Tubal Ectopic Pregnancy – A Clinical Study

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ABSTRACT

Background: The diagnosis of an ectopic pregnancy is usually unexpected and is often emotionally traumatic. Many women may have only recently discovered they were pregnant when they receive the diagnosis. Some women diagnosed with an ectopic pregnancy do not even know they are pregnant and suddenly must think about the possibility of major surgery or medical treatment. The objectives of the study were, 1. To know the age group, gravidity, parity and the risk factors with respect to the ectopic pregnancy. 2. To know the clinical presentation of the ectopic pregnancy. 3. To know the outcome of the ectopic pregnancy.

Methods: This is a retrospective study conducted at Multispeciality Hospital, Pune during the 7 month period commencing from June 2019 to December 2019. The study covered all the cases of Ectopic pregnancy that came during that time frame.

Results: Commonest gestational age to diagnose tubal ectopic pregnancy was 6-7 weeks. No significant differences existed in gestational age, pelvic inflammatory disease. The most common symptom in our study was anemia, lower abdominal pain and spotting. Fallopian tube was the commonest site of ectopic pregnancy and out of which Ampulla part was the commonest site in fallopian tube. Maximum number of patient of tubal ectopic pregnancy could be managed by Laporoscopy.

Conclusion: Tubal Ectopic pregnancy is a diagnosis of suspicious patient and can possible to manage in early gestational age to morbidity & mortality.

Key Words: Ectopic pregnancy, Fallopian tube, Salpingectomy, Laparoscopy, Laparotomy

INTRODUCTION

Ectopic pregnancy is defined as any intra or extrauterine pregnancy in which the fertilized ovum implants at an aberrant site which is inconducive to its growth and development. Ectopic pregnancy is assuming greater importance because of its increasing incidence and its impact on women’s fertility. Ectopic pregnancy remains the leading cause of maternal deaths in early pregnancy. With respect to the management of ectopic pregnancy, there has been tremendous technical advances. The early diagnosis and treatment of this condition over the past two decades has allowed a definitive medical management of unruptured ectopic pregnancies even before there were clinical symptoms in these high risk women. The current trend is a conservative way of management of these pregnancies be it chemotherapeutic agents or conservative surgical approaches, the ultimate goal is TUBAL CONSERVATIVE PROCEDURES rather than radical surgeries. Tubal ectopic pregnancy could be managed by Laporoscopy.

AIMS & OBJECTIVES

1. To know the age group, gravidity, parity and the risk factors with respect to the ectopic pregnancy. 2. To know the clinical presentation of the ectopic pregnancy. 3. To know the outcome of the ectopic pregnancy.

MATERIALS AND METHODS

This is a retrospective study conducted at Multispeciality Hospital, Pune during the period commencing from June 2019 to December 2019. The study covered all the cases of Ectopic pregnancy that came during that time frame and incidence, risk factors and mode of clinical presentation of ectopic pregnancy was calculated. All patients with a history suggestive of ectopic pregnancy and in whom diagnosis was confirmed by clinical acumen, ultrasound or direct observation at laparotomy are included in the study. All the surgeries were done by laparotomy and spinal/general anesthesia was used in all the cases. This retrospective analysis was done to determine the incidence, clinical features, risk factors, treatment and morbidity and mortality associated with ectopic pregnancy in a Multispeciality Hospital, Pune.
The following patient characteristics were recorded: age, height, weight, gestational age of ectopic pregnancy, and quantitative beta-hCG level. Conditions that predispose to adhesion formation, including prior surgeries, ectopic pregnancy, history of pelvic inflammatory disease, and endometriosis were recorded. Gravidity and parity were also noted. The amount of internal bleeding and unstable vital signs were the parameters used to determine whether to proceed with most laparotomy cases.

The following outcome information was collected from operative and anesthesia records: estimated blood loss, operative time, operative complications, type of surgery performed, and length of hospital stay. Estimated blood loss was defined as blood loss from the surgery and preexisting blood loss found on entry into the abdomen. Operative time was defined as time between starting and finishing the procedure.

RESULTS

During the period of study, there was 27 deliveries in the hospital and there were 7 cases of ectopic pregnancy.

Table 1. Age Distribution

<table>
<thead>
<tr>
<th>Age Groups (in years)</th>
<th>Number of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>26-30</td>
<td>04</td>
<td>57.14</td>
</tr>
<tr>
<td>31-35</td>
<td>02</td>
<td>28.57</td>
</tr>
<tr>
<td>36-40</td>
<td>03</td>
<td>14.28</td>
</tr>
</tbody>
</table>

The age of patients ranged between 26-40 years. The prevalence of ectopic pregnancy was highest in age groups of 26-30 years.

