@gmail.com

ABSTRACT

Ovarian pregnancy is a rare form of the non-tubal ectopic pregnancy accounting for 3% of all ectopic pregnancies (incidence: 1.38-1.5%). Diagnosis is mostly missed and patients usually present with hemoperitoneum and shock since ovaries have rich blood supply. We report a case of a 42-year-old G4P3L3 with 6 weeks of amenorrhea with severe pain in abdomen, giddiness, spotting p/v. Beta hCG was 5380 mIU/ml, hemoglobin (Hb): 4 gm%, with ultrasonography (USG) was s/o left adnexal mass with massive hemoperitoneum. Patient taken for emergency exploratory laparotomy with Intraoperative findings showing massive hemoperitoneum with b/l tubes being normal, left ovary having 1.5 cm cystic mass which was bleeding. Left partial oophorectomy with D and C done. Histopathology report suggestive of normal tubes and ovary with syncytiotrophoblast s/o ruptured ovarian ectopic pregnancy.

Keywords: Ectopic pregnancy, Ovarian ectopic

INTRODUCTION

Ovarian pregnancy is rare among ectopic pregnancy spectra. It accounts for almost 3% of all ectopic pregnancies and patients with ovarian ectopic pregnancies usually present with rupture and hemoperitoneum because ovaries have rich blood supply.[1]

Ideally post fertilization usually on D5-D6, blastocyst implants in endometrial lining of uterine cavity and so implantation anywhere else is termed as ectopic. It is a life-threatening emergency and can be fatal, if the diagnosis is missed. So, a high level of suspicion is required clinically as well as radiologically when any woman in the reproductive age group presents with what are classic symptoms like vaginal bleeding following a period of amenorrhea and abdominal pain. Incidence of ovarian ectopic varies from 1/7000-1/40,000 in live births and accounting for 3% of total pregnancy related deaths.[1]

Definitive diagnosis is based on Spiegelberg criteria which includes: intact ipsilateral tube, clearly separate from the ovary, gestational sac occupying the position of the ovary, sac connected to the uterus by the ovarian ligament, and histologically proven ovarian tissue located in the sac wall.

Making a definitive preoperative or even an intraoperative diagnosis of ovarian pregnancy is difficult, and is usually made by histopathological examination. This is because clinical picture of tubal and ovarian pregnancies are similar and intraoperative differences may be vague. Radiologically definitive diagnosis as ovarian ectopic can be given only when a G-sac with fetal pole is seen in ovary with classic ring of fire appearance and typically their appearance can be easily misdiagnosed as a hemorrhagic cyst, a tubal ectopic, or a corpus luteum cyst.[2] Hence, only one fourth of the patients are diagnosed correctly before surgery.

CASE REPORT

A 42-year-old, G4P3L3 with 6 weeks of amenorrhea came with pain in abdomen spotting p/v and giddiness since 6 days. Her previous cycles were normal. Pregnancy was detected by UPT after which patient experienced spotting p/v, came to OPD with beta hCG report of 5830 mIU/ml. Her general condition was poor, temperature 37.8^{0}C with

pulse of 104 bpm and BP of 100/700 mmHg. On examination abdomen was soft, with tenderness in left lower pelvic region. On P/V examination uterus was 18-week size with left forniceal fullness and cervical motion tenderness. Sonography showed 2.5cm echogenic cystic mass in left adnexa separate from left ovary with mild peripheral vascularity with hemoperitoneum. Uterus showed large anterior wall intramural fibroid with endometrial thickness of 7 mm. A tentative diagnosis of ruptured ectopic pregnancy was made. In view of Hb 4 gm% patient was posted for emergency exploratory laparotomy.

Intraoperative findings showed 16-18-week size uterus with 7×8 cm anterior wall intramural fibroid. Massive hemoperitoneum with 500-700 gm clots noted. Bilateral tubes normal with normal right ovary. Left ovary showed 2 cm cystic mass with active bleeding. Left partial oophorectomy with dilatation and curettage was performed. Patient received 3-pint PCV intraoperatively.

