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Ruptured Ectopic Pregnancy Two Years After Supracervical Hysterectomy

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Abstract: ***This is an interesting case report of a patient who presented with ruptured ovarian ectopic pregnancy two years after hysterectomy. Ovarian ectopic is a rare event and posthysterctomy ovarian ectopic is even more rare event . Any patient in reproductive age group with history of hysterectomy but with intact ovaries if presents with acute abdomen, a possibility of ectopic pregnancy should always be considered. A 30 yr. old female with history of supracervical hysterectomy done two years ago presented with acute pain in abdomen with vaginal bleeding. She was examined, investigated and diagnosed as a case of ectopic pregnancy, for which emergency laparotomy was done. Laparotomy confirmed the diagnosis and patient was subsequently successfully managed.***

Keywords: ectopic, supracervical hysterectomy, late presentation

1. Introduction

Ectopic pregnancy after hysterectomy (vaginal or abdominal) is a very rare event. “Early presentation” ectopic pregnancies occurs within few weeks of hysterectomy when operated in the periovulatory or luteal phase of menstrual cycle. “Late presentation” ectopic pregnancies are likely to be dependent on the type of hysterectomy performed and the presence of a residual cervix.(1)

2. Case Details

A 30 year old female P4L3A1, attended our outpatient department with complaints of pain lower abdomen associated with spotting per vaginum since last 2 days (patient gave history and discharge ticket of subtotal hysterectomy done for rupture uterus 2 years back in the same institution , and was amenorrhoic for last 2 years). The pain was acute in onset, severe in nature with increasing intensity in lower abdominal quadrant. The pain was associated with spotting per vaginum of dark red colour, for which she sought consultation at our hospital.

On examination the patient’s condition and vital parameters were stable with mild pallor. Per abdominal examination revealed a midline vertical healthy scar of previous hysterectomy. A mass was felt in lower abdomen corresponding to around 16 weeks, which was tender to touch. Per speculum examination revealed a healthy vagina, cervical stump was clearly seen with bleeding of altered dark red colour, slight in amount seen through the cervical os. On bimanual examination an ill-defined , tender, cystic mass of 14-16 weeks size of pregnancy was felt. Cervical motion tenderness was present.

Keeping a diagnosis of twisted ovarian tumor versus a less likely diagnosis of ectopic pregnancy a pelvic sonography was done, which revealed a collection of 5.2 X4.2X5.1 cm seen above the cervical region, bilateral ovaries appeared normal, uterus not visualized, fluid collection seen in pouch of Douglas. A urine pregnancy test was done immediately, which was strongly positive. With the diagnosis of ectopic pregnancy patient was prepared for emergency laparotomy. A blood sample was drawn and sent for serum beta HCG for confirmation.

During intraop, the peritoneal cavity was full of blood and clots amounting to about 1000ml, which were suctioned out. Dense adhesions were present between bladder, cervical stump, tubes, ovaries and omentum. On right side ovary was enlarged with a ruptured cyst wall, the right tube and fimbria densely adhered with ovaries. A thick whitish tissue like the wall of cyst was seen adhered to the serosa of sigmoid colon (3X2cm) which was vascular and appeared like chorionic villi. It was removed and sent for HPE. Left ovary and tube were apparently normal. Right sided salpingoopherectomy with left salpingectomy was done and sent for HPE. Left ovary, as it was normal looking and patient was young was left in-situ. Peritoneal cavity was cleaned, abdomen closed in layers. Patient tolerated the surgery well and was transfused 2 unit of whole blood postoperatively. The quantitative B-HCG level came out to be 646 miu/ml.

The HPE report showed multiple follicular cyst, marked haemorrhage,omental tissue, chronic inflammatory infiltrate,and few fragments of early chorionic villi and decidual tissue adhered to right cyst wall compatible with ovarian ectopic pregnancy.

Keeping the clinical picture, the intra operative findings ,B-HCG report & HPE report in view, a diagnosis of ruptured ovarian ectopic pregnancy was made (5).

3. Discussion

There has been around 60 reported cases of an ectopic pregnancy following hysterectomy so far. Most of these cases were due to pregnancies conceived before hysterectomy known as " early ectopic"and were subsequently identified 29to 96 days after hysterectomy. (1),(2)This is in contrast to" late ectopic" pregnancies which have been reported to occur as late as 12 years after hysterectomy.(3) These cases appear to be more common when a vaginal hysterectomy as opposed to an abdominal hysterectomy has been performed . Late ectopic pregnancies occur because of existence of a fistula between the cervical stump and peritoneum in subtotal hysterectomy. This fistulous tract allows a path for the sperm to reach and subsequently fertilize ova. It has been hypothesized that fallopian tube prolapsed after a vaginal hysterectomy increases the risk of an ectopic pregnancy(4).

4. Conclusion

Ectopic pregnancy is rarely entertained in the differential diagnosis of acute pelvic pain in patients after hysterectomy. Ectopic pregnancy under any circumstance is a surgical emergency that can cause significant risk for the patient's life, so it should be considered in any premenopausal woman with atleast one remaining ovary who comes with abdominal pain.(5) Our report illustrates that an inexpensive urine pregnancy test combined with ultrasonography can make a timely and correct diagnosis which could be lifesaving for the patient.(6)(7)

References

[1] Babikian S,Thoma DC, David,Berkey BD . Ruptured ectopic pregnancy after supracervical hysterectomy; J Ultrsound Med 2008;27:1087-1090
[2] Fader AN, Mansuria S,Guido RS,et al:A 14-week abdominal pregnancy after total abdominal hysterectomy.Obtet Gynecol 2007;109:519-521
[3] Pasic R ;Sootee J,Tolar B. Ectopic pregnancy months after laparoscopic supracervical hysterectomy J Am Assoc Gynecol Laparosc 2004 11: 94-95
[4] Wlesenfield HE, GuldoRS, images in clinical medicine intraabdominal preg. After hysterectomy N Eng J Med 2003 ; 349;1534.
[5] Brown WD, Burrows L,Todd CS. Ectopic pregnancy after Caesarean hysterectomy Obstet Gynecol 2002;99.933-934
[6] Adeyemo D,Qureshi M, Butler C. Tubal ectopic preg. Cause of acute abdomen following hysterectomy. J Obstet Gynecol 1999;19.320
[7] Binder DS: Thirteen -week abdominal pregnancy after hysterectomy.J Emerg Med 2003;25:159-161

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