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RIGHT CORNUAL ECTOPIC PREGNANCY-CASE REPORT

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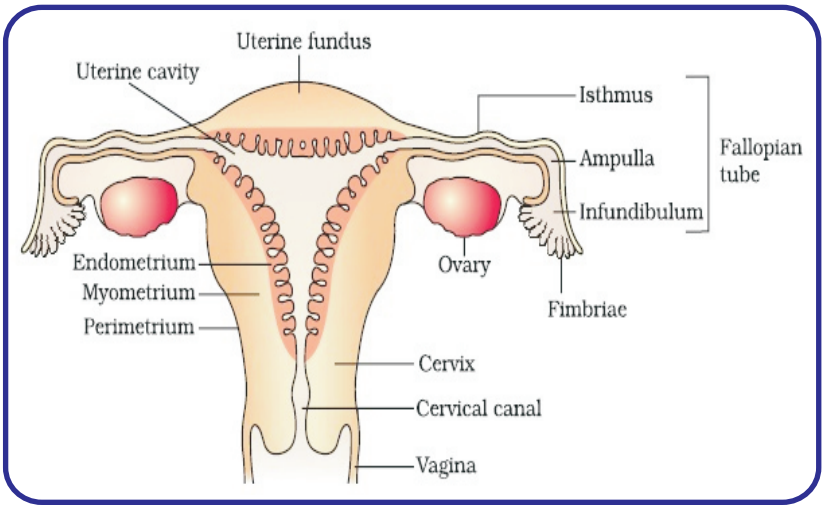
ABSTRACT

Aim: To report a rare case ofcornual ectopic pregnancy in a 21 year old primigravida with signs ofhaemoperitoneum.

Presentation of case:.Patient presented with signs of peritonism due to haemoperitoneum.Intraoperatively, she was found to have an intact gestational sac at the right cornu, with fetus 16 weeks in size.

Discussion: Cornual ectopic pregnancy usually presents during late first or early second trimester.The case was tackled initially by General surgeon as it was presented with signs of peritonism and live intra uterine fetus sonographically.

Conclusion: Cornual ectopic pregnancy can present as haemoperi toneum and should be investigated thoroughly before proceeding to further treatment.



Key words: Cornual ectopic; ultrasonography; laparotomy, pregnancy.

1. INTRODUCTION:

Pregnancy implantation in the intrauterine portion of fallopian tube is known as cornual ectopic or interstitial ectopic pregnancy[1]. There is an inherit difficulty in its diagnosis and treatment leading to high morbidity and mortality compared with other ectopic pregnancies. Although cornual ectopic pregnancy is a rare event. Its incidence has been reported to be varying from1.5–2%[2] to2% - 4% of all tubal pregnancies [3]. Late first trimester or early second trimester rupture is known to occur in cornual pregnancy. The therapy for this condition usually surgical which consists of either hysterectomy or cornual resection as the treatment of choice [4], but recently increasing number of laparoscopic or even hysteroscopic approach have been used[5]. Routine transvaginal ultrasound scanning should diagnose and allow prevention of rupture in most of these cases.

2. CASE PRESENTATION

A 21 year- old Gravida 1 Para 0 at 16 weeks and 4 days gestation, estimated date of delivery 16/5/11, no known medical illness, presented to the accident and emergency (A & E) department of Hospital Sultanah Nora Ismail, BatuPahat, with abdominal pain since 2pm (after taking the meal) on the day of admission. Initially the pain was suprapubic, which then became generalized. She also had 4 episodes of pre-syncopal attacks since the afternoon on the day of admission. It was associated with generalized body weakness and an episode of vomiting. She felt giddiness and shortness of breath after that. There was no chest pain, no per vaginal bleeding, no history of trauma or abdominal massage, no fever. She had normal bowel output, normal micturition and no diarrhoea. Antenatally, she had an ultrasound done at 8 weeks of gestation, which showed intrauterine pregnancy. At 15 weeks of gestation she had a history of admission due to generalized abdominal discomfort, however she was discharged well after that.

On examination, she was found to be pale. Her blood pressure was 100/60 mm Hg, and pulse rate was 109/minute. Oxygen saturation in pulse oximeter was 100% under room air. She was admitted to obstetric ward for further evaluation and management.

She was examined by the obstetrician on duty. On abdominal examination, uterine size was at 16 weeks size, generalized tenderness with guarding. However the uterus was not irritable. There was no contraction felt. On vaginal examination, external genitalia was normal, cervix 2cm, posterior, medium consistency. Os was closed, cervical excitation was positive. Bilaterl adnexa and pouch of douglas did not reveal any fullness. There was no blood stain at glove. On per rectal examination, there was fullness over posterior region. Stool was brownish, anal tone normal.

