Case report:

Case report of primary ovarian ectopic pregnancy

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Abstract
Primary ectopic pregnancy is a rare condition with incidence of 0.001%1,0.013%2 of normal pregnancies. Also diagnosis of this life threatening condition is difficult. We present a case of ruptured primary ovarian ectopic pregnancy with massive haemoperitoneum.

Key words: ovarian ectopic pregnancy, ovariectomy, haemoperitoneum

Introduction
Ectopic pregnancy is one in which the fertilized ovum becomes implanted in a site other than normal uterine cavity. In true ovarian pregnancy, ovum is fertilized while it is in the abdominal cavity,in the graffian follicle or in the process of leaving follicle. Pregnancy then develops within a capsule of ovarian tissue with corpus luteum immediately alongside it. Although incidence of ectopic pregnancy is on rise after assised reproductive technology techniques,primary ovarian ectopic pregnancy is still a rare condition. Incidence of such condition in literature is seen 0.001%,0.013%2 of normal pregnancies. It accounts for 0.15-3%3,0.3-3%4 of all ectopic gestations. This condition is difficult to diagnose before surgery5. Transvaginal ultrasound has proved to be an invaluable tool in the diagnosis of ovarian ectopic pregnancy6.

Case report
32 years old female presented with 7 weeks of amenorrhoea, complained of severe pain in abdomen & per vaginal bleeding since 2 days. Her previous menstrual cycles were regular,normal with average flow.Patient had history of 3 full term normal deliveries. She was not using any contraception. Last childbirth was 3 years back. On general examination-pulse rate-120/min,BP-100/60 mm Hg,pallor was present. On per abdominal examination there was slight distension of abdomen with tenderness in right iliac fossa. P/S examination-cervix,vagina were healthy.Slight vaginal bleeding noted. On bimanual examination-uterus was bulky,cervical movements were nontender,tender mass palpable through right fornix. Abdominal paracentesis revealed non clotting blood.

Investigations-Urine Pregnancy Test positive,Hb-6 gm%, TLC-10900/cmm, platelet count-2 lakhs /cmm,blood group O positive.

Ultrasonography of abdomen pelvis- suggestive of hemoperitoneum with hyperechoic shadow in right adnexa.Uterus was empty.

Diagnosis of ruptured tubal ectopic pregnancy was made and patient shifted for laparotomy. On exploration of abdomen,evidence hemoperitoneum about 1 litre and enlarged right ovary with oozing of blood from surface noted. Uterus , both fallopian
tubes and left ovary were normal. Right sided salpingo- ovariectomy done. Specimen sent for histopathology. Total 3 units of blood transfusion given intra & post-operatively. Post- operative period was uneventful. Patient was discharged on day 8 of operation. Histopath report confirmed diagnosis of primary ovarian ectopic pregnancy, showed villous structure embed in ovarian tissue.

Discussion

Primary ovarian pregnancy is a rare type of ectopic pregnancy with an estimated incidence of 0.5-3% of all ectopic gestations. With few exceptions, the initial diagnosis is made on operation table & final diagnosis only on the histopathology. Ovarian pregnancy can occur without any classical antecedent factors. However, there seems to be strong association with intra uterine contraceptive device. Other risk factors are ART, endometriosis & PID. Ovarian ectopic gestations are mostly associated with high parity, young age and ART. Common clinical features are abdominal pain, amenorrhea, with or without PV bleeding. Although early use of quantitative beta HCG assay & pelvic ultrasonography has increased our diagnostic capability for ectopic gestation, ovarian pregnancy still represents diagnostic problem. Ovarian pregnancy must be differentiated from tubal pregnancy, hemorrhagic ovary & ruptured corpus luteal cyst.

Spigelberg outlined four criterias for diagnosis of primary ovarian gestation

1. Intact fallopian tube on affected side.
2. Gestational sac should occupy the position of ovary on affected side.
3. Gestational sac should be connected to uterus by utero-ovarian ligament.
4. Ovarian tissue must be located in gestational sac wall.

In our case these criterias were fulfilled and histopathology further confirmed the diagnosis of ovarian ectopic pregnancy.

Classical management for ovarian pregnancy has been surgical. Different surgical options include- ovarian wedge resection, ovarian pregnancy enucleation, trophoblast curettage with coagulation of bed of ovarian pregnancy and ovariectomy.

In our case we performed salpingo ovariectomy on affected side.

Conclusion

Ovarian ectopic pregnancy is a very rare condition not only difficult to diagnose but also to distinguish from tubal ectopic pregnancy. Management is essentially surgical and early diagnosis and intervention can prevent mortality.

References


