International Journal of
Science Inventions Today
www.ijsit.com
ISSN 2319-5436
Case Report

UNILATERAL RUPTURED TWIN ECTOPIC PREGNANCY WITH DERMOID CYST OF LEFT OVARY

*[1]Yadav Jyotsna and [2]Yadav Punita

Assistant Professor, Department of Obstetrics and Gynaecology, B.P. Koirala Institute of Health Sciences, Dharan, Nepal.

ABSTRACT

Primigravida 21 years at 5 weeks of pregnancy presented in the obstetrics emergency with acute pain abdomen with urine pregnancy test positive. On examination patient was grossly pale and abdominal guarding was present. Ultrasonographic findings suggestive of single embryo of 9 weeks and 5 days with no cardiac activity in right adnexa with mild hemoperitoneum likely to be ruptured ectopic pregnancy with left sided dermoid cyst. Intraoperatively there was ruptured tubal ectopic pregnancy with two fetuses fully formed for which right sided salphingectomy was done and left sided cystectomy was done for left side dermaid cyst with two liters of hemoperitoneum. Patient was discharged on second post operative day without any complications.

Keywords: Dermoid cyst, ectopic pregnancy, rare , ruptured,

INTRODUCTION

An ectopic or extrauterine pregnancy is one in which the blastocyst gets implanted anywhere other than the endometrial lining of uterine cavity. This is true for both singleton and multi-gestational ectopic pregnancies. Nearly 95 percent of the ectopic pregnancies implants in fallopian tube. Other sites are ovarian (3%), cervical (<1%), abdominal (1%). The incidence of ectopic pregnancy has been increasing over the past. There are multiple factors that contribute to the relative risk of ectopic pregnancy such as a history of tubal surgery, conception after tubal ligation, using fertility drugs and assisted reproductive technology , pelvic inflammatory disease, smoking, prior IUD use, history of infertility, multiple sexual partners.[1] Although quite rare, the incidence of twin ectopic pregnancies is estimated to occur in 1/125,000 pregnancies, and twin tubal ectopic 1/200 of ectopic pregnancies. It is a rare condition, first described in 1891 by De Ott.[2]

The early diagnosis make the clinicians decide to treat the patients in the appropriate way and contribute to the decrease in morbidity that has occurred. The present report describes a successful management of acute ruptured unilateral twin tubal pregnancy in a patient who had no risk factors for both ectopic and twin pregnancy.

CASE REPORT

A 21 year old female married for primigravida at ?5 weeks period of gestation referred from local health health centre in view of ruptured ectopic pregnancy presented to the emergency department of obstetrics and gynaecology of B.P. Koirala Institute Of Health Sciences with chief complaints of pain abdomen for eleven days intermitent increasing intensity for two days. There was no history of per vaginal bleeding, nausea, vomiting. No history of shortness of breath loss of consciousness, dizziness, dyspnea, chest pain. Normal bowel bladder habit as usual.

The patient was married for two years and had spontaneous planned conception. Her menstrual cycle was regular. There was no any significant personal, past, family, contraception history.

The husband was abroad for two years and had returned 2 months back to Nepal. The husband had no history of sexually transmitted disease or any significant past history.

On presentation to the obstetric and gynaecology department her general condition was fair. Vitals was stable. On general physical examination pallor was noted. On her systemic examination her respiratory and cardiovascular examination was normal. On her per abdomen examination on palpation tenderness and guarding was present. On per speculum os was closed and no bleeding seen and on per vaginum examination uterus size could not be assessed due to guarding and fornices were free and non tender and cervical tenderness was present.

On her laboratory reports her hemoglobin was 6.8gm/dl, other parameters were normal. On her ultrasonographical examination there was single embryo of 9 weeks 5 days period of gestation with no cardiac activity in the right adnexa with mild hemoperitoneum likely to be ruptured ectopic pregnancy with left adnexal cyst of 4.5 * 4.3 cm likely to be left dermoid cyst.

Patient was planned for emergency exploratory laparotomy and immediately shifted to operation theatre. Patient was operated under general anesthesia and emergency exploratory laparotomy was done. Intra-operatively there was two liters of hemoperitoneum and 500 ml of clots present. There was right tubal ectopic pregnancy with one fetus intact and the other floating outside the fallopian tube in the peritoneal cavity for which right sided salphingectomy was done on the right side. Left sided cystectomy was done for dermoid cyst. Right ovary was normal. Patient received one pint of blood intra-operatively. Then patient was sent to post-op ward and there patient received two more pint of blood in post –op ward. The patient was stable and was discharged on second post –op day. Patient followed up after two weeks with her histopathological report which stated ectopic pregnancy with left dermoid cyst.

