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Bilateral tubal ectopic pregnancy ... Unusual Ectopic will become Less Unusual

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Abstract Bilateral tubal ectopic pregnancy is very rare and usually occurs following ovulation stimulation, with an estimated incidence of 1/2000000 during pregnancy and 1/725-1/1580 ectopic pregnancy. Totally more than 200 cases of bilateral tubal ectopic pregnancies have been reported in the literature. We report 34-year-old primigravida with spontaneous bilateral unruptured tubal ectopic pregnancy. The diagnosis of ectopic pregnancy has been made on clinical suspicion and ultrasonography. The diagnosis of bilateral tubal ectopic pregnancy has been made during surgery and confirmed on histopathological examination. Bilateral tubal ectopic pregnancy is rarely diagnosed preoperative, so both tubes at the time of surgery should be closely examined in order to prevent maternal mortality and morbidity.

Introduction:

Ectopic pregnancy is still the leading cause of pregnancy-related death in the first trimester, and accounts for 9% to 13% of all pregnancy related deaths.[1,2] Despite the increasing rates and the increased detection methods, ectopic pregnancy is misdiagnosed in more than 40% of patients on the initial emergency department visit.[2] Finally, missed ectopic pregnancy is one of the leading causes of emergency medicine malpractice risk, recently the incidence of ectopic pregnancy ,which was 4.5-16.8 per 1000 has increased because of using assisted reproductive techniques.[3] The least form of ectopic pregnancy is the bilateral tubal pregnancy, which occurs spontaneously.[4] The risk factor for bilateral tubal pregnancy are previous ectopic pregnancy, history of pelvic inflammatory disease, use of an intrauterine device (IUD), smoking, assistant reproductive techniques and tubal surgery. The presence of any of these risk factors should increase suspicion for ectopic pregnancy. The absence of risk factors is not reassuring, however, because at least 40% to 50% of patients with proven ectopic pregnancies have no risk factors.[1,5,6] There has been an increase in the number of published case reports of bilateral tubal pregnancies following assistant reproductive techniques, but spontaneous unruptured bilateral tubal pregnancy remains a rare event.

Case report: A 34-year-old primigravida has been admitted with sever colicky lower abdominal pain for 20 hours. She had 9 WK amenorrhea and PV spotting 3 days prior to admission. She has been married for 6 years. She had history of induction of ovulation with clomid several times with last doses for 6 months. She had no history of contraception use, sexual transmitted infections, or previous abdominopelvic surgery.

On Examination: The patient looked ill and feeling pain, with no pallor, PR was 90, BP was 90/60mmhg, and the temperature was 37°C. On Abdominal examination, there was tenderness at right and left lower quadrant, with positive rebound tenderness. On Pelvic examination, there was dark pv spotting, positive cervical excitation, with uterus size 12 WK, right and left adnexa were tender on palpation.

Heamoglobin 10g/dl, heamatocrit 30%, wbc 9300/mm, and BhcG 8000IU\L. Transvaginal ultrasound revealed anteverted uterus with ET of 12mm, right heterogeneous adenexial mass about 35*30mm and large amount of pelvic fluid suggestive of ectopic pregnancy. Exploratory laparotomy under effect of general anesthesia revealed bilateral unruptured tubal pregnancy with heamoperitoneum about 400cc. Right tube contained intact mass at ampullary portion about 3*4cm. The left tube contained an intact mass measuring 2*2cm in fimbrial portion, with active bleeding from fimbrial end. Right salpingestomy was done, milking to left tube with expulsion of ectopic tissue through fimbrial end and infiltration of adrenalin 1:1000 at mesosalpinx at level of left fimbria with heamostasis. The patient was discharged 3 days after operation, and serum BhcG declined to an undetectable level during 10 days. The pathology report confirmed the diagnosis of ectopic tubal pregnancy in ampullary portion of right tube and blood clot and chorionic villi in the tissue removed from the left tube.

Discussion:

Spontanous bilateral ectopic pregnancy is rare. Therefore, preoperative diagnosis is uncommon and most cases diagnoses were intraoperative. Ultrasonography in our case failed to diagnose of bilateral tubal pregnancy. In cases reported by Andrews et al., Campo et al., and Prady et al. they also failed to make diagnosis based on ultrasonography.[7-9] One case of preoperative diagnosis according to ultrasonographic finding was reported by Martinez et al.[10] In our case, because of the large amount of pelvic free fluid and BhcG which was 8000iu\l, it was not suitable for medical management with methotrexate. Therefore, exploratory laparotomy was performed. In published case report of bilateral tubal pregnancy, one tube was intact and other tube was rupture. But in our case both tubes were intact, Al Quraan et al and Brady et al. reported bilateral tubal pregnancy with one tube rupture and the other intact.[9-11] The management in our case was salpingostomy to the right tube ,milking

of left tube and infiltration of left mesosalpix by adrenalin. Treatment of bilateral tubal pregnancy is controversial and it ranges from bilateral salpingectomy to the conservative approach, such as salpingestomy and salpingectomy. Andrews et al.[7] reported bilateral tubal pregnancy that laparoscopic salpingectomy was used, and the patient was subsequent treated with methotrexate because of persistence ectopic pregnancy. Mandal et al.[12] reported a case with bilateral tubal pregnancy in which bilateral salpingectomy was done. When the exploratory laparotomy or laparoscopy is undertaken for ectopic pregnancy, close inspection of both adnexae is necessary even in the presence of adhesion to prevent maternal morbidity and mortality. **References**:

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