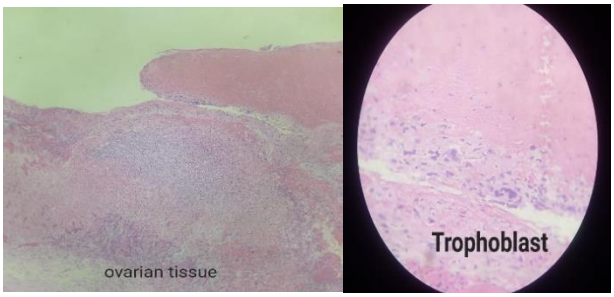

Figure 1: Histopathology findings.

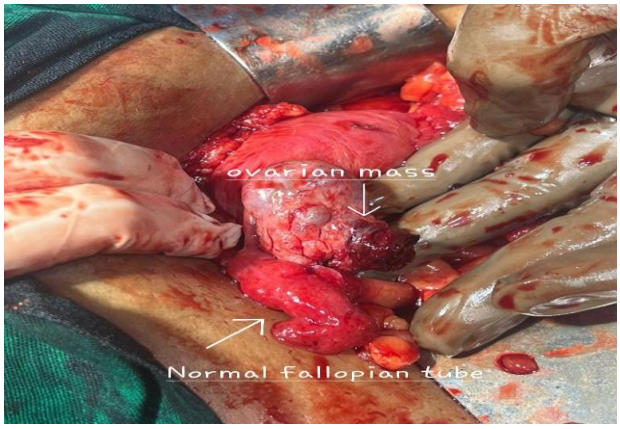

Figure 2: Intraoperative findings.

Serial beta hCG (48 hours apart) showed fall from 5830 mIU/ml to 955 mIU/ml, which came back to normal within 7 days. Histopathology report showed ovary with syncytiotrophoblast; features suggestive of ruptured ovarian ectopic gestation with secretory endometrium. Patient was discharged on fifth postoperative day.

DISCUSSION

Ovarian ectopic pregnancy is easily misdiagnosed since they are rare type of ectopic pregnancy. Their pathogenesis remains unclear. Presumed risk factors are intrauterine contraceptive device, salpingitis, infertility, and assisted reproductive techniques.[3]

Since the surface cortex of the ovarian pregnancy tissue is thin, they are always found to be ruptured in first trimester and misdiagnosed as corpus leuteal cyst.[4] The clinical manifestations of ovarian pregnancy are similar to those of tubal ectopic pregnancy, which include classic traid of amenorrhea, abdominal pain, and vaginal bleeding; thus, making diagnosis extremely difficult. Thus, investigations like beta hCG level and ultrasound are important. The classical management for ovarian pregnancies has been surgical which has both a diagnostic and a therapeutic value. Since oophorectomy is a radical procedure small lesions can be managed by ovarian wedge resection. With larger lesions oophorectomy is often performed. Considering patient's age, fertility and the size of the mass medical management with methotrexate can be tried to treat unruptured ovarian ectopic.[5]

CONCLUSION

Ovarian pregnancy is a rare entity with diagnosis being difficult and relies on criteria based on intraoperative findings. Thus, a high level of clinical and radiological suspicion is required. Its definitive management is surgical therapy.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Goyal LD, Tondon R, Goel P, Sehgal A. Ovarian ectopic pregnancy: A 10 years' experience and review of literature. Iran J Reprod Med. 2014;12(12):825-30.
2. Kadau JV. Sonographic Detection of Ovarian Ectopic Pregnancy: A Case Study. J Diagnostic Med Sonograph. 2016;32(5):299-303.
3. Goyal LD, Tondon R, Goel P, Sehgal A. Ovarian ectopic pregnancy: A 10 years' experience and review of literature. Iran J Reprod Med. 2014;12(12):825-30.
4. Ghasemi Tehrani H, Hamoush Z, Ghasemi M, Hashemi L. Ovarian ectopic pregnancy: A rare case. Iran J Reprod Med. 2014;12(4):281-4.
5. Birge O, Erkan MM, Ozbey EG, Arslan D. Medical management of an ovarian ectopic pregnancy: a case report. J Med Case Rep. 2015;9:290.

Cite this article as: Bendre K, Kulkarni S, Gejele S. A rare case of an ovarian ectopic pregnancy. Int J Reprod Contracept Obstet Gynecol 2023;12:2850-1.