DISCUSSION

The incidence of ectopic pregnancies has been increasing steadily over the past. Unilateral twin ectopic pregnancy is a rare condition. The classic clinical triad of ectopic pregnancy is pain, amenorrhea and vaginal bleeding. The incidence of ectopic pregnancies has been increasing since the 1970 AD.[3] Multiple risk factors which contribute to the incidence of ectopic pregnancy. In the present case, the conception was spontaneous without any risk factors and no any ultrasonograhy was done before the presentation.

The preoperative diagnosis of twin tubal pregnancy is difficult and potentially may lead to significant morbidity or mortality. The classic symptom triad of ectopic pregnancy is amenorrhea followed by vaginal bleeding and ipsilateral abdominal pain.[1] Based on the changing pattern amenorrhoea, pain abdomen and per vaginal bleeding of clinical presentation, the gynecologist should pay special attention in such suspected cases. All available methods of diagnosing the suspected cases should be used including ultrasonography and blood tests such as beta human chorionic gonadotropin (hCG) level.[1] Transvaginal ultrasonography has revolutionized in the diagnosis and clinical management of early pregnancy and gynaecological conditions and has become the method of choice for evaluating early pregnancy complications due to its high resolution.[4]

In the present case, transabdominal sonography was performed and the initial diagnosis was ruptured ectopic pregnancy with a single embyo. The serum hCG level was not tested. Therefore, the twin tubal pregnancy was not in mind. There is evidence that the hCG level of twin tubal pregnancies is higher than that of a singleton tubal pregnancy and surgical treatment of those cases is appropriate.

The pathogenesis of unilateral twin tubal pregnancy is not clear. Several factors are thought to contribute to the occurrence of ectopic pregnancy.

These include mechanical obstruction within the tube defects of the zygote itself or in the hormonal milieu. It is likely that the twin tubal ectopic pregnancy is also increased in patients treated by *in vitro* fertilization, but the conception in the present case was spontaneous. The unilateral twin tubal pregnancy cans occur spontaneously. Some investigators suggested that the larger cell mass of the fertilized twin zygote might cause retarded tubal transport along a damaged tube and result in tubal implantation. The zygosity of

twin in the present case was not studied. Most of the twin tubal pregnancies were thought to be monozygotic. In the past, there have been a few cases of twin tubal pregnancies diagnosed preoperatively.[5]

Almost all the reported cases were diagnosed retrospectively either by intraoperatively or histopathology. Over the years, the treatment of ectopic pregnancy has progressed from salpingectomy by laparotomy to conservative surgery by laparoscopy and more recently, by medical therapy .There are a few reports of successful laparoscopic management of ruptured tubal twin pregnancy and operative laparoscopic salpingostomy. The present case was not appropriate for that type of surgery because she was in an unstable hemodynamic condition. The emergency laparotomy is better for this situation to control the bleeding point from the ruptured site.

The present case underscores the need of early recognition and accurate diagnosis of twin tubal pregnancy, that may later grow larger and therefore, have a higher risk of rupture and increase chance of maternal morbidity and mortality.

CONCLUSION

A spontaneous unilateral twin tubal pregnancy can occur in patients who have no known predisposing factor. Early diagnosis has made this disorder amenable to appropriate treatment. Transvaginal sonography is the investigation of choice in the diagnosis.

Conflict of Interest: None.

Consent: Case Report Consent Form was signed by the patient and the original article is attached with the patient's chart.

REFERENCES

1. Williams Gynecology -3rd Edition. (FULL TEXT)
2. Rolle CJ, Wai CY, Bawdon R, Santos-Ramos R, Hoffman B. Unilateral twin ectopic pregnancy in a patient with a history of multiple sexually transmitted infections. Infect Dis Obstet Gynecol. 2006;2006:1–3. (PUBMED) (DOI)
3. Kakani A, Goel S, Shrivastava D, Shrivastava V. Unilateral Tubal Twin Ectopic Pregnancy: An Unusual Case. Internet J Gynecol Obstet. 2012;16(1):16–9. (DOI)
4. Vohra S, Mahsood S, Shelton H, Zaedi K, Economides DL. Spontaneous live unilateral twin ectopic pregnancy – a case presentation. Ultrasound. 2014;22(4):243–6. (PUBMED)
5. Report C. Case Report Rupture of Unilateral Twin Tubal Pregnancy. 2008;91(2):249–52. (DOI)