

CASE REPORT

Ruptured Second Trimester Ectopic Tubal Pregnancy: Case Report

Insia Ashfaq¹, Junaid Iqbal², Sara Zafar³, Ambreen Ibrahim⁴,
M. Kashif Shazlee⁵, Irfan Lutfi⁶.

ABSTRACT:

Ectopic pregnancy (EP) is one of the leading causes of maternal mortality. Its frequency in Pakistan is 1:13 pregnancy.¹ Tubal ectopic often becomes symptomatic in first trimester by eroding the tubal wall and causing hemorrhage and shock. It is very rare for an ectopic to progress into second trimester and remain asymptomatic². We are reporting a rare case of tubal ectopic pregnancy which ruptured at 16 weeks of gestation with non-viable fetus.

We report a case of 27-year-old female who presented to the emergency of Dr. Zia Uddin Hospital, North Nazimabad, Karachi, with bleeding per vagina and abdominal pain with history of 4 months of amenorrhea. Ultrasound showed 16 weeks fetus in abdomen without cardiac activity and severe hemoperitoneum. She was diagnosed as a case of non-viable, ruptured, tubal ectopic pregnancy of 16-week gestational age.

Diagnosis of ectopic pregnancy in first trimester can avert rupture and potential mortality and morbidity. Very few cases of second trimester ectopic pregnancy are reported. The purpose of this case report is to draw the attention for the potential of such incidence in this region and prompt management of such situation.

Keywords: Ectopic pregnancy, Rupture, Ultrasound

INTRODUCTION:

Incidence of EP ranges between 0.25% to 2% of all pregnancies and 15% of all maternal deaths³. The ampullary portion of the fallopian tube is the most common location⁴. The diagnosis of ectopic pregnancy is typically based on a combination of quantitative assay for β -HCG and findings on pelvic sonography⁵. Tubal pregnancies generally rupture between 5 and 11 weeks of gestation⁶.

However, some cases of advanced tubal pregnancies have been reported with a different presentation. This event is rare because it is unusual for the fallopian tube to dilate to the point of containing a second or third trimester fetus⁷. We report an unusual case of ruptured

advanced tubal pregnancy, which we have observed for the first time in our unit.

CASE REPORT:

A 27-year-old patient, primigravida, unbooked case presented with 16 weeks of gestation and was admitted with bleeding per vagina and abdominal pain. Her general medical history revealed no other problems. Her current obstetric care had included one clinic visit without any sonographic examination.

The patient was hemodynamically unstable with abdominal tenderness. A mass, around 15 cm in diameter with regular contour, was palpable between the umbilicus and the pubic bone on the right side of the abdomen. Mobilization was limited and painful.

An emergency transabdominal ultrasound was performed which revealed an empty, ante-verted bulky uterus with a fetus in the abdominal cavity. The endometrial thickness was 1.8cm. Both ovaries visualized in cul-de-sac appeared unremarkable. An intra-abdominal fetus corresponding to gestational age of 16-week was identified with surrounding amniotic sac at the level of umbilicus with posterior placental attachment. No cardiac activity was appreciated. Massive fluid with echoes was seen in pelvis and at hepatorenal angle which on ultrasound guided aspiration revealed hemorrhagic fluid. An emergency laparotomy was carried out. A large vascular mass, 15 cm x 15 cm was found which proved to be the right fallopian tube, ruptured at isthmus and containing a fetus weighing 190gm. The uterus was small with a normal left tube and both ovaries. Massive hemorrhagic fluid was also drained from peritoneal cavity. Gross morphological examination showed a placenta invading the external surface of the fallopian tube. Histopathology revealed second trimester villi with areas of inter villous fibrin deposit and hemorrhage. The patient had an uneventful postoperative recovery.

DISCUSSION:

Incidence of Ectopic pregnancies ranges from 0.25% to 2% of all pregnancies³. Ninety-five percent of ectopic

✉ **Dr. Insia Ashfaq**
Post graduate resident 4th year
Dr. Ziauddin Hospital
Karachi

✉ **Dr. Junaid Iqbal**
Senior registrar
Dr Ziauddin Hospital
Karachi
E-mail:junaid2008@gmail.com

✉ **Dr. Sara Zafar**
Post graduate resident 4th year
Dr Ziauddin Hospital
Karachi

✉ **Dr. Ambreen Ibrahim**
Post graduate resident 4th year
Dr Ziauddin Hospital
Karachi