Table 2. Parity

<table>
<thead>
<tr>
<th>Parity</th>
<th>No of Patient</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nullipara</td>
<td>02</td>
<td>28.57</td>
</tr>
<tr>
<td>Multi para</td>
<td>05</td>
<td>71.42</td>
</tr>
</tbody>
</table>

The parity ranged from nulliparous to multigravida. In this study, out of 7 case, 2(28.57%) were nulliparous and the rest 05(71.42%) were parous.

Table 3. Predisposing factors

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Number of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic inflammatory Disease</td>
<td>01</td>
<td>14.28</td>
</tr>
<tr>
<td>Previous Ectopic</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>Treatment of infertility</td>
<td>01</td>
<td>14.28</td>
</tr>
<tr>
<td>No significant risk factor</td>
<td>05</td>
<td>71.42</td>
</tr>
</tbody>
</table>

In the study of 07 cases of ectopic pregnancies, Pelvic inflammatory disease was found in 01(14.28%) cases. 1(14.28%) patients had conceived after treatment of infertility.

Table 4. Presenting Symptoms

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Number of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain abdomen</td>
<td>07</td>
<td>100</td>
</tr>
<tr>
<td>Amenorrhoea</td>
<td>07</td>
<td>100</td>
</tr>
<tr>
<td>Spotting per vagina</td>
<td>06</td>
<td>85.71</td>
</tr>
<tr>
<td>Fainting spells</td>
<td>04</td>
<td>57.14</td>
</tr>
</tbody>
</table>

All the cases (100%) had pain abdomen, amenorrhoea was present in all cases (100%). Abnormal vaginal bleeding- spotting was present in 06(85.71%) cases. Fainting spells in 04(57.14) cases.

Table 5. Duration of Amenorrhoea

<table>
<thead>
<tr>
<th>Duration In Weeks</th>
<th>Number of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>03</td>
<td>42.85</td>
</tr>
<tr>
<td>6</td>
<td>03</td>
<td>42.85</td>
</tr>
<tr>
<td>7</td>
<td>01</td>
<td>14.28</td>
</tr>
<tr>
<td>8 &amp; Above</td>
<td>00</td>
<td>00</td>
</tr>
</tbody>
</table>

Out of the 7 cases studied, 6 had definite period of amenorrhoea ranging from 5 to 6 weeks.

Table 6. Site of Ectopic pregnancy in fallopian tube

<table>
<thead>
<tr>
<th>Site of Tube</th>
<th>Number of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interstitial</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>Isthmic</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>Ampulla</td>
<td>06</td>
<td>85.71</td>
</tr>
<tr>
<td>Isthmic- Ampullary</td>
<td>01</td>
<td>14.28</td>
</tr>
<tr>
<td>Infundibulum/Fimbria</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>00</td>
<td>00</td>
</tr>
</tbody>
</table>

The commonest site of Tubal ectopic pregnancy constitutes 85.71% is Ampulla part of the Tube.

DISCUSSION

Ectopic pregnancy remains a common gynecologic condition that causes significant maternal morbidity and mortality. The incidence of ectopic pregnancy has increased from 0.5% 30 years ago to a current incidence of 1% to 2%. The risk of ectopic pregnancy is increased by several factors: previous ectopic pregnancy, tubal damage from surgery, a history of infertility, treatment using in vitro fertilization, and increased age. In our study, the laparotomy group
had a significantly greater number of patients with a
history of previous ectopic pregnancy.

Because laparoscopy has been shown to be superior
to laparotomy, it has become the gold standard for the
treatment of ectopic pregnancy. However, in women 
who are hemodynamically unstable, the role of 
laparoscopy remains controversial. But as surgeons 
gain increased expertise in laparoscopic surgery, even 
in the presence of a large hemoperitoneum, operative 
laparoscopy is still achievable.

Obesity has an impact on whether laparoscopic 
surgery can be performed. Obesity, defined as 
BMI_30, is considered by some to be a 
relative contraindication to operative laparoscopy. 
Also, laparoscopic surgery in the obese population can be 
challenging. Increased abdominal wall thickness makes it difficult to achieve pneumoperitoneum and to 
visualize the inferior epigastric vessels. Moreover, 
increased omental and retroperitoneal fat limits 
maneuverability of the instruments. However, a 
recent report reveals that laparoscopic management 
of tubal ectopic pregnancy does not appear to 
significantly increase surgical morbidity in obese 
patients. In our study, BMI was not significant.

The mean operative time was shorter in the 
laparoscopy. This may contradict the results of many 
studies documenting the unpredictability of time 
needed for laparoscopic surgery, especially for ectopic 
pregnancy. Blood loss was less and hospital stay 
was shorter in the laparoscopy group. Previous 
randomized studies also have shown that 
laparoscopy results in less blood loss, a shorter 
hospital stay, and lower cost compared with 
laparotomy.

Doubt of Ectopic pregnancy should be kept in mind if a 
patient present with complaint of amenorrhea, pain 

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