On transabdominal ultrasound, the fetal lie was longitudinal with breech presentation, Growth parameters corresponded to date. Fetal heart was seen, heart rate around 140beats per minute, placenta was found in the posterior upper segment of uterus, no retroplacental clot. No cysts or fibroid seen. Free fluid was noted at the Morrison pouch. She was transfused with 500mL whole blood. Repeated transabdominal ultrasound showed free fluid in abdomen and pelvis. Differential diagnosis of perforated viscus was considered. Subsequently exploratory laparotomy was done by the general surgeon on duty at midnight to rule out ruptured viscus.

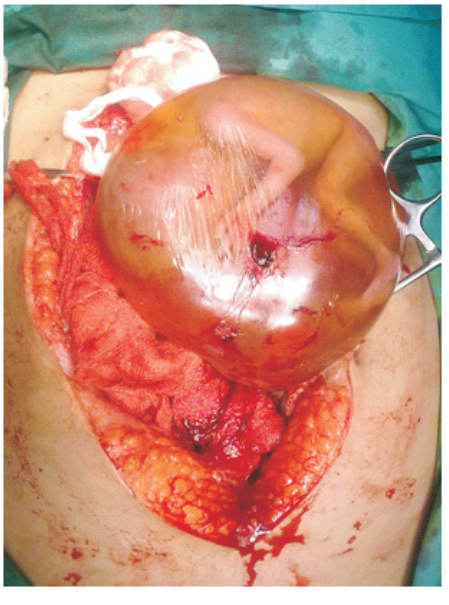


Figure 1 showing foetus with intact gestational sac in the peritoneal cavity.

After opening the perotonium,hemoperitoneumof 3 litres was sucked out. An intact gestational sac due toruptured right cornu with fetus 16 weeks in size was noted. The obstetrician was called to join the surgical team.

Fetal heart was present and umbilical cord was attached, but the placenta partially extruded, with a vascular area surrounding the cornual edges. However deeper areas of the placenta showed signs of placenta increta, and therefore the placenta was unable to be separated completely. Part of the placenta was retained. Hemostasis at placenta bed secured. There was also right moderate hydrosalpinx but viable tube, the right fimbrial end was free. There was adhesions between the large bowel and omentum to the left pelvic wall and uterine left cornual region. The left tube was tortuous, but the fimbrial ends free. The left fallopian tube and ovary was adhered to the posterior uterine wall. By this time fetus was found to be dead. After removal of dead fetus the right cornu was repaired in 2 layers once hemostasis secured at the placental bed. She was hemodynamically stable during the surgery. Total estimated blood loss was 5L, which was replaced with 8 units of whole blood in the operation theatre. After stabilization of the patient, appendectomy was performed in view of its long and hyperemic appearance.

She was transferred to intensive care unit (ICU) at around 4am for monitoring. In the ICU she was sedated with midamorphine and intubated. Her abdominal dressing was not soaked, bowel sounds sluggish, abdomen soft, distended. Drain at right side was 20cc in tubing and left was 80cc, hemoserousfluid.Urine output was 150cc over 1 hour. She was transfused with 2 units of packed cells. Intravenous cephelosporin 1g BD and intravenous metronidazole 500mg TDS were given for 5 days.She was subsequently extubated after 12 hours and transferred out from the ICU into the obstetric ward. She was discharged from the hospital and advised to come for suture removal after five days. Wound healed well and her general condition was good. She was advised to go for further follow up to obstetrics clinic

4. DISCUSSION

With the invention of assisted reproductive techniques, incidence of ectopic pregnancy is on the rise. The widespread use of transvaginalultrasonography and serum β hCG assays have improved the preoperative diagnosis of ectopic pregnancies, however diagnosing cornual pregnancy remains a challenge. Its diagnosis is usually delayed as this part of the tube has good muscular and vascular support which results in good distensibility and thus causing less pain [6]. The common risk factors of other types of ectopic pregnancies like pelvic inflammatory disease, history of previous ectopic, history of tubal surgery, assisted reproductive technology, use of intra uterine contraceptive device, increasing age, smoking, previous pelvic surgeries are similar for this type also [6]. In a patient of pregnancy presenting with acute abdomen, when haemoperitoneum or pelvic mass is found on ultrasonography, ectopic pregnancy should be considered. MRI was found to be usefull in the evalution of various types ectopic pregnancy [7] .In our case, we did only ultrasound abdomen which showed normal live fetus, so we did not order for trans vaginal ultrasound or MRI.

5. CONCLUSION

Cornual ectopic pregnancy can present very early in the first trimester. MRI and Trans vaginal ultrasound would be more useful to arrive proper diagnosis of cornual ectopic in difficult casesand acute presentations of the first trimester.

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