

# CASE REPORT

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## VARIABLE PRESENTATION OF ECTOPIC PREGNANCIES

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**ABSTRACT:** Ectopic pregnancies can have varied presentations. They are common in reproductive aged women. Here, we report series of case reports of ruptured ectopic pregnancies whose clinical signs & symptoms included history of amenorrhea, irregular bleeding with no pain and no cervical motion tenderness on internal examination. The increased ratio of extra uterine to intrauterine pregnancy is related to the rising incidence of STD.

**KEY WORDS:** Ectopic pregnancy, rupture, laparotomy.

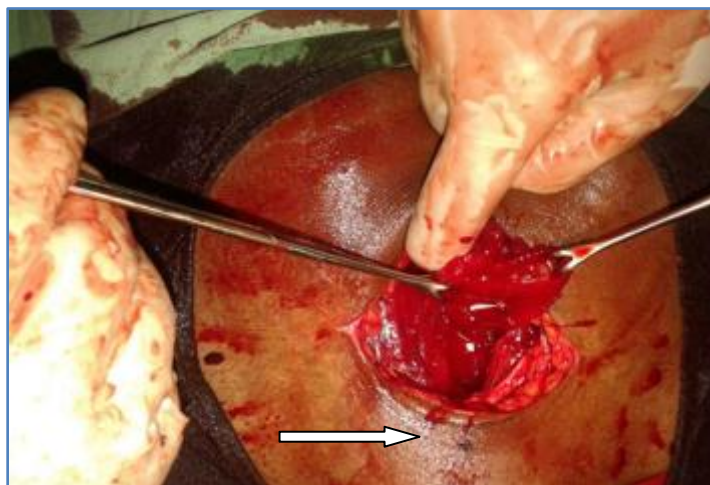
**INTRODUCTION:** Ectopic pregnancy commonly occurs in reproductive aged women with impaired tubal function. The usual symptoms and signs include history of ammenorhea, pain abdomen & bleeding. The diagnosis becomes difficult in cases when there is atypical presentation; however late diagnosis is fatal due to massive hemorrhage.

### CASE REPORTS:

1. G<sub>2</sub>P<sub>1</sub>L<sub>1</sub> with history of one and half months of amenorrhea with irregular bleeding per vaginum for three days. Patient was hemodynamically stable & internal examination revealed a 6weeks gravid uterus with no cervical motion tenderness & bilateral adnexa could not be appreciated because of obesity. Scan revealed features of incomplete abortion. Patient was treated with misoprostol 1000mcg. Check scan was done a week later as patient did not expel the products & beta HCG levels didn't fall as expected. Beta HCG was 400mU/L from the initial value (500m U/L). As scan findings were not confirmative, MRI was done which showed right adnexal ectopic measuring 4x3cms with cardiac activity. Proceeded to laparotomy, on table hemoperitoneum 150ml was noted. Right salpingectomy was done. Post-operative period was uneventful.
2. Primigravida with history of one and half months of amenorrhea with pregnancy test positive was advised for a routine pelvic scan for confirmation of pregnancy & its location. Scan showed right sided ectopic pregnancy of 4x5x2cms with cardiac activity. On examination, patient was hemodynamically stable. Internal examination revealed right fornix fullness with no cervical motion tenderness. Proceeded with laparotomy, hemoperitoneum of 200ml noted. Right partial salpingectomy was done. Post-operative period was uneventful.
3. G<sub>3</sub>P<sub>2</sub>L<sup>2</sup> with history of one and half months amenorrhea with pregnancy test positive following tubal sterilisation 2years back with complaints of 2 syncopal attacks. On examination, pallor ++, pulse rate 120/minute conscious & oriented. Internal examination revealed a 6weeks gravid uterus with free adnexa & no cervical motion tenderness. Scan

## CASE REPORT

showed hemoperitoneum of 1000ml. Proceeded for laparotomy, left tubal ruptured ectopic noted with 1000ml hemoperitoneum. Left salpingectomy was done & blood transfusion was given. Post-operative period was uneventful.



Rupture site – left fallopian tube

4. G<sub>2</sub>P<sub>1</sub>L<sub>1</sub> with h/o history of one and half months amenorrhea with positive pregnancy test took MTP pills outside. Following consumption, she had bleeding for a day. Patient visited hospital for a scan. Internal examination revealed 6weeks gravid uterus with right fornix fullness & no cervical motion tenderness. Scan showed a right sided ectopic pregnancy. On examination patient was hemodynamically stable & proceeded with laporotomy & right salpingectomy done. Hemoperitoneum of 200ml noted. Post-operative period was uneventful.

**DISCUSSION:** Classically diagnosis of ectopic pregnancy is based on clinical history of amenorrhea with positive pregnancy test with or without slight vaginal bleeding. Unfortunately these findings are non-specific. The classical triad occurs in less than 50% of the cases. It is the leading cause of maternal mortality in the first trimester accounting for 10-15% of maternal deaths.<sup>1,2</sup> In a prospective case series, 50% of ectopic pregnancies were missed at initial presentation based on history & physical examination only. Furthermore, ectopic pregnancy is misdiagnosed in more than 40% of patients during initial emergency department visit.<sup>3,4</sup> Nonetheless, the diagnosis remains a challenge. The most common implantation site is the fallopian tube (95.5%), followed by ovary (3.2%) & abdominal (1.3%) sites.<sup>5</sup> Assessment of risk factors such as previous ectopic, use of IUCD, pregnancy following tubal surgery or PID or ART helps in early diagnosis. Ectopic pregnancy can have a varied outcome. Mostly, it remains dormant; however it can abort, rupture intra-abdominally or extend into broad ligament. There are no specific reliable clinical, sonological or biochemical markers that can predict its rupture.<sup>6</sup> It is imperative to consider overall clinical symptoms, investigations & general status of the patient

# CASE REPORT

before planning the treatment.<sup>7</sup> These cases highlight the need of high suspicion for the diagnosis for effective treatment and prevention of fatal outcome.

**CONCLUSION:** Early diagnosis and treatment of ectopic pregnancies prevents the damage incurred from rupture. Therefore, one should have high suspicion for the diagnosis of ectopic pregnancies even in absence of classical signs and symptoms to prevent mortality.

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