✉ **Dr. M. Kashif Shazlee**
Head of Department
Dr Ziauddin Hospital
Karachi

✉ **Dr. Irfan Lutfi**
Associate professor
Dr Ziauddin Hospital
Karachi

Received: 16-01-2017
Revised: 03-02-2017
Accepted: 20-03-2017

pregnancies occur in the fallopian tube. Diagnosis and exact location of ectopic pregnancy is usually easy during the 1st trimester of pregnancy by ultrasonography. Ampulla is the most common site for ectopic tubal pregnancies⁸. They generally rupture between 5 and 11 weeks of gestation⁶. The diagnosis of ectopic pregnancy is typically based on a combination of quantitative assay for β -HCG and findings on pelvic ultrasound.

Hemorrhage from ectopic pregnancy is the leading cause of pregnancy-related maternal death in the first trimester. Thus, prompt and accurate diagnosis is critical⁵. However, in extremely rare conditions they may be carried up to an advanced gestational age and may be associated with diagnostic difficulty⁸.

In developing countries ectopic pregnancies are most often discovered when ruptured. Cissé et al⁹, in a study in Senegal, reported 242 out of 255 (94.9%) cases being detected at the time of rupture. The incidence of late diagnosis is the consequence of late antenatal care and absence of ultrasound facilities and is responsible for significant mortality: 1.2% in the study of Cissé et al. Risk factors for ectopic pregnancy include a previous ectopic pregnancy, the presence of tubal damage from

an infection or prior abdominal/pelvic surgery, a history of infertility, treatment for in vitro fertilization, increased maternal age and smoking¹⁰.

The treatment of advanced tubal pregnancy is always a total salpingectomy. Even if the patient has the desire for future child-bearing, it would be difficult to perform conservative tubal surgery due to excessive deformation of the fallopian tube⁶. In our case, laparotomy was performed due to the site of the ectopic pregnancy being near the interstitial portion of the tube.

CONCLUSION:

Second trimester un-ruptured tubal pregnancy is rare among ectopic pregnancies. Ultrasonography is still the diagnostic modality of choice. Diagnosis of ectopic pregnancy in first trimester can avert rupture and potential mortality and morbidity. There is need for health education to encourage women to attend clinic early in pregnancy, especially when experiencing unusual symptoms of lower abdominal pain and irregular vaginal bleeding. That could help in the diagnosis of un-ruptured ectopic pregnancy.

Figure: 1

Ultrasound scan uterus shows dilated endometrial canal without intrauterine pregnancy



Figure: 2

Ultrasound scan abdomen shows extra uterine (ectopic pregnancy). BPD & FL equivalent to 15-week fetus



REFERENCES:

1. Parveen S. Ectopic pregnancies at unusual location: Diagnosis and management with limited resources. *J of Surg.* 2011; 16(1)
2. Mhaskar R, Harish M Jaiprakash T. Unruptured Ampullary Ectopic Pregnancy at 16-week Period of Gestation with Live Fetus. *J Obstet Gynaecol India* 2014; 64(1): 73-4
3. Ayaz A, Emam S, Farooq U. Clinical course of ectopic pregnancy: A single-center experience. 2013; 6(1):70-73
4. 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): 3224-30
5. Kao LY, Scheinfeld MH, Chemyak V, Rozeenblit AM, Oh S, Dym RJ. Beyond ultrasound: CT and MRI of ectopic pregnancy. 2014; 202(4):904-11

6. Nkwabong E, Tincho EF. A case of a 26-week ampullary pregnancy mimicking intrauterine fetal death. *Anatol J Obstet Gynecol* 2012; 1(2): 1-3
7. Guèye MDN, Guèye M, Thiam I, Mbaye M, Gaye AM, Diouf AA, et al. Unruptured tubal pregnancy in the second trimester. *SSMJ* 2013; 4 (6)
8. Sachan R, Gupta P, Patel ML. Second trimester unruptured ampullary ectopic pregnancy with variable presentations: Report of two cases. *International Journal of Case Reports and Images* 2012; 3(8):1-4
9. Cissé CAT, De Bernis L, Faye EO, Diadiou F. Grossesse extra-utérine au Sénégal. *Carnets de Santé*; 2002 12(2): 271-274
10. Radaelli T, Bulfamante G, Cetin I, Marconi AM, Pardi G. Advanced tubal pregnancy associated with severe fetal growth restriction: a case report. *The Jour of Mat-Fet and Neonat Med.* 2003; 13: 422-25

